**Response to the Call for Contributions to the OHCHR analytical study on key challenges in ensuring access to medicines, vaccines and other health products (HRC resolution 50/13)**

This contribution has been jointly elaborated by the following members of the Global Health Law Consortium (GHLC), submitting their views in their own capacity: Luciano Bottini Filho, Helena Kennedy Centre for International Justice, Sheffield Hallam University; Safura Abdool Karim, Berman Institute of Bioethics, Johns Hopkins University; Judith Bueno de Mesquita, Essex Law School and Human Rights Centre, University of Essex; Mark Eccleston-Turner, Department of Global Health and Social Medicine, King’s College; Lisa Forman, Dalla Lana School of Public Health, University of Toronto; Roojin Habibi, Faculty of Law (Common Law Section), University of Ottawa; Helena Kennedy; Benjamin Mason Meier, Gillings School of Global Public Health, University of North Carolina at Chapel Hill; Alexandra Phelan, Johns Hopkins Bloomberg School of Public Health and Johns Hopkins Center for Health Security; Sharifah Sekalala, School of Law, University of Warwick; Alica E. Yamin, Petrie-Flom Center for Health Law Policy, Biotechnology and Bioethics at Harvard Law School and Harvard TH Chan School of Public Health.

The authors value the opportunity for public engagement with the OHCHR to facilitate comprehensive discussions on crucial measures aimed at implementing the right to health, specifically focusing on access to medicines, vaccines, and other essential health products. It is widely held that, despite numerous international efforts to reexamine and challenge persistent economic and political barriers to global healthcare access, thus far, the discussions have yielded less progress than needed to mitigate the stark disparities in the production, distribution, and affordability of essential healthcare technologies.

In presenting their contribution, the authors articulate how consolidated State obligations under global health law and international human rights law can be invoked to justify overhauling fundamental healthcare market dysfunctions, through both international solidarity and individual state programmes. The analysis provided here particularly focuses on issues suggested by the OHCHR under questions a, c, e, f and h. Most of the points are interdependent and mutually reinforcing. A common thread is to underscore State obligations to use all of its regulatory power to reshape and reform economic models and shared responsibilities between private and public actors, prioritising health as a common public good over liberal market distortions of prices and technologies availability. The observations in this submission serve to remind that global health and human rights law frameworks already provide the normative basis to stimulate and reinforce a more conducive environment for access to medicines, vaccines and other health products for all.

By recognising that ensuring access to medicines, vaccines, and other health products entails proactive government measures involving market regulation and interventions over non-state actors, this submission is consistent with the conclusions drawn by the WHO Council on the Economics of Health for All in its 2023 final report. According to the Council's perspective, we can guide and influence both public and private investments in healthcare to foster international cooperation toward overarching objectives (of health, as a common good).[[1]](#footnote-1) This vision holds particular significance in the context of access to medicines, vaccines, and other health products, which encompass a wide array of health technologies, each one presenting unique affordability challenges and particular commercial practices.

Our submission suggests that human rights bodies and international organisations must monitor and promote efforts aimed at providing healthcare goods by making a more explicit connection between better market regulations and the State progressive realisation of the right to health. This approach necessitates a more methodical and detailed examination of State obligations concerning each specific structural market hurdle bearing on medicines, vaccines and other health products against the domestic regulatory context. This approach extends beyond conventional intellectual property constraints to encompass a more diversified range of access policies that have been less prominent in public debates, such as intricate rules of procurement, competition laws and price negotiation, as well questions related to local manufactoring capacity and technology transfer.

Instead of merely identifying a human rights violation when a health technology is unavailable due to private healthcare sector barriers, a more refined evaluation of the applicable human rights standards is required to illustrate the causes of structural market constraints in the first place as a breach of obligations under international law by States individually or collectively. The obligations outlined in this document should be a matter of priority and deeper scrutiny under compliance mechanisms within the UN-system and other regional and domestic human rights institutions as a concerted action for better practices in access to medicines, vaccines and other health products.

The input provided in this document is divided into three priority areas, in relation to main challenges to the implementation of the international right to health:

1. Employing local legislation to reorganise the regulatory environment and redress dysfunctional markets to increase affordable and available medicines, vaccines and other health products;
2. Adopting adequate public health emergency legislation and policies which prevent and redress shortage and development constraints of medical countermeasures in the event of emerging health threats, by endorsing standards outlined by the *Principles and Guidelines on Human Rights and Public Health Emergencies*;[[2]](#footnote-2)
3. Advancing human rights extraterritorial obligations (ETO) as a model of global health governance entailing the application of more beneficial international norms and policies in relation to affordable and accessible health technologies for developing States.

**I. State resource maximisation through regulatory measures to remedy unfair healthcare markets**

Laws play a crucial role in shaping public health outcomes and governing health systems, influencing the accessibility and affordability of medicines, vaccines, and other health products. In accordance with the international right to health, States hold immediate obligations to enact laws that facilitate equitable access to healthcare and essential medicines, but in general international human treaty-bodies and courts do not address this lack of compliance directly and with specific recommendations, save for patent-related concerns.[[3]](#footnote-3)

One pivotal function of legislation is to establish and adjust market structures that may hinder availability and affordability of essential healthcare resources across different states. Unfortunately, the adoption of an optimal legal regime conducive to favourable market conditions is not consistently prioritised by States in their own jurisdiction and as part of global health governance under the international right to health.[[4]](#footnote-4)

As a result, the effectiveness of laws in promoting accessibility and affordability of healthcare resources varies across jurisdictions. Striking an appropriate balance between ensuring public health and fostering favourable market conditions requires a concerted effort by states to implement and refine legal frameworks that align with international health principles.

The implementation standards of economic and social rights involve laws and market regulation are also regarded as part of the State internal and external resources. As States are obliged to maximise resources to progressive realise the right to health (Article 2.1 of the International Covenant on Economic and Social Rights), it follows that states must maximise as well their “legal resources” (just as other financial, human or technical resources) to formulate market conditions conducive to affordability and availability of health technologies despite the constraints of private actors with economic coercion or abuse.[[5]](#footnote-5)

**Giving prominence to affordability as a human rights standard**

When formulating healthcare legislation and regulations, states must adhere to the affordability standard (or economic accessibility) as outlined by the well-established Availability, Accessibility, Acceptability, and Quality (AAAQ) framework developed through the Committee on Economic and Social Rights (CESCR) General Comment 14.[[6]](#footnote-6) Despite international discussions and high-level political negotiations, there is an inconsistency in prioritising affordability as a fundamental State obligation for access to health goods in practice as a primary focus in market regulation.

The goal of affordability in the development of legal frameworks and international cooperation is clouded by alternative terms such as value-based pricing and fair pricing.[[7]](#footnote-7) In this view, the interests of private companies and the pursuit of technological advancements have been pitted against the societal imperative to manufacture and distribute health goods in accordance with the economic capacity of the poorest populations.It is fundamental that manufacturers and patent-owners operate within a legal framework where affordability, as a matter of international economic and social rights, takes precedence over considerations of investment compensation and royalties. In considering commercialisation or private profits, rules should be adopted to establish an economic model that not only appears "favourable" or "equitable" but effectively ensures the availability of health products at affordable prices for economically disadvantaged states.

In recognising such obligations, we can foresee various specific scenarios, that can be used separately or in conjunction, as State approaches to align their regulatory resources with the right to health. The legal measures that can be grounded under the international right to health framework as a form of resource maximisation are non-exhaustive and encompass both IP mechanisms and different instruments of market regulation.

**Maximising resources through intellectual property flexibilities**

Access to medicines including vaccines is one of the core obligations of the right to health under Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR). In his report to the Human Rights Council in 2009, Special Rapporteur on Right to Health stated, “Developing countries and LDCs should be enabled to take steps to modulate the implementation of TRIPS on access to medicines including by encouraging competition and being able to access affordable generic versions of patented medicines.” Thus it is imperative that there is an enabling environment for countries in the global south to use TRIPS flexibilities. In CESCR’s 2006 General Comment 17 on article 15(1)(c), the Committee clarified that the enjoyment of the benefits of scientific progress means that states “have a duty to prevent unreasonably high costs for access to essential medicines … from undermining the rights of large segments of the population to health, food and education.”[[8]](#footnote-8)

In subsequent general comments, the Committee has indicated that core obligations to provide access to essential medicines impose duties to ensure that intellectual property and trade agreements do not impede access and to incorporate to the fullest extent safeguards and flexibilities to promote access to medicines care for all.[[9]](#footnote-9) In a 2017 General Comment 24 on state obligations regarding business activities, the Committee affirmed that when designing intellectual property rights frameworks, states “should ensure that intellectual property rights do not lead to denial or restriction of everyone’s access to essential medicines necessary for the enjoyment of the right to health.”[[10]](#footnote-10) In its 2020 General Comment 25 on science and economic, social, and cultural rights, the Committee affirmed that states should use TRIPS flexibilities such as compulsory licences to ensure access to essential medicines and should refrain from granting disproportionately long patents to new medicines in order to allow the production of generic medicines with a reasonable time frame.[[11]](#footnote-11) During COVID-19, the Committee went even further, acknowledging that while states held duties to use TRIPS flexibilities, these mechanisms were insufficient to adequately face the pandemic. Instead the Committee urged states to consider the TRIPS waiver as a means of assuring the global affordability of vaccines.[[12]](#footnote-12)

**Maximising legal resources through alternative access policies**

*Price negotiation and transparency*

The ability to negotiate prices and transparency in price negotiations are two powerful mechanisms to ensure affordable and available health technologies. Notwithstanding this, transparency in price negotiations has been a fraught area with pharmaceutical companies often attaching non-disclosures or confidentiality provisions to their agreements with governments. These confidentiality regimes also have the effect of shielding the agreements from scrutiny, particularly when it comes to issues of equitable pricing and access. As contracts for COVID-19 vaccines were leaked or disclosed publicly, it became apparent that low- and middle-income countries were frequently paying more for COVID-19 vaccine doses than wealthier countries and were also subject to onerous terms. In Brazil, for example, Pfizer extracted onerous indemnity clauses and demanded that sovereign assets be used as collateral for the indemnity clauses.[[13]](#footnote-13) This demonstrates how a lack of transparency may be grossly abused – particularly by pharmaceutical companies and how promoting or requiring transparency can ensure these actors are held to reasonable standards when contracting.

Price negotiations are a powerful mechanism that allow governments to leverage their buying power to reduce medicine and drug costs. Yet this power has often not been explicitly linked to the right to health or viewed as a part of the State’s obligations under the right to health. While many governments in the world exercise this power to purchase drugs for public healthcare systems, the United States government has historically not exercised this power when purchasing drugs for their public insurance scheme, Medicare. Recently, however, this changed with Medicare announcing that it would begin negotiating prices with drug companies in 2023.[[14]](#footnote-14)

*Procurement models*

Procurement models and strong capacity to determine competitive prices can be beneficial to reduce pharmaceutical prices. However, the position becomes considerably more complex for low income countries, some of whom may rely on external funding from organisations like Gavi, the vaccine alliance and PEPFAR, to fund vaccination or HIV treatment programmes. These non-state actors may then negotiate at scale for lower pricing of the drugs or pharmaceuticals they distribute. For countries in the “missing middle” pooled funding mechanisms may offer a means to more quickly roll out novel interventions at a lower price through a shared procurement process. This was seen in the pneumococcal advanced market commitment introduced by Gavi which was rolled out in Nicaragua only ten months after it had first been approved in the US. The African Medical Supply Platform is a state-based example of such a mechanism and enabled African countries, many of which are low-income, to pool their bargaining power to procure PPE and COVID-19 tests.

*Competition laws*

Many countries have both competition law (or anti-trust laws) regimes to ensure competition is protected and promoted and intellectual property regimes which, inter alia, afford developers of novel drugs effective monopolies on the sale of those drugs. These often are mutually exclusive regimes, with intellectual property regimes enabling pharmaceutical companies to escape competitional law requirements. More recently, however, there has been an intersection of the regimes which has seen pharmaceutical companies being charged with violations of competition laws for engaging in excessive pricing of drugs while they enjoyed patent protections over their drugs. In both the United Kingdom and South Africa, major pharmaceutical companies are being subjected to prosecutions regarding excessive pricing of drugs.[[15]](#footnote-15) A major challenge in these cases is to establish the cost of developing and producing these drugs to assess whether the profits are, in fact, excessive. However, the notion that notwithstanding intellectual property and patent protections, there should be limits on the profits that can be made on life-saving medicines seems deeply aligned with the right to health and recognition of this might aid countries in curbing excessive pricing practices.

*Public-Private Partnerships and local production frameworks*

Outside of intellectual property, manufacturing and regulatory capacity may also play a substantial role in determining access to medicines and health technologies. Regulatory capacity may often be an essential component in ensuring the safety and quality of medicines and limiting the availability of counterfeit drugs. However, many low- and middle income countries, particularly in Africa and Asia have minimal regulatory capacity.[[16]](#footnote-16) The lack of regulatory capacity in many countries often leads to delays in approving drugs, ultimately resulting in delays in the rollout and implementation of new medicines and limits access to life-saving medications.[[17]](#footnote-17) There have been initiatives to create regional regulatory authorities and the WHO’s pre-qualification programme has also been used to expedite the approval of medicines through mutual recognition provisions. However, there is a real need for regulatory capacity to be strengthened to ensure faster access to medicines.

Manufacturing capacity also remains a substantial barrier to accessibility of novel health technologies (though not medicines). Efforts to remedy this are fraught with difficulties as there are concerns that local vaccine manufacturers will not be profitable or sustainable in the long term. The Partnership for Vaccine Manufacturing attempted to create public-private partnerships that resulted in larger pharmaceutical companies effectively establishing “branches” in countries like Rwanda. However, this is similarly not a solution as these entities often have the same priorities as their head offices and, in emergency situations like COVID-19, may manufacture vaccines that are ultimately sent to other countries rather than being distributed to African countries – as was the case for the Johnson and Johnson vaccines that were partially manufactured in an AspenPharmacare were shipped to Europe.

**II Public health emergencies and access to medicines, vaccines and other products**

When a public health emergency arises, international legal obligations to realise the rights to life and to health require States to adopt - individually and collectively - a package of public health measures which must be justified by, *inter alia*, the magnitude of the crisis, the scientific evidence supporting the measures in question and strict adherence to the principle of proportionality.

As emphasised in the *Principles and Guidelines on Human Rights and Public Health Emergencies* (the PHE Principles) recently launched by the Global Health Law Consortium and the International Commission of Jurists, when States are faced with an imminent or ongoing public health emergency, they must “take extraordinary measures, to the maximum of their available resources, giving priority to their allocation on public health,”[[18]](#footnote-18) and by extension, implement “legally enforceable measures…to prevent profiteering on health and health-related rights.”[[19]](#footnote-19) Imperatives are heightened in times of public health crisis, not simply because of the urgency of the situation, but because the severity of a public health crisis (and the severity of public health measures which may be required to overcome the crisis in the absence of relevant pharmaceutical products which may have significant human rights impacts) is entirely dependent upon having access to lifesaving medical countermeasures when and where they are needed.

Both the actions and omissions of States, in the imminence of a public health emergency, where these lead to intentional or otherwise foreseeable and preventable life-terminating harm or injury, may amount to the deprivation of the right to life under Article 6 of the ICCPR.[[20]](#footnote-20) As the Human Rights Committee has clarified in General Comment 36, the determination of a right to life violation is not predicated on the actual loss of life, and States parties must exercise due diligence to protect deprivations of the right to life caused by private entities.[[21]](#footnote-21) Moreover, the Human Rights Committee has stated that the right to life should not be interpreted narrowly,”[[22]](#footnote-22) and has expansively interpreted this right, alongside national courts, to include the right to the highest attainable standard of physical and mental health (the right to health).[[23]](#footnote-23)

During the COVID-19 pandemic, experts widely agreed that an effective strategy to limit the spread of COVID-19, to help prevent the emergence of more transmissible or deadly variants, and to protect life and health in all countries (as well as minimize infringements on all other human rights) is to ensure that vaccines are made widely available in all countries, not just in high-income countries.[[24]](#footnote-24) The failure of States to ensure access to medical goods based on need - rather than ability to pay - ensured that inequalities in the COVID-19 only grew wider as the pandemic unfolded, and gave rise to situations of gross injustice and discrimination, as witnessed during the discriminatory travel bans imposed by the global North against travellers from southern Africa at the emergence of the Omicron variant.[[25]](#footnote-25)

Accordingly, following the PHE Principles, in fulfilling obligations concerning access to medicines, vaccines, and other health products, State should comply with specific standards applicable to such extraordinary events. This involves principles 11 (ensuring access to health goods, facilities, services, and technologies) and 14 (prioritising and mobilising resources during a public health emergency), now firmly entrenched in international human rights law.[[26]](#footnote-26)

These principles necessitate innovative and forward-thinking strategies, both in international relations and domestic policies. Such strategies encompass proactive measures and alternative frameworks within markets and supply chains. Exemplifying these principles are methods outlined earlier in section I, including negotiating prices and implementing governance of private actors through procurement and development contracts. Aligned with the PHE Principles, in anticipation of future public health emergencies, it is important to harmonise legal preparedness for such events. These frameworks, in conjunction with overall healthcare systems strengthening by recognising essential healthcare services, should facilitate states flexible response and resource maximisation resorting to all legal tools at disposal in access policies for medical countermeasures and to react to surges in the demand of healthcare.

**III. Extraterritorial obligations and enabling environment for access to medicines, vaccines and health products**

**ETO and enabling environment**

The COVID-19 pandemic has reaffirmed an imperative for the world to come together to realise human rights in global health, with global governance institutions optimally placed to coordinate a global rights-based health response to a shared threat. This imperative for international assistance and cooperation has long been recognised under international law, with the UDHR seminally declaring that “everyone is entitled to a social and international order in which the rights and freedoms set forth in this Declaration can be fully realised.”[[27]](#footnote-27) Extending international human rights law beyond the relationship between a State and the individuals within its territory, the 1966 International Covenant on Economic, Social, and Cultural Rights (ICESCR) required States “to take steps individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources ”.[[28]](#footnote-28) This cosmopolitan framing of human rights through global governance has evolved to encompass extraterritorial obligations of States under international human rights law.

Grounded in international human rights law, extraterritorial human rights obligations provide a foundation for global health partnerships to realise the right to health, creating a normative and legally binding framework to structure global health governance on the basis of solidarity, equality, and justice.[[29]](#footnote-29) Since the ability of states to realise the right to health at the domestic level is constrained by the actions and institutional arrangements of the international community, the realisation of extraterritorial obligation requires a restructuring of national assistance and international institutions, allowing states to enter global health negotiations not merely with a plea for charity, but on the basis of a right to assistance and cooperation to their populations. These extraterritorial obligations have also been found to frame human rights realisation through institutional duties in global health governance. The Committee on Economic, Social and Cultural Rights (CESCR) has specified that these obligations require the right to health to be given attention in international agreements, finding that States should “consider the development of further legal instruments” to this end and that States should ensure that other international agreements do not adversely impact on the right to health.[[30]](#footnote-30)

**Need for reforms in the international IP regime and the research and development landscape**

Despite considerable growth in the elaboration of a right to medicines in international human rights law and growing state recognition of this right, a legal disjuncture remains between human rights law and trade-related intellectual property rights codified under international trade law.[[31]](#footnote-31) This is particularly complex given the discussions around the TRIPS waiver in the WTO which failed to reinforce earlier gains in the Doha Declaration on the TRIPS Agreement which prioritised the right to access medicines over trade rights to own patents in the context of public health emergencies. The Doha Declaration expressly recognised countries’ ability to seek compulsory licences for medicines during a public health emergency under Article 31 of the TRIPS Agreement. However, this provision was limited to domestic supply until the adoption of the Article 31*bis* amendment. Despite this amendment, the circumstances in which a compulsorily licensed product may be exported is still significantly limited. In 2021, all of the 10 new instances of compulsory licences concerned products to prevent or treat COVID-19, but, as demonstrated by the requirement of a TRIPS Waiver, significant barriers during public health emergencies remain.

Further, given that compulsory licensing also extends only to patents and not to other forms of IP that are essential in vaccine production, such as manufacturing know-how, the utility of the decision for vaccines was limited and there are broader questions around technology transfers that still remain unanswered. Nor is it clear what a prospective pandemic treaty will codify when it comes to the interaction between these two areas of law, nor what its impact will be when it comes to the interpretation and enforcement of WTO law.[[32]](#footnote-32)

**ETO and access to scientific progress**

The Right to Enjoy the Benefits of Scientific Progress and its Applications, (which is articulated in Article 27 of the Universal Declaration on Human Rights, and Article 15(1)(b) of the ICESCR) has received significantly less attention than the Right to Health, although it is of clear relevance to access to medicines – which are the result and application of the scientific process. This is all the more important as the science resulting in medicines is a joint endeavour; low-income nations contribute scientific capacity, assist in study design, enrol participants in clinical trials, and provide biological materials, such as pathogen samples, all of which are integral to the scientific endeavour, and the development of new medicines. However, low-income nations typically have poor access to medicines, in particular during a health emergency; accessing insufficient doses of medicines, and accessing them far later during an emergency, when compared to their high-income neighbours. This is unjust, and clearly engages the Rights outlined above, indeed, “in the best of all worlds the global system would distribute scientific research so that states with high-capacity conducted research and developed products for the benefits of countries that have great needs but limited capacities.”

Indeed, following the Maastricht Principles on Extraterritorial Obligations in the Area of Economic, Social and Cultural Rights States parties must refrain from any activity or measure that may hinder the realisation of the above rights of peoples outside their own territory.[[33]](#footnote-33) This is notably the case when concerned with non-state actors and businesses domiciled in that state’s territory. As General Comment No. 24 goes on to express: “Extraterritorial obligations arise when a State party may influence situations located outside this territory, consistent with the limits imposed by international law, by controlling the activities of corporations domiciled in its territory and/or jurisdiction, and thus may contribute to the effective enjoyment of economic, social and cultural rights outside its national territory”.[[34]](#footnote-34)

There is a clear engagement with these rights in in respect of access to medicines in health, whereby the commercial practices of pharmaceutical companies, predominantly domiciled in the Global North, have hugely detrimental effects on rights enjoyment in the Global South, by failing to respect the Right to Health, and the Right to Benefit Enjoy the Benefits of Scientific Progress and its Applications. This is further buoyed by the nationalistic practices of high-income nations hosting the producers of medical goods, who use export licences, advance purchase agreements, and nationalistic practices to prevent the export or sale of drugs to low-income nations during times of emergency.

In future health emergencies, States must ensure that their actions, and the actions or omissions of non-State actors whose extraterritorial conducts do not impinge upon the enjoyment of the above rights of peoples or groups in other jurisdictions, as stated within articles 20-28 of the PHE Principles.[[35]](#footnote-35)

**Recommendations:**

Taking into account global health law standards and international human rights guidelines highlighted in this document, in particular the PHE Principles, we advise that the OHCHR, during this study, as well in the subsequent works within its competence, use all its influence and power to:

1. Encourage international human rights bodies and international organisations within the UN system to advocate for, engage with and closely monitor, by virtue of the progressive realisation of the right to health, State purposeful measures to control healthcare markets for more affordability and availability of health technologies. Such measures should not be solely focused on patents and compulsory licence and should extend to, inter alia, frameworks for price negotiation and transparency, procurement, public-private partnerships, competition laws and market-entry agreements. More attention to these policies should be paid in assessing the realisation of the right to health in human rights compliance mechanisms, and a more explicit linkage of human rights with access policies as State obligations should be also established in WHO guidance and programmes.
2. Promote, by associating such practices with the right to health, standardised guidelines for pharmaceutical negotiations, discouraging non-disclosure agreements, ensuring that health technologies pricing aligns with the affordability standard outlined by the AAAQ framework. In addition, international efforts should be made to research and collect comparative evidence and best practices of how healthcare legislation and regulations result in higher levels of affordability and availability of health technologies in different markets, as well which norms increase negotiation powers of developing countries.
3. Explore legal strategies to overcome barriers to manufacturing capacity, acknowledging concerns about the sustainability and profitability of local medicines and vaccines manufacturers while prioritising affordability of health technologies as essential to comply with State obligations under the right to health.
4. Advocate for and coordinate across international organisations and inter-State political negotiations the recognition and enforcement of extraterritorial obligations under international human rights law concerning access to medicines, vaccines, and other health products. This may involve calling for reforms in the international intellectual property regime, pushing for convergence between human rights law and trade-related intellectual property rights codified under international trade law.
5. Support and advocate for the enforcement and implementation of the PHE Principles among member states to ensure adherence to international legal obligations during public health emergencies, with regards to access to medicines, vaccines and other health products, in particular, harmonising domestic frameworks to address supply constraints and the development of medical countermeasures with effective access policies frameworks as a form of legal preparedness.

We express our appreciation to the OHCHR for its advancements in this study. We are available for further dialogue regarding this initiative. Kindly direct all communications regarding this submission to l.b.filho@shu.ac.uk.

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22. UN Human Rights Committee, General Comment No. 36 (Article 6: the right to life), CCPR/C/GC/36, (3 September 2019), para. 3. [↑](#footnote-ref-22)
23. UN Human Rights Committee, General Comment No. 36 (Article 6: the right to life), CCPR/C/GC/36, (3 September 2019), paras. 8, 25, 26, 54. The Human Rights Committee notably states at para. 26 that “the duty to protect the right to life also implies that States parties should take appropriate measures to address the general conditions in society that may give rise to threats to life or prevent individuals from enjoying their right to life with dignity…such as the bolstering of effective emergency health services, emergency response operations…and social housing programmes.”; See also Alicia Ely Yamin, Power, Suffering, and the Struggle for Dignity: Human Rights Frameworks for Health and Why They Matter (2015), p. 144. [↑](#footnote-ref-23)
24. Moore S and others, ‘Retrospectively Modelling the Effects of Increased Global Vaccine Sharing on the COVID-19 Pandemic’ [2022] Nature Medicine <<https://www.nature.com/articles/s41591-022-02064-y>> accessed 3 November 2022. [↑](#footnote-ref-24)
25. Jackson C and others, ‘Between Rules and Resistance: Moving Public Health Emergency Responses beyond Fear, Racism and Greed’ [2023] BMJ Global Health 8. [↑](#footnote-ref-25)
26. PHE Principles, art. 11 and 14. [↑](#footnote-ref-26)
27. UN General Assembly, Universal Declaration of Human Rights (1948), art. 28. [↑](#footnote-ref-27)
28. International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI) (1966), arts. 12, 2. The Committee on Economic, Social and Cultural Rights reiterated in 2000 that obligations to respect, protect, and fulfil the right to health include international assistance and cooperation, and that “it is particularly incumbent on States parties and other actors in a position to assist, to provide ‘international assistance and cooperation, especially economic and technical’ which enable developing countries to fulfil their core and other obligations.” [↑](#footnote-ref-28)
29. Benjamin Mason Meier and Ashley M. Fox, ‘International obligations through collective rights: Moving from foreign health assistance to global health governance,’ (2010) 12 Health & Human Rights, 65. [↑](#footnote-ref-29)
30. UN Committee on Economic, Social and Cultural Rights, General Comment No. 14, E/C.12/2000/4 (2000), para. 39. [↑](#footnote-ref-30)
31. Lisa Forman, “From the UDHR to a pandemic treaty: Will a right to medicines forever be ‘under construction’?” (2023) XX Journal of Human Rights Practice 1-12. [↑](#footnote-ref-31)
32. Ibid, and see Lisa Forman, Chuang-Feng Wu, and Katrina Perehudoff, “International Trade Governance: Free Trade & Intellectual Property Threaten Public Health,” in Lawrence O. Gostin and Benjamin Mason Meier, eds., *Global Health Law & Policy: Ensuring Justice for a Healthier World* (Oxford University Press, 2023). [↑](#footnote-ref-32)
33. ‘Maastricht Principles on Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights’. 2011. *Netherlands Quarterly of Human Rights* 29 (4): 578–90. [↑](#footnote-ref-33)
34. UN Committee on Economic, Social and Cultural Rights ‘General Comment No. 24: State obligations under the International Covenant on Economic, Social and Cultural Rights in the context of Business Activities ́ E/C.12/GC/24 (2017), 10. [↑](#footnote-ref-34)
35. PHE Principles arts 21-28. [↑](#footnote-ref-35)