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An Inquiry into State Agreement and Practice on the International Law Status of the Human Right to Medicines

LISA FORMAN, BASEMA AL-ALAMI, AND KAITLIN FAJBER

Abstract

Global disparities in access to COVID-19 vaccines have brought back into focus questions about whether the right to medicines has assumed any level of binding legality within international law. In this paper, we attempt to answer this question by considering if there is evidence of subsequent state agreement and practice to read the right to medicines into the rights to health and science protected in the International Covenant on Economic, Social and Cultural Rights. We adopt the interpretive framework in the Vienna Convention on the Law of Treaties and the International Law Commission's 2018 report to analyze the work of the United Nations Committee on Economic, Social, and Cultural Rights relevant to medicines, and its relationship to the content and voting in successive resolutions of the United Nations General Assembly. We find that these resolutions provide some evidence of state agreement that the rights to health and science, as enshrined in the International Covenant on Economic, Social and Cultural Rights, include access to affordable medicines. Yet the legal implications of this right remain highly contested, particularly when it comes to trade-related intellectual property rights. The negotiation of a pandemic treaty offers possibilities for codifying this right beyond these discursive instances, while political opposition remains likely to continue to undercut this emerging legal norm.

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Introduction

The severity of global disparities in access to COVID-19 vaccines has drawn back into focus longstanding questions about the status and implications of a human right to medicines in international law.[1] After the treatment campaigns of the 2000s, a scholarly consensus developed that this right had emerged as soft international law, an emerging human rights norm, a customary international law norm guaranteeing access to lifesaving medication in national health emergencies, a derivative right of the rights to health and scientific advancement, and an informal norm that all people should have access to essential medicines and not be blocked arbitrarily by patents.[2] Whatever its legal status, this right appears to have had little material impact in preventing or remedying global disparities in access to COVID-19 vaccines caused by a range of domestic and global factors, including vaccine hoarding, the restrictive impacts of intellectual property rights in trade agreements, inadequate domestic and global health financing, irrational use, and discrimination against and neglect of marginalized populations.[3] These disparities have prompted the central inquiry of this paper into whether the human right to medicines has evolved to assume any level of "hardness" in international law. We assume that this question matters not just because of these stark global disparities but because policy makers are focusing on hard law solutions to the deficiencies of global pandemic governance, including through a pandemic treaty currently being negotiated—and whose early drafts suggest that the treaty will address equitable access to essential pandemic medicines and vaccines, including through the impact of trade-related aspects of intellectual property rights.[4] To this extent, this treaty may offer a limited extent of linkage between the highly fragmented standards of international law relevant to pandemics and global health.[5]

The legal inquiry arises in part because there is no direct textual basis within the International Covenant on Economic, Social and Cultural Rights (ICESCR) for a right to medicines as part of article 12's right to health. Instead, this right has been read into article 12 and article 15 (the right to science) of the ICESCR by the United Nations (UN) Committee on Economic, Social and Cultural Rights (CESCR) through successive, increasingly specific, and nonbinding general comments and statements. Around this time, a plethora of resolutions through the UN Human Rights Council (and its predecessor, the Commission on Human Rights) and the UN General Assembly have explicitly recognized access to medicines as a fundamental element of the right to health (and later of the right to science) that places obligations on states when it comes to affordability, including in relation to trade-related intellectual property rights. These developments have come alongside extensive legal and political recognition of this right: successive affirmations by UN Special Rapporteurs on the right to health concerning the centrality of access to medicines; a proliferation of rights-based access to medicines claims in regional and domestic courts; codification of the right to medicines in 22 national constitutions, frequently as part of the right to health; access to affordable medicines incorporated into the Sustainable Development Goals; and successive international reports on the imperative of universal access to affordable medicines.[6]

While these developments indicate heightened global attention to advancing access to medicines, it remains unclear whether any of these processes and documents have transformed the right to medicines from *lex lata* (the law as it should be) to *lex ferenda* (the law as it is). In particular, it remains an open question whether the right to medicines has become part of any of the recognized sources of international law (treaties, custom, general principles of law, and judicial decisions and scholarly interpretation as a secondary source).[7] In this paper, we consider one such possibility: that some international iterations of this right substantiate state agreement that the ICESCR incorporates a right to medicines. This is the evolutionary potential identified within the Vienna Convention on the Law of Treaties for states to develop subsequent agreements and practices regarding a treaty's interpretation or application. These provisions of the Vienna Convention have been the subject of an au-

thoritative interpretation in a 2018 International Law Commission report on subsequent agreement and practice in international law.[8]

We use the conceptual framework of the Vienna Convention and International Law Commission report to examine what we consider to be the strongest evidence for state agreement regarding access to medicines in the ICESCR: CESCR's interpretive work on this topic and its relationship to the content (and state voting) in General Assembly resolutions. This focus is motivated not just by considerations of scope but of relevance: the CESCR is the expert treaty body tasked with interpreting the ICESCR, the primary source of the international right to health; and General Assembly membership extends to all 193 UN member states and ergo to all ICESCR state parties.[9] We also consider resolutions from the Human Rights Council and its predecessor, the Commission on Human Rights, to the extent that they provide a textual basis for General Assembly resolutions or offer insight into state consensus or debate relevant to ICESCR rights. We view these resolutions as offering an important supplementary source of interpreting the ICESCR.

The paper proceeds in the following way: First, it outlines the conceptual framework for treaty interpretation in the Vienna Convention and the 2018 International Law Commission report on subsequent agreement and practice. Second, it analyzes the text of ICESCR article 12 in its treaty context (including drafting history) and considering the CESCR's interpretive work on this and related rights. Third, it considers how successive General Assembly resolutions address access to medicines as a right, how these relate to the CESCR's interpretations, and crucially, how states have voted on these resolutions. Fourth, we consider whether these resolutions demonstrate a subsequent agreement to read medicines into the binding scope and enforcement of the ICESCR. The paper concludes with thoughts about the legal and political significance of this inquiry given the ongoing negotiation of a pandemic treaty.

The Vienna Convention and International Law Commission on subsequent agreement and practice

The interpretation and implementation of treaties is determined not just by treaty text but by subsequent state practice in relation to that text. This potential is enumerated in the Vienna Convention's legal rules on the interpretation of international treaties. Article 31(1) provides a general rule of interpretation that a "treaty shall be interpreted in good faith in accordance with the ordinary meaning to be given to the terms of a treaty in their context and in light of its object and purpose."[10] Article 31(3) outlines that this context comes not just from treaty text but also from agreements relating to the treaty, including "(a) any subsequent agreement between the parties regarding the interpretation of the treaty or the application of its provisions [and] (b) any subsequent practice in the application of the treaty which establishes the agreement of the parties regarding its interpretation."[11] Article 32 provides that the preparatory work of a treaty and the circumstances of its conclusion can be used as a supplementary means of interpretation "to confirm the meaning resulting from the application of article 31, or to determine the meaning when the interpretation according to article 31: (a) leaves the meaning ambiguous or obscure; or (b) leads to a result which is manifestly absurd or unreasonable."[12]

The International Law Commission's 2018 report offers considerable guidance on how to identify and analyze subsequent agreement and practice in Vienna Convention articles 31 and 32. The commission emphasizes that "the interpretation of a treaty consists of a single combined operation" and that articles 31 and 32 "must be read together as they constitute an integrated framework for the interpretation of treaties."[13] The implication is that subsequent agreement and practice count as much toward interpreting a treaty as the ordinary meaning of treaty terms, their context, and the treaty's object and purpose.[14] The commission defines a subsequent agreement as "an agreement between the parties, reached after the conclusion of a treaty, regarding the in-

terpretation of the treaty or the application of its provisions," while a subsequent practice "consists of conduct in the application of a treaty, after its conclusion, which establishes the agreement of the parties regarding the interpretation of the treaty."[15]

Once established, the possible effects of such practice and agreement are to clarify the meaning of a treaty such that it narrows, widens, or otherwise determines the range of possible interpretations of the treaty.[16] Because such agreements can effectively modify a treaty, the threshold for constituting such agreement or practice is very high. All state parties to a particular treaty must be in agreement: when subsequent practice consists of conduct by one or more states in applying the treaty rather than all states, this practice is instead considered a "supplementary means of interpretation under article 32."[17] As George Nolte (former chair of the International Law Commission working group on this topic) emphasizes, this means that subsequent agreement and practice must "embody the will of *all* parties to a treaty ... a practice by one party, or even the practice of *almost* all parties, is *not* subsequent practice under Article 31, paragraph 3, which an interpreter 'shall take into account'."[18] The weight of a subsequent agreement and practice depends, among other things, "on its clarity and specificity" and "whether and how it is repeated."[19]

One form these agreements and practices can take is in "voting at the international level" on General Assembly resolutions.[20] The resolutions of UN bodies without universal membership, such as the Human Rights Council, could therefore not give rise to a subsequent agreement or practice that established the agreement of all parties to a treaty, but may be relevant for interpreting a treaty under Vienna Convention article 32 and determining the ordinary meaning of treaty terms in context and in light of treaty object and purpose.[21] The International Law Commission points to two International Court of Justice decisions which indicate that when resolutions are "adopted by consensus or by a unanimous vote, they may be relevant for the interpretation" of the treaty in question and that what matters is "the attitude of States" and their consent to those resolutions.[22] These resolutions can also elevate treaty body pronouncements into subsequent agreements or practices when "all parties have accepted, explicitly or implicitly, that a particular pronouncement of an expert treaty body expresses a particular interpretation of the treaty."[23] These "pronouncements" include "all relevant factual and normative assessments" by treaty bodies, including concluding observations, views, and general comments. It is important to note that the International Law Commission is explicit in identifying the CESCR as an expert treaty body despite being established not under the ICESCR but by a resolution of the UN Economic and Social Council.[24]

The International Law Commission identifies two forms of evidence within General Assembly resolutions that treaty body pronouncements have been agreed on: (1) when such resolutions explicitly reference a treaty body's pronouncements, or (2) where resolutions use the language of such pronouncements, such as a 2015 General Assembly resolution defining the right to water using the CESCR's language in General Comment 15.[25] Such resolutions would give rise to a subsequent agreement regarding the ICESCR "if the consensus constituted the acceptance by all the parties of the interpretation that is contained in the pronouncement."[26] Even when such pronouncements fall short of a subsequent agreement, the International Law Commission reiterates their relevance to interpretation.[27]

The implication is thus clear that General Assembly resolutions that reference CESCR pronouncements can give rise to subsequent agreements regarding the ICESCR. To clarify, we do not in this paper intend to suggest that the contribution of CESCR pronouncements (such as general comments) to generating subsequent agreements and practice captures the full range of their legal influence and impact.[28] We focus our inquiry on the contribution of CESCR pronouncements to subsequent agreement and practice alone.

Access to medicines in the ICESCR and CESCR's interpretive work

If treaty interpretation requires a "single combined operation" between Vienna Convention articles 31 and 32, then establishing subsequent agreement and practice around access to medicines and the right to health must begin with a good-faith interpretation of the ordinary meaning of ICESCR article 12 in its context and in light of the object and purpose of the ICESCR.[29] The following section conducts this interpretation, first considering the gaps in ICESCR's text around medicines in the context of the preparatory work of the ICESCR, and then considering CESCR pronouncements that have explicitly filled this gap.

A good-faith interpretation of ICESCR article 12 in context

Nowhere in the text of ICESCR article 12 are medicines or vaccines explicitly named: article 12(1) recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health," while article 12(2) indicates that

> the steps to be taken by [state parties] to achieve the full realization of this right shall include those necessary for:
> a. The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
> b. The improvement of all aspects of environmental and industrial hygiene;
> c. The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
> d. The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

That article 12(2) should be interpreted to extend to medicines and vaccines is supported in two primary ways. First, the wording of the chapeau of article 12(2) that steps to be taken "shall include those necessary" suggests that the four subsequent measures do not reflect an exhaustive list. The open-ended nature of these steps is similarly suggested by the fact that states also have duties in ICESCR article 2(1) to "take steps … to the maximum of [their] available resources, with a view to achieving progressively the full realization of [ICESCR] rights."[30] This reading is supported by the covenant's drafting history, which indicates that the phrasing of the chapeau of article 12(2) was intended to make this article subject to article 2, and that article 2 in turn was not intended to "prevent the elaboration of what the obligation of the general article would signify in relation to any selected right, or even the imposition of stricter obligations in connexion with such a right."[31]

Second, almost all the steps in article 12(2) would necessitate the provision of medicines or vaccines—alongside other public health measures—to address infant mortality and healthy child development; to prevent, treat, and control diseases; and to assure medical service and attention for the sick. Yet if this is the case, why not specifically identify medicines within article 12? This lacuna surely reflects that when the ICESCR was concluded "drugs played only a marginal role in the treatment of diseases" and the "idea that lack of access to medicines was contrary to human rights was not considered."[32] This absence is apparent in the ICESCR's drafting records: when the word "medicine" is used, it is to refer to the practice of medicine rather than to pharmaceuticals; the words "pharmaceuticals" and "medication" are never used; and instead the term "medical treatment" appears repeatedly. To contextualize this gap, the drafting of the ICESCR was completed between 1948 and 1966, while the first World Health Organization essential drugs list was published in 1977, and the "golden era" of the discovery of new antibiotics occurred between the 1950s and 1970s.[33] In the same way that the drafters of the ICESCR never foresaw the need to elaborate a right to sanitation and water, so too were medications elided from the covenant. Read in this light, the text and drafting history of the ICESCR strongly support that ICESCR article 12 (as with other ICESCR rights) was intended to be open ended and progressive. This reading is also consistent with the ICESCR's object and purpose to progressively realize economic, social, and cultural rights in service of the "ideal of free human beings enjoying freedom from fear and want."[34] The implication is that any

interpretation of ICESCR article 12 in a context that excluded the potential for the inclusion of the right to medicines would arguably produce a manifestly absurd or unreasonable outcome.

CESCR general comments and statements

Whatever the outcome of a textual inquiry into the ICESCR, since the 2000s the CESCR has remedied this gap by reading a progressively more explicit and detailed right to medicines into the ICESCR's article 12 and article 15. These pronouncements leave little doubt that CESCR considers access to medicines and vaccines as a prioritized part of ICESCR rights. As the section that follows illustrates, only a small number of these interpretations have shown up in General Assembly resolutions. Yet we elaborate on the full range of these interpretations here in order to both show CESCR's persuasive interpretations of the ICESCR around medicines and highlight the disjuncture between these interpretations and General Assembly resolutions on this topic.

One of the first and most important of these pronouncements is in the CESCR's 2000 General Comment 14 on the right to health, which reads medicines and vaccines into several aspects of ICESCR article 12.[35] Essential drugs "as defined by the WHO Action Programme on Essential Drugs" are included as an essential element of the availability of health care goods and services (as part of the availability, accessibility, acceptability, and quality—or AAAQ—framework).[36] They are also identified as a minimum core obligation (and hence a highly prioritized element of this right) and as a part of article 12(2)(c)'s duty to prevent, treat, and control disease.[37] The right to prevention, treatment, and control of disease in ICESCR article 12(2)(c) is specified to include immunization programs and to impose a state duty to fulfill through "immunization programmes against the major infectious diseases."[38] This obligation is defined along with the duty to take measures to prevent, treat, and control epidemic and endemic diseases as comparable in priority to minimum core obligations.[39] Yet ongoing debates over intellectual property rights show up only indirectly in General Comment 14's indication that states should take steps to ensure that other international agreements do not adversely impact the right to health and to ensure that their actions as members of international organizations take due account of the right to health.[40]

CESCR soon moved to directly address this question through a general comment on the impact of intellectual property rights on ICESCR article 15(1)(c)—everyone's right to benefit from the protection of the moral and material interests resulting from any scientific, literary, or artistic production of which they are the author. The committee issued a November 2001 statement on human rights and intellectual property emphasizing that "any intellectual property regime that makes it more difficult for a state party to comply with its core obligations in relation to health" is inconsistent with its legally binding obligations.[41] It emphasized the need for states to strike a balance between intellectual property rights and human rights, as evidenced in the Doha Declaration on the TRIPS Agreement and Public Health.[42] These interpretations were elaborated in the CESCR's 2006 General Comment 17 on article 15(1)(c), which emphasizes that states should ensure that intellectual property rights "constitute no impediment to their ability to comply with their core obligations" in relation to ICESCR rights, including the rights to health and the enjoyment of the benefits of scientific progress.[43] This 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."[44] The CESCR has built on these duties in other general comments. Its 2016 General Comment 22 defines access to essential medicines as an essential element and core obligation under the right to sexual and reproductive health, imposing duties to ensure that intellectual property and trade agreements not impede access to medicines for sexual and reproductive health and incorporate to the fullest extent safeguards and flexibilities to promote access to medicines care for all.[45] The committee's 2017 General Comment 24 on state obligations regarding business activities outlines that when designing intellectual property rights frameworks, states "should ensure that in-

tellectual 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."[46] These duties are extended further in the committee's 2020 General Comment 25 on science and economic, social, and cultural rights, adopted after the start of COVID-19.[47] Beyond reiterating state duties to prevent unreasonably high costs for access to essential medicines, states have duties to promote scientific research to make new medical applications accessible and affordable to everyone and to facilitate better and more accessible means for preventing, controlling, and treating disease.[48] In addition, states should use TRIPS flexibilities such as compulsory licenses 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.[49]

Since the onset of COVID-19, the committee has issued three statements that have restated and extended much of this content to COVID-19 vaccines. An April 2020 statement cautioned states to promote intellectual property flexibilities "to allow universal access to the benefits of scientific advances relating to COVID-19 such as diagnostics, medicines and vaccines."[50] A December 2020 statement on universal and equitable access to COVID-19 vaccines articulated a right to access a safe, effective COVID-19 vaccine based on the right to health's requirement of "immunization programs against the major infectious diseases" and the right to the benefits of scientific progress's requirement of access to "the best available applications of scientific progress necessary to enjoy the highest attainable standard of health."[51] While the statement reiterated state duties to use TRIPS flexibilities, it acknowledged that they were insufficient to adequately face the pandemic and urged states to consider the TRIPS waiver as a means of assuring the global affordability of vaccines.[52] The committee went further than earlier pronouncements by directly outlining pharmaceutical companies' duties, at a minimum, to respect ICESCR rights, including by refraining from invoking intellectual property rights in a manner inconsistent with everyone's right of access to a safe and effective COVID-19 vaccine.[53] States similarly have duties to ensure that business entities do not invoke such intellectual property rights in such a manner domestically or abroad.[54] Finally, the CESCR outlined the extraterritorial obligation of states to guarantee universal and equitable access to vaccines for COVID-19 globally, "including for populations of least developed countries, which might not have the financial resources to guarantee access to vaccines for their people."[55] The inequitable distribution of COVID-19 vaccines was itself framed as contrary "to the extraterritorial obligations of States to avoid taking decisions that limit the opportunity of other States to realize their right to health."[56]

As global inequities in access to COVID-19 vaccines deepened, an April 2021 statement identified TRIPS as a central obstacle to global cooperation, TRIPS flexibilities as inadequate to address these restrictions, and the TRIPS waiver as a crucial strategy.[57] While the committee urged states to support COVAX, it acknowledged that "other measures are urgent and necessary, particularly with regard to intellectual property, in order to achieve, as expeditiously as is technically possible, universal access to vaccines."[58] This meant going beyond TRIPS flexibilities, which had proven insufficient to guarantee equitable distribution in developing countries given their case-by-case nature and complexity.[59] For the first time, the committee acknowledged that the restrictions imposed by TRIPS made "it very difficult to achieve the international cooperation needed for the massive scale up in production and distribution of vaccines to the levels that are now technically possible and urgently required to achieve herd immunity as soon as possible."[60] This situation necessitated "urgent additional measures" in relation to intellectual property rights, with the TRIPS waiver "an essential element of these complementary strategies." The committee strongly recommended that states support the proposals of this temporary waiver, including by using their voting rights within WTO."[61]

As this discussion illustrates, the CESCR has over time read increasingly more explicit and detailed state duties around medicines and vaccines

into the ICESCR's rights to health and science. The committee has progressively expanded these duties when it comes to the impact of trade-related intellectual property rights on the affordability and universality of medicines. It has now explicitly extended these duties to COVID-19 vaccines and to support for a waiver of TRIPS. Yet these pronouncements are persuasive and authoritative but not binding. In the following section, we consider whether there is any evidence that CESCR's pronouncements on this topic have been accepted by states.

Access to medicines as a right at the General Assembly and Human Rights Council

Since the late 1990s, the Commission on Human Rights, Human Rights Council, and, to a lesser extent, General Assembly have issued successive resolutions that directly and indirectly address access to medicines as a right. How these resolutions address this question, relate to the ICESCR and CESCR's interpretive work and are agreed on by states illuminates whether and to what extent there is state agreement to read this right into the ICESCR. This is particularly the case with voting on UN General Assembly resolutions where all 193 UN member states vote, such that resolutions adopted without a vote or by consensus by those bodies may reflect the unanimity of ICESCR state parties required to constitute state agreement. While resolutions by the Commission on Human Rights and Human Rights Council cannot give rise to a subsequent agreement or practice establishing the agreement of all parties to a treaty, they are a relevant supplementary means of treaty interpretation.[62]

In the following section, we consider whether a series of General Assembly, Commission on Human Rights, and Human Rights Council resolutions since 2000 can be said to have constituted subsequent agreement to include access to medicines within the ICESCR. UN bodies in general can adopt resolutions with a vote (yay, nay, or abstain), without a vote, or by consensus.[63] When states all vote the same way, this is considered a unanimous decision.[64] Abstentions are considered an important part of voting and a weaker signal of disapproval than a no vote.[65] Abstentions from voting are thus considered to be different from absences from voting, which typically are less reflective of a country's view on a particular issue as opposed to indicating their temporary absence from voting due to conflict or natural disaster.[66] Paradoxically, resolutions adopted without a vote are considered to reflect consensus on the text and to reflect the agreement of all member states to adopt the resolution in question.[67] Similarly, when a decision is made by consensus, no formal vote is taken, and consensus is "understood as the absence of objection rather than a particular majority."[68] Since 2001, General Assembly resolutions related to medicines can be categorized according to three distinct temporal and substantive categories: (1) 2001–2009: access to medicines for HIV/AIDS, tuberculosis, and malaria; (2) 2009–2020: access to medicines in the context of the right to health, global health, and foreign policy; and (3) 2020–present: access to COVID-19 vaccines.

2001–2009: Access to medicines for HIV/AIDS, tuberculosis, and malaria

The first General Assembly resolution on this topic was issued in 2003 and drew from three preceding years of resolutions issued through the Commission on Human Rights. The first of these was issued by the commission in April 2001 as an explicit response to global debates over antiretroviral treatments. This resolution recognizes "that access to medication in the context of pandemics such as HIV/AIDS is one fundamental element for achieving progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[69] The resolution explicitly references the Universal Declaration of Human Rights and ICESCR, the right of everyone to the highest attainable standard of physical and mental health, and CESCR's General Comment 14.[70] The resolution is also replete with implicit references to General Comment 14, including a call for states to promote the "availability, accessibility, appropriate-

ness and quality" of HIV/AIDS pharmaceuticals; and direct use of General Comment 14's language on state duties to respect, protect, and fulfill and its language on states' international duties "to take steps, individually and through international cooperation" to facilitate access in other countries to essential HIV/AIDS-related pharmaceuticals and technologies and to ensure that their actions as members of international organizations take due account of "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[71] At the request of the United States, a roll-call vote was taken, and the resolution was adopted by 52 votes to none, with 1 abstention by the United States.

In April 2002, the Commission on Human Rights reissued this resolution virtually verbatim, albeit now welcoming and reaffirming the contents of the November 2001 adoption of the Doha Declaration on TRIPS and Public Health.[72] This resolution was adopted without a vote, reflecting the consensus of all Commission on Human Rights member states. In April 2003, this resolution was broadened beyond HIV/AIDS to include tuberculosis and malaria, and this resolution was also adopted without a vote.[73] Notably, a US call for a vote to delete the first and second preambular paragraphs (reaffirming the Universal Declaration of Human Rights and ICESCR, and the right to health) was rejected by 52 votes to the United States' single vote.[74] In December 2003, this resolution was adopted virtually verbatim by the General Assembly, with 181 states voting in favor, 1 voting against (the United States), no abstentions, and 9 non-voting states.[75] While the United States voted against the resolution, as a non-state party to the ICESCR it is arguable that this vote could not detract from the consensus of the rest of UN member states voting. However, the fact that five of the non-voting states were ICESCR state parties (Chad, Equatorial Guinea, Iraq, Liberia, and Vanuatu) suggests that this resolution could not amount to a subsequent agreement by ICESCR state parties that access to medicines at least for these three infectious diseases was a fundamental element of the right to health. This resolution does, however, provide important evidence of state consensus on this point.

Subsequent Commission on Human Rights resolutions on this topic did not return to the General Assembly but were adopted without a vote by the commission, with substantially similar content.[76] The 2004 resolution additionally urged states to "consider, whenever necessary, adapting national legislation in order to use to the full the flexibilities contained in the TRIPS Agreement," language that at that stage reflected the Doha Declaration rather than any extant CESCR pronouncements.[77] It is notable that in both 2004 and 2005, US calls for the references to the ICESCR and the right to health to be modified rather than deleted were opposed by the vast majority of voting member states.[78]

2009–2020: Access to medicines in context of the right to health, global health, and foreign policy

Over the next 10 years, while the Human Rights Council moved from this infectious disease focus to locate access to medicines broadly in the right to health, the General Assembly did not again consider this specific resolution. Instead, it considered access to medicines tangentially within a series of resolutions that generally addressed global health and foreign policy, sometimes focusing specifically on health systems strengthening. The majority of these were adopted without a vote.

The General Assembly's 2012, 2013, 2014, 2017, and 2019 resolutions on global health and foreign policy include preambular language recognizing access to medicines as a part of the ICESCR right.[79] For example, the 2012, 2013, and 2014 resolutions note that "the right to the enjoyment of the highest attainable standard of physical and mental health, including access to medicines, remains a distant goal." This framing directly quotes ICESCR article 12(1) on the right to health and straightforwardly indicates that it includes access to medicines. The 2017 resolution's preamble goes further, recalling the Universal Declaration of Human Rights, ICESCR, and World Health Organization Constitution, as well as a 2016 Human Rights Council resolution recognizing access to medicines as a fundamental element of the right to health.[80] The General Assembly's 2019 and 2020 resolutions on

strengthening health systems go even further, referencing all primary human rights instruments relevant to the right to health, including the Universal Declaration of Human Rights, ICESCR, Convention on the Elimination of Racial Discrimination, Convention on the Elimination of All Forms of Discrimination against Women, Convention on the Rights of Persons with Disabilities, International Covenant on Civil and Political Rights, and World Health Organization Constitution.[81] Yet the 2019 resolution's language is more muted: it reaffirms the right to health and an adequate standard of living but frames the inaccessibility of medicines as "a distant goal" rather than an essential or fundamental element of this right.[82] This language is absent in the 2020 resolution, which reiterates this broad treaty basis for the right to health but frames access to medicines in the context of Sustainable Development Goal 3. This resolution was adopted with 181 votes to the United States' solitary no vote.

The implicit language of the AAAQ repeatedly shows up in these resolutions. For example, in several places, the 2020 resolution calls on states to improve access to "quality, safe, effective, affordable and essential medicines, vaccines, diagnostics and health technologies."[83] While many of these resolutions reaffirm states' right to use TRIPS flexibilities to the fullest extent, this is not linked in any explicit way to the right to health. However, the language in multiple resolutions adopted without a vote (and ergo by consensus) recognizing access to medicines as a part of the right to health is arguably the strongest evidence coming from this line of resolutions of subsequent agreement by states regarding the place of medicines within the right to health.

The Human Rights Council continued issuing resolutions on access to medicines as a right over this period. These resolutions are notable for several reasons: first, they go beyond infectious disease to recognize "that access to medicine is one of the fundamental elements in achieving progressively the full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[84] This framing clearly reflects the language in ICESCR articles 2 and 12, and it is arguable that the language of "fundamental element" to some extent reflects the CESCR's inclusion of medicines within the essential elements of the right to health in General Comment 14. Second, the resolutions reflect the content of General Comment 14 in multiple other ways, including state responsibility to ensure nondiscriminatory access to essential medicines that are "affordable, safe, effective and of good quality" and the call for states to ensure that their actions as members of international organizations take the right to health into due account.[85] Third, later resolutions broaden the treaty basis for the right to health beyond the Universal Declaration of Human Rights and ICESCR, affirming that "such a right derives from the inherent dignity of the human person."[86] The 2019 resolution calls states to take action to "promote access to medicines for all," including through using TRIPS flexibilities to the full.[87] Fourth, all but one of the five Human Rights Council resolutions during this period were adopted without a vote, reflecting growing state agreement that access to medicines is a fundamental element of the right to health that imposes duties on states to assure affordability, including by using TRIPS flexibilities.

2020–present: Global access to COVID-19 vaccines

With the onset of COVID-19, the General Assembly has issued numerous resolutions directly and indirectly addressing this topic. An April 2020 resolution of the General Assembly adopted without a vote during the very early stages of the global pandemic urges international cooperation to ensure global access to medicines, vaccines, and medical equipment to face COVID-19.[88] This resolution reaffirms the right to health and notes that "the availability, accessibility, acceptability and affordability of health products of assured quality are fundamental to tackling the pandemic."[89] It calls on member states to "immediately take steps to prevent, within their respective legal frameworks, speculation and undue stockpiling that may hinder access to safe, effective and affordable essential medicines, vaccines, personal protective equipment and medical equipment as may be required to effectively address COVID-19."[90] A September

2020 General Assembly resolution on a comprehensive and coordinated response to the COVID-19 pandemic recalls the broad treaty basis for this imperative and emphasizes that state responses to the pandemic should be in full compliance with their international law obligations, specifically naming the right to health.[91] In several places, the resolution urges member states to enable access to "quality, safe, efficacious and affordable" medicines and vaccines.[92] It reaffirms TRIPS and the Doha Declaration.[93] The resolution was adopted by 169 votes to 2 (United States and Israel), with 2 abstentions and 20 non-voting states.[94]

In March 2021, the Human Rights Council issued a resolution adopted without a vote which lays out in explicit and implicit terms the treaty and human rights basis for "ensuring equitable, affordable, timely and universal access for all countries" to COVID-19 vaccines.[95] In December 2021, this resolution was issued in substantially similar form by the Human Rights Council and then by the General Assembly.[96] This resolution has strong and explicit language locating vaccines and medicines within the right to health in multiple places. The resolution grounds itself in relation to the Universal Declaration of Human Rights, International Covenant on Civil and Political Rights, ICESCR, Convention on the Elimination of All Forms of Discrimination against Women, Convention on the Rights of the Child, Convention on the Rights of Persons with Disabilities, and Convention on the Elimination of Racial Discrimination, with the implication that all these treaties have bearing on universal and equitable access to affordable COVID-19 vaccines.[97] The resolution explicitly recognizes that "the availability of vaccines, medicines, health technologies and health therapies is an essential dimension of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health."[98] It references the CESCR's 2020 statement on universal and equitable access to COVID-19 vaccines.[99] The resolution emphasizes the urgent need to ensure everyone's right to health and to facilitate the development of robust health systems and universal health coverage, which encompasses "universal, timely and equitable access to all essential health technologies, diagnostics, therapeutics, medicines and vaccines in response to the COVID-19 pandemic and other health emergencies."[100] It names the right to health as requiring states to remove unjustified obstacles to the export of COVID-19 vaccines and to facilitate the trade, acquisition, access, and distribution of vaccines as "a crucial element of their response to the pandemic."[101]

Importantly, this resolution links access to medicines not just to the right to health but also to the right to scientific progress: it calls on the international community to continue to assist developing countries in promoting

> *full realization of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health and the right of everyone to enjoy the benefits of scientific progress and its applications, including through access to medicines that are affordable, safe, efficacious and of quality … while recognizing that the primary responsibility for promoting and protecting all human rights rests with States.*[102]

The other notable element of the resolution is its emphasis on the availability, affordability, accessibility, and quality of vaccines in language that directly reflects the CESCR's articulation of these as essential elements of ICESCR rights, including health.[103] For example, the resolution underscores that "the availability, accessibility, acceptability and affordability of health products of assured quality are fundamental to tackling the pandemic."[104]

Yet this resolution was not adopted by consensus, with 179 UN member states voting in favor, 7 abstaining, and 7 not voting. The abstaining countries were Armenia, Australia, Israel, Japan, Republic of Korea, United Kingdom of Great Britain and Northern Ireland, and the United States, all but the last ICESCR state parties.[105] To this extent, this resolution cannot be said to offer evidence of state agreement regarding the ICESCR. Yet interestingly, the meeting record for this vote shows that at least some of these abstentions were motivated because of a *lack* of sufficient references to human rights, rather than an excess. For example, Australia explained its

abstention as motivated in part because "references to marginalized groups and human rights had been removed."[106] Similar concerns were voiced by New Zealand, Switzerland, and Canada.[107] It is arguable that the resolution offers strong subsidiary evidence that medicines and vaccines have been read not just into the ICESCR right to health but also into the right to science.

Weighing the evidence for subsequent agreement on an ICESCR right to medicines

Considering the CESCR's pronouncements and these General Assembly resolutions, can we say that the gap in the ICESCR around medicines has been resolved through the subsequent agreement of states? Since 2000, the CESCR has strongly and consistently read access to medicines and vaccines into the ICESCR and outlined state duties, including in relation to trade-related intellectual property rights. In COVID-19, it has named a right to safe, effective COVID-19 vaccines based on the rights to health and to benefit from scientific progress.[108] Here, the CESCR for the first time proposed going beyond TRIPS flexibilities through a TRIPS waiver and specifically named duties for pharmaceutical companies. While the committee's latter interpretations go considerably further than anything states have been willing to support at the General Assembly and Human Rights Council, there is sufficient evidence given comparable language in successive General Assembly resolutions adopted by consensus to suggest that the CESCR's extension of ICESCR articles to medicines and its framing of the AAAQ has been agreed to. While the General Assembly's 2003 resolution recognizes access to medication for HIV/AIDS, tuberculosis, and malaria as a fundamental element of the right to health and adopts much of General Comment 14's language around the AAAQ and state duties, this resolution was not adopted by consensus. The United States was the sole country voting against this resolution, and several members who did not vote were ICESCR state parties. While the General Assembly did not directly consider this resolution again, it is notable that its progression through the Commission on Human Rights broadened beyond infectious disease and consistently recognized access to medicines as part of the right to health. It is also notable that US attempts to remove ICESCR references and right to health language were consistently voted down.

There is, however, consensus in the General Assembly's 2012, 2013, and 2014 resolutions on global health and foreign policy that the right to health includes access to medicines. This framing is clearly that of ICESCR article 12(1) and arguably reflects some of the strongest evidence to date of state consensus that this right includes access to medicines. The 2017 resolution, also adopted without a vote, goes further by explicitly citing the Universal Declaration of Human Rights, ICESCR, and World Health Organization Constitution, as well as a 2016 Human Rights Council resolution on access to medicines as a fundamental element of the right to health. Yet the most targeted of these resolutions on affordable health care, from 2020, has less explicit language on this front. It acknowledges a broad treaty basis that includes the ICESCR and references AAAQ-like language when it urges states to progressively cover one billion people by 2023 with quality, safe, affordable essential medicines. Yet there is no explicit recognition here of access to medicines as a part of the right to health, nor was this resolution adopted by consensus, again with the United States the sole country not voting and no abstentions. Because the resolution was adopted without a vote, it is not apparent whether any ICESCR members were absent from that General Assembly. Here too, as a non-ICESCR state party, the United States' solitary opposition to the 2020 resolution is not dispositive of a lack of agreement among ICESCR state parties. More apparent is that the resolutions adopted without a vote offer evidence of state agreement to read access to medicines into the ICESCR right to health. On the other hand, it cannot be ignored that these resolutions only tangentially address access to medicines, rendering them less persuasive as the smoking gun within General Assembly resolutions to establish subsequent agreement in relation to the ICESCR.

Nor does this evidence emerge from the General Assembly's 2021 resolution on COVID-19 vaccines, which is the first time since 2003 that access to medicines are the explicit focus of a resolution. This resolution explicitly cites the ICESCR and the CESCR's 2020 statement on this topic. It implicitly reflects aspects of this statement, recognizing vaccines and medicines as essential dimensions of ICESCR rights to health and to benefit from science and noting that the right to health requires states to ensure universal access, remove unjustified obstacles, and assist developing countries in promoting these rights. Yet this resolution was not adopted by consensus, with six of the seven states abstaining from voting being ICESCR state parties. Certainly, these same resolutions offer strong and credible evidence to support this inclusion as a legitimate interpretation of ICESCR article 12 under Vienna Convention article 32: the repetition of the framing of access to medicines as a part of the right to health in these General Assembly resolutions and Human Rights Council resolutions indicates growing state agreement on this point and on aspects of the CESCR's pronouncements including the AAAQ framework.

Equally significant is what these resolutions do not do.[109] While the language of the Doha Declaration is repeatedly reaffirmed, there is little language in any of these resolutions to connect the imperative to use TRIPS flexibilities directly to the right to health or to cite any of the CESCR's increasingly specific invocation of other state and now corporate duties to ensure that intellectual property rights do not impact the affordability of medicines or vaccines.

Conclusion

It is arguable that the 22 years of legal and political iterations assessed above provide limited evidence of state agreement to read the right to medicines into the ICESCR, although the evidence base to suggest that this is a legitimate interpretation of ICESCR articles 12 and 15 has only grown stronger. Yet global disparities in access to COVID-19 vaccines underscore the gap not just between state rhetoric and CESCR rhetoric on a right to medicines, but between state rhetoric and state action on this front. Even if states accept the normative proposition that access to medicines is a part of international rights to health and science, this recognition appears to have limited impact on their domestic and international conduct when it comes to medicines and intellectual property rights during a pandemic. This is a devastating signal of the continued weakness and contestation of a universal right to affordable medicines that places reasonable limits on commercial imperatives or that effectively coordinates global cooperation on this front. The extent of this contestation is likely to similarly appear in ongoing state negotiations for the pandemic treaty and may make these negotiations unlikely to advance this right in any legally significant ways beyond recognizing access to medicines and vaccines as a part of ICESCR rights and recognizing state entitlements to use TRIPS flexibilities. Yet even a limited codification of this nature would be a welcome move toward recognition of a binding right to medicines within international law.

Nor can these limited outcomes negate the extraordinary growing extent to which access to affordable medicines as a part of rights to health and science are repeatedly being legally and politically embraced by courts and legislatures, and crucially by civil society, as always, the single most crucial actor when it comes to the protection and development of human rights. To this extent, the developments outlined in this paper considered against this broader backdrop offer some hope that the evolutionary emergence of this right is nowhere yet complete.

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