

A LIFE WORTH LIVING: ENFORCEMENT OF THE RIGHT TO HEALTH THROUGH THE RIGHT TO LIFE IN THE INTER-AMERICAN COURT OF HUMAN RIGHTS

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INTRODUCTION

In three recent decisions, the Inter-American Court of Human Rights has knocked a hole through the wall that has long separated civil and political rights from economic and social rights. Civil and political rights have been characterized as imposing “negative” obligations on states (e.g., the prohibition on torture) while economic and social rights impose “positive” obligations (e.g., the duty to provide housing). Whether the distinction between the groups of rights is appropriate has been vigorously debated.¹ But

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1. See generally Henry J. Steiner et al., *International Human Rights in Context* 263 (3d ed. 2008) (noting that the “official” position that the two sets of rights should be treated equally “masks a deep and enduring disagreement”

during the modern human rights era, civil and political rights have been broadly enforced while economic and social rights have often been given little more than aspirational lip service.²

The right to health, quintessential among the economic and social rights, was recognized shortly after World War II.³ Since that point, human rights systems have struggled, as they have with other rights imposing “positive” obligations, to find a workable standard for enforcing the right to health. Definitional ambiguity and the problem of limited governmental resources have led to murky treaty provisions often considered merely aspirational. Countries around the world have signed on to conventions protecting economic and social rights in addition to conventions protecting civil and political rights. Today, every country in the world is party to at least one treaty that explicitly protects the right to health.⁴ But with inadequate enforcement mechanisms—namely the lack of individual complaint procedures—the right to health remains the prototypical example of the failure of economic and social human rights to achieve their purpose.

The Inter-American Court of Human Rights is beginning to bridge the enforcement gap between negative and positive rights in the area of health and welfare. In *Yakye Axa Indigenous Community v. Paraguay*,⁵ *Sawhoyamaxa Indigenous Community v. Paraguay*,⁶

between those who consider economic, social and cultural rights fundamental and those who think they do not constitute rights at all).

2. See generally *id.* at 263–64 (noting that the position of most governments on social and political rights “has involved (a) support for the equal status and importance of [economic and social rights], together with (b) failure to . . . entrench those rights constitutionally, to adopt legislative or administrative provisions . . . or to provide effective means of redress to individuals or groups alleging violations of those rights”).

3. See *infra* notes 9–10 and accompanying text.

4. See Sophia Gruskin, *Is There a Government in the Cockpit: A Passenger's Perspective on Global Public Health: The Role of Human Rights*, 77 *Temp. L. Rev.* 313, 320 (2004) (arguing that, consequently, every country is bound by international law to protect health-related human rights).

5. 2005 Inter-Am. Ct. H.R. (ser. C) No. 125 (June 17, 2005) (holding that the state has a positive duty to protect dignified life, particularly in high risk, vulnerable communities).

6. 2006 Inter-Am. Ct. H.R. (ser. C) No. 146 (Mar. 29, 2006) (holding that the government must adopt positive administrative and legislative measures to ensure the Sawhoyamaxa community's right to life).

and *Ximenes-Lopes v. Brazil*,⁷ the Inter-American Court of Human Rights began enforcing the right to life, traditionally considered a “negative” right, in a way that closely resembles enforcement of the right to health, traditionally viewed as a “positive” right. The court had confirmed in an earlier case what many human rights advocates have been arguing for decades: “[T]he fundamental right to life includes, not only the right of every human being not to be deprived of his life arbitrarily, but also the right that he will not be prevented from having access to the conditions that guarantee a dignified existence.”⁸ The court took the idea that the right to life must be a right to a dignified life and began to enforce many elements of the right to health, finding violations even when victims did not die and requiring government provision of food, water, sanitation, medicine, and adequate medical care.

The right to life and the right to health are converging in the Inter-American Court’s protection of a “dignified life.” In Part I of this Article, we briefly describe the struggle to obtain recognition and adequate enforcement of the right to health. In Part II, we define the essential elements of the right to health. In Part III, we analyze the court’s three recent decisions showing how the groundbreaking “right to a dignified life” closely resembles the right to health and how this development creates a new enforcement mechanism for the right to health in the Inter-American system. Finally, in Part IV, we propose a working standard for identifying violations of the right to a dignified life based on the court’s jurisprudence and policy considerations. In the end, this right has become a vehicle to protect the right to health—or at least many elements of the right to health—and at the same time strengthens the notion of access to healthcare as a human right.

7. 2006 Inter-Am. Ct. H.R. (ser. C) No. 149 (July 4, 2006) (declaring that the state has a responsibility to protect life and personal integrity and to regulate and monitor available healthcare).

8. Case of the “Street Children” (Villagrán-Morales et al.) v. Guatemala, 1999 Inter-Am. Ct. H.R. (ser. C) No. 63, ¶ 144 (Nov. 19, 1999); cf. Hum. Rts. Comm., *General Comment 6, Art. 6, The Right to Life*, ¶ 5, U.N. Doc. HRI/GEN/1 (Apr. 30, 1982) (“[T]he right to life has been too often narrowly interpreted. . . . [T]he protection of this right requires that States adopt positive measures. . . . States parties [should] take all possible measures to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics.”).

I. PAPER PROMISES AND THE RIGHT TO HEALTH

The right to health was conceptually born and internationally recognized in the late 1940s. In 1946, the parties to the Constitution of the World Health Organization enshrined the right to health: “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being”⁹ Two years later, the United Nations General Assembly adopted the right to health as part of the Universal Declaration of Human Rights: “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”¹⁰ Numerous treaties have since incorporated the right to health. They include the 1966 International Covenant on Economic, Social and Cultural Rights (ICESCR),¹¹ the 1966 International Convention on the Elimination of All Forms of Racial Discrimination,¹² the 1981 Convention on the Elimination of All Forms of Discrimination Against Women,¹³ the

9. Const. of the World Health Organization pmbl., *opened for signature* July 22, 1946, 62 Stat. 2679, 14 U.N.T.S. 185, 186 (entered into force Apr. 7, 1948).

10. Universal Declaration of Human Rights, G.A. Res. 217A, art. 25(a), U.N. GAOR, 3d Sess., U.N. Doc. A/810 (Dec. 12, 1948) [hereinafter Universal Declaration].

11. International Covenant on Economic, Social and Cultural Rights, *opened for signature* Dec. 16, 1966, art. 12, 993 U.N.T.S. 3, 8 (entered into force Jan. 3, 1976) [hereinafter ICESCR] (recognizing “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health” and obligating steps to reduce infant mortality, improve environmental hygiene, prevent disease, create conditions that assure medical service).

12. International Convention on the Elimination of All Forms of Racial Discrimination, *opened for signature* Mar. 7, 1966, art. 5, S. Exec. Doc. C, 95-2, at 4 (1978), 660 U.N.T.S. 195, 222 (entered into force Jan. 4, 1969) [hereinafter Race Convention] (guaranteeing the “right to public health, medical care, social security and social services” without discrimination).

13. Convention on the Elimination of All Forms of Discrimination Against Women, *opened for signature* Dec. 18, 1979, art. 12, 1249 U.N.T.S. 13, 19 (entered into force Sept. 3, 1981) [hereinafter Women’s Convention] (obligating parties to “take all appropriate measures to eliminate discrimination against women in the field of health care,” including provision of “services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary”).

1989 Convention on the Rights of the Child,¹⁴ and the 2006 Convention on the Rights of Persons with Disabilities.¹⁵

Most of the American states are parties to most of the treaties explicitly protecting the right to health, and all of the American states—like all countries worldwide—are party to at least one of them. However, enforcement of the right to health has been elusive. First, the obligations to protect the right to health—along with other social and economic rights—are generally subject to “progressive realization.”¹⁶ The progressive realization principle takes into account the limited resources that countries have to supply goods and services related to health, and this often, practically speaking, excuses inaction. Second, the treaties do not provide a forum for individual complaints.¹⁷ This leaves aggrieved

14. Convention on the Rights of the Child, *opened for signature* Nov. 20, 1989, art. 24, 1577 U.N.T.S. 3, 52 (entered into force Sept. 2, 1990) [hereinafter Children’s Convention] (recognizing “the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health” and obligating measures to diminish infant mortality, ensure pediatric care, and combat disease and malnutrition).

15. Convention on the Rights of Persons with Disabilities, G.A. Res. 61/106, art. 25, U.N. Doc. A/Res/61/106 (Jan. 24, 2007) (recognizing that “persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability” and obligating measures to ensure access to health services).

16. *See, e.g.*, ICESCR, *supra* note 11, art. 2(1) (“Each State Party to the present Covenant undertakes to take steps . . . to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant”); Children’s Convention, *supra* note 14, art. 24(4) (“States Parties undertake to promote and encourage international cooperation with a view to achieving progressively the full realization of the right recognized in the present article. In this regard, particular account shall be taken of the needs of developing countries.”).

17. *See generally* Michael J. Dennis & David P. Stewart, *Justiciability of Economic, Social, and Cultural Rights: Should There Be an International Complaints Mechanism to Adjudicate the Rights to Food, Water, Housing, and Health?*, 98 Am. J. Int’l L. 462 (2004) (describing the troubled history of attempts to get an individual complaints mechanism for social and economic rights and analyzing the various issues involved). Currently there is no binding individual complaint mechanism available in the U.N. system. Individuals may submit complaints to the Special Rapporteur on the Right to Health, who may then correspond with the government involved to clarify the veracity of the complaint and urge compliance with international legal obligations. *See* Office of the High Comm’r of Hum. Rts., Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health—Individual Complaints, <http://www2.ohchr.org/english/issues/health/right/>

parties without an international remedy; if domestic legislation provides no cause of action, there is no legal recourse. Third, at least until recently and to some extent today, the contours of the right to health have been so difficult to define that a claim alleging a violation of the right to health is practically nonjusticiable.¹⁸

Within the Inter-American system specifically, the right to health has been practically, if not explicitly, unenforceable. The right to health first appeared on paper in the Inter-American system's analogue to the Universal Declaration. In 1948, the Ninth International Conference of American States adopted the American Declaration on the Rights and Duties of Man, which articulates the "right to the preservation of . . . health through sanitary and social measures related to food, clothing, housing and medical care, to the extent permitted by public community resources."¹⁹ Like the Universal Declaration, the American Declaration is a resolution of an intergovernmental organization. Because it is not a treaty, the extent to which it binds member states is unclear.²⁰

complaints.htm (last visited Feb. 5, 2009). Also, on December 10, 2008, the U.N. General Assembly adopted the Optional Protocol to the ICESCR, which when in force will provide for a more formal individual complaint mechanism for economic and social rights, including the right to health. See Hum. Rts. Comm., *Draft Optional Protocol to the International Covenant on Economic and Social Rights*, U.N. Doc. A-HRC-8-7, Annex I (May 6, 2008); Press Release, General Assembly, Adoption of Optional Protocol to International Covenant on Economic, Social and Cultural Rights Caps Year-Long Worldwide Celebration, GA/10795 (Dec. 10, 2008), available at <http://www.un.org/News/Press/docs/2008/ga10795.doc.htm>.

18. See George P. Smith, II, *Human Rights and Bioethics: Formulating a Universal Right to Health, Health Care, or Health Protection?*, 38 Vand. J. Transnat'l L. 1295, 1314–17 (2005) (discussing the challenge of defining a meaningful and enforceable right to health when standards of health vary between persons and countries).

19. American Declaration of the Rights and Duties of Man, O.A.S. Res. XXX, 9th Int'l Conference of American States, art. XI, O.A.S. Off. Rec., OEA/Ser.L/V/II.23, doc.21 rev.6 (1948), reprinted in Basic Documents Pertaining to Human Rights in the Inter-American System, OEA/Ser.L.V/II.82 doc.6 rev.1 at 19, 21 (2003) [hereinafter American Declaration].

20. Like the Universal Declaration, however, the American Declaration is now, at least in part, considered customary international law. See Inter-Am. Ct. H.R., Basic Documents Pertaining to Human Rights in the Inter-American System at 7, OEA/Ser.L.V/II.82 doc. 6 rev. 1 (2003) (including the American Declaration as a basic document under Inter-American law).

The American Convention on Human Rights²¹—which entered into force in 1978 and created binding norms and functioning enforcement mechanisms²²—focuses on civil and political rights. It does not include the right to health or other economic and social rights specifically, but instead lumps them together in Article 26, which encourages states to “adopt measures . . . with a view to achieving progressively . . . the full realization” of economic and social rights.²³ Moreover, the Inter-American Court of Human Rights has viewed Article 26 rights collectively, finding that individual claims are nonjusticiable standing alone. For example in *The Case of “Five Pensioners” v. Peru*, the court rejected a claim brought by five retired civil employees alleging a violation of Article 26 when the Government of Peru unexpectedly and without explanation cut their pension payments by approximately seventy-eight percent.²⁴ The court held that the state did not violate the Article 26 requirement of progressive development of economic, social, and cultural rights, because such rights should be measured with respect to the entire population, rather than the particular group of petitioners.²⁵

In the Inter-American system, the right to health is codified in the Additional Protocol to the American Convention on Human

21. American Convention on Human Rights, *opened for signature* Nov. 22, 1969, O.A.S.T.S. No. 36, 1144 U.N.T.S. 123 (entered into force July 18, 1978) [hereinafter American Convention].

22. The American Convention created enforcement mechanisms accessible through two organs. The Inter-American Commission on Human Rights, among other things, receives complaints from individuals and nongovernmental organizations. *See id.* art. 44. Such complaints have several requirements, including that all domestic law remedies have been exhausted, that petitions be filed within six months of the notification of final judgment, and that the subject of the complaint is not pending in another international proceeding. *See id.* art. 46. In response to complaints, the Commission determines admissibility, requests and examines information from the state defendant, negotiates settlements, and makes recommendations. *Id.* arts. 48–51.

The second organ, the Inter-American Court of Human Rights, issues decisions binding on defendant states who have recognized the court’s jurisdiction. *See id.* art. 62. Individuals cannot file petitions before the court, but their case may be submitted by the Commission or states parties. *See id.* art. 61. The court has the authority to determine violations and order remedies. *See id.* art. 63.

23. *See id.* art. 26.

24. 2003 Inter-Am. Ct. H.R. (ser. C) No. 98, ¶ 88(e) (Feb. 28, 2003).

25. *See id.* ¶ 147.

Rights in the Area of Economic, Social, and Cultural Rights,²⁶ commonly referred to as the “Protocol of San Salvador.” Only fourteen states, however, have ratified the Protocol since it opened for signature in 1988. Further, like the ICESCR and Article 26 of the American Convention, the Protocol merely calls for progressive realization.²⁷ The Protocol of San Salvador contains no mechanism for individual complaints under the right to health, and claims under the Protocol are generally inadmissible, considered by the Inter-American Commission to be beyond both the Commission’s and the Inter-American Court’s purview.²⁸

II. DEFINING THE RIGHT TO HEALTH

Despite the international community’s reluctance to recognize the right to health as enforceable, the Inter-American Court, in three recent decisions, has begun to enforce the right to life in a way that also protects many elements of the right to health.

In order to appreciate the court’s jurisprudence, it is helpful to first determine the essential elements that comprise the right itself. Indeed, defining the right to health has been one of the basic difficulties in addressing both what a violation and what enforcement should mean in practice. This problem of definition stems from several issues. First, the right to health has often been confused with the right to be healthy. A right that attempted to guarantee healthiness across large populations could not be realistically achieved. Even a government with unlimited resources could guarantee healthiness no more than it could guarantee happiness. This is why international agreements and experts on the subject

26. Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, *opened for signature* Nov. 17, 1988, art. 10, O.A.S.T.S. No. 69, 28 I.L.M. 161 (entered into force Nov. 16, 1999) [hereinafter Protocol of San Salvador] (stating that “[e]veryone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being” and obligating measures that facilitate primary health care, universal immunizations, disease prevention, and health education).

27. *Id.* art. 1 (“The States Parties . . . undertake to adopt the necessary measures . . . to the extent allowed by available resources, and taking into account their degree of development, for the purpose of achieving progressively . . . the full observance of the rights recognized in this Protocol.”).

28. Under Article 19, paragraph 6 of the Protocol of San Salvador, however, the Inter-American Commission and the court can review alleged violations of Article 8(a) (on trade union rights) and Article 13 (on education).

prefer to speak of the right in its long form: the right to the “enjoyment of the highest attainable standard of health.” The second challenge to defining the right to health lies with determining a baseline standard or benchmark. The target moves according to governmental resources, cultural expectations, the age of the individual, etc. Certain line-drawing questions are inevitable: Is a government obligated to treat diabetes, for example? What about arthritis? Does it make a difference if the patient is twelve or ninety-two? Does it make a difference if the government is the United States or Paraguay? In answering these questions, advocates face a constant tension. When human rights practitioners and scholars sweep too many aspirational goals into the right to health, it can become an impractical ideal. Danger also lies in the other extreme; if too little is included in the right to health, it can fail to achieve its purpose of protecting what is truly fundamental to human dignity.

In 2000, the U.N. Committee on Economic, Social and Cultural Rights published General Comment 14 in order to clarify the normative content of the right to health.²⁹ As the most authoritative and comprehensive articulation of the right to health, General Comment 14 will serve as our point of departure. In defining the right to health, the Committee first asserted what the right to health is not. It is not the right to be *healthy* nor is it protection from “every possible cause of human ill health,” such as genetic factors or risky lifestyles.³⁰ Rather, the right to health must be understood as “a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health.”³¹ According to the Committee, these necessities include food and nutrition, housing, potable water, sanitation, safe work conditions, healthy environment, hospitals and clinics, and essential drugs.³² To be adequately enjoyed, these necessities should be (1) *available* in sufficient quantity; (2) *accessible*—physically, economically, informationally, and without discrimination; (3) *acceptable* culturally; and (4) of adequate *quality*—scientifically and medically appropriate.³³

29. Comm. on Econ., Soc. & Cultural Rights, *General Comment 14, Art. 12, The Right to the Highest Attainable Standard of Health*, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) [hereinafter General Comment 14].

30. *Id.* ¶¶ 8–9.

31. *Id.* ¶ 9.

32. *See id.* ¶¶ 4, 11 & 12.

33. *Id.* ¶ 12.

General Comment 14's description of state obligations can be divided into two categories: core obligations and non-core obligations. General Comment 14 uses the term "core obligations," referring to the assertion in General Comment 3 that "state parties have a core obligation to ensure the satisfaction of, at the very least, minimum levels of each of the rights enunciated" in the ICESCR.³⁴ Looking at other documents, such as the Alma-Ata Declaration, the Committee determined that the core obligations include at least the following:

- (a) To ensure the right to health facilities, goods and services on a nondiscriminatory basis, especially for vulnerable or marginalized groups;
- (b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
- (c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
- (d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
- (e) To ensure equitable distribution of all health facilities, goods and services;
- (f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population . . . [including] methods, such as right to health indicators and benchmarks, by which progress can be monitored . . . [giving] particular attention to all vulnerable or marginalized groups.³⁵

The Committee stressed that "a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations . . . which are non-derogable."³⁶

Although General Comment 14 does not use the term "non-core obligations," we use this label for everything else identified by the Committee as an obligation under the right to health. These non-core obligations are in a longer, non-exhaustive, and meandering

34. *Id.* ¶ 43 (paraphrasing Comm. on Econ., Soc. & Cultural Rights, *General Comment 3, Article 2, The Nature of States Parties Obligations*, U.N. Doc. E/1991/23, Annex III, ¶ 10 (Dec. 14, 1990) [hereinafter *General Comment 3*]).

35. *Id.*

36. *Id.* ¶ 47

discussion of services and protections.³⁷ General Comment 14's description of non-core obligations appears to survey the universe of governmental actions that affect health. The list includes prevention of air pollution, abstention from nuclear weapon testing, guarding against the dangers of health sector privatization, and refraining from trade embargos on medical supplies.³⁸ The Committee did, however, highlight several non-core obligations as being "of comparable priority" to the core obligations: ensuring maternal and child healthcare, providing immunizations against infectious diseases, preventing epidemics, providing education on health issues, and training health personnel.³⁹ The Committee urged that states are obliged "to take the necessary steps to the maximum of its available resources" for the realization of non-core obligations.⁴⁰

In sum, General Comment 14 has made great progress in resolving the definitional problem that has been the right to health. It first narrowed the right's requirements to tangibles—facilities, goods, services—rejecting the idea that the right to health encompasses a right to be *healthy*. Second, and most importantly, by separating out the core obligations—health facilities, food, shelter, water, drugs—the Committee has defined obligations that can realistically be treated as non-derogable.

III. PARADIGM SHIFT: THE RIGHT TO LIFE JUST GOT BIGGER

As described above in Part II, the right to health requires governments to fulfill a short list of core health needs in a manner that is accessible to the people—regardless of limited resources—and to achieve multiple non-core goals as resources permit. In Part I, we described the failure of the current system to enforce these obligations under the right to health. In Part III, we will analyze how the Inter-American Court has begun to enforce them through its evolutionary interpretation of the right to life.

37. *See id.* ¶¶ 30–42.

38. *See id.*

39. *Id.* ¶ 44.

40. *Id.* ¶ 47.

A. Yakye Axa, Sawhoyamaxa, and the “Evolutionary Interpretation to the Right to Life”

In the cases of *Yakye Axa Indigenous Community v. Paraguay*⁴¹ and *Sawhoyamaxa Indigenous Community v. Paraguay*,⁴² the Inter-American Court used an expansive definition of the American Convention’s Article 4 right to life,⁴³ one that practically mimics the right to health. *Yakye Axa* and *Sawhoyamaxa* built on a series of cases that sought to hold states accountable, not only for actions directly linked to official government action, but also for state-created circumstances that led to Article 4 violations. The first of these precedents was the 1999 *Case of the “Street Children” (Villagran-Morales et al.) v. Guatemala*,⁴⁴ where Guatemalan police kidnapped and murdered five young men in efforts to counter juvenile delinquency.⁴⁵ In finding a violation of Article 4, the Inter-American Court stated:

The right to life is a fundamental human right, and the exercise of this right is essential for the exercise of all other human rights. If it is not respected, all rights lack meaning In essence, the fundamental right to life includes, not only the right of every human being not to be deprived of his life arbitrarily, but also the right that he will not be prevented from having access to the conditions that guarantee a dignified existence. States have the obligation to guarantee the creation of the conditions required in order that violations of this basic right do not occur⁴⁶

“*Street Children*” hinted that Article 4 imposed on states a positive rather than a negative obligation. In 2003, this interpretation was confirmed in *Case of Juan Humberto Sánchez v. Honduras*,⁴⁷ where the Honduran military kidnapped and murdered

41. 2005 Inter-Am. Ct. H.R. (ser. C) No. 125 (June 17, 2005).

42. 2006 Inter-Am. Ct. H.R. (ser. C) No. 146 (Mar. 29, 2006).

43. American Convention, *supra* note 21, art. 4 (“Every person has the right to have his life respected. This right shall be protected by law and, in general, from the moment of conception. No one shall be arbitrarily deprived of his life.”).

44. 1999 Inter-Am. Ct. H.R. (ser. C) No. 63 (Nov. 19, 1999).

45. *Id.* ¶¶ 79–83.

46. *Id.* ¶ 144.

47. 2003 Inter-Am. Ct. H.R. (ser. C) No. 99 (June 7, 2003).

an alleged political dissident:⁴⁸ “Compliance with Article 4 . . . not only requires that no person be deprived of his life arbitrarily (negative obligation), but also that the States take all appropriate measures to protect and preserve the right to life (positive obligation)”⁴⁹ The expansive reading of Article 4 in “*Street Children*” was repeatedly affirmed by the court⁵⁰ in what Judge Fogel-Pedroso later called the “evolutionary interpretation of the right to life.”⁵¹

This “evolutionary interpretation,” which emphasized a positive obligation to protect the conditions necessary for life, formed the backdrop for the 2005 *Yakye Axa* and 2006 *Sawhoyamaxa* cases. These cases confronted the “evolutionary interpretation” with facts of extreme poverty and isolation from health services. The cases shared a set of nearly identical facts.⁵² The *Yakye Axa* and *Sawhoyamaxa* communities were indigenous groups that traditionally subsisted as hunter-gatherers, but were displaced as non-indigenous populations acquired their land.⁵³ In response to poor living conditions, the

48. *Id.* ¶¶ 70(1)–(10).

49. *Id.* ¶ 110 (parentheticals in original).

50. *See, e.g.,* *Huilca-Tecse v. Peru*, 2005 Inter-Am. Ct. H.R. (ser. C) No. 121, ¶ 66 (Mar. 3, 2005) (finding that Article 4 of the American Convention not only protects against arbitrary deprivation of the right to life but also imposes affirmative obligations on the state to ensure that right is protected and preserved); “*Juvenile Reeducation Institute v. Paraguay*, 2004 Inter-Am. Ct. H.R. (ser. C) No. 112, ¶¶ 156–60 (Sept. 2, 2004) (“The right to life and the right to humane treatment require not only that the State respect them (negative obligation) but also that the State adopt all appropriate measures to protect and preserve them (positive obligation)”); *Mack Chang v. Guatemala*, 2003 Inter-Am. Ct. H.R. (ser. C) No. 101, ¶¶ 152–53 (Nov. 25, 2003) (finding that the state must adopt all necessary measures, not only to prevent and punish deprivation of life, but also to prevent arbitrary executions by its own police forces).

51. *Yakye Axa Indigenous Community v. Paraguay*, 2005 Inter-Am. Ct. H.R. (ser. C) No. 125, ¶ 33 (June 17, 2005) (Fogel-Pedroso, J., dissenting) (expressing his belief that the more expansive interpretation of the right to life must also take into account the context and socio-economic situation in Paraguay and other Latin American countries).

52. *See Sawhoyamaxa Indigenous Community v. Paraguay*, 2006 Inter-Am. Ct. H.R. (ser. C) No. 146, ¶ 69 (Mar. 29, 2006) (Cançado Trindade, J., concurring) (noting that the victims belonged to the same indigenous group, suffered through the same conditions, shared the same representatives, were guaranteed emergency protection under the same executive order, and even endured chronic poverty on the side of the same road).

53. *Id.* ¶¶ 73(1)–(4); *Yakye Axa*, 2005 Inter-Am. Ct. H.R. (ser. C) No. 125, ¶¶ 50.1–.11.

communities took legal steps to reclaim their traditional territories.⁵⁴ While awaiting restitution, the groups settled on strips of land between a public road and the barbed wire fence that separated them from their land.⁵⁵ The roadside settlements had precarious living conditions. The inhabitants could not farm, hunt, fish, or gather food.⁵⁶ Their lack of clean water, sanitation, and access to medical care led to desperate and inhumane living conditions that included malnutrition, anemia, widespread parasitism, and high infant mortality.⁵⁷

In both *Yakye Axa* and *Sawhoyamaxa*, the court adopted the expansive interpretation of the Article 4 right to life that was laid out in the “*Street Children*” line of cases. The *Yakye Axa* court wrote:

Essentially, this right includes not only the right of every human being not to be arbitrarily deprived of his life, but also the right that conditions that impede or obstruct access to a [dignified existence] should not be generated.

One of the obligations that the State must inescapably undertake as guarantor, to protect and ensure the right to life, is that of generating minimum living conditions that are compatible with the dignity of the human person and of not creating conditions that hinder or impede it. In this regard, the State has the duty to take positive, concrete measures geared toward fulfillment of the right to a [dignified life], especially in the case of persons who are vulnerable and at risk, whose care becomes a high priority.⁵⁸

The *Sawhoyamaxa* court similarly stated:

States must adopt any measures that may be necessary to create an adequate statutory framework to discourage any threat to the right to life; to establish an effective system of administration of

54. *Sawhoyamaxa*, 2006 Inter-Am. Ct. H.R. (ser. C) No. 146, ¶¶ 73(6)–(7), 73(17)–(61); *Yakye Axa*, 2005 Inter-Am. Ct. H.R. (ser. C) No. 125, ¶¶ 50.12–.90.

55. *Sawhoyamaxa*, 2006 Inter-Am. Ct. H.R. (ser. C) No. 146, ¶ 73(7); *Yakye Axa*, 2005 Inter-Am. Ct. H.R. (ser. C) No. 125, ¶¶ 50.8, 50.92.

56. *Sawhoyamaxa*, 2006 Inter-Am. Ct. H.R. (ser. C) No. 146, ¶ 73(64); *Yakye Axa*, 2005 Inter-Am. Ct. H.R. (ser. C) No. 125, ¶ 50.93.

57. *Sawhoyamaxa*, 2006 Inter-Am. Ct. H.R. (ser. C) No. 146, ¶¶ 73(67)–(74); *Yakye Axa*, 2005 Inter-Am. Ct. H.R. (ser. C) No. 125, ¶¶ 50.93–.98.

58. *Yakye Axa*, 2005 Inter-Am. Ct. H.R. (ser. C) No. 125, ¶¶ 161–62.

justice able to investigate, punish and repair any deprivation of lives by state agents, or by individuals; and to protect the right of not being prevented from access to conditions that may guarantee a [dignified life],⁵⁹ which entails the adoption of positive measures to prevent the breach of such right.⁶⁰

The court's interpretation that Article 4's "life" includes, not merely survival, but a "dignified existence"⁶¹ or a "dignified life" expanded the scope of what states are obligated to protect.

Although the *Yakye Axa* and *Sawhoyamaxa* cases shared common facts and the court adopted the same expansive interpretation of the right to life, the court analyzed state obligations differently and arrived at different outcomes. These cases are worth looking at independently to see what they might mean for enforcement of the right to health.

The *Yakye Axa* court stated that in order to find a violation of the right to life, it needed to establish (1) that "the State generated conditions that worsened the difficulties of access to a [dignified life]" and (2) if so, that Paraguay failed to take "appropriate positive measures" to alleviate those conditions.⁶² In making these determinations, the court said that two factors should be taken into account. First, the vulnerability of the individuals should be considered.⁶³ Second, the right to life should be viewed in light of economic and social rights recognized in Article 26 of the American Convention, the ILO Convention 169 on Indigenous and Tribal Peoples, and the Protocol of San Salvador (specifically mentioning the right to health, the right to a healthy environment, and the right to food, among others).⁶⁴

59. The Inter-American Court of Human Rights, sitting in Costa Rica, drafts most of its opinions in Spanish, and the English translations are at times inconsistent. The operative terms used by the court in these cases are "vida digna" (dignified life) and "existencia digna" (dignified existence). Here "vida digna" was translated "decent life," so we changed the translation to prevent any confusion.

60. *Sawhoyamaxa*, 2006 Inter-Am. Ct. H.R. (ser. C) No. 146, ¶ 153.

61. See Case of the "Street Children" (Villagrán-Morales et al.) v. Guatemala, 1999 Inter-Am. Ct. H.R. (ser. C) No. 63, ¶ 144 (Nov. 19, 1999).

62. *Yakye Axa*, 2005 Inter-Am. Ct. H.R. (ser. C) No. 125, ¶ 163.

63. *Id.*

64. *Id.* Paraguay is party to both the Protocol of San Salvador and ILO Convention 169. See Protocol of San Salvador, *supra* note 27; Int'l Labor Org.,

The court concluded that Paraguay violated the Yakye Axa community's right to life. It reasoned that Paraguay "did not guarantee the right . . . to communal property," which "had a negative effect on the right of the members of the Community to a [dignified life]."⁶⁵ And Paraguay did not take "the necessary positive measures to ensure the members of the Yakye Axa Community . . . living conditions that are compatible with their dignity."⁶⁶ The court highlighted the especially vulnerable position of the community as an indigenous group and specifically the children and elderly individuals within the community as a factor that intensified the state's obligation under the right to life.⁶⁷

Although the court found that Paraguay violated the right to life with regard to the community in its failure to ensure adequate living conditions, the court mysteriously stopped short of finding a violation with regard to the sixteen Yakye Axa individuals who *died* as a result of the inadequate conditions.⁶⁸ The majority opinion, with little explanation, merely stated that the court did not have "sufficient evidence to establish the causes of said deaths."⁶⁹ The dissenting judges found this outcome dumbfounding.⁷⁰ They painstakingly retraced the causal links that the majority itself had seemingly laid out between the state's "lack of due diligence" and the deaths of the community members.⁷¹ The dissent concluded by saying, "We hope that our reasoning will help to correct, as soon as possible, the regression that . . . the instant Judgment constitutes in connection with evolution of the jurisprudence of this Court."⁷²

The correction that the dissenting judges desired would come the next year with *Sawhoyamaya*, but two points should be made

Convention on Indigenous and Tribal Peoples (No. 169), *adopted on June 27, 1989*, 72 ILO Off. Bull. 59 (entered into force Sept. 5, 1991).

65. *Yakye Axa*, 2005 Inter-Am. Ct. H.R. (ser. C) No. 125, ¶ 168.

66. *Id.*

67. *See id.* ¶¶ 163, 165–67, 172–75.

68. *Id.* ¶ 177.

69. *Id.*

70. *Id.* ¶ 6 (Cançado Trindade & Ventura Robles, JJ., dissenting) ("[W]hat we do not understand is why the Court, once it found that Article 4(1) of the Convention had been abridged . . . deemed that it did not have 'sufficient evidence to prove violation of the right to life' to the detriment of members of the Yakye Axa Indigenous Community, who in fact died of the aforementioned conditions . . .").

71. *See id.* ¶¶ 11–20 (Cançado Trindade & Ventura Robles, JJ., dissenting).

72. *Id.* ¶ 23 (Cançado Trindade & Ventura Robles, JJ., dissenting).

about *Yakye Axa* before moving on to *Sawhoyamaxa*. First, *Yakye Axa* signaled a substantial expansion of what is included in the right to life. Although the “*Street Children*” line of cases did provide the “conditions that guarantee a dignified existence” language that proved pivotal in *Yakye Axa* and *Sawhoyamaxa*, the “*Street Children*” cases focused on the duties of states to prevent their agents from engaging in violent acts such as kidnappings, disappearances, and arbitrary killings. *Yakye Axa*’s extrapolation of the right to a dignified life meant something much more holistic as evidenced by the reparations ordered by the court for the community:

[T]he Court orders that . . . the State must supply, immediately and on a regular basis, sufficient drinking water for consumption and personal hygiene of the members of the Community; it must provide regular medical care and appropriate medicine to protect the health of all persons, especially children, the elderly and pregnant women, including medicine and adequate treatment for worming of all members of the Community; it must supply food in quantities, variety and quality that are sufficient for the members of the Community to have the minimum conditions for a [dignified life]; it must provide latrines or any other type of appropriate toilets for effective and healthy management of the biological waste of the Community; and it must supply sufficient bilingual material for appropriate education of the students at the school in the current settlement of the Community.⁷³

Within the Inter-American system, then, the right to life had come to include more than protection from arbitrary murder. Enjoying the right to a dignified life now required medicine, food, clean water, and sanitation.

Second, although the court’s failure to find a violation of the right to life with respect to those who died seems incongruous with its finding of a violation with respect to the community as a whole, this fact underscores the dramatic shift in the court’s jurisprudence. An earlier and more formalistic interpretation of the right to life might require a death (a literal loss of life) before a violation would be found. That a violation was found in *Yakye Axa* with reference only to the destitute conditions in the community and not to the

73. *Id.* ¶ 221 (majority opinion).

actual deaths shows just how far the court had moved from the formalistic understanding of the right to life.

Less than a year after *Yakye Axa*, the Inter-American Court corrected what the dissenting judges viewed as a profound mistake. With indistinguishable facts, the *Sawhoyamaxa* court found violations of the right to life, not only for the destitute condition of the community, but also for the individuals who died as a result.⁷⁴

The court appeared conscious of the potential problems of enforcing the “evolutionary interpretation of the right to life.” It wrote:

It is clear for the Court that a State cannot be responsible for all situations in which the right to life is at risk. Taking into account the difficulties involved in the planning and adoption of public policies and the operative choices that have to be made in view of the priorities and the resources available, the positive obligations of the State must be interpreted so that an impossible or disproportionate burden is not imposed upon the authorities.⁷⁵

The court recognized the difficulties of scope and limited resources as it carefully crafted its standard. The court declared that a violation of Article 4 required (1) that “the authorities knew or should have known about the existence of a situation posing an immediate and certain risk to the life of an individual or of a group of individuals” and (2) “that the necessary measures were not adopted within the scope of their authority which could be reasonably expected to prevent or avoid such risk.”⁷⁶ The first prong in *Sawhoyamaxa*, requiring knowledge of the conditions, is significantly less stringent than *Yakye Axa*’s requirement that the state must have generated the conditions.⁷⁷ But this increased positive obligation on the state is tempered by *Sawhoyamaxa*’s second prong, which limits the obligation of the state actors to the “scope of their authority.”

The court quickly recognized as undisputed that the *Sawhoyamaxa* living conditions were inadequate and that

74. See *Sawhoyamaxa Indigenous Community v. Paraguay*, 2006 Inter-Am. Ct. H.R. (ser. C) No. 146, ¶ 178 (Mar. 29, 2006).

75. *Id.* ¶ 155.

76. *Id.*

77. See *supra* note 62 and accompanying text.

Paraguayan officials knew this,⁷⁸ and turned to the more difficult scope of authority question. The court looked to the domestic legal system to determine who had the authority to adopt risk-preventing measures. It first found Paraguay deficient in its failure to provide communal property for the Sawhoyamaxa community, either in its claimed lands or elsewhere. The state's authority to provide this communal property was found in the administrative proceedings before the Instituto Paraguayo del Indígena (Paraguayan Indigenous Institute) and the Instituto de Bienestar Rural (Institute of Rural Welfare), but the court found the state's action slow and inefficient. Accordingly, Paraguay had failed to "adopt[] the necessary measures for the members of the Community to leave the roadside, and thus, abandon the inadequate conditions that endangered . . . their right to life."⁷⁹

Second, the court found Paraguay's efforts to provide medical care to the Sawhoyamaxa community inadequate. State actors had authority to provide medical services, granted to them by both a presidential order and domestic legislation. For example, Presidential Order 3789 declared the Sawhoyamaxa community in a state of emergency and provided for delivery of food, medical services, and educational materials to the community.⁸⁰ Paraguayan law also gives indigenous individuals the right to free medical care at public health centers, the Itaugua National Hospital, and all other medical centers under the jurisdiction of the Paraguayan Ministry of Public Health and Social Welfare.⁸¹

Considering both provisions, the court found the state's efforts insufficient. The actual services delivered under the presidential order were too little and too late:

[T]he measures adopted by the State in compliance with [the] order cannot be considered sufficient and adequate. Indeed, for six years after the effective date of the order, the State only delivered food to the alleged victims on ten opportunities, and medicine and educational material in two opportunities, with long intervals between each delivery. These deliveries, as well as the amounts delivered, are

78. See *Sawhoyamaxa*, 2006 Inter-Am. Ct. H.R. (ser. C) No. 146, ¶¶ 156–59.

79. *Id.* ¶¶ 163–66.

80. *Id.*

81. *Id.* ¶ 167.

obviously insufficient to revert the situation of vulnerability and risk of the members of this Community and to prevent violations to the right to life, to the point that after the emergency Presidential Order became effective, at least 19 persons died.⁸²

Impediments to reaching health centers and inadequate care for those who did reach them hindered the provision of the statutorily guaranteed free care.⁸³ Several children died in the hospital when they were denied medicines because their parents could not pay. Others were released early only to die in the community. In one case, the hospital asked a mother to leave with her sick son after the death of her first son, because she was unable to pay for medicine. Six days later, her second son died in the community.⁸⁴ Considering all of the above, the court found violations of Article 4 because the state did “not adopt[] the necessary positive measures within its powers, which could reasonably be expected to prevent or avoid risking the right to life of the members of the Sawhoyamaxa Community.”⁸⁵

In addition to recognizing the state’s finite resources through the “scope of authority” requirement, the court limited the scope of healthcare required of the state. The court did not hold Paraguay responsible for three individuals who died in work and traffic-related accidents, nor for the death of another person killed by a member of the community.⁸⁶ Neither did the court find violations for the deaths of three elderly individuals caused by pneumonia and tuberculosis, considering that all three had aged either beyond the national life expectancy or close to it.⁸⁷

B. *Ximenes-Lopes* and the Duty to Provide and Regulate Public Healthcare

The court in *Sawhoyamaxa* set out the test for a right to life violation requiring: (1) knowledge of a threat to the right to life; and

82. *Id.* ¶ 170.

83. *Id.* ¶¶ 174–76.

84. *Id.* ¶ 175.

85. *Id.* ¶ 178.

86. *Id.* ¶ 179.

87. *Id.* ¶ 180. In declining to declare state culpability for these deaths, the court also took into account the lack of more conclusive evidence implicating state responsibility. *Id.*

(2) inaction in the state's scope of authority.⁸⁸ A domestic statutory mandate or a presidential order to provide medical care to a particular group provided Paraguay's state actors with authority to do so.⁸⁹ Failure to respond to known conditions threatening a decent life for that group constituted a violation of the right to life. However, after *Sawhoyamaxa*, it remained unclear how the right to life applied generally to the failures of a state's healthcare system. The 2006 case *Ximenes-Lopes v. Brazil*⁹⁰ concluded that the "scope of state authority" with respect to the provision of healthcare includes an affirmative duty to regulate healthcare systems.

On October 1, 1999, Albertina Viana-Lopes checked her son Damião Ximenes-Lopes, into the mental health facility of Casa de Reposo Guararapes in Sobral, Brazil.⁹¹ Mr. Ximenes-Lopes, then thirty years old, had suffered from a mental illness since childhood. In the previous few days, he had been suffering from anxiety and was unable to eat or sleep.⁹² He was admitted to the facility with no signs of physical aggression or external injuries.⁹³ When his mother visited three days later, she "found him bleeding, with bruises, his clothes torn, dirty and smelling like excrement, with his hands tied backwards, having difficulty breathing, agonizing, and shouting."⁹⁴ She requested that the staff bathe him and subsequently searched for a doctor to treat her son. Without an examination, the doctor prescribed medicine for Mr. Ximenes-Lopes.⁹⁵ When Damião Ximenes-Lopes died approximately two hours later, there was no doctor in the healthcare unit.⁹⁶

Casa de Reposo Guararapes was a private institution, which contracted with the state to provide mental health services under Brazil's Sistema Único de Salud (Single Health Care System).⁹⁷ The Inter-American Court described the facility as having "an atmosphere of violence, aggression, and abuse where many inpatients frequently suffered injuries" at the hands of the facility's

88. *See supra* note 76 and accompanying text .

89. *Sawhoyamaxa*, 2006 Inter-Am. Ct. H.R. (ser. C) No. 146, ¶¶ 163–67.

90. 2006 Inter-Am. Ct. H.R. (ser. C) No. 149 (July 4, 2006).

91. *Id.* ¶¶ 112(2)–(4).

92. *Id.* ¶ 112(4).

93. *Id.* ¶ 112(5).

94. *Id.* ¶ 112(9).

95. *Id.* ¶ 112(10).

96. *Id.* ¶ 112(11).

97. *Id.* ¶ 112(55).

employees.⁹⁸ Hospital employees applied choke holds and physically restrained patients without direction from physicians, and “physical confrontations between patients were encouraged.”⁹⁹ The court characterized the hospital as “inhumane and degrading,” noting that medicine was lacking and, for a period of time, there was no examination room so that medical procedures had to be administered in the lobby in front of other patients as well as visitors.¹⁰⁰ At least two patients had died before Damião Ximenes-Lopes, which “may have involved blows to the head with a blunt instrument, and where patients were admitted to the hospital in good physical condition and died during hospitalization.”¹⁰¹ The court recounted further “[r]eports of abuse and offenses against patients” that went uninvestigated by the hospital management and absentee director, including a rape allegation and an incident where a nurse’s aide allegedly broke a patient’s arm.¹⁰²

Responding to these facts, the court applied the two-part right to life test from *Sawhoyamaxa*. First, the court determined that the state was aware of the conditions that threatened the right to life.¹⁰³ Second, the court found that the state failed to take action within the scope of its authority. As in *Sawhoyamaxa*, the court found authority in domestic law.¹⁰⁴ Perhaps more significantly, however, the court implied that no domestic authority is necessary to obligate the state to provide healthcare. The court said that the duty

98. *Id.* ¶ 112(56).

99. *Id.*

100. *Id.* ¶ 112(57).

101. *Id.* ¶ 112(58).

102. *Id.* ¶ 112(59).

103. *Id.* ¶¶ 143–44 (recounting problems with the facilities that had led state authorities to conclude that the institution did not meet the requirements set forth in pertinent regulations).

104. The court, finding authority in two provisions of the Brazilian Constitution, noted that “article 197 of the Constitution provides that ‘health care services are of public relevance, and it is incumbent upon the power of the State to provide for their regulation, supervision, and control, pursuant to the legislation in force.’” *Id.* ¶ 142. The court went on to point out that “article 200 states that ‘the [S]ingle [H]ealth [S]ystem . . . has the duty to control and supervise procedures . . . [and] implement health surveillance policies.’” *Id.* (alterations in case). The court further found authority in a Brazilian statute, which provided that “the scope of action of the Single Health System (SUS), includes [*inter alia*,] the adoption of measures to implement health surveillance, [which] is understood as a set of policies aimed at preventing health risks and taking action regarding health problems” *Id.* (alterations in case).

of states to provide and regulate public health services springs from the American Convention itself, citing Article 2, which requires adoption of “legislative or other measures . . . necessary to give effect to” the rights in the Convention:

Pursuant to Article 2 of the Convention, the States must create an appropriate legal framework to establish the standards of treatment and hospitalization to be complied with by health care institutions. The States must establish and adopt in their respective legal systems all such measures as may be necessary so that the provisions of the Convention may be met and enforced, and legislation does not become a mere formality drifted apart from reality.

In view of the foregoing, the Court considers that the States are responsible for regulating and supervising at all times the rendering of services and the implementation of the national programs regarding the performance of public quality health care services so that they may deter any threat to the right to life and the physical integrity of the individuals undergoing medical treatment. They must, *inter alia*, create the proper mechanisms to carry out inspections at psychiatric institutions, submit, investigate, and solve complaints and take the appropriate disciplinary or judicial actions regarding cases of professional misconduct or the violation of the patients’ rights.¹⁰⁵

There are several important points about the scope of the duty identified by the court. First, the duty to regulate healthcare institutions applies to the state’s overseeing of both public and private facilities.¹⁰⁶ Second, the duty is not limited to mental health services. The court emphasized the special care owed to individuals with mental disabilities because of their vulnerability,¹⁰⁷ but the state’s obligation was stated with general applicability.¹⁰⁸ Third, the reparations ordered by the court were not limited to compensation to

105. *Id.* ¶¶ 98–99.

106. *Id.* ¶¶ 89–90 (noting that “the rights to life and personal integrity . . . are particularly vulnerable when a person is undergoing health treatment” and that the American Convention holds states liable when the state fails to regulate private entities that violate the right to life).

107. *See id.* ¶¶ 101–11.

108. *See id.* ¶¶ 89–90.

the individual victims, and included institutional reform. By the time of the judgment, Brazil had instituted multiple mental health system reforms, but the court additionally required the implementation of training programs for all staff working at Brazilian mental health institutions.¹⁰⁹

IV. HOW THE RIGHT TO A DIGNIFIED LIFE FACILITATES THE RIGHT TO HEALTH

In Part II of this Article, we described the content of the right to health as set out in General Comment 14. The right to health imposes an obligation on governments to ensure access to the facilities, goods, and services necessary for health. Specifically the right to health imposes a narrow group of core obligations: provision of health facilities, food, shelter, water, and drugs. In Part III we then examined the Inter-American Court's paradigmatic shift in enforcing the right to a dignified life. In *Yakye Axa, Sawhoyamaya*, and *Ximenes-Lopes*, the Inter-American Court has taken the right to life, traditionally considered a negative right—the duty not to take a person's life—and incorporated the positive obligations of ensuring the conditions necessary for a dignified life.¹¹⁰ This new interpretation of the right to life echoes the spirit of the right to

109. *Id.* ¶¶ 243, 250.

110. *See supra* notes 46–49 and accompanying text. *Ximenes-Lopes* raises an interesting question: whether provisions of the Protocol of San Salvador might also be able to provide the “authority” necessary to trigger obligations to protect the right to life for states party to the Protocol. In *Yakye Axa*, the court found an obligation to take positive measures only once the government had “generated conditions that worsened the difficulties of access to a [dignified life].” *See supra* note 62 and accompanying text. This was more like a negative obligation, because the state had no special duty so long as it did nothing wrong. A violation of omission could only be found once there was a violation of commission. As noted above, however, the court backed away from this position in *Sawhoyamaya*. It no longer waited for a wrongful act to find a positive obligation, but the knowledge and authority standard still required the government to pass domestic legislation before the state would be bound. *See supra* notes 76–81 and accompanying text. But even this limitation to the positive obligation was probably wiped away when the court held in *Ximenes-Lopes* that the authority to take action can be found in the American Convention's Article 2 duty to adopt legislation to protect the right to life. *See supra* notes 104–105 and accompanying text. Thus, the Protocol of San Salvador may provide independent authority for imposing positive obligations on states party to the Protocol.

health found in General Comment 14 and provides a means of redress within the Inter-American system.

In light of the findings and guidelines suggested by the Inter-American Court in *Yakye Axa*, *Sawhoyamaya*, and *Ximenes-Lopes*, we recommend the following standard for national policy makers when formulating or reviewing public health laws and programs:

- (1) It shall be considered a violation of the right to life if
 - (a) life-threatening conditions exist; and
 - (b) the state knows or should know about the conditions; and
 - (c) the state fails to adopt appropriate measures, either through direct action or through regulation, to alleviate the life-threatening conditions.
- (2) “Life-threatening conditions” that affect the right to a dignified life and the right to health shall be found to exist if
 - (a) there is an imminent and probable risk of death; and
 - (b) any of the following are insufficient, inaccessible, culturally unacceptable, or medically inappropriate:
 - (i) potable water,
 - (ii) food,
 - (iii) sanitation,
 - (iv) medicine, or
 - (v) health facilities.

This standard synthesizes the court’s factual and legal findings in its recent cases adjudicating claims based on the right to life. Moreover, this standard closely resembles the right to health as described in General Comment 14. In our view, the court’s new standard regarding the right to a dignified life also provides a workable solution for enforcing the right to health recognized in Article 10 of the Protocol of San Salvador.

The standard for finding a violation of the right to life has three prongs: (1) a finding of life-threatening conditions; (2) governmental knowledge of those conditions; and (3) failure to act. The first prong, requiring life-threatening conditions, follows from the facts of each of the three cases where violations of Article 4 were found. Each included actual deaths as well as serious threats to life

itself.¹¹¹ The severity of these circumstances leads to the realistic observation that the court will probably not find a violation of the right to a dignified life for a poor sanitation system or unacceptably bad service in an emergency room (when no one's life is at stake). Such a limitation provides a practical enforcement benefit. The scope of the right to a dignified life, similar to the right to health, must be limited in order for state governments to comply and the court to measure concrete violations.¹¹²

The definition of "life-threatening conditions" is critical to the first prong of the test laid out by the Inter-American Court. The definition incorporates what is strikingly similar to General Comment 14's list of core obligations. To comply with the right to life, the Inter-American Court required the Paraguayan government to provide adequate drinking water, medical care, medicine, food, and sanitation to the *Yakye Axa* community.¹¹³ Similarly, the list of core obligations under the right to health include: health facilities, minimum essential food, basic shelter, sanitation, potable water, essential drugs, and a national public health strategy¹¹⁴ (the only General Comment 14 core obligations missing from the *Yakye Axa* list are shelter and a public health strategy, neither of which were at issue in the case¹¹⁵). The court did not explicitly state that failure to

111. The Inter-American Court showed its willingness to find violations of the right to life even before a state's actions led to death. The court's new interpretation of the right to life "includes not only the right of every human being not to be arbitrarily deprived of his life, but also the right that conditions that impede or obstruct access to a decent existence should not be generated." *Yakye Axa Indigenous Community v. Paraguay*, 2005 Inter-Am. Ct. H.R. (ser. C) No. 125, ¶ 161 (June 17, 2005). This construction was especially evident in *Yakye Axa*, where the court found a violation regarding the survivors but not regarding those who died. *See supra* notes 68–72 and accompanying text. But in all of these cases the conditions were serious enough to be considered at least life threatening. The right to health has no explicit requirement that someone die, or even that life be threatened, before a violation will be found. But the right to health is unlikely to be enforced in situations that are not serious enough to be considered life-threatening.

112. The right to the "highest attainable standard of health" envisions something much more holistic than mere survival. The Inter-American Court's right to life enforcement is narrower than the full scope of health rights, but it appears to overlap with significant elements of the right to health.

113. *See supra* note 73 and accompanying text.

114. *See supra* note 35 and accompanying text.

115. Practically speaking, the exclusion of the right to shelter from the definition of life-threatening conditions is not terribly significant, because in

ensure these necessities would constitute a violation of the right to life regardless of resource limitations. However, it made no indication that resource limitations would mitigate Paraguay's responsibility, despite the fact that Paraguay is among the poorest nations in South America. By defining the right to life more expansively, the court enforced critical elements of the right to health.

The definition of "life-threatening conditions" in the first prong of the test also requires that the necessities of water, food, medicine, sanitation, and healthcare be provided effectively. In *Yakye Axa*, the court required "appropriate" medicine and food in "quantities, variety and quality that are sufficient . . ." ¹¹⁶ In *Sawhoyamaya*, the court took the inadequacy of healthcare and the physical and financial impediments faced by community members when attempting to access health facilities as evidence of a violation of the right to life. ¹¹⁷ Finally, the *Ximenes-Lopes* case emphasized that healthcare must be effective and it described the duty to provide decent health treatment. The court required that healthcare workers be adequately trained and that consent to treatment and minimal restraint rules be followed. ¹¹⁸ The Inter-American Court cases indicate that, like the right to health, the right to life requires not merely *some* food, water, and health services, but rather *enough* to ensure a dignified existence. Taken together, the standard that emerges from these three decisions parallels General Comment 14, which states that for the right to health to be adequately enjoyed, health necessities must be available, accessible, acceptable, and of adequate quality. ¹¹⁹ Maintaining health facilities only in major cities, for example, or providing fee-for-service or low-quality care will not meet a state's human rights obligations. ¹²⁰

situations where lack of shelter becomes life-threatening, in all likelihood, one of the other "core obligations" is also not being met.

116. See *supra* note 73 and accompanying text.

117. See *supra* notes 83–85 and accompanying text.

118. *Ximenes-Lopes v. Brazil*, 2006 Inter-Am. Ct. H.R. (ser. C) No. 149, ¶¶ 128–36, 243, 250 (July 4, 2006).

119. See *supra* note 33 and accompanying text.

120. If there is anything that we have underemphasized, it is the extent to which both General Comment 14 and the Inter-American Court discuss the special protection required for vulnerable individuals. General Comment 14 spends two pages of the nineteen page document emphasizing special needs of vulnerable groups. See General Comment 14, *supra* note 29, ¶¶ 21–27 (discussing the needs of women, children, the elderly, persons with disabilities, and indigenous persons). Perhaps even more exhaustively, the court in all three cases

The second and third prongs of the standard—knowledge and failure to act—are identical to those that the court applied in *Sawhoyamaxa*¹²¹ and *Ximenes-Lopes*.¹²² The standard does not say that the inaction must be within the government’s “scope of authority” as was required in *Sawhoyamaxa* and *Ximenes-Lopes*. This is based on the Inter-American Court’s willingness to find authority in both domestic public health law and the American Convention itself.¹²³ With such broad parameters of authority, and the fact that any party under the court’s jurisdiction will be a party to the American Convention, there is no imaginable scenario where the scope of authority prong would not be satisfied.

The third prong—failure to act—further emphasizes the extent of the government’s positive obligation. States can violate the right to life by neglecting to adopt appropriate measures, either through direct action or through regulation, to alleviate conditions that threaten the right to life. The court in *Ximenes-Lopes* made it

put great emphasis on the vulnerability of indigenous groups, women, children, elderly, and people with mental disabilities. *See, e.g., Ximenes-Lopes*, 2006 Inter-Am. Ct. H.R. (ser. C) No. 149, ¶¶ 101–11 (discussing “the special care due to persons with mental disabilities by reason of their special vulnerability”); *Sawhoyamaxa Indigenous Community v. Paraguay*, 2006 Inter-Am. Ct. H.R. (ser. C) No. 146 ¶¶ 73.74, 83, 159, 177 (Mar. 29, 2006) (describing the special situation of children, the elderly, indigenous groups, and women); *Yakye Axa Indigenous Community v. Paraguay*, 2005 Inter-Am. Ct. H.R. (ser. C) No. 125 ¶ 163 (June 17, 2005) (taking into account “the especially vulnerable situation in which they were placed, given their different manner of life. . . and their life aspirations, both individual and collective, in light of the existing international *corpus juris* regarding the special protection required by the members of the indigenous communities”). The special attention given to vulnerable groups is not unique to right to life or right to health jurisprudence, so not too much should be made of the similarity. But the emphasis by the court raises the question of whether the expansive interpretation of the right to life depends on the complainant belonging to a vulnerable group. The court in *Ximenes-Lopes* seemed to dodge this question by implying that all people undergoing health treatment are vulnerable. *See Ximenes-Lopes*, Inter-Am. Ct. H.R. (ser. C) No. 149, ¶ 89 (identifying a special duty in all medical treatment because life is “particularly vulnerable when a person is undergoing health treatment”). Following this reading of vulnerability, a person is vulnerable any time life or health is threatened. The court, however, did not explicitly require vulnerability. And in *Ximenes-Lopes*, the court seemed to say that any vulnerability requirement would always be met for individuals seeking medical treatment. *See supra* notes 105–108 and accompanying text. This is especially the case when patients have a life-threatening condition.

121. *See supra* note 76 and accompanying text.

122. *See supra* notes 103–105 and accompanying text.

123. *See supra* notes 104–105 and accompanying text.

clear that states can be held accountable for the actions of private parties if the life-threatening conditions are tied to insufficient government regulation of private healthcare providers:

The failure to regulate and supervise such activities gives rise to international liability, as the States are liable for the acts performed by both public and private entities which give medical assistance, since under the American Convention international liability comprises the acts performed by private entities acting in a State capacity, as well as the acts committed by third parties when the State fails to fulfill its duty to regulate and supervise them. Therefore, the duty of the States to regulate these acts is not limited to public hospitals, but includes any and all health care institutions.¹²⁴

General Comment 14 similarly states that “[v]iolations of the right to health can occur through the direct action of States or other entities insufficiently regulated by the States.”¹²⁵ However, government liability for private actors’ human rights violations has limits. Both General Comment 14 and *Ximenes-Lopes* indicate that a state should not be liable for a human rights violation if there are adequate state guidelines and monitoring.¹²⁶ But without appropriate regulations protecting a dignified life, governments risk violating Article 4 of the Convention.¹²⁷

124. *Ximenes-Lopes*, Inter-Am. Ct. H.R. (ser. C) No. 149, ¶ 90.

125. General Comment 14, *supra* note 29, ¶ 48.

126. As a practical matter, if adequate domestic mechanisms were in place to deal with private violations, a human rights claim would never reach the Inter-American Court because of admissibility rules. *See supra* note 22.

127. Although this article has emphasized the difficulty of enforcing obligations subject to the progressive realization principle, General Comment 14 illustrates how the doctrine can impose real obligations. Progressive realization allows nations to develop their health systems gradually as available resources allow. But it cuts two ways: realization must be progressive and not retrogressive. It is a violation of the right to health to repeal “legislation necessary for the continued enjoyment of the right to health or the adoption of legislation or policies which are manifestly incompatible with pre-existing domestic or international legal obligations in relation to the right to health.” General Comment 14, *supra* note 29, ¶ 48. In *Sawhoyamaya*, the court found a violation of the right to life in the fact that Paraguay failed to comply with its own health laws. Providing free medical care to *all* indigenous people would probably not be considered a core obligation under the right to health. But once Paraguay took the step of codifying such a domestic right, the court would not let the state retreat from that progressive measure. *See supra* notes 80–82 and

In short, both the right to life as interpreted by the Inter-American Court and the right to health impose positive obligations on states. Both require provision of core necessities including water, food, medicine, and access to healthcare facilities. Both instruct that these necessities be provided in adequate quality and quantity. Both provide no excuse for governments who fail to act when they have knowledge of life-threatening conditions. And both require governments to regulate private parties so that the conditions necessary for a dignified life are not denied to any individual.

CONCLUSION

Our standard, synthesized from Inter-American Court decisions, undeniably departs from past notions that a government's only obligation under the right to life is to refrain from killing. Human dignity and the inevitable integration of human rights law require such an expansion. The protection of life, if it is to retain meaning, necessitates protection of those things that make life possible and which make life worth living. As the court wrote in "*Street Children*," if the right to life "is not respected, all rights lack meaning."¹²⁸ And the right to life necessarily includes "access to the conditions that guarantee a dignified existence."¹²⁹ The decisions in *Yakye Axa*, *Sawhoyamaxa*, and *Ximenes-Lopes* show that the right to a dignified life includes the core elements of the right to health. And the Inter-American Court will provide remedies for individuals who are denied adequate access to the basic necessities of food, water, medicine, sanitation, and healthcare.

The Inter-American Court of Human Rights has brought civil and political rights together with economic and social rights in a way that was always intuitive. They are interrelated and interdependent. In order to give meaningful content to the right to life—in order to protect life that is worth living—the core elements of the right to health must be protected as well. The court's recent jurisprudence on "the right to a dignified life" opens a new avenue to effective enforcement of the right to health.

accompanying text. What is really intriguing about the court's position in *Sawhoyamaxa* is that it is judging whether the state was fulfilling its right to life obligations under a domestic *public health* law, not a *right to life* law.

128. Case of the "Street Children" (Villagrán-Morales et al.) v. Guatemala, 1999 Inter-Am. Ct. H.R. (ser. C) No. 63, ¶ 144 (Nov. 19, 1999).

129. *Id.*