SDG 3: GOOD HEALTH AND WELL-BEING

A LEGAL GUIDE

This Legal Guide to the Sustainable Development Goals (SDGs) was first published by Advocates for International Development (A4ID).

Disclaimer

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About A4ID

Advocates for International Development (A4ID) was founded in 2006 with a clear vision – to see the law and the skills of lawyers used effectively to fight global poverty. Today, A4ID is the leading international, civil society organisation that harnesses legal expertise globally toward the achievement of the UN Sustainable Development Goals. Through us, the world's top lawyers offer free legal support to organisations that work to advance human dignity, equality and justice. A4ID currently works with 50,000+ lawyers, supports over 800 NGOs, has delivered over £45 million worth of legal advice and in the last year, has carried out work impacting 130 countries.

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Foreword

The SDG Legal Initiative

There are less than ten years left to achieve the targets of the 2030 Agenda for Sustainable Development. Advocates for International Development (A4ID) are taking active steps to ensure the achievement of this agenda by harnessing the law and the work of lawyers. The SDG Legal Initiative has been developed to do just that. It is more important than ever that lawyers use their skills to advance positive global change. The A4ID's SDG Legal Initiative aims to reach every lawyer in the world and provide them with the knowledge and opportunities to take practical action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity. The Initiative aims to build Thought Leadership, create Communities of Practice and Amplify the role of legal community in achieving the SDGs.

Legal Guide to the SDGs

This Chapter forms part of the world's first Legal Guide to the Sustainable Development Goals focussing on SDG 3- Good Health and Well-Being. This Guide has been published as part of the SDG Legal Initiative. It is as a unique resource providing a foundational analysis of the role the law can and should play in the achievement of the SDGs. Developed in collaboration with lawyers, academics and development practitioners, this Guide is made up of 17 chapters specific to each of the 17 goals. Each chapter provides an overview of the relevant regional, national and international legal frameworks that highlight how the law can be applied to promote implementation of the SDGs. The Guide also offers key insights into the legal challenges and opportunities that lawyers may encounter, and clear examples of the actions they can take to help achieve the goals.

Role of Law in Advancing Good Health and Well-Being

Good health is central to human happiness and well-being. Health is also instrumental to poverty reduction. Healthy populations live longer and are more productive, while poverty creates ill-health, depriving people of adequate food and clean water, forcing them to live in unhealthy environments and to work in dangerous conditions. Major progress has been made these past decades in improving the health of millions of people, increasing life expectancy, reducing maternal and child mortality and fighting against leading communicable diseases. However, progress has not been rapid enough with respect to some major diseases, such as malaria, or to reduce the financial barrier to access healthcare services. Moreover, new challenges have emerged, such as the globally growing burden of non-communicable disease, mental health disorders, and antibiotic resistance.

The COVID-19 pandemic is a powerful wake-up call for more international cooperation, not only to better coordinate the global response to health crises, but more generally to build affordable, universally accessible and quality health systems worldwide. The Sustainable Development Goals (SDGs), and particularly SDG 3, set specific targets to address these challenges and provide a comprehensive framework to achieve good health for all.

The role of law and lawyers in advancing good health and well-being is still underestimated or poorly understood.

The law is a powerful tool for implementing SDG 3 and advancing global health: from road safety to tobacco control or work safety, regulations can directly improve public health and laws are essential to design or improve a health coverage scheme that is truly universal (SDG target 3.8). The right to health, recognised as a human right by numerous legal instruments, should serve as a compass for health-related legal reforms to ensure that 'no one is left behind' when it comes to access to quality healthcare services and medicines. The principles of the rule of law must also ensure that, in times of health crisis, measures restricting freedom are taken by the competent authorities in accordance with the procedures laid down by law and without giving rise to unjustified discrimination. Yet, the role of the law and lawyers in advancing good health and well-being is still underestimated or poorly understood. With this Legal Guide to SDG 3, Advocates for International Development (A4ID) seeks to fill this gap.

Yasmin Batliwala

Chief Executive

Advocates for International Development

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The Sustainable Development Goals

The UN Sustainable Development Goals are a universal call to action to end poverty, protect the planet and ensure that all people enjoy peace and prosperity.

Also known as the Agenda 2030, the SDGs, set in 2015 by the UN General Assembly (Resolution 70/1) and adopted by all UN Member States, are intended to be achieved by the year 2030.

Compared to the Millennium Development Goals (MDGs), to which they succeed, the SDGs cover more ground, with ambitions to address inequalities, climate change, economic growth, decent jobs, cities, industrialisation, oceans, ecosystems, energy, sustainable consumption and production, peace and justice. The SDGs are universal and apply to all countries, whereas the MDGs were intended for action in developing countries only.

The 17 interdependent goals are broken down into 169 targets. At the global level, this agenda is monitored and reviewed using a set of 232 indicators. The Addis Ababa Action Agenda provides concrete policies and actions to support the implementation of the 2030 Agenda. Every year, the UN Secretary General publishes a report documenting progress towards the targets. The annual meetings of the High-Level Political Forum on sustainable development also play a central role in reviewing progress towards the SDGs at the global level.

At the national level, even though the SDGs are not legally binding, governments are expected to implement country-led sustainable development strategies, including resource mobilisation and financing strategies, and to develop their own national indicators to assist in monitoring progress made on the goals and targets.

SDG 17 stresses the importance of multi-stakeholder partnerships to achieve the goals. The mobilisation of governments, local authorities, civil society, and the private sector is needed to achieve the goals. Today, progress is being made in many places, but, overall, action to meet the SDGs is not yet advancing at the speed or scale required. 2020 must initiate a decade of rapid and ambitious action to deliver the SDGs by 2030.

Key terms

SDG 3: Ensure healthy lives and promote well-being for all at all ages

In the context of SDG 3, the key terms are defined as follows:

'**Health**': Health is a state of complete physical, mental and social well-being. It is not merely the absence of disease or infirmity. According to the Constitution of the World Health Organisation (WHO), 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.'[1]

'**Well-being**': Well-being is a multi-factorial concept that is based on the satisfaction of material, physical, affective and psychological needs. Physical and mental health is key to well-being. However, this also includes good living conditions (housing, education, employment, etc.).[2]

'**For all at all ages**': The WHO promotes a life course approach to health. Key stages in people's lives have particular relevance for their health. A life course approach studies the physical and social hazards during gestation, childhood, adolescence, young adulthood and midlife that affect chronic disease risk and health outcomes in later life. This approach also recognises the importance of the broader social, economic and cultural context. It promotes addressing the causes, not the consequences, of ill-health.

The concept of **universal health coverage** is also key for SDG 3 and is defined as 'all communities and all people receiving the services they need and being protected from health threats, whilst also ensuring that they are protected from financial hardship.'[3]

1 World Health Organisation (2006). Constitution of the World Health Organisation. [online] p. 1. Available at: http://www.who.int/governance/eb/who_constitution_en.pdf

2 Center for Disease Control and Prevention (2018). Well-being concepts. [online]. Available at: https://www.cdc.gov/hrqol/wellbeing.htm

3 WHO (2015). Health in the 2030 Agenda for Sustainable Development (11 December 2015). [online] p. 24. Available at: http://apps.who.int/gb/ebwha/pdf_files/EB138/B138_14-en.pdf

Overview of the targets

The protection of health was already at the heart of the development agenda under the Millennium Development Goals (MDGs) (2000-2015). Several of the goals were concerned with health, including MDG 4: reduce child mortality; MDG 5: improve maternal health; and MDG 6: combat HIV/AIDS, malaria and other diseases.

According to the WHO 2015 report on the MDGs, the MDGs have been successful in mobilising money and political attention towards health-related issues. The 2000-2015 period also saw an improvement in several health indicators.[4] However, 'many of the mechanisms established over the last 15 years have contributed to creating a competitive institutional landscape globally, with fragmented delivery systems at country level. The result is that competition for funds for one target over another, and for the limelight of public attention, too often outweigh collaboration on improving health as a whole'.[5] The MDG Report also acknowledges that ensuring healthy lives and well-being for all at all ages remains a global challenge.

Several of the SDGs' health-focused targets follow on from the unfinished agenda of the MDGs. Others derive from World Health Assembly resolutions and related action plans. Whereas the MDGs focused on the fight against specific diseases or the improvement of selected health indicators, the SDGs adopt a more comprehensive approach aiming at the strengthening of health systems. Target 3.8 which aims at achieving universal health care is a testament to this comprehensive approach.

SDG 3 goes beyond the promotion, development and protection of health and is intertwined with all other SDGs. The achievement of SDG 3 will therefore influence the fulfilment of other SDGs' targets and vice-versa. Access and use of quality healthcare services is only one factor affecting the health of individuals and communities. Whether people are healthy or not is also determined by the conditions in which they are born, grow, work, live and age. These conditions are known as 'social determinants of health'. The SDGs address many of these underlying determinants in the targets of SDG 3 itself, such as road safety, alcohol and tobacco use, and environmental pollution. They are also addressed in other goals and targets, including on poverty reduction (SDG 1); nutrition (SDG 2); education (SDG 4); gender equality (SDG 5); clean water and sanitation (SDG 6); access to energy (SDG 7); decent work (SDG 8); reduced inequalities (SDG 10); climate change (SDG 13); and peace, justice and strong institutions (SDG 16).

The achievement of SDG 3 will have a huge influence on the fulfilment of other SDG targets.

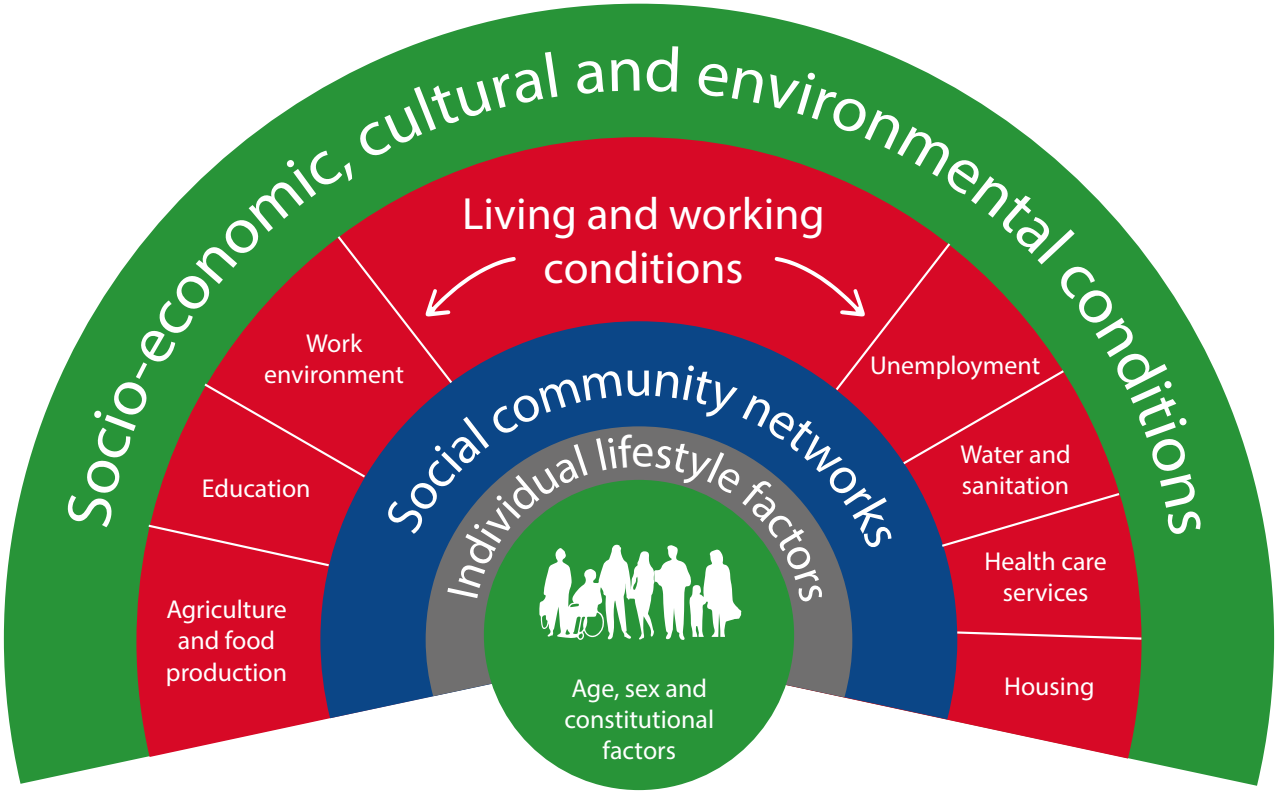
The WHO's Thirteenth General Programme of Work 2019-2023 covers all the main priorities of SDG 3.[6] Therefore, there is hope that the implementation of the SDGs will result in overcoming the fragmented character of the MDGs in relation to health.

4 WHO (2013). Monitoring the achievement of the health-related Millennium Development Goals. [online]. Available at: http://apps.who.int/gb/ebwha/pdf_files/WHA66/A66_13-en.pdf

5 WHO (2015). The SDGs: Reflections on the Implications and Challenges for Health. [online] p. 197. Available at: http://www.who.int/gho/publications/mdgs-sdgs/MDGs-SDGs2015_chapter9.pdf

For more details on global and regional progress made by States towards achieving SDG 3 and other health-related SDGs and targets, you can consult the report by the WHO Director-General on Implementation of the 2030 Agenda for Sustainable Development (2019).[7]

The Dahlgren-Whitehead Rainbow



This widely-used model, developed by Göran Dahlgren and Margaret Whitehead in 1991, maps the relationship between the individual, their environment and health. Individuals are placed at the centre and surrounded by layers of different influences on health.

6 WHO (2018). Thirteenth General Programme of Work, 2019-2023 (5 April 2018). [online]. Available at: http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_4-en.pdf?ua=1

7 WHO (2019). Implementation of the 2030 Agenda for Sustainable Development (6 May 2019). [online]. Available at: https://apps.who.int/gb/ebwha/pdf_files/WHA72/A72_11Rev1-en.pdf

By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births

Maternal mortality refers to deaths due to complications from pregnancy or childbirth. The global maternal mortality ratio declined by 44% between 1990 and 2015, from 385 to 216 deaths per 100,000 live births.[8] However, in 2017, nearly 300,000 women still died from complications relating to pregnancy and childbirth. Over 90% of them lived in low- and middle-income countries.[9] Achieving the SDG target 3.1 of less than 70 maternal deaths per 100,000 live births requires increased investment and attention. This could save more than one million lives over the course of a decade.[10]

8 WHO (2015). Maternal Deaths Fell 44% since 1990. [online]. Available at: https://www.who.int/news-room/detail/12-11-2015-maternal-deaths-fell-44-since-1990-un

9 The United Nations Department of Economic and Social Affairs (2019). The Sustainable Development Goals Report 2019. [online]. Available at: https://unstats.un.org/sdgs/report/2019/The-Sustainable-Development-Goals-Report-2019.pdf

10 Ibid.

By 2030, end preventable deaths of new-borns 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

The global under-five mortality rate has dropped from 77 to 39 deaths per 1,000 live births between 2000 and 2017.[11] To reduce these child deaths even further, greater focus must be on the first 28 days of life (the neonatal period), where achievements have not been as rapid. In 2017, the global neonatal mortality rate was reduced by 40% in comparison with 2000, from 30 to 18 deaths per 1,000 live births. To diminish this rate to less than 12 per 1,000 births by 2030, reductions need to accelerate.[12]

More than half the number of deaths in early childhood are preventable.

More than half of early child deaths are due to conditions that could be prevented or treated with access to simple, affordable interventions. Most of these deaths are concentrated in Sub-Saharan Africa.[13] Thus, this target requires action in the poorest parts of the world. If the SDG target for under-5 mortality is met, the lives of an additional 10 million children will be saved by 2030.[14]

By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, water-borne diseases and other communicable diseases

There has been important progress on increasing access to clean water and sanitation and reducing communicable diseases such as malaria, tuberculosis and the spread of HIV/AIDS. According to reports published by WHO, the global malaria mortality rate decreased by 47% between 2000 and 2013[15] and the global tuberculosis mortality rate fell by 21% between 2000 and 2017.[16] However, after more than a decade of steady gains against malaria, progress has stalled. No significant advances were made in reducing the number of malaria cases worldwide from 2015 to 2017.[17] According to the SDG Report, the global incidence of HIV among adults declined by 22% from 2010 to 2017, well short of the progress required to meet the 2030 target.[18]

11 The United Nations Department of Economic and Social Affairs (2019). The Sustainable Development Goals Report 2019. [online]. Available at: https://unstats.un.org/sdgs/report/2019/The-Sustainable-Development-Goals-Report-2019.pdf

12 The United Nations (2017). The Sustainable Develoment Goals Report 2017. [online] p. 20. Available at: https://unstats.un.org/sdgs/files/report/2017/TheSustainableDevelopmentGoalsReport2017.pdf

13 WHO (2017). Children: Reducing Mortality. [online]. Available at: https://www.who.int/en/news-room/fact-sheets/detail/children-reducing-mortality

14 WHO (2014). World Malaria Report 2014. [online] p. 1. Available at: https://www.who.int/malaria/publications/world_malaria_report_2014/report/en/

15 Ibid.

16 The United Nations Department of Economic and Social Affairs (2019). The Sustainable Development Goals Report 2019. [online]. Available at: https://unstats.un.org/sdgs/report/2019/The-Sustainable-Development-Goals-Report-2019.pdf

17 Ibid.

18 Ibid.

By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being

In 2015, the risk of dying between the ages of 30 and 70 from one of the four main non-communicable diseases (NCDs) – cardiovascular disease, cancer, diabetes or chronic respiratory disease – fell from 23% in 2000 to 19%, a rate too slow to meet the target in 2030.[19] NCDs have increased in low and middle-income countries, where currently 75% of the total global NCDs-related deaths and disability occur.[20] This threatens to 'overwhelm fragile health systems unless rapid investments are made in disease prevention and health promotion'.[21] Internationally, the fight against NCDs has not been funded on the same level as the fight against AIDS or other pandemics.

Promoting mental health was also introduced in the SDGs, marking the global recognition of its importance. People with mental disorders face disproportionately higher risk of disability and premature mortality. Mental, neurological and substance use disorders accounted for 13% of the total global burden of disease in 2004.[22] Mental health is also highly related to other aspects of well-being. For example, mental disorders frequently lead individuals and families into poverty.[23] Suicide is the second leading cause of death for 15-29-year-olds globally, and 79% of suicides happen in low- and middle- income countries.[24]

Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol

The harmful use of alcohol resulted in three million deaths worldwide in 2017.[25] In contrast to other health related issues under the SDG 3, this target refers to health issues largely faced by developed countries, as alcohol is consumed more heavily in wealthier countries.[26] In 2017, narcotic drugs had been used at least once by about 271 million people or 5.5% of the world's adult population, while problem drug users numbered at around 35 million. Compared to 2009, this shows an increase of 30% in the number of people who use drugs.[27] National surveys conducted in India and Nigeria revealed that there are many more opioid users and people with drug use disorders than previously estimated.[28]

19 The United Nations (2017). The Sustainable Development Goals Report 2017. [online] p. 6. Available at: https://unstats.un.org/sdgs/files/report/2017/TheSustainableDevelopmentGoalsReport2017.pdf

20 Alwan, A., Binagwaho, A., Debartolo, M., et al. (2019). The legal determinants of health: harnessing the power of law for global health and sustainable development. The Lancet, [online], Volume 393, p. 34. Available at: https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(19)30233-8.pdf

21 WHO (2015). Health in the 2030 Agenda for Sustainable Development. [online] p. 7. Available at: http://apps.who.int/gb/ebwha/pdf_files/EB138/B138_14-en.pdf

22 The Global Burden of Disease (GBD) provides a tool to quantify health loss from hundreds of diseases, injuries, and risk factors. GBD research incorporates both the prevalence of a given disease or risk factor and the relative harm it causes. Collected and analysed by a consortium of more than 3,600 researchers in more than 145 countries, the data capture premature death and disability from more than 350 diseases and injuries in 195 countries, by age and sex, from 1990 to the present. More info on: www.healthdata.org/gbd/

23 WHO (2019). Mental Health Action Plan 2013-2020. [online] p. 7. Available at: http://www.who.int/mental_health/action_plan_2013/en/

24 WHO (2019). Suicide. [online]. Available at: http://www.who.int/en/news-room/fact-sheets/detail/suicide

25 WHO (2018). Alcohol. [online]. Available at: https://www.who.int/news-room/fact-sheets/detail/alcohol

26 WHO (2019). Management of Substance Abuse: Alcohol. [online]. Available at: http://www.who.int/substance_abuse/facts/alcohol/en/

27 United Nations Office on Drugs and Crime (2019). World Drug Report. [online], pp. 7-8. Available at: https://wdr.unodc.org/wdr2019/prelaunch/WDR19_Booklet_1_EXECUTIVE_SUMMARY.pdf

28 Ibid.

By 2020, halve the number of global deaths and injuries from road traffic accidents

In 2013, approximately 1.25 million people died as a result of road traffic accidents, an increase of 13% since 2000. Approximately, 20-50 million more people suffered non-fatal injuries, leading to disability in many cases. According to the WHO, it was predicted that road traffic accidents would rise to become the 7th leading cause of death by 2030, if no action is taken.[29]

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.

In developing countries, about 19% pregnancies occur before the age of 18, and about 3% occur before the age of 15.[30] These figures can be reduced significantly through better access to modern contraception. In 2017, 78% of the girls and women of reproductive age worldwide, who were married or in a union, had their need for family planning satisfied. However, the global average masks wide regional disparities.[31] Currently, more than 60% of adolescents do not have access to modern contraception in Sub-Saharan Africa and Central and South-East Asia.[32] In most countries, comprehensive sexual education (CSE) programmes are unavailable even though they have been proved to delay sexual activity, reduce the number of sexual partners, increase condom or contraceptive use, and reduce sex-related risk-taking behaviour.[33]

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.

According to WHO, at the end of the year 2015, 400 million people globally lacked access to one or more essential health services. Additionally, 100 million people per year were pushed into poverty and 150 million suffered financial catastrophe because of out-of-pocket expenditure on health services. [34]

Access to health technology remains a major challenge, with new drugs being researched and produced but still

29 WHO (2015). Road Traffic Injuries Factsheet. [online]. Available at: http://www.who.int/mediacentre/factsheets/fs358/en/

30 United Nations Foundation (2015). Briefing Cards: Sexual and Reproductive Health and Rights (SRHR) and the Post-2015 Development Agenda. Universal Access Project [online]. Available at: https://www.msh.org/sites/default/files/srhr_post-2015_briefing_cards_v2.pdf

31 The United Nations (2017). The Sustainable Development Goals Report 2017. [online] p. 21. Available at: https://unstats.un.org/sdgs/files/report/2017/TheSustainableDevelopmentGoalsReport2017.pdf

32 United Nations Foundation (2015). Briefing Cards: Sexual and Reproductive Health and Rights (SRHR) and the Post-2015 Development Agenda. Universal Access Project [online]. Available at: http://www.universalaccessproject.org/wp/wp-content/uploads/2015/06/BriefCards_RH_6.30.2015.pdf

33 Ibid.

34 WHO (2019). Universal Health Coverage Factsheet. [online]. Available at: http://www.who.int/mediacentre/factsheets/fs395/en/

inaccessible to many. In a 2016 report, the United Nations Secretary-General's High-Level Panel on Access to Medicines noted that some of the barriers to accessing medicine and healthcare include under-funded healthcare systems, a lack of investment in developing qualified and skilled healthcare workers, deep inequalities within and between countries, discrimination, exclusion, stigma, and exclusive marketing rights to different medicines.[35]

Two indicators have been chosen to measure the progress towards universal health coverage:

i. the average coverage of essential health services
ii. the proportion of people covered by health insurance or a public health system

It is estimated that 18 million additional health workers will be needed by 2030 to attain effective coverage of the broad range of health services necessary to ensure healthy lives for all.[36] In addition, every 5 years, 1 billion more people will need to be covered by health insurance.[37]

"UHC is the centrepiece of the Sustainable Development Goal health targets. If countries choose to invest in making progress towards universal health coverage, they lay the foundation for making progress towards all the other health targets." – Dr Ghebreyesus, Director-General, The WHO

By 2030, substantially reduce the number of deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination.

According to the MDG Report, in 2015, 91% of the global population were using improved drinking water sources, compared to 76% in 1990. Since 1990, 2.1 billion people have gained access to improved sanitation.[38] But the number of deaths related to pollution remain alarming. In 2016, an estimated four million deaths were caused by household air pollution from cooking with unclean fuels and inefficient technologies. Additional 4.2 million deaths were attributed to ambient air pollution from traffic, industrial sources, waste burning and residential fuel combustion.[39] These environmental issues are also addressed under SDGs 13, 14 and 15 that tackle climate change, protecting life under water and life on land. Reaching this target represents a huge challenge, as it depends on complex environmental negotiations and often non-binding agreements.

35 United Nations Secretary-General High Level Panel on Access to Medicines (2016). Promoting Innovation and Access to Health Technologies. [online] p. 15. Available at: http://static1.squarespace.com/static/562094dee4b0d00c1a3ef761/t/57d9c6ebf5e231b2f02cd3d4/1473890031320/UNSG+HLP+Report+FINAL+12+Sept+2016.pdf

36 The United Nations (2017). The Sustainable Development Goals Report 2017. [online] p. 23. Available at: https://unstats.un.org/sdgs/files/report/2017/TheSustainableDevelopmentGoalsReport2017.pdf

37 Ghebreyesus, T. A. (2018). Draft Thirteenth General Programme of Work, 2019-2023: Promote health, keep the world safe, serve the vulnerable. [online] p. 7. Available at: http://apps.who.int/gb/ebwha/pdf_files/WHA71/A71_4-en.pdf?ua=1

38 United Nations (2015). The Millennium Development Goal Report 2015. [online] p.7. Available at: http://www.un.org/millenniumgoals/2015_MDG_Report/pdf/MDG%202015%20rev%20(July%201).pdf

39 The United Nations Department of Economic and Social Affairs (2019). The Sustainable Development Goals Report 2019. [online]. Available at: https://unstats.un.org/sdgs/report/2019/The-Sustainable-Development-Goals-Report-2019.pdf

Key actions lawyers can take

The final section of this chapter provides more details on how the international legal community can engage in efforts to achieve SDG 3. However, the following short summary describes some of the key actions you can take to contribute to the sustainable development agenda for universal good health and well-being.

Learn and educate

The multi-faceted links between the law and good health and well-being create a complex web of connections. In order to enact effective change, lawyers must first strengthen their understanding of the legal determinants of health, and in particular, of universal health coverage. Armed with this knowledge, lawyers can play a key role in promoting legal and policy reform to support the achievement of SDG 3.

Integrate

As employers, law firms should lead by example and ensure they foster a healthy working environment. Additionally, firms should align their practice with SDG 3. This extends beyond lawyers specialised in the healthcare and pharmaceutical sectors, to any policy and legal work related to, among other areas, market regulations, education, nutrition and urban planning. All lawyers should examine how their own practice intersects with public health and well-being and seek to use their expertise to enhance positive outcomes in the pursuit of SDG 3.

Act

The COVID-19 pandemic has revealed significant gaps in public health provision worldwide and offers lawyers the opportunity to use litigation as a tool to push governments to take greater strides towards more equal healthcare for all.

More broadly, law firms, corporate legal departments, judiciaries and barrister's chambers can partner with A4ID to provide pro bono legal services to governmental and non-governmental organisations dedicated to improving human health and well-being.

Elements of the international legal framework

The Universal Declaration of Human Rights (UDHR) and the International Covenant on Economic, Social and Cultural Rights (ICESCR) are the backbone of the right to health in international treaties. Alongside these two treaties, there are several other influential international instruments concerning health and well-being, some of which specifically address vulnerable groups.

Universal Declaration of Human Rights

Adopted by the UN General Assembly: 10 December 1948

The Universal Declaration on Human Rights (UDHR) is a landmark in the articulation and advancement of fundamental human rights and freedoms. In thirty articles, the UDHR sets forth a series of civil, political, economic, social and cultural rights. Although it was not intended to create legally binding obligations, the UDHR presents a common standard of achievement that is widely regarded as customary international law. Moreover, many of its provisions were later adopted in binding international human rights instruments.

Article 25 of the UDHR refers to health as part of the right to an adequate standard of living. This shows how closely health is related to other human rights. Other articles are relevant to health because they enshrine rights related to social determinants of health, such as social security (Article 22), work conditions (Article 23), and education (Article 26).

The Constitution of the World Health Organization

Adopted by the International Health Conference: 22 July 1946

Entered into force: 7 April 1948

Status of ratification (as of April 2020): 194 Parties

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.

The WHO Constitution first articulated the right to health as the right to the enjoyment of the highest attainable standard of physical and mental health. The preamble of the WHO Constitution defines health as 'a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'. It further provides that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.'[40]

40 WHO (2006). The Constitution of the World Health Organisation. [online] p. 1. Available at: https://www.who.int/governance/eb/who_constitution_en.pdf

International Covenant on Economic, Social and Cultural Rights

Adopted by the UN General Assembly: 16 December 1966

Entered into force: 3 January 1976

Status of ratification (as of April 2020): 170 Parties

The International Covenant on Economic, Social and Cultural Rights (ICESCR), drawing on the UDHR, affirms a series of human rights and encourages social progress. Legally binding on a large number of States, it indicates a wide consensus on economic, social and cultural human rights. However, several States have signed but not ratified the ICESCR, notably Cuba, Malaysia, Saudi Arabia, and the United States.

Article 2 of the ICESCR reflects a 'progressive realisation principle' imposing a duty on parties to 'take steps (...) to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant by all appropriate means'.[41]

Article 12 of the ICESCR recognises 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. It further provides that States must take the necessary steps with respect to child mortality and development; environmental and industrial hygiene; disease prevention and control; and medical services. Article 12 is to be understood based on the General Comments of the Committee on Economic, Social and Cultural Rights (CESCR), particularly General Comment 14 (2000) which focuses on Article 12 of the ICESCR (see below).[42]

Convention on the Rights of the Child

Adopted by the UN General Assembly: 20 November 1989

Entered into force: 2 September 1990

Status of ratification (as of April 2020): 196 Parties

The United Nations Convention on the Rights of the Child (CRC) is a human rights treaty which sets out the civil, political, economic, social, health and cultural rights of children. It defines a child as any human being under the age of eighteen, unless the age of majority is attained earlier under national legislation. Compliance is monitored by the UN Committee on the Rights of the Child. The CRC is the most widely ratified international human rights treaty. Notably, the United States is the only country in the world that has signed but not ratified this convention.

Article 24 recognises the right of every child to the enjoyment of the highest attainable standard of health. State parties shall submit regular reports on how the rights are being implemented, including the legislative, judicial, administrative or other measures they have adopted.[43]

41 Office of the High Commissioner for Human Rights (2000). CESCR General Comment No. 14:The Right to the Highest Attainable Standard of Health. [online] p.15. Available at: http://www.refworld.org/pdfid/4538838d0.pdf

42 Ibid, p. 15.

43 United Nations Human Rights Office of the High Commissioner (2015). Reports submitted by State Parties. [online]. Available at: http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=5&TreatyID=10&TreatyID=11&DocTypeID=29&DocTypeCategoryID=4

WHO Framework Convention on Tobacco Control

Adopted by the World Health Assembly: 21 May 2003

Entered into force: 27 February 2005

Status of ratification (as of April 2020): 181 Parties

The Framework Convention on Tobacco Control (FCTC) is an evidence-based treaty developed in response to the globalisation of the tobacco epidemic. The core demand-reduction provisions are contained in Articles 6-14, including price, tax and non-price measures to reduce the demand for tobacco. The core supply-reduction provisions are contained in Articles 15-17, including illicit trade in tobacco products, sales to and by minors, and provision of support for economically viable alternative activities.

States are required to submit regular reports on implementation, including the legislative, judicial, administrative or other measures they have adopted.[44] According to the 2018 Global Progress Report on Implementation of the FCTC, more than 90% of the States have implemented tax or price policies to discourage smoking and have banned smoking from all public spaces. However, many States indicated that financial resources available for national tobacco control do not match their needs. States of all income levels noted that interference by the tobacco industry and its allies was the most common challenge to overcome.[45]

Protocol to Eliminate Illicit Trade in Tobacco Products

Adopted by the Conference of Parties to the WHO FCTC: 12 November 2012

Entered into force: 25 September 2018

Status of ratification (as of April 2020): 58 Parties

The Protocol builds upon and complements Article 15 of the WHO FCTC, which addresses means of countering illicit trade in tobacco products, a key aspect of a comprehensive tobacco control policy.

The Protocol was developed in response to the growing international illicit trade in tobacco products, which poses a serious threat to public health. Illicit trade increases the accessibility and affordability of tobacco products, thus fuelling the tobacco epidemic. It also causes substantial losses in government revenues, and at the same time contributes to the funding of transnational criminal activities.

The Protocol aims to secure the supply chain of tobacco products through the establishment of a global tracking and tracing regime within five years of entry into force of the Protocol. The Protocol also covers important matters such as offences, prosecutions, sanctions, seizure payments, special investigative techniques, and the disposal and destruction of confiscated products.

44 WHO Framework Convention on Tobacco Control (2014). Global Progress Report. WHO, [online] p. 13. Available at: https://www.who.int/fctc/reporting/2014globalprogressreport.pdf?ua=1

45 WHO Framework Convention on Tobacco Control (2018). Global Progress Report. [online] p. 8 and 73. Available at: https://www.who.int/fctc/reporting/WHO-FCTC-2018_global_progress_report.pdf?ua=1

The International Health Regulations

Adopted by the World Health Assembly: 23 May 2005

Entered into force: 15 June 2007

Status of ratification (as of April 2020): 196 Parties

The purpose and scope of the International Health Regulations (2005) are 'to prevent, protect against, control and provide a public health response to the international spread of disease in ways that are commensurate with and restricted to public health risks, and which avoid unnecessary interference with international traffic and trade' (Article 2).

The entry into force of the revised International Health Regulations in 2007 was meant to be a public health landmark for the WHO and its Member States. The global community had a new legal framework to better manage its collective defences to detect disease events and to respond to public health risks and emergencies that can have devastating impacts on human health and economies. Each State Party has an obligation to notify the WHO of all events which may constitute a public health emergency of international concern within its territory (Article 6).[46] Since 2007, in application of Article 12, the WHO Director-General has declared six public health emergencies of international concern, the latest to date being the COVID-19 pandemic.

According to the IHR, each State Party shall develop and strengthen its capacity to respond promptly and effectively to public health emergencies. Annex 1 identifies the core capacity requirements that each State should meet. The WHO developed guidance on implementation of the IHR in national legislation to help countries to build such capacities.[47]

However, the WHO has been criticised after the West African Ebola outbreak in 2014 for what has been perceived as a delayed and inadequate response to the crisis. The COVID-19 pandemic aftermath will likely bring renewed scrutiny to the IHR and the role of the WHO in international public health emergency. Strengthening the capacity of all countries, particularly the developing countries, for early warning, risk reduction and management of national and global health risks should be a priority.

46 WHO (2005). International Health Regulations: Guidance on the Implementation of National Legislation. [online]. Available at: https://www.who.int/ihr/legal_issues/legislation/en/

47 Ibid

Convention on the Rights of Persons with Disabilities

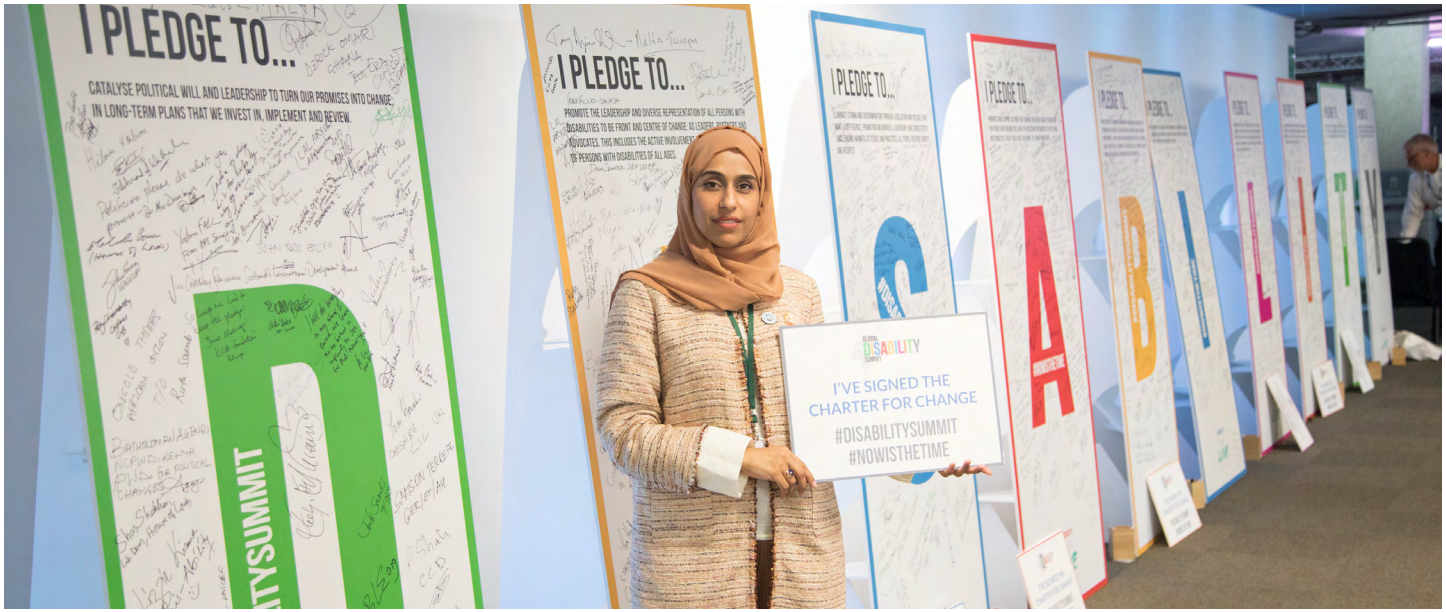
Adopted by the UN General Assembly: 13 December 2006

Entered into force: 3 May 2008

Status of ratification (as of April 2020): 181 Parties

The Convention on the Rights of Persons with Disabilities (CRPD) is a UN treaty intended to promote and protect the full and equal enjoyment of all human rights and fundamental freedoms by persons with disabilities. Article 25 of the CRPD provides that 'States Parties recognise that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination based on disability. States shall take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation.'

States are required to submit regular reports on how rights are being implemented, including the legislative, judicial, administrative or other measures they have adopted.[48] According to a survey conducted by the WHO, between 35% and 50% of people with serious mental disorders in developed countries, and between 76% and 85% in developing countries, received no treatment in 2015.[49] These statistics demonstrate that much still needs to be done to implement the Convention.



48 United Nations Human Rights Office of the High Commissioner (n.d.). Reports Submitted by State Parties. Available at: https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=4&DocTypeID=29

49 WHO (2018). Disability and Health Factsheet. [online]. Available at: http://www.who.int/mediacentre/factsheets/fs352/en/

Soft law and declarations

Declaration of Alma-Ata on Primary Healthcare (1978)

Adopted at the International Conference on Primary Health Care, the Alma-Ata Declaration of 1978 identified primary health care as the key to health for all. This Declaration is still considered as a major milestone in the field of public health. It affirms that, as the first level of contact with the national health system, primary healthcare should be the 'central function and main focus' of national health policies.[50]

CESCR General Comment No.14: The Right to the Highest Attainable Standard of Health (Art. 12) (2000)

Adopted by the Committee on Economic, Social and Cultural Rights in 2000, the General Comment No.14 interprets Article 12 of the ICESCR. The Comment identifies the legal foundations of the right to health, recognises the close relation of the right to health with other human rights, and adopts an extensive definition of the right to health, considering the importance of the social determinants of health. This is followed by details of the State Parties' obligations to guarantee the effectiveness of the rights to health in terms of availability, accessibility, acceptability and quality of health facilities, goods and services (para. 12). The Committee then elaborates on cross-cutting issues, such as non-discrimination and gender mainstreaming, and on the rights of specific vulnerable groups (women, children and adolescents, older persons, persons with disabilities, indigenous peoples). Since it clarifies the normative content of States' obligations to respect, protect and fulfil the right to health, the General Comment appears to be a useful interpretive tool in legal proceedings.

Political Declaration on HIV/AIDS: Intensifying our Efforts to Eliminate HIV/AIDS (2011)

This UN General Assembly Declaration notes the contributing factors to the spread of the HIV/AIDS epidemic, reaffirms a human rights approach to tackling HIV/AIDS and declares a commitment to take action. The 2011 Declaration follows on from the Political Declaration on HIV/AIDS adopted by the General Assembly in June 2006 and renews the Declaration on HIV/AIDS of June 2001, in which countries committed to provide universal access to HIV prevention, treatment, care and support services to all those in need by 2010.[51]

50 USSR (1987). Declaration of Alma-Ata: International Conference on Primary Healthcare (6-13 September 1978). Alma-Ata: World Health Organisation, [online] pp. 1-3. Available at: https://www.unaids.org/sites/default/files/sub_landing/files/20060615_hlm_politicaldeclaration_ares60262_en_0.pdf

51 United Nations General Assembly (2016). Resolution 60/262: Political Declaration on HIV/AIDS (15 June 2016). UNAIDS [online]. Available at: http://data.unaids.org/pub/Report/2006/20060615_HLM_PoliticalDeclaration_ARES60262_en.pdf

Countries also committed to adopting anti-discrimination laws to further protect those with HIV. According to the 2011 Report of the UN Secretary-General 'Uniting for universal access: towards zero new HIV infections, zero discrimination and zero AIDS-related deaths', the number of countries reporting anti-discrimination laws against people with HIV increased from 56% in 2006 to 71% in 2010.[52] The latest Declaration on HIV/AIDS sets forth new targets and calls for UN Member States to redouble their efforts to achieve universal access to treatment by 2015.

ILO Recommendation 202 on Social Protection Floors (2012)

The International Labour Organisation (ILO) Recommendation 202 provides guidance to Member States in extending social security coverage by prioritising the establishment of national floors of social protection accessible to all in need.[53] The Recommendation aims at the rapid implementation of basic social security guarantees that ensure universal access to essential health care and income security at a nationally defined minimum level. These guarantees should ensure at a minimum that, over the life cycle, all in need have access to essential health care and basic income security, which is in line with SDG 3, and especially SDG target 3.8.

52 Secretary General (2011). Uniting for Universal Access: Towards zero new HIV infections, zero discriminations and zero AIDS-related deaths (28 March 2011). United Nations General Assembly, A/65 [online]. Available at: http://www.unaids.org/sites/default/files/en/media/unaids/contentassets/documents/document/2011/20110331_SG_report_en.pdf

53 International Labour Office (2012). Recommendation 2020 concerning National Floors of Social Protection (30 May 2012). Geneva: International Labour Conference, 101st session [online]. Available at: https://www.ilo.org/wcmsp5/groups/public/---ed_norm/---relconf/documents/meetingdocument/wcms_183326.pdf

Regional legal and policy frameworks

African Union

Africa confronts the world's most urgent public health crisis. Despite marked improvements in health over the past decade, the life expectancy at birth for Africans is still fourteen years shorter than the mean global life expectancy.[54] This section summarises regional treaties of relevance to SDG 3 on health in Africa.

African Charter on Human and Peoples' Rights (1981)

The Organisation of African Unity, now replaced by the African Union, adopted the Charter on Human and Peoples' Rights in 1981 which formally entered into force on 21st October 1986. The Charter encompasses civil, political, economic, social and cultural rights.[55]

Article 16 recognises individuals' right to enjoy the best attainable state of physical and mental health. States are required to take the necessary measures to protect the health of their people and to ensure that they receive medical attention when they are sick.

The African Charter on the Rights and Welfare of the Child (1999)

The African Charter on the Rights and Welfare of the Child came into force on 29 November 1999. Like the UN Convention on the Rights of the Child, the African Charter is a comprehensive instrument that sets out rights and defines principles and norms relating to the wellbeing of the child. Article 14 specifically addresses children's right to health. Full implementation of this right requires measures to reduce the infant and child mortality rate, ensure the necessary medical assistance and health care of all children, as well as the provision of nutrition and safe drinking water.

States are required to submit periodic reports on their domestic implementation, including national legislation reformed or adopted for the purpose of implementing the right to health. According to the 2018 African Report on Child Wellbeing, the last few years have seen positive political advances for children at the continental level, with campaigns to eliminate harmful practices such as female genital mutilation and initiatives to combat violence against children. The past two decades have also seen a substantial increase in vaccination against deadly childhood illnesses and steady, albeit slow, progress in access to safe drinking water. However, child undernutrition still is a major area of concern,

54 WHO (2014). The African Regional Health Report 2014: The Health of the People. Regional Office for Africa [online]. Available at: https://apps.who.int/iris/bitstream/handle/10665/137377/9789290232612.pdf?sequence=4

55 African Commission on Human and Peoples Rights (1981). African Charter on Human and People's Rights (27 June 1981). Kenya: 18th Assembly of Heads of State and Government, CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982). [online]. Available at: https://www.achpr.org/legalinstruments/detail?id=49

along with the poor educational levels of Africa's children. Moreover, although there has been considerable progress in law reform, the lack of enforcement or poor implementation leads to continued high incidence of child marriage, child labour, and violence against children.[56]

The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003)

The African Protocol on Women's Rights, also known as the Maputo Protocol, came into force on 25 November 2005. Women's health is addressed under Article 14 which provides that the right to health of women, including sexual and reproductive health, shall be protected by States. This entails the obligation to take appropriate measures to provide adequate, affordable and accessible health services to all women. The Protocol has been signed and ratified by 40 countries, while an additional 13 have only signed it.[57] The Protocol on Women's Rights has received significant religious and cultural opposition since its adoption, focused on articles granting reproductive health access and condemning female genital mutilation.[58] Legislative and other measures undertaken for the full realisation of women's rights are included in the periodic reports submitted by States pursuant to the African Charter.

56 The African Child Policy Forum (2018). The African Report on Child Wellbeing 2018: Progress in the Child-Friendliness of African Governments. [online]. Available at: https://www.africanchild.report/

57 African Commission on Human and Peoples Rights (n.d.). Ratification Table: Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa. [online]. Available at: https://www.achpr.org/legalinstruments/detail?id=37

58 Human Life International (2011). The Fight Against the Maputo Protocol, Catholic and African Opposition, The Maputo Protocol. [online]. Available at: http://www.maputoprotocol.com/the-fight-against-the-maputo-protocol

Examples of relevant national legislation

At least 115 constitutions around the world have entrenched the right to health or health care,[59] whether as justiciable claim-rights, aspirational guarantees, or a combination of the two.[60]

India

The Constitution of India imposes a duty on the State to raise the level of nutrition and the standard of living, and to improve public health under Article 47. In 2018, the Indian government announced an ambitious health insurance programme that would provide up to INR 500,000 (US$ 7,800) per family to 100 million poor families and give half a billion citizens free health insurance.[61]

The Mental Healthcare Act of 2017 is an effort by India to legislate according to the UN Convention on the Rights of Persons with Disabilities to enhance the rights and services available to people living with mental illness. Mental illness has previously been a neglected area of healthcare in India with only 0.06% of the Indian health budget allocated to its services,[62] compared to 13% of the National Health Service budget in England.[63] The rights-based approach of the 2017 Act has received widespread praise and has been recognised as an inspiration for other States to follow. However, concerns remain related to resources and feasibility.[64]

59 Office of the United Nations High Commissioner for Human Rights (2008). The Right to Health: Factsheet No. 31. World Health Organisation, [online] p. 10. Available at: https://www.ohchr.org/Documents/Publications/Factsheet31.pdf

60 Young, K.G. and Lemaitre, J. (2013). The Comparative Fortunes of the Right to Health: Two Tales of Justiciability in Colombia and South America. Harvard Human Rights Journal, [online], 26, p. 179. Available at: https://harvardhrj.com/wp-content/uploads/sites/14/2013/05/V26-Young-Lemaitre.pdf

61 Doshi, V. (2018). India just announced a vast new health insurance programme. But can it afford it?. Washington Post, [online]. Available at: https://www.washingtonpost.com/world/asia_pacific/india-just-announced-a-vast-new-health-insurance-program-but-can-it-afford-it/2018/02/01/805efb46-0757-11e8-ae28-e370b74ea9a7_story.html?noredirect=on&utm_term=.6993b4077e58

62 Alwan, A., Binagwaho, A., Debartolo, M., et al. (2019). The legal determinants of health: harnessing the power of law for global health and sustainable development. The Lancet, [online], 393, p. 39. Available at: https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(19)30233-8.pdf

63 Duffy, R., Kelly, B. (2018). India's Mental Healthcare Act, 2017: Content, context, controversy. International Journal of Law and Psychiatry, [online], 62, p. 169. Available at: https://pubmed.ncbi.nlm.nih.gov/30122262/

64 Ibid

Philippines

In the Philippines, the right to health is protected under the Constitution. Article I Section 15 of the Constitution, provides that 'the State shall protect and promote the right to health of the people and instil health consciousness among them.'[65]

Article I Section 16 of the Philippines Constitution further provides that 'the State shall protect and advance the right of the people to a balanced and healthful ecology in accord with the rhythm and harmony of nature.'

Chile

Named after the journalist Ricarte Soto, who led a movement calling for effective healthcare coverage with a focus on high cost diseases, the Law 20850, adopted in 2015, creates a financial protection system for low-incidence and high-cost diagnostics and treatments.[66] It includes a set of explicit guarantees for patients diagnosed and treated for a rare disease.

Decisions to provide financial coverage of diagnosis, medicines, therapies and treatments involve health professionals, patients, and the Ministries for Health and Finance, based on elements of cost and clinical effectiveness as well as epidemiological data.

65 Constitutional Commission (1987). The 1987 Constitution of the Republic of the Philippines. [online]. Quezon City: National Government Centre, Section 15. Available at: http://hrlibrary.umn.edu/research/Philippines/PHILIPPINE%20CONSTITUTION.pdf

66 Ley Chile (2015). Crea un Sistema de Protección Financiera para Diagnósticos y Tratamientos de Alto Costo y Rinde Homenaje Póstumo a Don Luis Ricarte Soto Gallegos. Ministerio de Salud, Available (in Spanish) at: https://www.leychile.cl/Navegar?idNorma=1078148

Insights for the legal profession
a) Examples of relevant cases and legal proceedings

Health-related litigation is now commonly pursued in domestic courts on ground of negligence or medical malpractice, failure to provide adequate healthcare. Failure to make basic health care affordable for the most vulnerable, and refusal to provide emergency medical assistance. However, there are vast differences between States as to how enforcement through litigation is promoted.

Argentina

In Argentina, the number of health litigation cases is low, and the enforcement impact of such litigation is weak. The drinking water supply of the indigenous community of Paynemil had been contaminated with lead and mercury by a private oil company's operations. In Menores Comunidad Paynemil/ accion de amparo Expte. 311-CA-1997, an Appeal Court held that the right to health of the indigenous community, as protected by the Argentinean Constitution, had been violated by the State's neglect in remedying this situation. The Court explained its ruling as follows, 'even though the Government has performed some activities as to the pollution situation, in fact there has been a failure in adopting timely measures in accordance with the gravity of the problem.'[67]

67 ESCR net (n.d.). Menores Comunidad Paynemil, Accion de amparo, Expte. 311-CA-1997, Cámara de Apelaciones en lo Civil de Neuquén, Sala II [online]. Available (with a summary in English) at: https://www.escr-net.org/caselaw/2006/menores-comunidad-paynemil-saccion-amparo-eng

Colombia

In contrast, in Colombia, huge numbers of individual cases have been initiated, seeking remedies for claimed breaches of national laws protecting rights of access to health care. In these cases, the courts have strengthened the right to health in several respects. The State's obligation to provide access to health care for children, found in Article 44 of the Constitution, encompasses free vaccination programmes for children in the poorest areas. Health providers, both private and public, may be compelled to cover the costs of specialised overseas medical treatment of children under several conditions. Both public and private care institutions are required to make available free retroviral medications to adult HIV/AIDS patients who cannot afford them, even though the relevant medicines are not included in the free compulsory health plan. This range of cases led to systematic changes within the Colombian healthcare system. The Constitutional Court developed a special monitoring chamber to oversee the implementation of these judgments.[68] This case law, however, has largely favoured relatively wealthy claimants rather than the poorest.

Nigeria

The Social and Economic Rights Action Centre (SERAC) and the Centre for Economic and Social Rights (CESR) brought a case against the Nigerian government on behalf of the Ogoni people. The action was motivated by the state oil company's environmental degradation of Ogoniland and harm to local community through the reckless disposing of toxic wastes. These actions resulted in serious health outcomes.

The African Commission held that Nigeria had violated a wide range of rights of the Ogoni people. The Commission, stressing the intertwined characters of human rights, held that the environmental degradation caused to the Ogoni community, which led directly to human health problems, was a violation of Article 16 of the Charter.[69]

68 Yamin, A. E., Parra-Vera, P. (2009). How Do Courts Set Health Policy? The Case of the Colombian Constitutional Court. PLoS Med Journal, [online], 6(2). Available at: https://www.semanticscholar.org/paper/How-Do-Courts-Set-Health-Policy-The-Case-of-the-Yamin-Parra-Vera/80d96abf18b069599d61de3d7454fa821ad7e31d

69 African Commission on Human and People's Rights (2002). Social and Economic Action Rights Centre (SERAC) v. Nigeria Communication No.155/96. [online]. Available at: https://www.escr-net.org/caselaw/2006/social-and-economic-rights-action-center-center-economic-and-social-rights-v-nigeria

b) Legal context and challenges

Law and health

Although the nexus between law and health is often overlooked and sometimes poorly understood, law is a key determinant of health.[70] Laws establish the basis for organising, governing and financing a country's health system. They regulate the operation of hospitals and other health services, set the training and practice standards of health workers, regulate the safety and efficacy of medicines and medical devices, and protect patient rights. Beyond the healthcare system, laws exert a powerful influence on the underlying conditions known as the social determinants of health: education, food, housing, income, employment, sanitation, etc. Laws and policies can also address non-communicable disease risk factors, for instance by discouraging smoking or promoting healthy nutrition.

Domestic laws can be a powerful tool to promote public health and to ensure equity. However, when they are outdated or discriminatory, laws can represent major barriers to quality healthcare for all. When deficient, laws need to be reformed or adopted. In addition to recognising the right to health in national Constitutions, specific laws addressing healthcare and the social determinants of health need to be reformed or passed as well. Healthcare systems are complex and typically involve many public and private stakeholders, making legislative reform processes long and complicated, unaligned with the urgency. Moreover, legislative reform can be opposed by powerful stakeholders, including businesses and lobbyists. Even when strong legal frameworks are in place, achieving real progress requires governments to devote financial and other necessary resources. In some cases, general provisions are passed without reference to enforcement, monitoring, resourcing and the wider measures needed to deliver results. Specific institutions should be identified for implementing laws in order to promote efficiency in responsibility and accountability. More effort should be put on impact assessment of legislations, rather than emphasising legislative initiative per se.

Accountability and implementation of legislation are central to ensuring SDG 3 is achieved.

Law can also be a formidable to hold governments accountable. The justiciability of economic, social and cultural rights, as opposed to civil and political rights, has been controversial. However, today, it is generally accepted that all human rights are indivisible, interdependent, and interrelated.[71] This is reflected through the entry into force of complaints procedures for the ICESCR.[72]

While the right to health is recognised by numerous

70 World Conference on Human Rights (1993). Vienna Declaration and Programme of Action. Vienna: United Nations Human Rights Office of the High Commissioner [online]. Available at: https://www.ohchr.org/en/professionalinterest/pages/vienna.aspx

71 General Assembly (2008). Optional Protocol to the International Covenant on Economic, Social and Cultural Rights. [online]. Available at: https://www.ohchr.org/Documents/HRBodies/CESCR/OProtocol_en.pdf

72 United Nations Human Rights Office of the High Commissioner (2020). Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health. [online]. Available at: https://www.ohchr.org/en/issues/health/pages/srrighthealthindex.aspx

international instruments, it is subject to progressive realisation, which means that States have an obligation to 'move expeditiously and as effectively as possible, through concrete and targeted steps towards the full realisation of the right.[73] Adopted by the Committee on Economic, Social and Cultural Rights in 2000, the General Comment n°14 on the right to health provides a highly authoritative interpretation of the States' obligations to guarantee the effectiveness of the rights to health.

73 Barder, O. (2015). Addis: A Good First Step, but a Terrible Last Word for 2015. Centre for Global Development. [online]. Available at: https://www.cgdev.org/blog/addis-good-first-step-terrible-last-word-2015

The challenges to achieve SDG 3

The SDGs are integrated and indivisible: progress in one area is dependent on progress in many others. Health, understood as a state of complete physical, mental and social well-being, can only be achieved through a strengthening of health systems (SDG 3) as well as an improvement of all social determinants of health. Some synergies are well known, such as those that exist between health and education (SDG 4), gender equality (SDG 5), nutrition (SDG 2) and social protection (SDG 8). Other links may seem less direct but are not less important, for example the inverse relationship between health and inequalities (SDG 10) or the effects of climate change on communicable diseases (SDG 13). Transferring this vision into practical action is a key challenge for the Agenda 2030.

The MDGs were created in a global climate of optimism: the increased spending in development assistance seemed fruitful, and results were indeed reached. The global context surrounding the SDGs is very different: with economic austerity and rising inequalities in many developed countries, international development is no longer on top of the political agenda and public hostility towards aid increases.[74]

An unresolved question is how to better integrate short-term humanitarian aid and development assistance, as local health systems can be weakened by ill-defined emergency assistance.[75]

A challenge to the realisation of universal health coverage (UHC) is the need to dispel the many misinterpretations that exist surrounding it. These include concerns that providing universal health care to citizens would be too expensive, that such a system would end up depriving citizens of medical services through, for example, a shortage of doctors; and the idea that the private sector is better suited to providing efficient health care. The WHO has tried to dispel some myths around universal health coverage:

- UHC is not just health financing, it should cover all components of the health system to be successful: health service delivery systems, health workforce, health facilities or communications networks, health technologies, information systems, quality assurance mechanisms, governance and legislation.

- UHC is not only about assuring a minimum package of health services, but also about ensuring a progressive expansion of coverage of health services and financial risk protection as more resources become available.

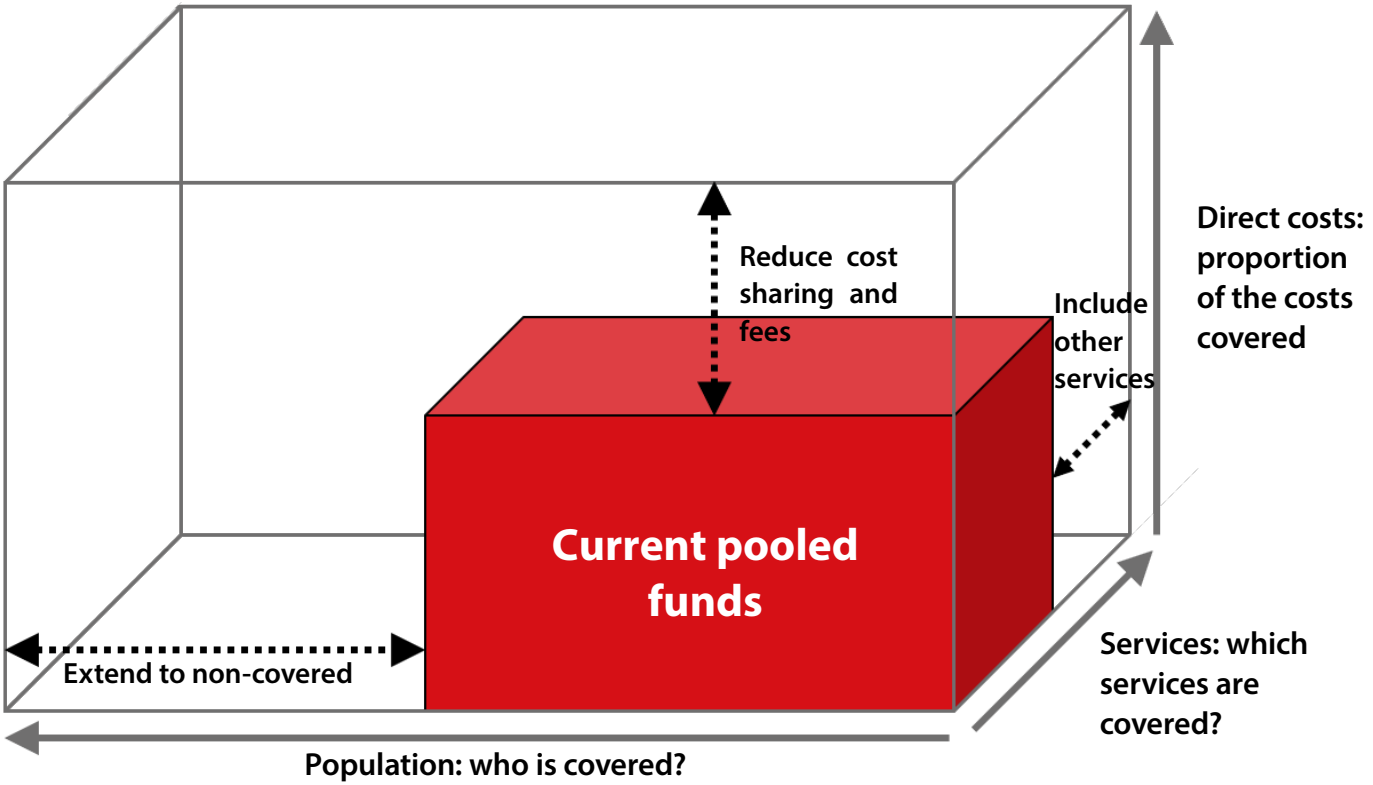
74 Barder, O. (2015). Addis: A Good First Step, but a Terrible Last Word for 2015. Centre for Global Development. [online] Available at: https://www.cgdev.org/blog/addis-good-first-step-terrible-last-word-2015

75 World Health Organisation Secretariat (2015). Health in the 2030 Agenda for Sustainable Development. [online]. Available at: https://apps.who.int/gb/ebwha/pdf_files/EB138/B138_14-en.pdf

- UHC does not mean free coverage for all possible health interventions, regardless of the cost, as no country can provide all services free of charge on a sustainable basis.
- UHC is comprised of much more than just health; taking steps towards UHC means steps towards equity, development priorities, social inclusion and cohesion.[76]

Advocacy efforts are currently ongoing to encourage adoption of the WHO Framework Convention on Global Health.[77] Grounded in the right to health, this legally binding instrument would establish a global health governance framework with clear obligations for States, robust standards, monitoring and enforcement. It is hoped that the treaty would help overcome challenges in global public health such as underfunding, fragmented policies, and lack of enforceability of the right to health.

Three dimensions to consider when moving towards universal coverage



76 WHO (2017). Universal Health Coverage Factsheet. [online]. Available at: http://www.who.int/mediacentre/factsheets/fs395/en/

77 Gostin, L. O., Friedman, E-A. (2013). Towards a Framework Convention on Global Health: a transformative agenda for global health justice. Yale J Health Policy Law Ethics, [online] 13(1), pp.1-75. Available at: https://www.who.int/bulletin/volumes/91/10/12-114447/en/

c) So, what can lawyers do?

This section highlights several avenues through which the legal community can build its understanding of the SDGs in general, and of SDG 3. It focuses on how lawyers can use this knowledge to improve their practice and share their learning with colleagues and clients (learn and educate). This section also examines ways that law firms and lawyers can integrate SDG 3 within their organisations, both in their internal operations and in their daily work (integrate). Finally, it recognises the broader opportunities for law firms to engage with SDG 3 through pro bono work, positive advocacy and community involvement (act).

The ideas put forward here are intended to kickstart a conversation about the role of the legal community in the realisation of the SDGs. A4ID's SDG Legal Initiative will continue to push this global conversation forward and create pathways of opportunity for lawyers, the development community, and academics.

Learn and educate

Lawyers can enhance their understanding of international public health and universal health coverage, along with policies and programmatic efforts to promote these at national and international levels. Substantial research and analysis are available, including resources that focus on SDG 3. The WHO portal provides essential information on how to create an enabling national legal environment for universal health coverage.[78] The reports of the Special Rapporteur on the right to health are also of particular interest for lawyers.[79]

Law firms and individual lawyers can get involved in activities to raise awareness on the right to health and the ways to implement it, such as publishing research papers and organising events (including legal clinics, seminars, panel presentations and international roundtables) on relevant legal topics. Strengthening legal literacy in the general population can also be instrumental in relation to the underlying determinants of health, such as obtaining social housing (SDG 1 and target 11.1); protecting or establishing land rights (SDGs 1, 5 and 11); establishing identity and citizenship (target 16.9) or preventing gender-based discrimination (SDGs 5 and 16).[80]

At the firm level, the managing and senior partners responsible for strategic decisions should review and familiarise themselves with the SDG 3 targets. Firms should identify the direct opportunities to positively contribute to achieving SDG 3, as well as the potentially negative or unintended impacts that the organisation could have on the targets and ways to mitigate these risks.

78 WHO (n.d.). Laws for Universal Health Coverage. [online]. Available at: http://www.who.int/health-laws/en/

79 United Nations Human Rights Office of the High Commissioner (n.d.). Annual reports of the Special Rapporteur on the right to health. [online]. Available at: https://www.ohchr.org/EN/Issues/Health/Pages/AnnualReports.aspx

80 United Nations Human Rights Office of the High Commissioner (2016). Report of the Special Rapporteur on the right to health and Agenda 2030. Available at: https://www.ohchr.org/EN/Issues/Health/Pages/AnnualReports.aspx

Integrate

The adoption of the SDG agenda provides impetus for law firms, corporate legal departments, law societies, chambers, and other law-related organisations to examine and re-align their own policies and practices.

In their internal operations and human resources management, law firms should be at the forefront of the promotion of good health and well-being. The legal requirements for healthcare coverage for employees will differ depending on where offices are based. However, beyond meeting basic legal requirements, law firms should ensure that all employees receive comprehensive healthcare benefits, including sexual and reproductive health services and mental health support. As employers, law firms should lead by example and provide healthy working environments. They should also promote a strong sense of well-being and healthy lifestyle habits through training, awareness raising events and campaigns, and counselling. Other schemes and policies, such as supporting childcare costs or a policy to support breastfeeding mothers, can positively impact on the health and well-being of employees.

Contributions to the SDG agenda must go beyond internal practices and should be reflected in core business operations. Alongside the public sector and civil society, the private sector has a fundamental role to play in the success of the SDGs. As legal advisors to companies all over the world, law firms are in a unique position to guide and influence business practices towards better sustainable development outcomes.

In the case of SDG 3, lawyers specialised in the healthcare and pharmaceuticals sectors can work to reduce their clients' potentially negative impacts on the SDG 3 targets and enhance positive outcomes in the pursuit of health and equity. This may include examining aspects of client advisory services, assessing the potential impact of transactions and investments, and implementing good practices.

Lawyers whose primary area of work lies outside the health sector can also play a significant role in contributing towards SDG 3 and the improvement of public health. Policies and laws related to market regulations, education, nutrition and urban planning, to name a few, can all impact health outcomes. Regulations on tobacco, alcohol and unhealthy foods are some examples where regulations have resulted in enhanced health.[81] Traffic regulations can also have a major impact on health outcomes. For example, evidence has proven that the introduction of laws on the use of seatbelts (and safety-helmets in the case of motorbikes) reduced fatalities and injuries from motor accidents.[82] Lawyers that do not directly engage in health-related legislation can therefore have significant impact on achieving SDG 3 by considering the indirect implications of their work on the health and well-being of employees, third-party suppliers, consumers and the general public.

81 Alwan, A., Binagwaho, A., Debartolo, M., et al. (2019). The legal determinants of health: harnessing the power of law for global health and sustainable development. The Lancet, [online], 393, pp. 34-36. Available at: https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(19)30233-8.pdf

82 Ibid

Act

Many law firms are working to make their pro bono work more strategic, collaborative and sustainable. By aligning their work with the SDGs, lawyers can be confident that they are taking practical steps towards a comprehensive and inclusive roadmap for sustainable development. This can help firms to establish and develop collaborative, cross-sector partnerships with other organisations that are working towards the same goals. When considering international pro bono, law firms should establish relationships with NGOs and local partners that can provide insight on the context and the national legal environment. Such partnerships will not only help to broaden the impact of the firm's pro bono work, but also ensure that it responds to the local context.

Developing a pro bono strategy with clearly identified goals enables firms to assess the effectiveness of pro bono work overtime and therefore increase its impact. The SDG framework offers law firms the opportunity to effectively measure and demonstrate their positive impact towards globally recognised goals. There is wide recognition that pro bono work, which is focused on progressing long-term goals and implemented in partnership with relevant organisations will lead to more sustainable results than ad hoc pro bono assistance.

The SDGs thus present a compelling opportunity for law firms, corporate legal departments and other lawyers to expand their pro bono legal activities domestically and abroad. In regard to SDG 3, law firms and lawyers can expand their pro bono work in several ways.

- Lawyers can actively participate in the legislative process to facilitate national implementation of SDG 3. Laws and regulations are a key lever for governments to affect the quantity, quality, safety and distribution of services in health systems. Legal frameworks can help countries to attain important health goals, including universal health coverage, implement health policies, and apply international health regulations.

- In some legal systems, the legislative process requires public consultation during which draft bills are open to public comments for a specific period. Individual lawyers, as citizens, can provide their input based on their expertise of the domestic legal system. Lawyers with experience representing clients in healthcare related cases might have more to contribute as they have gained a better understanding of practical obstacles preventing individuals from enjoying their right to health.

- Law firms and individual lawyers can also contribute to the implementation of SDG 3 by providing pro bono legal services to governmental and non-governmental organisations dedicated to improving healthy lives and human well-being. Lawyers can also provide pro bono services to individuals who cannot afford the legal costs to pursue their health-related rights where they have been violated.

- Law firms and lawyers can also provide legal support to patients' associations, which advocate for the rights and interests of patients.

- Discriminatory laws and practices can have a direct impact on the well-being of vulnerable groups. Pro bono legal services may help marginalised communities to secure access to health care or to seek remedy for violations of

their right to health. For example, poor people are often excluded from access to health services because they lack an official legal identity.[83]

- At the national level, and increasingly at the regional and global levels, judicial and quasi-judicial reviews are playing a role in supporting accountability for the right to health. Litigation can play a transformative role where the right to health has been violated. For example, in Africa, lawyers and law firms can make submissions to the African Commission on Human and People's Rights on behalf of individuals who have had their right to health violated by a State Party to the African Charter.[84] In order for such submissions to be accepted by the Commission, a prima facie violation of the right guaranteed under the African Charter must be alleged. Lawyers can use their legal analysis and drafting skills when preparing such communications.

Working collaboratively, A4ID has produced resources to guide law firms seeking to align their pro bono practice to the SDGs. [85]

83 United Nations Human Rights Office of the High Commissioner (2016). Report of the Special Rapporteur on the Right to Health and Agenda 2030. [online]. Available at: https://documents-dds-ny.un.org/doc/UNDOC/GEN/N16/250/84/PDF/N1625084.pdf?OpenElement

84 African Commission on Human and People's Rights (n.d.). Communications Procedure. [online]. Available at: https://www.achpr.org/communications

85 ROLE UK (2018). Pro bono and the Sustainable Development Goals: A guide for international law firms working with NGOs. [online]. Available at: https://www.roleuk.org.uk/resources/pro-bono-and-sustainable-development-goals-guide-international-law-firms-working-ngos

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