BOOK REVIEWS

THE RIGHT TO HEALTH IN INTERNATIONAL LAW BY JOHN TOBIN (OXFORD, UK: OXFORD UNIVERSITY PRESS, 2012) 440 PAGES. PRICE £74.00 (HARDBACK) ISBN 9780199603299.

Over the past several decades, the right to health has gained greater visibility as a potential tool for improving health outcomes. A number of factors, including political developments and global threats to public health, have played an important role in fostering a strong interest within various sectors in understanding and utilising the right to health to promote the wellbeing of individuals and populations.[1] While the amount of scholarship on the right to health has grown over the years, John Tobin's book *The Right to Health in International Law* stands as a valuable addition as it constitutes an ambitious, careful, critical and objective assessment of our current understanding of the international right to health and its implementation.

In September 2000, the international community formed a new global partnership committed to reducing extreme poverty by 2015, establishing a platform for what have come to be known as the eight Millennium Development Goals ('MDGs').[2] Six of the eight have direct implications for health.[3] The *United Nations Millennium Declaration* ('*Millennium Declaration*') therefore signifies global recognition of the importance of health in the lives of the more than seven billion people currently living in the world. There is an express recognition of 'a collective responsibility to uphold the principles of human dignity, equality and equity at the global level' and states' duties to 'all the world's people, especially the most vulnerable'.[4] This focus on health underscores the need for a tool that effectively addresses the health needs of individuals and populations across the world.

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[1] John Tobin, *The Right to Health in International Law* (Oxford University Press, 2012) 1; Oscar A Cabrera and Ana S Ayala, 'Advancing the Right to Health through Litigation' in José M Zuniga, Stephen P Marks and Lawrence O Gostin (eds), *Advancing the Human Right to Health* (Oxford University Press, 2013) 25.

[2] See *United Nations Millennium Declaration*, GA Res 55/2, UN GAOR, 55th sess, 8th plen mtg, Agenda Item 60(b), UN Doc A/RES/55/2 (18 September 2000) (from which the Millennium Development Goals ('MDGs') were derived). See also World Health Organization, 'Millennium Development Goals (MDGs)' (Fact Sheet No 290, November 2012) <http://www.who.int/mediacentre/factsheets/fs290/en/index.html>.

[3] The MDGs related to health include: halving the proportion of people who suffer from hunger (MDG 1, target 1.C); reducing child mortality (MDG 4); improving maternal health (MDG 5); and combating HIV/AIDS, malaria and other diseases, including neglected tropical diseases (MDG 6); halving the proportion of people without sustainable access to safe drinking water and basic sanitation (MDG 7, target 7.C); and in cooperation with pharmaceutical companies, providing access to affordable essential medicines in developing countries (MDG 8, target 8.E): United Nations Department of Public Information, *2015 Millennium Development Goals* <http://www.un.org/millenniumgoals/>.

[4] *United Nations Millennium Declaration*, UN Doc A/RES/55/2, para 2.

While human rights prominently appear in the *Millennium Declaration*,[5] only light references are made to them in the MDGs themselves.[6] Indeed, the MDGs were drafted as a global development agenda rather than a human rights agenda.[7] Nevertheless, 'human rights and the MDGs are clearly linked and constitute shared global commitments'[8] and there has been widespread recognition of the obvious overlap in interest between human rights and the MDGs.[9] Moreover, in light of the fast-approaching deadline for meeting the MDGs and the ongoing international campaign for a Framework Convention on Global Health ('FCGH'),[10] Tobin's interpretation and analysis of the right to health becomes particularly valuable. For one, the establishment of a post-2015 development agenda and the international community's preoccupation with the post-MDG era provides an opportunity to better define state obligations under the international right to health with respect to achieving the successors to the MDGs.

Similarly, the aims of a FCGH will be to 'dramatically reduce health inequities and establish a post-[MDGs] global health agenda rooted in the right to health'.[11] Moreover, the proposed FCGH is envisioned as going hand-in-hand with 'a social movement that supports the treaty and the right to health more broadly',[12] with the right to health and its principles (such as equality, accountability and empowerment) placed 'at the center of [a FCGH] agenda in ways that the MDGs did not'.[13] A FCGH is intended to 'further elaborate on the right to health, from clarifying and codifying the interpretation of this right … to setting clearer standards for the progressive realization and maximum of available resource obligations'.[14] Therefore, as it will be shown below, Tobin's analysis is clearly relevant to the aims of a FCGH.

Taking these developments into consideration, this review focuses on those specific aspects of Tobin's analysis that should be highlighted above others for their greater significance to the field. First, this review highlights his discussion of the historical origins of the right to health. These, as he points out, are often overlooked by scholars and help to fully comprehend the right's intended content and dispel some persisting misconceptions about the right, particularly its (mis)perceived lack of instrumentality.[15] This review then addresses the

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5 See, eg, *United Nations Millennium Declaration*, UN Doc A/RES/55/2, paras 24–5. See also Philip Alston, 'Ships Passing in the Night: The Current State of the Human Rights and Development Debate Seen through the Lens of the Millennium Development Goals' (2005) 27 *Human Rights Quarterly* 775, 779.

6 Ibid 760.

7 See ibid 775–829.

8 Shyama Kuruvilla et al, 'The Millennium Development Goals and Human Rights: Realizing Shared Commitments' (2012) 34 *Human Rights Quarterly* 141, 148.

9 Ibid 149.

10 See, eg, Lawrence O Gostin, 'A Framework Convention on Global Health: Health for All, Justice for All' (2012) 307 *Journal of the American Medical Association* 2087, 2087; Lawrence O Gostin et al, 'The Joint Action and Learning Initiative on National and Global Responsibilities for Health' (Background Paper No 53, World Health Organization, 2010).

11 Eric A Friedman and Lawrence O Gostin, 'Pillars for Progress on the Right to Health: Harnessing the Potential of Human Rights through a Framework Convention on Global Health' (2012) 14(1) *Health and Human Rights: An International Journal* 4, 5.

12 Ibid 15.

13 Ibid 5.

14 Ibid.

15 Tobin, above n 1, ch 1.

persuasive methodology that Tobin has developed as a first step to uncovering the intended meaning of the right to health and allowing for an appropriate interpretation of the right to health and its implied state obligations.[16] Importantly, this review elaborates on Tobin's suggested application of his methodology to states' obligations, including the vague concept of progressively realising the right to health to the maximum extent of available resources.

Understanding the relevance of the right to health to effectively addressing the health needs of individuals and populations across the globe, Tobin engages in an in-depth analysis of the long history and theoretical foundations of the right to health.[17] Tobin considers that this type of careful analysis is necessary for uncovering the intended meaning of the right and, thusly, achieving a more effective application of the right to health to a variety of health issues.[18] What is more, prior to embarking on this quest, Tobin concedes that the right has undergone 'dramatic progress',[19] but emphasises that it has yet to overcome many challenges to effectively influence health policy. In fact, Tobin recognises that the right to health has received much attention from advocates and critics alike,[20] but he voices the need to take a centrist and objective stance on the right to health's ability to influence health policy and health outcomes.[21] This approach adds credibility to Tobin's analysis of the right and hopefully increases its chances of application on the ground.

Tobin's historical exploration of the right to health underscores a number of important facts that existing literature on the right to health generally does not address or only mentions lightly.[22] As he rightly points out, states' interest in protecting the health of their people is by no means a recent development.[23] Indeed, the history of the right to health, particularly its intersection with the history of public health, deserves attention — especially considering the scepticism that continues to exist about the practicality and effectiveness of the right to health.[24]

Tobin emphasises that the protection of health has, for a very long time, been perceived as particularly important to those in power, including the Incan sewage systems and baths as well as the Romans' provision of free medical care to the poor during the second century AD.[25] What has varied has been the nature of the motivation behind this interest, which has ranged from religious to social,

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16 Ibid ch 3.

17 Ibid ch 1.

18 Ibid 6.

19 Ibid 3.

20 For examples of advocates of the right to health, see, eg, John Harrington and Maria Stuttaford (eds), *Global Health and Human Rights: Legal and Philosophical Perspectives* (Routledge, 2010). For some critics of the right to health, see, eg, James Griffin, *On Human Rights* (Oxford University Press, 2008); William Easterly, 'Human Rights are the Wrong Basis for Healthcare', *Financial Times* (online), 12 October 2009 <http://www.ft.com/cms/s/0/89bbbda2-b763-11de-9812-00144feab49a.html>.

21 Tobin, above n 1, 1, 3–6.

22 See, eg, Alicia Ely Yamin and Siri Gloppen (eds), *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Harvard University Press, 2011); Varun Gauri and Daniel M Brinks (eds), *Courting Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World* (Cambridge University Press, 2008).

23 Tobin, above n 1, 15.

24 See ibid ch 2.

25 Ibid 35.

political and economic. Tobin explains that 19th century Latin American philosophical approach to human rights was deeply rooted in 'Catholic teachings with respect to human dignity and social justice',[26] whereas the emergence of the modern nation state in the 16th century brought about the realisation that a healthier population and less disease meant a politically and economically stronger state.[27]

Furthermore, the 'right to health' is a mere reconceptualisation of the interest to protect health and not the creation of this interest. As Tobin explains, the emergence of the right was an expression of states' recognition of an individual's entitlement to the protection of his or her health[28] and the realisation that the state bears primary responsibility for the protection of this entitlement.[29] The creation and recognition of a right to health therefore constituted a move away from states' instrumentalist attitude toward the protection of their people's health. Indeed, Tobin recognises 19th century Latin American philosophy of human rights, which he refers to as 'social liberalism', as the bedrock of the right to health — not 'communist ideology' during the Cold War, as is often believed.[30] He clarifies that during the 19th century, Latin America experienced a movement dedicated to addressing 'the human needs of the poor and working class'.[31] Moreover, while World War II played an important role in strengthening the perception that health was directly linked to peace and security, culminating in the inclusion of the right to medical care within the *Universal Declaration of Human Rights* in 1948,[32] it was not until the Cold War that the protection of health as a human right became 'reduced' to being an invention of 'communist ideology'.[33]

Tobin's historical discussion is valuable in its ability to show that the right to health is founded and 'deeply interwoven with pragmatic and instrumentalist considerations' and not a concept that originated during the Cold War and that was influenced by communism.[34] Considering that sceptics rely on arguments that the right to health is abstract and not realisable,[35] the intersection between the history of the right to health and the historical instrumentalist approach to protecting the public health provides the right to health with a strong foundational basis.

Tobin underscores that the right to health is often criticised for being particularly abstract and lacking concrete philosophical foundations, creating a need for a solid and persuasive methodology of interpretation for finding the meaning of the right to health.[36] Here, Tobin develops what could be his greatest contribution to the field.

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26 Ibid 21–2.
27 Ibid 36.
28 Ibid 42.
29 Ibid 41.
30 Ibid 15.
31 Ibid 22.
32 Ibid 24–7. See also *Universal Declaration of Human Rights*, GA Res 217A (III), UN GAOR, 3rd sess, 183rd plen mtg, UN Doc A/810 (10 December 1948).
33 Tobin, above n 1, 42.
34 Ibid.
35 See ibid ch 2; Griffin, above n 20.
36 Tobin, above n 1, 10.

Prior to presenting his methodology, however, Tobin explores the conceptual foundations of the right in order to challenge the belief of many philosophers that the right to health is philosophically unjustified.[37] He describes a number of challenges facing the right and concludes that it is indeed justifiable as it represents a consensus among states that 'the highest attainable standard of health for an individual is an appropriate interest upon which to ground a human right'.[38] This is in accordance with the 'social interest theory of rights', which he embraces.[39] Under this theory, an interest becomes a right — such as the highest attainable standard of health — when it undergoes 'a social process that leads to [its] recognition … as a human right' and is accepted by the duty bearer of the right and not just by the beneficiary of the right.[40] Accordingly, the rights are not perceived as being 'inherent, essential, urgent, or capable of determination by reference to a single test or moral theory'. Rather, they are interests that are continuously 'contested, negotiated, historically contingent, and produced by particular social processes'.[41] Tobin admits that the justification he offers for the right to health is not perfect, but emphasises that this imperfection is overcome by the meaning of the right to health — the principal focus of his book.[42]

In presenting his methodology of interpretation, Tobin rightfully stresses that the 'act of interpretation' is essentially an 'act of persuasion', an approach that advocates are encouraged to adopt.[43] He concedes that the right to health can indeed have a number of meanings[44] that can change over time, and that 'controversy is … a constant feature of the interpretative enterprise'.[45] He explains that 'the accepted meaning of this right at a particular point in time will be that which attracts and achieves dominance over all other alternative understandings within the *relevant interpretative community*'.[46]

Tobin understands 'the relevant interpretative community' to mean the group of 'persons or entities and their agents that have an interest either direct or implied in the meaning of the right to health in international law' for reasons of 'impos[ing] legal obligations or creat[ing] benefits for certain persons or entities or for its implementation to carry practical consequences for certain persons or entities'.[47] This understanding is in line with the author's call for engaging a variety of actors from different disciplines — particularly non-lawyers — in developing an interdisciplinary understanding of the right to health. It is through this approach that the right to health can gain greater support and therefore be more effectively implemented.

This in turn requires support from 'the relevant interpretative community' made up of a diverse set of actors, including states. The 'act of interpretation' is

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37 Ibid ch 2.
38 Ibid 73–4.
39 Ibid 54–5.
40 Ibid 54.
41 Ibid.
42 Ibid 74.
43 Ibid 10.
44 Ibid 79.
45 Ibid 80.
46 Ibid (emphasis added).
47 Ibid 81.

therefore ultimately an 'act of persuasion'[48] as the interpretative community must be convinced that the interpretation in question is the most appropriate above other meanings offered.[49] Tobin clarifies that because states continue to hold 'primary legal responsibility for the implementation of obligations under international treaties', they are still 'the central actors to be persuaded'.[50]

With this observation in mind, Tobin argues that a persuasive interpretation of the right to health that can lead to a clearer understanding of the right must meet four non-severable criteria. The meaning of the right to health must

> be principled; be clear and practical; demonstrate coherence in both its reasoning *and* within the system of international law; and be sensitive to the nature of the socio-political context within both individual states and the international legal order.[51]

Tobin aims to provide a meaning that is as objective as possible, exploring each of these criteria in detail.

With regard to the 'principled interpretation' of the right to health, Tobin recognises that the *Vienna Convention on the Law of Treaties* ('*VCLT*')[52] continues to be a necessary starting point, because it adds to the persuasiveness of the interpretation and sets a 'constraint' on the interpretative process.[53] However, he does not consider the *VCLT* capable of providing 'the' meaning of the right to health[54] and suggests that human rights treaties require a 'special interpretative methodology' in which human rights treaty monitoring bodies play a valuable role.[55] Indeed, Tobin refers to their work throughout the book, providing a critical analysis of their interpretations of the right to health.[56] Because the book treats the *International Covenant on Economic, Social and Cultural Rights* ('*ICESCR*')[57] and the *Convention on the Rights of the Child*[58] as the two treaties that provide 'the most comprehensive expression of the right in international law', Tobin focuses on the interpretations of their corresponding treaty monitoring bodies.[59] However, he does point out that regional bodies, such as the European Court of Human Rights and the Inter-American Court of Human Rights, have been more explicit in their methodology for interpreting the content of human rights treaties, while treaty monitoring bodies have not.[60] Supporting the interpretation methodologies advanced by these regional bodies, Tobin calls for an interpretation that is 'non-restrictive', effective and dynamic, all of which

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48 Ibid 10.
49 Ibid 80, 118.
50 Ibid 84.
51 Ibid 87 (emphasis in original).
52 *Vienna Convention on the Law of Treaties*, opened for signature 23 May 1969, 1155 UNTS 331 (entered into force 27 January 1980).
53 Tobin, above n 1, 91, 119, 373.
54 Ibid 118, 119.
55 Ibid 92.
56 See, eg, ibid 92–3.
57 *International Covenant on Economic, Social and Cultural Rights*, opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976) ('*ICESCR*').
58 *Convention on the Rights of the Child*, opened for signature 20 November 1989, 1577 UNTS 44 (entered into force 2 September 1990).
59 Tobin, above n 1, 7.
60 Ibid 92–3 (citations omitted).

should be used to facilitate '*an*' interpretation of the right to health, not to 'justify *any* interpretation'.[61]

Tobin explains that the abstract language typically found in human rights treaty provisions make clarity and practicality necessary components of the treaties' interpretations. In fact, he describes them as 'essential' to making the interpretation persuasive to the interpretative community.[62] The Committee on Economic, Social and Cultural Rights' ('CESCR') minimum core obligations are provided as an example of a vague concept that lacks clarity, undermining its practicality in guiding states to effectively implement the right to health.[63]

Tobin's third criterion is 'coherence', meaning the interpretation's connection with both its legal reasoning and the legal system.[64] Particularly, Tobin emphasises that the reasoning behind the interpretation must extend beyond the law, especially considering the number and variety of 'fields that intersect either directly or indirectly with the implementation of the right to health'.[65] Moreover, an interpretation's coherence with the system of international law refers to the interpretation's consistency with principles underlying both the entire system of international law (ie, harmonisation with other treaties' provisions) and the treaty in which the right to health is enshrined.[66] This criterion becomes particularly important in the author's analysis of treaty monitoring bodies' interpretations of the right to health and its underlying state obligations. For example, Tobin finds major 'coherence' gaps in the CESCR's *General Comment on the Right to Health*.[67] Specifically, he highlights the inclusion of underlying determinants of health listed in the General Comment that are not mentioned under art 12 in the *ICESCR*.[68] Moreover, other rights contained in the treaty already address them, resulting in what Tobin describes as an encroachment on the 'normative territory' of these other rights.[69] Justifiably, he considers that instead of listing underlying determinants that are already protected by other rights contained in the treaty, the CESCR could have easily recognised the interdependence of these health-related rights with the right to health, as this would be consistent with the principles of 'interdependence' and 'indivisibility' under international law.[70]

Finally, Tobin underscores the need for the interpretation to be sensitive to the local and global contexts. 'Local context sensibility' requires the interpretation to 'reflect the needs and interests of local populations', which according to Tobin is best achieved through community participation.[71] However, he does emphasise that 'sensitivity to the social, cultural, and political practices within a particular state' and the flexibility granted in the implementation of measures for the protection of the right to health should not be used to justify human rights

61 Ibid 94 (emphasis in original).
62 Ibid 97.
63 Ibid.
64 Ibid 100.
65 Ibid 104.
66 Ibid 105.
67 Ibid 107–9.
68 Ibid 108.
69 Ibid.
70 Ibid 109.
71 Ibid 111.

violations.[72] As elaborated in his discussion of traditional practices with regards to children's health, the elimination of practices that constitute human rights violations should be achieved through a collaboration and consultation process rather than through the imposition of 'hegemonic visions' of the right to health.[73] Indeed, the 'margin of appreciation' principle, developed by the European Court of Human Rights, that grants states a level of flexibility as to the measures that they can adopt to meet their obligations under the treaty, is supported throughout the book.[74] This flexibility allows states to 'accommodate cultural diversity' particular to their territory.[75] The recognition that the interpretation be sensitive to the global context acknowledges that states play an important role in determining the validity of the interpretation and they should not be ignored, much less antagonised. Thus, a persuasive interpretation of the right to health requires that it recognise that 'the power of states and their legitimate interests cannot be dismissed'.[76]

In the book, Tobin applies these four criteria to his analysis of both the meaning of 'the highest attainable standard of health' as well as the state obligations under the right to health.[77] While this review focuses on Tobin's application of his methodology of interpretation to state obligations, it is worth highlighting his assertion that the right to health 'does not, and was never intended, to provide individuals with a guarantee of health'.[78] Furthermore, the 'highest attainable standard' encompasses the idea that 'the level of health enjoyed by an individual, whether physical or mental, will be dependent on factors peculiar to an individual *and* the resources available to the state',[79] making the 'implementation and level of enjoyment' relative.[80] These observations are important to understanding the author's approach to interpreting the state obligations under the right to health.

Just as the right to health has been described as abstract and vague, so have the state obligations associated with it, particularly the obligation to

> (a) take steps; (b) individually and through international assistance and co-operation; (c) subject to its available resources; to (d) progressively realize the right to health by; (e) all appropriate (legislative, administrative and other) means.[81]

Tobin observes that CESCR's interpretation of state obligations lacks coherence.[82] As such, he finds it necessary to apply his methodology to give a more precise meaning to these obligations.[83]

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72 Ibid 111–12.
73 Ibid 112.
74 Ibid 112–13. See also *Handyside v United Kingdom* (1976) 24 Eur Court HR (ser A) (in which the principle was applied for the first time).
75 Tobin, above n 1, 112.
76 Ibid 120.
77 Ibid chs 3, 4, 6.
78 Ibid 121.
79 Ibid (emphasis in original).
80 Ibid 121.
81 Ibid 177. See also *ICESCR* arts 2(1), 12.
82 Tobin, above n 1, 177.
83 See ibid.

Tobin explains that an obligation to 'take steps' essentially means that states are expected to immediately work towards the realisation of the right to health 'with a view to achieving an "obligation of result"'.[84] Indeed, he recognises that in this case, the CESCR's recommendations, or interpretations of state obligations, have been principled, as they are 'consistent with the view expressed during drafting of the *ICESCR*, that the obligation assumed by states under this treaty must be practical yet resistant to loop holes'.[85] Moreover, Tobin indicates that this obligation is in line with the general obligation under international law to 'perform the obligations assumed under that treaty in good faith'.[86]

Yet the obligation to take 'all appropriate means' to progressively realise the right to health is often seen as ambiguous, leading Tobin to apply his methodology to arrive at a clearer definition.[87] Tobin recognises the 'margin of appreciation' that must be granted to states, but also reminds the reader of the importance of requiring states to justify whatever measures they decide to take for the effective implementation of the right to health.[88] Tobin explains that whether legislative measures on the right to health — which are often recommended by human rights treaty bodies — are 'appropriate measures' ultimately depends on the particular state's need for legislation. Furthermore, given that human rights bodies have not provided states with useful guidance on balancing conflicting rights created by legislative measures aimed at realising the right to health,[89] Tobin provides an explanation of the proportionality test through which states can demonstrate the reasonableness of such measures.[90]

With respect to evaluating the appropriateness of other measures, the author offers an analysis based on the tripartite typology of state obligations to respect, protect and fulfil.[91] He underscores that this typology serves as a good foundation for interpreting and classifying state obligations, especially considering that the interpretative community has 'embraced [it] as a practical tool by which to generate an understanding as to the nature of states' obligations under a right'.[92] However, Tobin stresses that this typology must go hand-in-hand with the four requirements for a 'principled, practical, coherent and context-sensitive interpretation', something that the CESCR has overlooked, particularly with regards to guaranteeing system coherence.[93]

In a similar vein, Tobin discusses the work of human rights treaty monitoring bodies to further arrive at a reasonable interpretation of state obligations under the right to health.[94] Specifically, he explores the work of the CESCR and that of the Committee on the Rights of the Child ('*CRC* Committee') — which monitors state implementation of the *Convention on the Rights of the Child* — with

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84 Ibid 178.
85 Ibid.
86 Ibid 177.
87 See ibid.
88 Ibid 179.
89 Ibid 180–1.
90 Ibid 183.
91 Ibid 185–97.
92 Ibid 185.
93 Ibid 186.
94 Ibid 197–224.

respect to the need for national plans and policies as appropriate measures.[95] Based on his analysis, he concludes that treaty monitoring bodies allow for 'a reasonable margin of appreciation to states' in the implementation of the right to health through national plans and policies.[96] These human rights bodies fittingly 'attempt to strike an appropriate balance between the need to accommodate the specific socio-political context within individual states and at the same time the need to insist on effective implementation of international obligations'.[97]

Moreover, Tobin addresses treaty monitoring bodies' emphasis on the development of accountability systems and the need to provide domestic judicial remedy. He explains that states are required to ensure that the accountability mechanisms adopted by states are effective.[98] However, with regard to the obligation to provide judicial remedy, Tobin is particularly critical of using the courts to protect the right to health.[99] He finds this approach 'reactive rather than preventative, adversarial rather than conciliatory, excessively legalistic and invariably resource intensive'.[100] While Tobin recognises that litigation could constitute 'an important strategy to secure aspects of the right to health',[101] he relies on relatively recent studies that show right to health litigation's tendency to increase health inequities rather than to alleviate them. Nevertheless, in light of even more recent studies[102] that contradict this conclusion, other scholars have pointed out that the impact of right to health litigation deserves further research and analysis.[103] Such studies appear to support the argument that the success of this type of litigation may largely depend on the local context of the place in question and that recent data shows a wide spectrum of distributive impact on the poor across countries.[104] Despite Tobin's short discussion on the topic and especially considering that the literature on health rights litigation continues to grow,[105] it is important to note that there is still much to be explored.

Tobin also emphasises the need for data collection to be 'timely and reliable' as well as disaggregated in order to be effective.[106] However, he criticises the *CRC* Committee for unreasonably focusing on data collection in its comments.[107] According to Tobin, the *CRC* Committee fails to realise the level of financial and human resources required to effectively collect such data.[108] Therefore, he calls on human rights treaty monitoring bodies to provide guidance to states on how to prioritise data and to also request that states explain the gaps created in ensuring

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95 Ibid 199–201.
96 Ibid 200.
97 Ibid.
98 Ibid 201.
99 Ibid 207–8.
100 Ibid.
101 Ibid 207.
102 See Cabrera and Ayala, above n 1.
103 See, eg, Daniel M Brinks and Varun Gauri, 'The Law's Majestic Equality? The Distributive Impact of Litigating Social and Economic Rights' (Policy Research Working Paper No 5999, World Bank, March 2012) <http://elibrary.worldbank.org/content/workingpaper/10.1596/1813-9450-5999>.
104 Ibid 7–8.
105 Tobin, above n 1, 202–8.
106 Ibid 209.
107 Ibid 210–11.
108 Ibid 210.

the four normative elements of the right to health (availability, accessibility, acceptability and quality) and the costs associated with addressing these gaps.[109] Furthermore, Tobin highlights the benefits of using indicators and benchmarks and calls for a margin of appreciation for states.[110] However, considering their importance to measuring the implementation of the right, Tobin advocates for a participatory and collaborative process for determining such indicators and benchmarks. This process must involve a variety of actors to ensure legitimacy.[111]

Indeed, Tobin places significant weight on states using a participatory process to define the measures necessary for the effective implementation of the right to health.[112] While he recognises that the participation of all stakeholders is impossible for practical and financial reasons, Tobin offers the reasonableness test to ensure that states undertake reasonable efforts for the effective participation of all stakeholders.[113]

Returning for a moment to the idea of a proposed FCGH, it is significant that the objectives of a FCGH and process for defining its content largely reflect this approach. A FCGH would fundamentally be defined by the participatory process as it would work to engage and empower, to the greatest extent possible, local communities who stand to benefit from the realisation of the right, particularly the marginalised and vulnerable populations.[114]

One of Tobin's valuable contributions to right to health scholarship is his attempt to better interpret states' obligations to progressively realise the right to health subject to the maximum extent of the state's available resources. As Tobin indicates, this obligation stems from states' preoccupation with making their commitments to the *ICESCR* reasonable.[115]

Tobin is quick to point out that the term 'resources' includes both financial and non-financial resources.[116] In this respect, Tobin explains that this ambiguity allows for a 'context sensitive understanding' of the term 'resources'.[117] This means that a margin of appreciation must be granted to states as long as the measures they decide to adopt work to effectively realise the right to health. While adopting a 'context sensitive' interpretation of this obligation signifies taking into consideration a country's relative lack of resources, it must not act as a justification for states' failure to take steps toward the realisation of the right.[118] Rather, states are expected to explain how they are actively distributing and redistributing their existing resources to protect the right to health and what measures they are adopting to increase resources.[119] As Tobin illustrates, the

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109 Ibid 211.
110 Ibid 212–13.
111 Ibid 213.
112 See, eg, ibid 214–15.
113 Ibid 217.
114 Friedman and Gostin, above n 11, 12.
115 Tobin, above n 1, 225.
116 Ibid 226–7.
117 Ibid 227.
118 Ibid 229.
119 Ibid 230.

phrase 'maximum available resources' takes on a 'dynamic understanding', which has been embraced by human rights treaty monitoring bodies.[120]

Moreover, the complex and somewhat amorphous nature of this obligation is counterbalanced by yet another abstract state obligation: the obligation to cooperate and provide assistance at the international level. Under this principle, states have the obligation to seek international assistance, as this too counts as an 'available resource'. This particular obligation is oftentimes ignored, even by treaty monitoring bodies.[121] As Tobin stresses, international cooperation 'must occupy a more central place in [right to health] debates given that cooperation between states is critical to ensure the effective enjoyment of the right to health'.[122] This observation becomes particularly relevant to meeting the MDGs and advancing the post-2015 development agenda because of the level of commitment that is required from states to not only meet their own targets, but to also function together as one community in ensuring the realisation of MDGs across the world. Indeed, as the deadline nears, some improvement in each of these six health-related areas has been observed. However, much more still needs to be done.[123]

A FCGH offers an opportunity for right to health advocates to work with the interpretative community that is forming around a FCGH and further define right to health state obligations in that context. Advocates stand to benefit from FCGH campaigning efforts to engage a variety of actors, including governments, civil society, local communities and international institutions like the World Health Organization, the World Trade Organization, the International Monetary Fund, the World Bank and the Food and Agriculture Organization.[124] It is precisely this type of opportunity that Tobin envisions for further strengthening the content of the right to health so as to effectively reduce health inequities, which is the core objective of a FCGH. It could also bring about Tobin's much advocated interdisciplinary understanding of the right to health and push the right to health 'to the centre of such debates'.[125] For these reasons, advocates and the field have much to gain from such an opportunity.

In light of these and other current developments in the area of health,[126] this review commends Tobin's concerted effort to jump-start the discussion around

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120 Ibid 229.

121 Ibid 368–9.

122 Ibid 368.

123 World Health Organization, above n 2.

124 Friedman and Gostin, above n 11, 11; Gostin, above n 10, 2091.

125 Tobin, above n 1, 6.

126 For example, preparations for the post-2015 development agenda include the formation of the Joint Action and Learning Initiative on National and Global Responsibilities for Health for a potential Framework Convention on Global Health, as well as several other international initiatives: see *World Health Organization Framework Convention on Tobacco Control*, opened for signature 21 May 2003, 2302 UNTS 166 (entered into force 27 February 2005); *Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases*, GA Res 66/2, UN GAOR, 66th sess, 3rd plen mtg, Agenda Item 117, Supp No 49, UN Doc A/RES/66/2 (24 January 2012) annex ('*Political Declaration of the High-Level Meeting of the General Assembly on the Prevention and Control of Non-Communicable Diseases*'); World Health Organization, *Global Action Plan for the Prevention and Control of Noncommunicable Diseases 2013–2020* (15 March 2013) <http://www.who.int/cardiovascular_diseases/15March2013UpdatedRevisedDraftActionPlanAPPROVEDBYADG.pdf>.

effectively defining and clarifying the content of the right to health and its underlying state obligations. This review has aimed to highlight several aspects of the book, particularly Tobin's interpretative methodology, that constitute valuable contributions to our understanding of the right to health. These will hopefully inform the process of revising the MDGs and shaping the post-MDG era as well as the future negotiations and content of a FCGH towards ensuring the effective implementation of the right to health.

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