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Did the right to health get across the line? Examining the United Nations resolution on the Sustainable Development Goals

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ABSTRACT

Since the new global health and development goal, Sustainable Development Goal (SDG) 3, and its nine targets and four means of implementation were introduced to the world through a United Nations (UN) General Assembly resolution in September 2015, right to health practitioners have queried whether this goal mirrors the content of the human right to health in international law. This study examines the text of the UN SDG resolution, *Transforming our world: the 2030 Agenda for Sustainable Development*, from a right to health minimalist and right to health maximalist analytic perspective. When reviewing the UN SDG resolution's text, a right to health minimalist questions whether the content of the right to health is at least *implicitly* included in this document, specifically focusing on SDG 3 and its metrics framework. A right to health maximalist, on the other hand, queries whether the content of the right to health is *explicitly* included. This study finds that whether the right to health is contained in the UN SDG resolution, and the SDG metrics therein, ultimately depends on the individual analyst's subjective persuasion in relation to right to health minimalism or maximalism. We conclude that the UN General Assembly's lack of cogency on the right to health's position in the UN SDG resolution will continue to blur if not divest human rights' (and specifically the right to health's) integral relationship to high-level development planning, implementation and SDG monitoring and evaluation efforts.

Key messages

What is already known about this topic?

- The Sustainable Development Goals (SDGs) were introduced to the world by the United Nations (UN) General Assembly in September 2015. The 17 SDGs considerably expand the eight millennium development goal agenda of 2001, and importantly the SDGs are to be applied to all, everywhere, living in low-income, middle-income and high-income nations alike. Furthermore, the SDGs explicitly recognise the economic, social and environmental dimensions of sustainable development and need to leverage technological innovation for strengthening countries' performance measurement systems and statistical data.
- In the lead up to September 2015, there was advocacy in the global health landscape for the new health SDG to include the human right to health.

What are the new findings?

- This study reviews the text of the UN SDG resolution by applying a right to health minimalist and maximalist analytic lens, and finds that the inclusion of the right to health in the resolution depends on the individual analyst's subjective position.

Recommendations for policy

- The fact it is unclear whether the right to health is expressed in the UN SDG resolution reflects larger unanswered questions around the relationship between the right to health and global health and development policy and planning, as well as human rights and sustainable development implementation and practice more broadly.

INTRODUCTION

As discussion on health and development progressed at the United Nations (UN) Global Thematic Consultation on Health in the post-2015 Agenda in 2012,[1] so too did advocacy for the inclusion of the right to health in the Sustainable Development Goals (SDGs).[2] This article will explain why the right to health's inclusion in the UN resolution on the SDG agenda is important, as well as examine whether the right to health was incorporated in this resolution by UN Member States. This will involve reviewing the text of the UN General Assembly's 25 September 2015 resolution, *Transforming our world: the 2030 Agenda for Sustainable Development* (the UN SDG resolution),[3] from a right to health minimalist and right to health maximalist perspective. A right to health minimalist seeks to establish whether the content of the right to health is *implicitly* included in the UN SDG resolution document, focusing on SDG 3 (ensure healthy lives and promote

Goal 3. Ensure healthy lives and promote well-being for all at all ages

3.1 *By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births*
3.2 *By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births*
3.3 *By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases*
3.4 *By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and wellbeing*
3.5 *Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol*
3.6 *By 2020, halve the number of global deaths and injuries from road traffic accidents*
3.7 *By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes*
3.8 *Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all*
3.9 *By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination*
3.a *Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate*
3.b *Support the research and development of vaccines and medicines for the communicable and non-communicable diseases that primarily affect developing countries, provide access to affordable essential medicines and vaccines, in accordance with the Doha Declaration on the TRIPS Agreement and Public Health, which affirms the right of developing countries to use to the full the provisions in the Agreement on Trade-Related Aspects of Intellectual Property Rights regarding flexibilities to protect public health, and, in particular, provide access to medicines for all*
3.c *Substantially increase health financing and the recruitment, development, training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States*
3.d *Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks*

Figure 1 Content of Sustainable Gevelopment Goal 3.

well-being for all at all ages) (figure 1). A right to health maximalist queries whether the content of the right to health is *explicitly* included. This study finds that whether the right to health is contained in the UN SDG resolution, and the SDG metrics therein (the 17 goals, associated targets and means of implementation set out on pages 14–27 of that document), depends on the individual analyst's subjective right to health minimalist or maximalist leanings. Here, much will depend on the value apportioned by the individual analyst on the location of 'human rights' (*that must include the human right to health*) in the UN SDG resolution document. For instance, the central role human rights play in the SDG agenda and its achievement is especially emphasised in the first half of the UN SDG resolution, notably in the preamble and paragraphs 8, 10, 19 and 20.[3] On the other hand, human rights and the language of rights is substantially diluted in the SDG metrics in the same document. As the adage in international development circles is 'what gets measured gets done', the fact human rights are indeed marginalised from the SDG metrics is an inconsistency that will speak volumes to *some* right to health analysts.

The imperative for incorporating the right to health in the SDG framework

It will be difficult for governments to be held accountable for their SDG 3 policy commitments without cogent domestic right to health law and corresponding remedies. Therefore, sewing into SDG 3 a legal obligation to further press countries to implement the necessary

domestic policy changes and investment strategies to reflect the health goal's content is important. Express inclusion of the right to health in SDG 3 could add a legal safety net to catch and protect the most marginalised who would otherwise fall between the cracks of any global health and SDG policy.

A 'principal value add' of inserting the right to health in the SDGs would be one of accountability: 'Because it converts passive beneficiaries into claim[s] holders and states and other actors as duty-bearers that can be held to account for their discharge of legal, and not merely moral, obligations'.[4] The use of both legislation and litigation as strategic tools to hold governments and inter-related non-state actors accountable for their right to health and post-2015 health goal commitments is appealing as part of a broader public health advocacy strategy.[5–8] However, litigation is not the only tool at citizens and right to health advocates disposal; it should be the last resort.[8 9] As Forsythe states, 'the optimum situation is for legal standards to be internalised by individuals to such an extent that court cases are unnecessary'.[10]

Yet if SDG 3 is to have any bite, it needs *legal* teeth: 'Rights remove discretion from development and provide a framework of accountability'.[11] The right to health underpins global development policy, planning and implementation with a normative basis rooted in law, allowing development to become a process by which people can progressively realise their human rights. Thus, achievement of the content of SDG 3 by the international community of states (and their partners) between 2016 and 2030 should not be based solely on state commitments engendered by a SDG global health policy. Rather, UN Member State commitments must be combined with states obligations under international law, and complemented by the consequential government accountability mechanisms and legal remedies that surround this. It is the right to health in international law, liked or not,[12] which is the gold standard for health that all UN Member States have adopted (in some form) to respect, protect and fulfil.[13–15]

What is the right to health?

The right of everyone to enjoy the highest attainable standard of physical and mental health ('right to health') was introduced in the preamble of the WHO's Constitution of 1946.[16] The WHO Constitution 'was visionary in its understanding of both health, and health as a human right' because it 'recognised health as a complete state of physical, mental and social well-being and not merely the absence of disease or infirmity'.[17] Soon after, the right to health was expressed in Article 25 of the[18] Universal Declaration of Human Rights 1948 (UDHR) as 'a standard of living adequate for the health and well-being of everyone, 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 control'.[18] The contours of the right to health were next shaped almost 20 years later by the UN General Assembly in its adoption of the International Covenant on Economic Social and Cultural Rights 1966 (ICESCR). In that Covenant, Article 12(1) codifies the right to health as 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.[19] Through this pivotal UN resolution, the right to health now amounted to a binding legal provision in the domestic jurisdictions of state parties who ratified the ICESCR.

It was some 40-plus years later, in 2000, when the UN Committee on Economic, Social and Cultural Rights clarified in General Comment No. 14 that the right to health contained in Article 12 ICESCR included the right to timely and appropriate healthcare *and* underlying determinants of health, 'such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions and access to health-related education and information, including on sexual and reproductive health'.[20] The Committee further interpreted the right to health to contain four essential elements (availability; accessibility; acceptability; quality) and like all human rights, imposed on state parties three obligations to respect (do not obstruct), to protect (prevent third-party obstruction) and to fulfil (facilitate and provide) its terms. The Committee also clarified the meaning of state party 'core obligations' (to provide minimum levels of essential health and healthcare), and outlined how governments could 'progressively realise' this right for all citizens, especially those most vulnerable. As part of a country's 'core obligations', the Committee was unequivocal that this right's achievement depended on shared responsibility among developed and low- and middle-income countries and other actors for implementation.[20]

Minimalist versus maximalist analysis of the right to health in the UN SDG resolution

Returning to the formulation of the SDGs, as discussion grew around the content of the health and development goal from 2012, parallel argument burgeoned that universal health coverage (UHC) is the practical expression of the right to health in international human rights law.[21] Therefore, and in the context of the emerging SDG agenda, a right to health minimalist would argue that so long as UHC is incorporated in SDG metrics (eg, the goals, targets and indicators), then derogation from *explicit* right to health language within the SDG context is permissible because the right to health is still *implicitly* preserved via the inclusion of UHC. A minimalist could also argue if UHC is not the overarching goal that it should be/is sufficient if it is incorporated into SDG 3's targets or (at very least) indicators. A right to health minimalist might alternatively stress that the content of the final post-2015 health goal, its targets and indicators must reflect the content of General Comment No. 14 (ie, that the right to health must implicate access to health services and the underlying determinants of health).

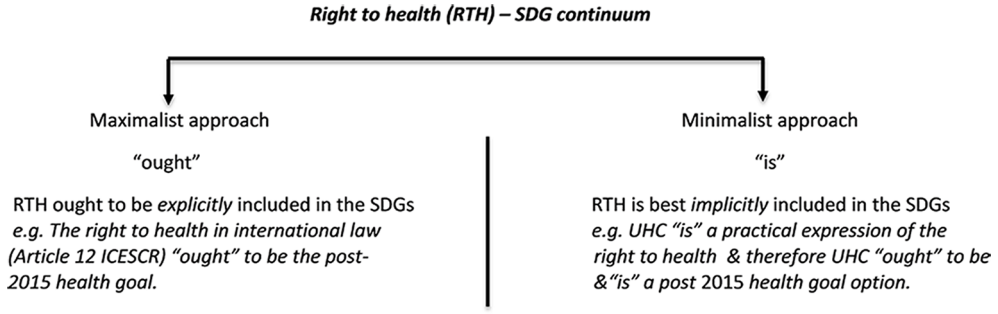

Figure 2 The right to health (RTH) maximalist and minimalist continuum. ICESCR, International Covenant on Economic Social and Cultural Rights 1966; SDG, Sustainable Development Goal; UHC, universal health coverage.

Conversely, a right to health maximalist would view the minimalist approach problematic because it presents a diluted version of the right to health. For the maximalist, the minimalist approach towards health in the SDG agenda does not adequately safeguard the right to health in international law.[22] Consequently, a right to health maximalist aligns with a 'black-letter law' approach: human rights are a set of *rules* that states have signed-up to.[23] In the SDG advocacy and policy-making environment, this means a maximalist might advocate for one of two things: either the right to health as prescribed in international law ought to expressly *be* the health SDG; or, there is no need for a health 'goal' when UN Member States *already have* global health goal(s) prescribed in well-established international human rights law. For a maximalist, derogation from right to health language is untenable, with the right to health viewed as holding primacy in policy and legal contexts and with the human rights established by international human rights law viewed as unquestionably universal in application. However, a right to health maximalist (pending where they sit on the right to health continuum in the SDG context, figure 2) might concede that if the right to health is not the overarching goal that this right should nonetheless be incorporated into the targets or (at the very least) indicators of the health goal.

Professor Alicia Ely Yamin used the maximalist/minimalist framing in 1996 to characterise two ways the right to healthcare as part of the right to health was appearing to be construed by the public health community at that time. According to Yamin, the minimalist advocacy position interpreted the right to healthcare as a right to medical care, while the maximalist position construed the right to healthcare 'more inclusively as the right to healthcare *and healthy conditions*'.[24] Use of the maximalist/minimalist construct in this study, however, occurs some 20 years after Yamin's, *and* after the release of General Comment No. 14 of 2000 (that clarified or overcame the tension underlying Yamin's maximalist/minimalist right to health dichotomy), *and* in the context of a very different debate. For these reasons, we do not critically compare the use of the maximalist/minimalist construct in this paper with that of Yamin's application two decades ago. In the author's view, this would be similar to comparing apples and pears and risks confusion. We note that Yamin in fact sought to 'step away' from this construct,[24] whereas we contend the right to health minimalist/maximalist prism resonates well with, and best frames, our analysis of the UN SDG resolution.

When the UN SDG resolution, a 35-page 91 paragraph document, is examined through a right to health minimalist and maximalist lens, *multiple* interpretations of the right to health's location within the SDG document are found. This is because neither the right to health minimalist/maximalist approaches are fixed, but shift depending on where the individual right to health minimalist or maximalist sits on the *continuum* of analytic perspectives regarding the issue, topic or document at hand. Consequently, our analysis of the UN SDG resolution found that depending on the right to health analyst's minimalist or maximalist position on the right to health-SDG continuum, the right to health has *multiple* and, indeed, *conflicting* framings in the UN SDG document.

UN SDG resolution reviewed through a right to health maximalist lens

The multiplicity of maximalist perspectives on the treatment of the right to health in the UN SDG resolution, and specifically within the content of the 17 SDGs found between pages 14 and 27 of that document, resulted in conflicting findings. For the legal purist sitting on the conservative outer edge of the maximalist right to health continuum, SDG 3 does not contain the right to health: the content of SDG 3 is completely devoid of express human rights language, including express incorporation of the right to health, and the right to health is otherwise not expressly incorporated elsewhere in the UN SDG resolution. Yet for those sitting midway on the maximalist side of the right to health continuum, the right to health might arguably be expressly incorporated in the UN SDG resolution via this document's larger embrace of international human rights law *that includes* the right to health. This is because the UN SDG resolution reiterates the association between human rights and the SDG agenda:

> "[The 17 SDGs and 169 targets are a] … new universal Agenda. They seek to build on the MDGs and complete what they did not achieve. They seek to realise the human rights of all… " (preamble).[3]

The SDG Declaration envisages a world 'of universal respect for human rights and human dignity, the rule of law, justice, equality and non-discrimination' (paragraph 8),[3] noting the new SDG agenda is:

> "Guided by the purposes and principles of the Charter of the UN, including full respect for international law. It is grounded in the UDHR, international human rights treaties, the Millennium Declaration and the 2005 World Summit Outcome. It is informed by other instruments such as the Declaration of the Right to Development" (paragraph 10).[3]

The UN SDG resolution again reinforces the centrality of human rights to SDG achievement:

> "We reaffirm the importance of the UDHR, as well as other international instruments relating to human rights and international law. We emphasise the responsibilities of all States, in conformity with the Charter of the UN, to respect, protect and promote human rights and fundamental freedoms for all…" (paragraph 19).[3]

> "…The achievement of full human potential and of sustainable development is not possible if one half of humanity continues to be denied its full human rights and opportunities" (paragraph 20).[3]

On account of the UN SDG resolution's preamble and paragraphs 8, 10, 19 and 20, the following argument supporting the intersection of human rights in the SDGs can be made by the right to health maximalist sitting midway on the continuum: human rights are prominent in the SDG agenda, they are integral to its realisation—the SDG agenda is a human rights agenda explicitly grounded in international law, and specifically laws espoused in international human rights treaties. According to the UN SDG resolution, sustainable development cannot and will not occur if human rights for all as established in international law, and especially the human rights of women and girls ('half of humanity') are not respected, protected and promoted (paragraph 20).[3] Therefore, international human rights law (which includes right to health law) permeates, and is fundamental to, the SDG document and realisation of the SDG agenda unanimously agreed by the UN Member States.

It is also important to illuminate that unlike the Millennium Declaration of 2000, the UN SDG resolution *contains* the 17 SDGs between pages 14 and 27 of that document. Inclusion of the goals, associated targets and means of implementation within the SDG text juxtapose the eight millennium development goals (MDGs) release a year after the Millennium Declaration in the annexure of a UN Secretary-General report. Hence, from a right to health maximalist perspective, there can be no quibble among UN Member States as to the authority of the 17 SDGs, nor the underpinning authority of international human rights law *because* the 17 SDGs are located in a UN General Assembly resolution.

UN SDG resolution reviewed through a right to health minimalist lens

Findings from the analysis of the UN SDG resolution through a right to health minimalist lens are far clearer than the vacillating findings arising from maximalist analysis. From a minimalist perspective, the right to health is implicitly incorporated in the SDG metrics. Again, however, a right to health minimalist analytic perspective, like its maximalist counterpart, is not a fixed polar view. One minimalist reading of the UN SDG resolution might conclude that the right to health is not effectively incorporated in the SDG agenda because UHC was not part of the headline global health goal, SDG 3. However, the majority of right to health minimalist analyses would find the UN SDG resolution does contain the right to health for one of two reasons, or both. First, the right to health could be found to be implicitly included in the UN SDG resolution because UHC achievement is a target in SDG 3.8: 'Achieve UHC, including financial risk protection, access to quality essential healthcare services and access to safe, effective, quality and affordable essential medicines and vaccines for all'.[3] Second, the right to health could be found to be implicitly included in the UN SDG resolution because Article 12 ICESCR's two elements of healthcare and the underlying determinants of health, as outlined by the ICESCR in 2000, are largely evident in the SDG metrics *more broadly*.[20] This overlap is shown in online supplementary table. Within this lengthy table, gender equality is included as part of the determinants of health in view of the nod towards the same in General Comment No. 14 (paragraph 10).[20] The expansive content of the table verifies the significant overlap of the right to health (per Article 12 ICESCR) with SDG metrics. In fact, right to health elements are identified in 16 of the 17 SDGs (ie, SDGs 1–16), and in 66 SDG targets. This means approximately 94% of the goals and 40% of the targets coalesce with the content of the right to health as prescribed by the UN Committee on Economic, Social and Cultural Rights in its General Comment No. 14 of 2000.

CONCLUSION

This study found that where the individual analyst sits on the right to health continuum in the SDG context will ultimately shape their conclusion on whether or how the right to health is present in the UN SDG resolution. The fact it is unclear whether the right to health is included in the UN SDG resolution reflects larger unanswered questions around the relationship between the right to health and global health and development policy and planning, as well as the broader relationship between human rights and sustainable development implementation and practice. For right to health practitioners, right to health *law* as opposed to global health *policy* will frequently be the preferential remedy to tackle health inequities and injustices experienced by minorities at domestic or international levels. This is because the pursuit of the right to health is not a matter of the ad hoc that is and can

be global health policy—but a matter of human rights law.[4 25 26]

If the MDGs are the litmus test, then it is reasonable to anticipate that as the SDGs are rolled-out in years to come, country focus will not be on achieving the content of the prologue of the UN SDG resolution and *its* human rights imperative. Rather, achievement of the neutrally worded SDG metrics framework, bereft of human rights discourse, will be the main focus for governments moving forward. Thus, implementing the SDG targets and indicators, and building countries performance measurement systems so as to facilitate states ability to measure, monitor and report on achieving their SDG numerical ambitions (*also* a goal of the SDG agenda), *will* be the priority of governments worldwide. This is the realpolitik of the sustainable development landscape within which right to health and other rights advocates will engage.

If anything, this study has highlighted that human rights (and the right to health in particular) risks exclusion from the frame of SDG *monitoring*. This is because human rights are marginalised from the language and content of the goals and targets. Following the position of the right to health minimalist in this paper, right to health advocates must thus be vigilant to ensure that the inference of rights in the SDG metrics can be maintained as the goals and targets are implemented in coming years. The incremental country achievements must be critically held by rights advocates against the framing of the UN SDG resolution's prologue, which is far more explicit with respect to the relationship of human rights to and in the 2030 Agenda. Otherwise not everyone, everywhere, will be counted and the marginalised, discriminated, poor, unwell and unhealthy at the heart of the SDG agenda may well likely become the Nobodies Left Behind.

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