

# Global Health and Human Rights

Legal and philosophical  
perspectives

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# 8 The World Health Organization, the evolution of human rights, and the failure to achieve Health for All

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## 1 Introduction

Human rights are heralded as a modern guide for public health. Cited by health advocates throughout the world, the human right to health – proclaimed seminally in the Universal Declaration of Human Rights (UDHR) and codified in the International Covenant of Economic, Social and Cultural Rights (ICESCR) as ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’ – has become a cornerstone of global health governance. As a normative framework for international public health, the right to health is seen as foundational to the contemporary policies and programs of the World Health Organization (WHO).

It was not always so.

This chapter traces the political history leading up to WHO’s invocation of human rights for the public’s health. With both the UDHR and WHO coming into existence in 1948, there was great initial promise that these two institutions would complement each other, with WHO – as a specialised agency of the United Nations (UN) – upholding human rights in all its activities. In spite of this promise, and early WHO efforts to advance a human rights basis for its work, WHO policy intentionally neglected the right to health during crucial years of its evolution, projecting itself as a technical organisation above ‘legal rights’.

Where WHO neglected human rights – out of political expediency, legal incapacity and medical supremacy – it did so at its peril. After 25 years of shunning the development of the right to health, WHO came to see these legal principles as a political foundation upon which to frame its ‘Health for All’ strategy under the Declaration of Alma-Ata. But it was too late: WHO’s constrained role in developing international human rights for health – specifically the transition from Article 25 of the UDHR to Article 12 of the ICESCR – had already set into motion a course for the right to health that would prove fatal to the goals of primary healthcare laid out in the Declaration of Alma-Ata (see Table 8.1).

This chapter evaluates the evolution of legal obligations for a human right to health, focusing on WHO’s role in developing these obligations. Scholars have reached contradictory conclusions as to WHO’s role in the advancement and

Table 8.1

<i>UDHR (1948)</i>	<i>ICESCR (1966)</i>	<i>Declaration of Alma-Ata (1978)</i>
<p>Article 25:</p> <p>(1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.</p>	<p>Article 12:</p> <p>1. The States Parties to the present Covenant recognize the right of everyone to the highest attainable standard of physical and mental health.</p> <p>2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of the right shall include those necessary for:</p> <p>(a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;</p> <p>(b) The improvement of all aspects of environmental and industrial hygiene;</p> <p>(c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;</p> <p>(d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.</p>	<p>I. The Conference strongly reaffirms that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.</p> <p>V. Governments have a responsibility for the health of their people which can be fulfilled only by the provision of adequate health and social measures. A main social target of governments, international organizations and the whole world community in the coming decades should be the attainment by all peoples of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Primary health care is the key to attaining this target as part of development in the spirit of social justice.</p>

implementation of human rights – finding either that WHO had an influential presence in the evolution of human rights for health (Alston 1979) or that public health and human rights always ‘evolved along parallel but distinctly separate tracks’, joined for the first time at the advent of the HIV/AIDS pandemic (Gruskin *et al.* 2007: 449). Both of these accounts, however, present an incomplete history of global health governance, disregarding the vital human rights leadership displayed by WHO in its early years, and the consequences that resulted from WHO’s subsequent renunciation of its authoritative role as a leading voice for health rights. Through legal analysis and historical narrative, this research examines WHO’s early contributions to and subsequent abandonment of the

evolution of health rights. While other studies have examined the treaty language of the right to health (Roscam Abbing 1979; Toebe 1999), no previous study has examined the underlying WHO communications that framed international treaty negotiations (Thomas and Weber 2004). Employing archival research to clarify these communications, it becomes possible to analyse the processes of global health governance in translating health discourses into international legal norms through the development of a human right to health.

## 2 The foundations of human rights for health

The international codification of a right to health begins in the context of the Second World War. On 6 January 1941, US President Franklin Delano Roosevelt announced to the world that the postwar era would be founded upon four ‘essential human freedoms’: freedom of speech, freedom of religion, freedom from fear, and freedom from want (Roosevelt 1941). It is the final of these ‘Four Freedoms’ – freedom from want – that introduced a State obligation to provide for the health of its peoples. Rising out of the cauldron of war, and drawing on working-class struggles of the late nineteenth and early twentieth centuries, this freedom from want became enshrined in the lexicon of social and economic rights, seeking State obligations to prevent deprivations such as had taken place during the Depression and the War that followed (United Nations Conference on Food and Agriculture 1943). Elaborated at a 1944 postwar planning conference among the Allied Powers, these social and economic rights would take form in the development of State obligations for human rights, providing binding mechanisms for assessing and adjudicating principles of justice under international law (US Department of State 1944).

The Charter of the United Nations (UN Charter) became the first international legal document to recognise the concept of human rights. While not initially enumerated or elaborated, States raised human rights as one of the four principal purposes of the nascent UN, which would ‘make recommendations for the purpose of promoting respect for, and observance of, human rights and fundamental freedoms for all’ (UN 1945: Art 62). During the drafting of the UN Charter, however, States did not initially include any mention of health, either as a goal of the UN or as a human right (*Lancet* 1945). But for the efforts of the Brazilian and Chinese delegations to the 1945 UN Conference in San Francisco – inserting the word ‘health’ in the UN Charter, finding international health cooperation to be among the purposes of the UN’s Economic and Social Council (ECOSOC), and advocating the establishment of an international health organisation – health would have received no mention in the creation of the UN, blunting the legitimacy of health in international law and the creation of WHO as a UN specialised agency (AJPH 1945). With this promise of international health and human rights cooperation in the UN Charter, it would fall to subsequent human rights treaties to codify a human right to health in international law.

In doing so, the rapid drafting and adoption of the Constitution of the World

Health Organization (WHO Constitution) would make it the first international treaty to find a unique human right to health. During an International Health Conference in June 1946, delegates adopted WHO Constitution pursuant to the UN Charter, thereby establishing an Interim Commission to subsume within WHO all of the prior obligations of the League of Nations Health Organization, the Office International d'Hygiene Publique (OIHP), and the Health Division of the United Nations Relief and Rehabilitation Administration (UNRRA). To achieve these ends, the International Health Conference established three organs through which to implement the goals of the new organisation: (a) The World Health Assembly, the legislative policy-making body of WHO, made up of representatives from each member state; (b) the Executive Board, an executive program-developing subset of the World Health Assembly; and (c) the WHO Secretariat, carrying out the decisions of the aforementioned organs through the elected Director-General and appointed WHO staff (WHO 1946). Recognising a necessity to facilitate international cooperation through global health governance, representatives of 61 States signed WHO Constitution on 22 July 1946, after which it remained open for signature until it came into force on 7 April 1948 (Goodman 1948).

In establishing the contours of a human right to health under WHO Constitution – a document far more extensive than those of its institutional predecessors (Masters 1947) – the Preamble declares that ‘the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being’, defining health positively to include ‘a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity’ (WHO 1946: Preamble). By expanding the mandate of international public health far beyond the ‘absence of disease’ envisioned by early international health treaties, the International Health Conference ‘extended [WHO] from the negative aspects of public health – vaccination and other specific means of combating infection – to positive aspects, i.e. the improvement of public health by better food, physical education, medical care, health insurance, etc’ (Štampar 1949). In meeting this expansive vision of underlying determinants of health, a vision commensurate with public health’s contemporaneous focus on ‘social medicine’ (Sand 1934), the Preamble declares that ‘governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate health and social measures’ (WHO 1946: Preamble). Under such far-reaching legal principles, WHO Constitution created a veritable ‘Magna Carta of health’ (Parran 1946: 2), ‘represent[ing] the broadest and most liberal concept of international responsibility for health ever officially promulgated’ and encompassing the aspirations of WHO’s mandate to build a healthy world out of the ashes of the Second World War (Allen 1950: 30).

Drawing on the negotiations for WHO Constitution, the UN proclaimed its UDHR on 10 December 1948, enacting through it ‘a common standard of achievement for all peoples and all nations’ (UDHR 1948). By defining a set of interrelated social welfare rights to underlie health, the nascent UN framed a right to health by which:

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

(UDHR 1948: Art 25(1))

In developing this right to a standard of living adequate for health, there was widespread international agreement that a human right to health included both the fulfillment of medical care and the realisation of underlying determinants of health – explicitly including public health systems for food, clothing, housing, and social services (UN 1950). This broad, rights-based vision of public health systems was in accordance with: (a) the expansion of European welfare policy, founded on the notion that ‘social security cannot be fully developed unless health is cared for along comprehensive lines’ (Beveridge 1942); (b) the development of human rights in the Americas, incorporating ‘the right to the preservation of . . . health through sanitary and social measures relating to food, clothing, housing and medical care’ (International Conference of American States 1948: Art XI); and (c) the Soviet Constitution, which established protections of medical care and ‘maintenance in old age and also in case of sickness or disability’ (Konstitutsiia SSSR 1936: Art 120). With this consensus on the underlying determinants of health, framed under the broad umbrella of ‘social security’, there was widespread expectation that this expansive declaratory language would soon be elaborated by specific human rights obligations.

### **3 The development of a right to health**

This narrative chronicles the political dynamics of WHO in the evolution of human rights for health, from the UDHR to the immediate aftermath of the Declaration of Alma-Ata. In the midst of WHO’s role in the codification of the 1948 UDHR in the 1966 ICESCR, WHO Secretariat walked away from its efforts to develop the international legal language of the right to health. When WHO sought to reclaim the mantle of human rights in the pursuit of its ‘Health for All’ strategy, its past obsolescence in rights-based strategies left it without the human rights obligations necessary to implement primary healthcare pursuant to the Declaration of Alma-Ata. In a chronological series of subparts, this research describes WHO’s early influence on human rights (1948–1953), subsequent neglect of human rights (1953–1973), and ultimate rediscovery of human rights as the basis of its ‘Health for All’ strategy (1973–1979) – with these time periods corresponding with successive changes in WHO leadership and direction.

#### **3.1 WHO influences human rights (1948–1952)**

From the moment of its inception, WHO sought to pursue dual policy paths in its work: an extension of previous coordination in international disease prevention;

and an ambitious rights-based project in national health promotion, implemented programmatically through medical interventions for curative care and public health systems for underlying determinants of health (*Lancet* 1948). In the aftermath of the Second World War, medical technologies – in the form of new physician practices, newly discovered scientific therapies and global epidemiologic surveillance – had created unlimited possibilities to extend and improve life. As articulated by Brock Chisholm, WHO's first Director-General, 'I strongly believe that with all the marvellous tools which modern science and medicine have put at our disposal, we could make tremendous strides towards the attainment by "all peoples of the highest possible level of health"' (Chisholm 1951: 25). Notwithstanding this moment of exultation for the observed 'miracles' of modern medical care, global health discourse continued to emphasise the importance of underlying determinants of health, focused on the relation between economic conditions and physical well-being (Ryle 1948). Adopting the term 'healthcare' rather than 'medical care' as the basis of health discourse, public health practitioners sought to acknowledge that the full development of health requires both insurance for medical services *and* underlying conditions for, *inter alia*, adequate nutrition, housing, education, and social security (Grant 1948). It is in this undercurrent of social medicine – this understanding of the limits of technological progress, and correspondingly, the importance of national public health systems to address underlying determinants of health – that WHO concerned itself with what it considered an 'inseparable triad' for public health – 'the interdependence of social, economic and health problems' (WHO 1952). To address these interdependent determinants of health, WHO sought to coordinate international health policy, with Member States finding that 'under the leadership of the World Health Organization, the various national and international programs have become, in a very real sense, a single, unified movement with a common goal and common methods of attaining that goal' (van Zile Hyde 1953: 605). With a synoptic view of underlying determinants of health and a predilection for collaborative effort to attain its multi-sectoral health goals, WHO Secretariat sought to work with the UN to develop human rights for health.

In fulfilling its global health mission through human rights frameworks, WHO's early years are marked by its active role in developing human rights treaty language, working with States and UN agencies to expand human rights principles for public health through the codification of the UDHR into legally-enforceable covenants, first in the draft International Covenant on Human Rights and subsequently in the ICESCR. Following WHO's preliminary initiative to advance the civil and political rights implicated by human experimentation (Commission on Human Rights 1950), ECOSOC's Commission on Human Rights would take up legal obligations concerning economic, social and cultural rights in its 1951 session, giving WHO Secretariat its first opportunity to influence the development of a human right to health. With the UN reaching out to WHO on collaborative opportunities with the Commission on Human Rights, Director-General Chisholm responded enthusiastically in January 1951, quoting from the preambular language of WHO Constitution and 'welcom[ing] opportunities to

co-operate with the Commission on Human Rights in drafting international conventions, recommendations and standards with a view to ensuring the enjoyment of the right to health' (WHO 1951a). To this cooperative end, Director-General Chisholm concluded that:

It is clear that the whole programme approved by the World Health Assembly represents a concerted effort on the part of the Member States to ensure the right to health . . . I am well aware of the obligation of WHO to be guided by this fundamental relationship in planning its work with governments as well as with other international organizations.

(WHO 1951a)

Based upon this general direction, WHO staff followed up on the Director-General's response by suggesting specific human rights treaty language well beyond the UDHR – on topics ranging from occupational health, to nutrition, to child welfare and maternal and child health clinics, to medical and nursing education and research, to international health policy (WHO 1951b).

To further this human rights cooperation, arrangements were made for WHO to direct negotiations on the right to health during the Commission on Human Rights' 1951 session (WHO 1951c). Having received notice of WHO's human rights initiative, the US Representative to WHO Executive Board wrote to the Director-General, expressing his scepticism toward the successful implementation of economic and social rights and his 'hope' that WHO recognise 'the problems inherent in attempting to draft enforceable rights for health services' (van Zile Hyde 1951). Overcoming this scepticism, WHO Secretariat suggested in April 1951 that the right to health should be couched in terms – drawn from WHO Constitution and language abandoned in compromises on the UDHR (UN 1950a) – that emphasised (a) a positive definition of health; (b) the importance of social measures as underlying determinants of health; and (c) the obligation of State health ministries for these underlying determinants:

Every human being shall have the right to the enjoyment of the highest standard of health obtainable, health being defined as a state of complete physical mental and social well-being.

Governments, having a responsibility for the health of their peoples, undertake to fulfil that responsibility by providing adequate health and social measures.

Every Party to the present Covenant shall therefore, so far as it [sic] means allow and with due allowance for its traditions and for local conditions, provide measures to promote and protect the health of its nationals, and in particular:

– to reduce infant mortality and provide for healthy development of the child;

- to improve nutrition, housing, sanitation, recreation, economic and working conditions and other aspects of environmental hygiene;
- to control epidemic, endemic and other diseases;
- to improve standards of medical teaching and training in the health, medical and related professions;
- to enlighten public opinion on problems of health;
- to foster activities in the field of mental health, especially those affecting the harmony of human relations.

(Commission on Human Rights 1951a)

The Commission on Human Rights met in June 1951 to draft legal provisions for – among other economic, social and cultural rights – the right to health (Commission on Human Rights 1951b). Director-General Chisholm opened this debate by challenging State delegates to define health in international human rights law, advocating adoption of the positive definition of health from WHO Constitution. In the shadow of his impassioned plea for health promotion, international consensus developed around WHO’s approach – providing simultaneously for the general recognition of a right to health in an opening paragraph with an enumeration of state obligations in subsequent paragraphs. Framed by WHO’s outline, the Commission on Human Rights concluded its session with the following draft right:

The States Parties to this Covenant recognize the right of everyone to the enjoyment of the highest standard of health obtainable.

With a view to implementing and safeguarding this right, each State party hereto undertakes to provide legislative measures to promote and protect health and in particular:

1. to reduce infant mortality and to provide for healthy development of the child;
2. to improve nutrition, housing, sanitation, recreation, economic and working conditions and other aspects of environmental hygiene;
3. to control epidemic, endemic and other diseases;
4. to provide conditions which would assure the right of all its nationals to a medical service and medical attention in the event of sickness.

(Commission on Human Rights 1951c)

Although States had reverted from the expansive vision of ‘complete’ health to the delimited ‘highest standard of health obtainable’, the revised draft of the right to health was the most detailed of the draft economic, social and cultural rights, placing explicit obligations on states to progressively realise underlying determinants of health through public health systems.

While a right to health lacked the support of medical practitioners (e.g. World Medical Association 1951), WHO Secretariat continued to engage in constructive UN debates to develop the normative language of this legal right. In doing so,

WHO leadership in health rights proved influential, as the UN Division of Human Rights drew upon WHO's background documents in subsequent drafts of the Covenant (UN 1951), highlighting WHO's policy leadership in its catalogue of UN human rights activities (UN 1952). With WHO Secretariat receiving broad authorisation from its Executive Board to develop human rights standards for health and to implement those standards through national health legislation and global health reports (WHO 1951d), WHO returned to the 1952 session of the Commission on Human Rights to assist in the finalisation of the language of the right to health.

When the 1952 session of Commission on Human Rights reached the right to health – now incorporated in the draft ICESCR (Commission on Human Rights 1952a) – State delegates presented and adopted the following amendments in line with WHO's original vision, expanding:

- the first paragraph to include the definition of health from WHO Constitution, and
- the second paragraph to replace the obligation of 'legislative measures' with all 'those necessary for' realising underlying determinants of health (Commission on Human Rights 1952b).

As a result, and in correcting a translation error to replace 'obtainable' with 'attainable standard of health,' the draft text of the article on the right to health was amended to:

The States Parties to the Covenant, realizing that health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, recognize the right of everyone to the enjoyment of the highest attainable standard of health.

The steps to be taken by the States Parties to the Covenant to achieve the full realization of this right shall include *those necessary* for:

- (a) The reduction of infant mortality and the provision for healthy development of the child;
- (b) The improvement of nutrition, housing, sanitation, recreation, economic and working conditions and other aspects of environmental hygiene;
- (c) The prevention, treatment and control of epidemic, endemic and other diseases;
- (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

(Commission on Human Rights 1952c)

With the Commission unable to complete its drafting of the human rights covenants before the end of the session, ECOSOC authorised States to revisit the covenants at the Commission's 1953 session (ECOSOC 1952). However, between

the 1952 and 1953 sessions, a change in leadership and health priorities would lead WHO to relinquish its leadership in health rights, and as a consequence, the right to health would be progressively weakened in the years to come.

### **3.2 WHO neglects human rights (1953–1972)**

As the UN sought to expand its treaty framework for human rights – beginning with the transition from the UDHR to the ICESCR, and then extending these rights outward through international conventions – WHO eschewed the development of health rights under international law. With WHO adopting a medicalised view of health, it shifted away from the development of national health systems for underlying determinants of health and toward the provision of individual medical treatments then thought to be singularly necessary for achieving the ‘highest attainable standard of health’ (Pannenberg 1979). Turning its attention to purely technical enterprises, which it approached through a medical lens, WHO sought a vertical, disease-specific approach to international public health (Brockington 1958). This technical agenda – under the leadership of Director-General Marcolino Gomes Candau – focused largely (a) at the domestic level, in assisting countries through specific requests for medical assistance; and (b) at the international level, in coordinating communicable disease eradication for the control of malaria, tuberculosis, plague, cholera, yellow fever and smallpox. As explained by WHO’s chief legal officer, ‘a programme based on the notion of priorities has given way to one based on the needs of the countries themselves, expressed through their requests for advice and assistance’ (Gutteridge 1963: 8). Rather than working with States to develop comprehensive public health systems, WHO Secretariat merely trained health ministries in medical techniques, with the new Director-General viewing WHO personnel simply as a ‘catalyst’, ‘who, working on projects, pass on to their national counterparts the skill and knowledge needed to attack a specific health problem’ (Candau 1957: 676). Thus, despite operating with more than triple its original staff and more than double its original funding, WHO’s programme agenda shifted away from its previous emphasis on global health priorities for the disadvantaged (which included noncommunicable diseases and underlying determinants of health), delegating programs to regional health offices and decentralising leadership for health policy within the UN system (Ascher 1952).

Under such a medical framework, there was little room for the utilisation of human rights to develop and implement social measures to realise underlying determinants of health. Despite an understanding from the UN General Assembly that specialised agencies would take responsibility for creating detailed definitions of the human rights principles within their respective fields of action, WHO took no specific actions to explain these broadly defined rights for health promotion. When the 1953 session of the Commission on Human Rights sought to finalise the language of the right to health in the ICESCR, WHO communicated previously produced technical documents, many of which had no bearing on human rights norms (Commission on Human Rights 1953).

When specialised agencies were again asked to submit detailed comments on their human rights reporting procedures, WHO responded with far fewer comments relative to other agencies, requesting only that simpler reporting procedures be instituted, based on the notion that few States submit WHO reports for the Secretariat then to summarise for the Commission on Human Rights (WHO 1953).

In the ensuing years, WHO did not respond to repeated requests for comments on final drafts of the ICESCR (UN 1954), enabling the weakening of health protections as States resurrected debates on the inclusion of (a) a definition of health, (b) the idea of ‘social well-being’, and (c) the ‘steps to be taken’ by States, with Director-General Candau responding repeatedly that WHO had ‘no comments to offer concerning the right to health’ (WHO 1955). When the finalisation of the right to health moved to the UN General Assembly in 1957 (UN 1957a), WHO had lost credibility to affect policy within the UN Secretariat or among State delegations. As delegates summarily eliminated the definition of health and the reference to ‘social well-being’ from the right to health – under the contradictory rationales that the definition was either unnecessarily verbose or irreconcilably incomplete – WHO personnel made no attempt to prevent these deletions (UN 1957b). In limiting the ‘measures to be taken’ by States, UN representatives removed obligations for underlying determinants of health, replacing ‘the improvement of nutrition, housing, sanitation, recreation, economic and working conditions and other aspects of environmental hygiene’ with the vague ‘improvement of all aspects of environmental and industrial hygiene’ (UN 1957c, 1957d). Abandoning its previous efforts to strengthen health rights, WHO took little part in the concluding debates relative to other specialised agencies, and no amendments were offered to expand the obligations of this enfeebled right. On 30 January 1957, the General Assembly approved the right to health, leaving it substantively unchanged until the December 1966 adoption of the ICESCR:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
  - (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
  - (b) The improvement of all aspects of environmental and industrial hygiene;
  - (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
  - (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

(UN 1957f: Art 12)

Although subsequent changes were made to strengthen other articles of the ICESCR, WHO made no additional comments on the right to health. Even once the ICESCR was completed, WHO claimed no ownership over the new Covenant's obligations on health, noting in meetings with UN staff that 'acceptance of WHO Constitution covers this matter fully in health terms and WHO could not press its Member States with respect to the covenants' (WHO 1972).

With States moving independently to adopt the ICESCR, WHO's continued silence on health rights in international law eliminated opportunities for health advocates to elaborate the scope and content of human rights in accordance with public health discourse, leaving this imprecise elaboration of the right to health as the seminal, final and definitive international legal obligation pursuant to this right. As seen in the following examples, WHO's neglect for human rights development continued to deny the right to health a place in evolving international legal frameworks:

- In 1959 debates on the Draft Declaration of the Rights of the Child, although the UN Secretariat welcomed WHO comments in the process, WHO representative to the Commission on Human Rights received instructions from WHO Headquarters to offer only 'general support' (WHO 1959a), leading the representative not to make any statement or offer any substantive comments (WHO 1959b).
- When the UN General Assembly began work in 1964 on a Draft Declaration on the Elimination of Discrimination against Women (UN 1964), WHO considered this to be outside its mandate, finding that the 'non-discrimination clause' in the Preamble of WHO Constitution did not refer to discrimination on account of sex (WHO 1964a) and responding that because it 'is not entrusted with responsibility for direct action to overcome such restrictions', it was 'not possible to derive from the work of WHO principles that might be incorporated into a draft declaration' (WHO 1964b).
- In developing a Convention on the Elimination of All Forms of Racial Discrimination in 1965, WHO responded dismissively that while legislation is outside its competence, its technical programs 'may be said to give effect to the principle of non-discrimination', blithely submitting that WHO's publications 'breathe a spirit of equality and are intended, by their universal treatment of many topics, by showing people as people wherever they may live, to help the advancement of human rights and the improvement of race relations' (WHO 1965). As a result, health discrimination and inequities in healthcare – while forming a contemporaneous impetus for Martin Luther King's invocation 'of all the forms of inequality, injustice in health care is the most shocking and inhumane' (Gordon and Assefa 2006: 697) – would not be a part of the international human rights debate.

In the midst of such non-cooperation in treaty development, WHO staff also engaged in a purposeful campaign to distance WHO from any UN responsibilities in implementing human rights (ECOSOC 1956), with Director-General

Candau's announcing to the UN beginning in 1957 that 'the Organization, not being entrusted with safeguarding legal rights, is not in a position to take a share in a report describing developments and progress achieved . . . in the field of human rights and measures taken to safeguard human liberty' (WHO 1957). Following over a decade of criticism by the Commission on Human Rights (WHO 1958a), with WHO requesting that the UN Secretariat not include a section on health in its human rights summaries (WHO 1958b), WHO then attempted to excise itself entirely from the human rights reporting process and measures of progress in the protection of human rights. Arguing that the UDHR dealt far more with 'social questions' than with health, WHO suggested that the UN would be the only appropriate reviewing agency for the UDHR, noting that 'the provisions contained in Article 25 of the Declaration, in their letter and spirit, go substantially beyond the competence of the World Health Organization' (WHO 1959c). With the UN declining to request future WHO comments on UN reports and WHO resisting all subsequent efforts to submit reports to the UN, the UN's 1968 review of specialised agency efforts in human rights includes only vague generalities on the right to health and includes the activities of every specialised agency except WHO (UN 1968a, UN 1968b).

### **3.3 WHO rediscovers human rights (1973–1980)**

Given changes in health discourse, WHO would return to the promise of international human rights standards as a means to realise an improved standard of global health. The perceived emergence of new threats – in the form of heart disease, cancer, labor migration and exploitation, drug addiction, overpopulation and environmental harms – was shifting public health toward an emphasis on socio-economic determinants of health (Rosen 1974). Through this appreciation of the systemic conditions that structure health inequalities, public health practitioners reengaged underlying determinants of health, drawing on theories of social medicine and recognising a 'need for a shift in the balance of effort [to] modification of the conditions which led to disease rather than from intervention in the mechanism of disease after it has occurred' (McKeown 1976: 179). Given a growing gap between what could be done and what was being done to address underlying determinants of health, scholars and practitioners began to examine national health systems – including political institutions and financial distributions – as moving health rights beyond the purview of the physician and the dominion of medical services (Evang 1973). With the failures of prominent disease eradication programs (e.g. the global malaria campaign) and successes of national health promotion systems (e.g. China's 'barefoot doctors'), WHO's health goals and technical documents would transition from a persistent faith in a disease-specific approach to health to an increased emphasis on comprehensive 'primary healthcare' – healthcare in addition to underlying social, political, and economic determinants of health (WHO 1973). In translating these public health discourses into international legal norms, WHO came to recognise that human rights could bind States to realise

primary healthcare. While a comprehensive approach to public health had long garnered technical support within WHO, only political support could bring these evolving health ideas to the fore of WHO policy (Brown *et al.* 2006). With health rights providing this political foundation, WHO – under Director-General Halfdan Mahler – would come to advocate for primary healthcare as a human right, and under its ‘Health for All’ strategy to primary healthcare, WHO would again take a leading role in developing health policy pursuant to a human right to health.

Concurrent with the expansion of the human rights movements, organisations and instruments, WHO sought to expand its influence by redefining its health goals to reflect human rights standards. Within the UN system, increased human rights coordination among specialised agencies buttressed WHO efforts, providing added collaborative opportunities for human rights advancement in health (UN 1974). After years of absence, WHO re-emerged in 1973 as a voice for social justice – at the Commission on Human Rights and in human rights seminars. In doing so, WHO leadership held out human rights as a force for health, using treaties, articles, and conferences to analyse the relevance of the right to health to public health practice and extolling human rights as a clarion call to the realisation of health for all.

WHO would embark on its ‘Health for All’ campaign as a means to advance primary healthcare, with specific public health targets to be achieved by the year 2000. Viewing health equity as a human rights challenge, Director-General Mahler noted as early as 1974 that ‘in the context of the universal human right to a socially optimal standard of individual physical and mental health . . . the very sophistication of today’s medical wisdom tends to prevent individual and community participation without which health often becomes a technological mockery’ (Mahler 1975). This argument was extended in WHO’s 1975 embrace of underlying determinants of health, wherein the Director-General’s Annual Report argued that ‘we must also remind ourselves that the urgent health problems of developing countries relate to poverty, to infection, to malnutrition and undernutrition, to lack of accessible potable water, and to multiple environmental hazards’ (WHO 1975).

Framing this rights-based vision of global public health around underlying determinants of health and reflecting the ‘basic needs approach’ of contemporaneous human rights scholars through programs to meet ‘basic health needs’ (Djukanovic and Mach 1975), WHO Secretariat advocated for primary healthcare as a human right, and under its ‘Health for All’ strategy, the WHO would again take a leading role in developing rights-based health policy.

This ‘Health for All’ strategy, defined by the World Health Assembly in 1977 and regarded as WHO’s ‘main thrust’ for developing the right to health (Taylor 1991), would seek ‘the attainment by all citizens of the world by the year 2000 of a level of health that would permit them to lead socially and economically productive lives’ (WHO 1977). In fulfilling this right through State obligations for primary healthcare, the World Health Assembly proclaimed government responsibility for ‘a complex of economic and social measures which directly

or indirectly promote the attainment of the highest possible level of health, through the establishment of a nation-wide system of health services' (WHO 1977). At the pinnacle of this WHO reengagement with human rights for underlying determinants of health, there was internal agreement that WHO had the constitutional authority to develop legal obligations for its 'Health for All' strategy (Vigne 1979), which it pursued through the 1978 Declaration of Alma-Ata.

With the 'Health for All' strategy providing rights-based policy reflective of public health discourse, the Declaration of Alma-Ata would provide international consensus for national primary healthcare systems consistent with WHO's vision of health and human rights. As WHO was participating for the first time in celebrations of the anniversary of the UDHR, as the ICESCR was entering into force, and as WHO was preparing its first progress report on the right to health (ECOSOC 1980), WHO and UNICEF convened an international conference to frame a human rights agenda for achieving WHO's 'Health for All' strategy (Taylor and Jolly 1988). To design the contours of this agenda – moving the human right to health from vertical hospital-based technologies to horizontal primary healthcare – WHO sought to bring together interdisciplinary public health and development actors to evaluate national health systems. With representatives from 134 State governments, this International Conference on Primary Health Care adopted the Declaration on Primary Health Care (a document that has come to be known as the 1978 Declaration of Alma-Ata), affirming that primary healthcare would be the key to addressing underlying determinants of health pursuant to the right to health.

Drawn from the rights-based language of WHO Constitution, Article I of the Declaration of Alma-Ata outlines that:

health, which is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector.

(WHO 1978)

To realise this right, the Declaration of Alma-Ata focuses on primary healthcare, from which it derives a collective right to

essential health care made universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and the country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination.

(WHO 1978)

In reifying the goals of WHO's 'Health for All' strategy, the Declaration of

Alma-Ata sought to narrow health inequalities within and between States, encouraging States to work toward establishing a New International Economic Order, and prioritising disadvantaged groups in achieving ‘equity-oriented targets’. Under this approach, the Declaration of Alma-Ata adopted a holistic view of underlying determinants of health, seeking social justice in the distribution of health resources in line with the interconnectedness of human rights in the realisation of public health.

From this definition of health as a human right, the Declaration of Alma-Ata found that realisation of the right to health requires ‘intersectoral’ government Policy in the social and economic sectors to achieve health equity. To frame programmatic obligations for addressing underlying determinants of health – creating a national system of primary healthcare based on individual and collective participation in the planning and implementation of health policy decisions – the Declaration of Alma-Ata promoted a reorientation of national health strategies to incorporate and fund public health in line with the needs of each nation. In framing these national health needs in the context of economic development, the Declaration expanded upon the provisions outlined in the ICESCR, enumerating specific rights-based government obligations for essential aspects of primary healthcare, including:

- (a) education concerning prevailing health problems;
- (b) promotion of food supply and proper nutrition;
- (c) an adequate supply of safe water and basic sanitation;
- (d) maternal and child healthcare, including family planning;
- (e) immunization against major infectious diseases;
- (f) prevention and control of endemic diseases;
- (g) appropriate treatment of common diseases and injuries; and
- (h) the provision of essential medicines

(WHO 1978: §VII).

Thus, despite giving flexibility to national policy based upon States’ varying stages of development, the Declaration of Alma-Ata guides States in creating health systems, emphasising underlying determinants of health rather than individual curative treatments (Leary 1993).

By laying out criteria for States in developing primary healthcare, and declaring these criteria to be human rights – rights that would have priority over other national goals – the Declaration of Alma-Ata presented a unifying framework for advancing public health under the aegis of the right to health (MacDonald 2008). Subsequent to the Declaration of Alma-Ata, WHO invited States in January 1979 to use the Declaration as the basis of national policies to meet the goals of ‘Health for All’ (WHO 1979). Yet, despite the development of the right to health in the Declaration of Alma-Ata, WHO’s past neglect of human rights had created insurmountable obstacles to the evolution of the right to health – obstacles that ultimately contributed to the failure of WHO’s ‘Health for All’ strategy and the abandonment of the Declaration of Alma-Ata.

#### **4 The failure of ‘Health for All’**

Where the human right to health did not reflect WHO’s expansive definition of health – with the right narrowed in the course of its evolution from underlying determinants of health to medical care – the ‘Health for All’ campaign would not find support in human rights frameworks. Without international law to support human rights obligations for underlying determinants of health, States could credibly find WHO’s ‘Health for All’ strategy, with a focus on social and economic development, to be beyond the purview of WHO’s organisational mandate (Starrels 1985). Although there existed a movement to implement the ‘Health for All’ strategy through primary healthcare, the obligations of the Declaration of Alma-Ata represented an illusory success for public health advocacy, with the Declaration failing to create sustainable frameworks for international health law and national health policy (Battista 1981).

When international legal frameworks moved from the UN system to international economic institutions at the end of the 1970s, there were no commensurate health rights in law to challenge these new institutional realities and prevent the collapse of the ‘Health for All’ strategy. With global health governance encumbered by neo-liberal economic policy, the Declaration of Alma-Ata suffered from medical reductionism in its obligations (Cueto 2004), reducing the breadth of primary healthcare to ‘selective primary healthcare’ (Walsh and Warren 1979). Steeped in the provision of medicine and health technology, this medicalisation of the right to health was incorporated into the 1981 WHO Global Strategy for ‘Health for All by the Year 2000’ (WHO 1981). Rather than proposing effective public health systems to facilitate underlying determinants of health, WHO focus would shift to ‘health services systems’ to address the provision of medical care (Roemer 1984). In this return to a focus on vertical health programming – through which international economic institutions sought efficient healthcare expenditure as a means to economic growth – developing States reduced health expenditures, and health inequalities widened (Horwitz 1983). By 1988, WHO conceded the impossibility of its initial primary healthcare goal, removing the language of ‘by the Year 2000’ from its ‘Health for All’ campaign (WHO 1988).

Despite WHO’s efforts to reclaim the legal standards of the right to health in its ‘Health for All’ strategy, rigid international legal paradigms leave human rights fixed in outmoded models of health, codified in weak international legal standards that cannot easily evolve to encompass underlying determinants of health. WHO Constitution envisioned an expansive role for human rights protection and promotion in realising the highest attainable standard of health, but WHO failed to live up to this role. Given WHO’s longstanding (a) reluctance to politicise health policy, (b) incapacity to create legal frameworks for health rights and (c) grounding in medical practice, these vicissitudes in institutional leadership for human rights ultimately limited WHO’s ability to carry out its public health mission under the right-based ‘Health for All’ strategy.

First, WHO had long sought to avoid politicising its public health work,

disengaging from national healthcare and global health policy debates where those issues presented international relations conflicts. Given the State welfare obligations inherent in a human right to health, the Cold War posed normative and budgetary challenges to the development of health rights in international law (Hoole 1976; Mingst 1990). Compounding these constraints, a decentralised structure prevented WHO Secretariat from creating uniform health policy, allowing national governments to manipulate WHO regional offices in the pursuit of short-term medical interventions rather than underlying determinants of health (Berkov 1957; Jacobson 1974). Despite the quixotic vision of a universal organisation devoted to achieving health equity through non-political policy, 'efforts to place health goals above power politics were pointedly rejected' (Lee 2009: 24). While some have faulted WHO for engaging in political advocacy under its 'Health for All' strategy (Siddiqi 1995), this narrative reveals that public health is inherently political, with WHO failing to achieve its health goals where these goals were not crafted in the political terms of human rights.

Second, in spite of WHO's efforts to concretise human rights through its 'Health for All' strategy, it was hobbled in these efforts by its inability to engage with the language of legal rights, set standards under international agreements or develop models for national legislation. The reticence of WHO Secretariat toward human rights – never developing personnel devoted to human rights or involving its legal staff in rights-based communications – limited WHO's contributions to human rights institutions and treaties (Taylor 1992; Lakin 2001). Even when WHO came to develop human rights principles under its 'Health for All' strategy, it did so ineffectually, engaging in superficial statements unsuited to the implementation of legal standards (Nielsen 1999). Where WHO had sought to address health issues in the absence of its constitutionally endowed legal authorities (Burr 1988), the inherent limitations of this approach became transparent in the failure to achieve rights-based reform through the Declaration of Alma-Ata, with legal advocates thereafter recognising the importance of international law and national health legislation to the creation of global health policy (Fuenzalida-Puelma and Connor 1989). While WHO possesses invaluable technical expertise in health, giving it preeminent legitimacy in developing public health standards to address underlying determinants of health, this history shows that WHO must be competent to frame these normative processes pursuant to legal frameworks if it is to bind States meaningfully to realise the right to health.

Third, WHO Secretariat elevated medical practice over health rights, finding that its pragmatic approach to selective medical care was incompatible with a rights-based approach to underlying determinants of health. Given ambiguities in the language of the right to health – ambiguities largely caused by a lack of WHO participation in the development of legal norms – the right to health was left open to shifting definitions on the very object of the right, with the medical establishment holding sovereign authority to define the policies necessary to realise health (Taylor 1991). As medical practitioners abandoned public health in the aftermath of the Second World War – a unique and

unrepresentative moment in the history of ideas surrounding health – WHO would institutionally support this medicalised agenda, with the right to health regressing to a right to the individual medical technologies and services then thought to be singularly necessary to bring about the ‘end of disease’ (King 1974). With its technical agenda long focused on the provision of medicines and the training of medical practitioners, WHO’s medical staff gave scant attention to underlying determinants of health under the Director-General’s ‘Health for All’ strategy (Litsios 2005). In implementing this strategy through the Declaration of Alma-Ata, WHO Secretariat would not concern itself with the human rights necessary to support an expansive public health approach to primary healthcare.

With these institutional impediments stymieing the evolution of a human right to health, WHO leaders could not bring States to accept their obligations for underlying determinants of health pursuant to the ‘Health for All’ strategy. Unlike other specialised agencies, WHO viewed its mission solely through a functional lens, and ‘[f]ulfilling its mandate was not done from a rights perspective nor with the aim of setting standards to be met by states’ (Jamar 1994: 45). Where WHO had focused on health as a set of functional problems rather than as a human right, it failed to achieve both, undercutting its own health goals by denying them a foundation in human rights norms. This enduring neglect for international legal approaches to health has led the right to health to fall from the UDHR’s promise of lexical rigidity to its current state of aspirational fluidity, rarely legislated or litigated to realise underlying determinants of health (Chapman and Russell 2002).

## **5 The enduring legacy of WHO neglect**

As a result of the medicalisation of primary healthcare and the downfall of WHO’s ‘Health for All’ strategy, a limited individual right to health – interpreted predominantly as a right to healthcare – has confined rights-based advocates to pressing for discrete medical services in response to problems demanding widespread change through public health systems. Given WHO’s abnegation of global health governance for human rights, this framework for the right to health has set up an obligation that few States can fulfil, and which has proven inadequate to addressing growing socio-economic disparities in underlying determinants of health (Meier and Mori 2005). With responsibility for the provision of health services passing to partnerships of public, private and not-for-profit actors, neither States nor international organisations are held to account under this atomised right to individual healthcare (Stuttaford 2004).

Following the fall of the Declaration of Alma-Ata – with the hegemony of the neo-liberal economic paradigm necessitating a return to the ‘Health for All’ strategy – WHO’s weaknesses in rights-based approaches to health have been most painfully felt by those in greatest need (Tarantola 2008). The neo-liberal economic paradigm – including policy prescriptions for privatisation, deregulation and decentralisation – has led to the dismantling of national health systems

and the reorienting of economic development to the detriment of public health, exacerbating health inequalities within and between countries (Chen and Berlinguer 2001). In the wake of neo-liberal economic reforms, exposing developing States to exorbitant national debt repayments and insalubrious structural adjustment programs, the broad definition of primary healthcare laid out in the Declaration of Alma-Ata has been replaced with one that focuses on curative interventions in the context of national health system retrenchment and reduced social welfare expenditure (McMichael and Beaglehole 2000). Rather than opposing this paradigm under the legal mantle of health rights, 'WHO has fallen victim to neo-liberal globalization' (Katz 2007), forced into public-private partnerships for individual healthcare instead of primary healthcare for the public's health (MacDonald 2005). Evincing this paradox between healthcare policy and underlying determinants of health, WHO's Director-General was left to concede that although '[n]ever have so many had such broad and advanced access to healthcare . . . never have so many been denied access to health' (Millen *et al.* 2000: 4).

Without access to international legal standards, WHO could be denied a seat at the development table, excluding it from the global socio-economic institutions most crucial to realising improvements in public health (Meier and Fox 2008). Given WHO's inability to apply human rights to reclaim global health governance and to alleviate the harmful ramifications of neo-liberal economic policies (Kirby 1999), health advocates, not accustomed to working with WHO to develop human rights norms, abandoned legal obligations for health, relegating themselves to the non-binding 'commitments' of the UN's Millennium Development Goals (UN 2000) and UNAIDS' and WHO's '3 by 5' programme for the distribution of HIV medications (WHO 2004). Yet these efforts, much like previous hortatory goals – celebrated in their creation but abandoned in their codification – have failed to achieve programmatic specificity and legal accountability, enabling further regression from the universal standards of 'Health for All'.

In the absence of WHO leadership for health rights, it has fallen to the UN's human rights institutions – the Committee on Economic, Social and Cultural Rights (CESCR) and Special Rapporteur on the Right to Health (UN 2003) – to do what WHO could not: interpret the right to health in an expansive way that would set legal standards for addressing underlying determinants of health. Given past WHO neglect in developing these legal norms under the right to health, such UN interpretations required an explicit acknowledgement of the 'dynamic definition of the right to health' (CESCR 1994: 7), and an attempt to reinterpret the right to health commensurate with evolving health discourses (CESCR 2000). To the extent that these UN efforts have faced criticism for exceeding the limits of their legal mandate for norm clarification (Gorove 2004), constraining these interpretations in influencing State health policy, these obstacles to international legal obligations for underlying determinants of health can be traced back to the foundations of WHO's ill-fated movement for health and human rights.

## 6 Conclusion

Only by appreciating the rich political history of WHO involvement with human rights are we able to recognise the squandered opportunities for WHO leadership in advancing a rights-based approach to health – and to learn from those lost opportunities. After decades without enforceable legal obligations under the right to health, with repeated criticism of WHO for its lack of human rights coordination, the UN's 'cross-cutting approach' to human rights has paved the way for WHO to mainstream human rights in its public health policies (UN 1997). WHO has only begun to institutionalise this cross-cutting approach, most prominently through the creation of its Department of Ethics, Trade, Human Rights and Health Law, which has collaborated with organisations, scholars, and advocates to advance consensus at the intersection of health and human rights. After a decade under this new UN approach, however, this WHO human rights department has faced attrition in its budget and prominence, and nascent WHO health policies have faced criticism for their disconnection from the path of human rights. As these challenges continue to confound rights-based approaches to health, WHO's 2008 World Health Report, 'Primary Health Care – Now More Than Ever', notes striking public health inequities within and between countries and calls for a return to the primary healthcare approach of the 'Health for All' campaign (WHO 2008). Given WHO's inconstant commitment to human rights, it remains to be seen whether WHO will adhere to this evolving rights-based imperative or revert to its previous institutional neglect of human rights for the public's health.

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