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Evolution and Complementarity? Traditional and Complementary Medicine as Part of the International Human Rights Law Right to Health

ANGELA DOOLAN* AND GREG CARNE**

Abstract

In International Human Rights Law, the International Covenant on Economic, Social and Cultural Rights defines the right to health as the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Millions of people use traditional and complementary medicine ('T&CM') to realise their right to health. This article analyses whether the scope of the right to health includes T&CM. Although not expressly provided for in the legally binding treaties, there is substantial evidence in international law to infer a right to T&CM as part of the right to health. The article analyses some of the failings of T&CM policy and regulation in Australia and offers a draft convention article in the recently proposed Framework Convention on Global Health ('FCGH') which codifies an express and legally binding right to T&CM. This would assist States Parties address the policy, legislative and regulatory gaps that currently exist regarding T&CM. A clear duty imposed on States Parties would ensure everyone including indigenous peoples have access to quality, safe, culturally appropriate, and effective T&CM health care facilities, goods and services. States Parties including the Australian Government might then more effectively harness the potential contribution of T&CM, and fundamentally reorientate health systems towards significantly more cost-effective wellness and people centred health care in realising the right to health for all.

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I Introduction

In international human rights law, the legally binding formulation of the right to health is contained in art 12 of the *International Covenant on Economic, Social and Cultural Rights* ('ICESCR'). Article 12(1) ICESCR provides a definition of the right to health as 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.'¹ The Committee monitoring implementation on the Right to Health describes it in this way: 'Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity.'² The right to health was first described in the 1946 *Constitution of the World Health Organisation* as 'a state of complete mental and physical and social well-being and not merely the absence of disease or infirmity... and it is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.'³ The 1948 *Universal Declaration of Human Rights* art 25(1) affirmed 'everyone has the right to a standard of living and medical care adequate for the health and wellbeing of himself [*sic*] and his [*sic*] family, including food, clothing, housing and medical care.'⁴ Art 25 has been discussed as reflecting a 'distributive justice' perspective, in the sense of the just and equitable distribution of benefits in society.⁵

The right to health is recognised in five other legally binding treaties including: the *Convention on the Elimination of All Forms of Discrimination against Women* ('CEDAW');⁶ *Convention on the Rights of the Child* ('CRC');⁷ *International Convention on the Elimination of All Forms of Racial Discrimination* ('ICERD');⁸ *International Convention on the Protection of the Rights of All Migrant*

¹ *International Covenant on Economic, Social and Cultural Rights* ('ICESCR') opened for signature 16 December 1966, 993 UNTS 3 (entered into force 3 January 1976) art 12(1).

² Committee on Economic, Social Cultural Rights ('CESCR'), *General Comment No 14: The Right to the Highest Attainable Standard of Health (Art. 12)*, 22nd sess, UN Doc E/C. 12/2000/4 (11 August 2000) [1].

³ *Constitution of the World Health Organisation*, Geneva, 1946 preamble.

⁴ *Universal Declaration of Human Rights*, GA Res 217A (III), UN GAOR, UN Doc A/810 (10 December 1948).

⁵ Michael Weir, *Law and Ethics in Complementary Medicine A Handbook for Practitioners in Australia and New Zealand* (Allen & Unwin, 5th ed, 2016) 18 citing Megan-Jane Johnstone, *Bioethics – A Nursing Perspective* (Churchill Livingstone, 5th ed, 2009) 45.

⁶ *Convention on the Elimination of All Forms of Discrimination Against Women* ('CEDAW') opened for signature 18 December 1979, 1249 UNTS 13 (entered into force 3 September 1981) art 12.

⁷ *Convention on the Rights of the Child* ('CRC') opened for signature 20 November 1989, 1577 UNTS 3 (entered into force 2 September 1990) art 24.

⁸ *International Convention on the Elimination of All Forms of Racial Discrimination* ('ICERD') opened for signature 21 December 1965, 660 UNTS 195 (entered into force 4 January 1969) art 5(e)(iv).

Workers and Members of Their Families ('ICRMW');⁹ and Convention of the Rights of Persons with Disabilities ('CRPD').¹⁰ The right to health is also affirmed in non-binding, 'soft' law declarations including: *United Nations Declaration on the Rights of Indigenous Peoples* ('UNDRIP');¹¹ *Declaration of Alma-Ata* ('DAA');¹² *Beijing Declaration* ('BD');¹³ and the *Declaration of Astana* ('DA').¹⁴

The World Health Organisation ('WHO') defines Traditional and Complementary Medicine ('T&CM') as follows:

Traditional Medicine has a long history. It is the sum total of knowledge, skill and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness.¹⁵

Examples of Traditional Medicine ('TM') include Ayurveda, traditional Chinese medicine and traditional Aboriginal medicine. Complementary medicine ('CM'), also referred to as Complementary and Alternative Medicine ('CAM') is defined as 'a broad set of health care practices that are not part of that country's own tradition or conventional medicine and are not fully integrated into the dominant health care system.'¹⁶ Examples of CM include chiropractic, naturopathy and osteopathy. 'T&CM merges the terms TM and CM, and encompasses products, practices and practitioners.'¹⁷ It is interesting to note that 'many of the defining values of CAM are now considered part of mainstream care. These include patient-centred care, a holistic approach, emphasis on self-management and prevention.'¹⁸

This article uses both doctrinal and persuasive interpretative methodology to analyse the binding and multiple non-binding instruments to determine whether the scope of the right to health

⁹ *International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families* ('ICRMW') opened for signature 18 December 1990, 2220 UNTS 3 (entered into force 1 July 2003) arts 28, 43(1)(e).

¹⁰ *Convention of the Rights of Persons with Disabilities* ('CRPD') opened for signature 13 December 2006, 2515 UNTS 3 (entered into force 3 May 2008) art 25.

¹¹ *United Nations Declaration on the Rights of Indigenous Peoples* ('UNDRIP') GA Res 61/295, UN Doc A/RES/61/295 (2 October 2007, adopted 13 September 2007).

¹² *Declaration of Alma-Ata* ('DAA') (International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978).

¹³ *Beijing Declaration* ('BD') (Adopted by the WHO Congress on Traditional Medicine, Beijing, China, 8 November 2008).

¹⁴ *Declaration of Astana* ('DA') (International Conference on Primary Health Care, Astana, Kazakhstan, 25 – 26 October 2018).

¹⁵ World Health Organisation, *WHO Traditional Medicine Strategy 2014-2023* (World Health Organisation, Geneva, 2013) 15.

¹⁶ Ibid.

¹⁷ Ibid.

¹⁸ Deborah Sharp et al, 'Trying to Put a Square Peg into a Round Hole: A Qualitative Study of Healthcare Professionals' Views of Integrating Complementary Medicine into Primary Care for Musculoskeletal and Mental Health Comorbidity' (2018) 18 (290) *BMC Complementary and Alternative Medicine* 1, 2.

includes a right to T&CM. ‘Doctrinal research provides a systematic exposition of the rules governing a particular legal category, analyses the relationship between rules, explains areas of difficulty and, perhaps, predicts future developments.’¹⁹ ‘The essential features of doctrinal scholarship involve a critical conceptual analysis of all relevant legislation and case law to reveal a statement of the law relevant to the matter under investigation.’²⁰ According to Tobin, persuasive interpretative methodology

[a]cknowledges the limitations ... of art 31 *Vienna Convention on the Law of Treaties*. Persuasive appeal ... will be enhanced if it is principled, clear and practical, coherent within the system of international law and sensitive to socio-political context in an attempt to persuade the relevant interpretative community that a particular interpretation of the right to health is the most appropriate meaning to adopt.²¹

The interpretative community relevant to the realisation of the right to health extends beyond States Parties who are ultimately accountable for compliance with the Covenant and includes ‘... all members of society...’²² Given that ‘millions of people use T&CM’²³ to realise their right to health, the World Health Organisation has identified ‘improving equitable access to safe, quality and effective T&CM services can potentially meet communities’ needs and build sustainable and culturally sensitive primary health care.’²⁴ One group of researchers have argued for the need for future research to establish the legal basis for the right to traditional, complementary and alternative health care.²⁵ They also posited that the lack of clarity on the legal basis for a right to traditional, complementary and alternative health care has resulted in weak legal and professional guidance and regulation in this area.²⁶ This article demonstrates, although T&CM is clearly within the scope of the International Human Rights Law Right to Health, an express articulation of the Right to T&CM could assist in achieving the WHO goal of improving equitable access to safe, quality and effective T&CM.

¹⁹ Terry Hutchinson and Nigel Duncan, ‘Defining and Describing What We Do: Doctrinal Legal Research’ (2012) 17(1) *Deakin Law Review* 83, 101.

²⁰ Terry Hutchinson, ‘The Doctrinal Method: Incorporating Interdisciplinary Methods in Reforming the Law’ (2015) 3 *Erasmus Law Review* 130, 131 quoting Terry Hutchinson, ‘Vale Bunny Watson? Law Librarians, Law Libraries and Legal Research in the Post-Internet Era’ (2014) 106(4) *Law Library Journal* 579, 584.

²¹ John Tobin, *The Right to Health in International Law* (Oxford University Press, 2014) 162-3.

²² CESCR (n 2) [42].

²³ Karl Peltzer and Supa Pengpid, ‘Prevalence and Determinants of Traditional, Complementary and Alternative Medicine Provider Use Among Adults from 32 Countries’ (2018) 24 (18) *Chinese Journal of Integrative Medicine* 584, 584.

²⁴ World Health Organisation, *World Global Report on Traditional and Complementary Medicine 2019* (World Health Organisation, 2019) 10.

²⁵ Maria Stuttaford et al, ‘The Right to Traditional, Complementary and Alternative Health Care’ (2014) 7 *Global Health Action* 1, 2.

²⁶ *Ibid* 3.

Consideration is then given to examples of T&CM policy and regulatory failures in Australia and how the proposed *Framework Convention on Global Health* ('*FCGH*') could be helpful in addressing these.

II The Right to Health and T&CM

The legally binding and 'most important formulation of the right to health is contained in art 12 *ICESCR* which provides the cornerstone protection of the right to health in international law.'²⁷ Article 12(1) *ICESCR* provides a definition of the right to health as the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. 'The highest attainable standard' accounts for both the individual's biological and socioeconomic preconditions and a States available resources.²⁸ It is important to note that 'the right to health is not meant to be understood as the right to be healthy.'²⁹ Good health cannot be ensured by a State, nor can States provide protection against every possible cause of ill health. Genetic factors, individual susceptibility to illness or risky lifestyles play ... roles in a person's health.³⁰

The *ICESCR* is a treaty. Treaties are international agreements concluded between states in written form. Treaties are primary sources of international law.³¹ 'Every treaty in force is binding upon the parties to it and must be performed by them in good faith.'³² Currently 170 States Parties, including Australia, have ratified the *ICESCR*.³³ The *Optional Protocol to the ICESCR*, which enables individual and groups of individuals' communications to be considered by the Committee on Economic, Social and Cultural Rights (CESCR), is currently ratified by 24 States Parties. Australia has neither signed nor ratified the *Optional Protocol to the ICESCR*.³⁴ The '*ICESCR* clearly imposes a duty on each State to take whatever steps are necessary to ensure that everyone has access to health care facilities, goods and services so that they can enjoy ... the highest attainable standard of physical and mental health.'³⁵

²⁷ Anand Grover, *Thematic Study on the Realisation of the Right to Health of Older Persons by the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*. Human Rights Council, 18th sess, UN Doc A/HRC/18/37 (4 July 2011) 6.

²⁸ CESCR (n 2) [9].

²⁹ Ibid [8].

³⁰ Ibid [9].

³¹ *Statute of the International Court of Justice* art 38(1).

³² *Vienna Convention on the Law of Treaties*, opened for signature 23 May 1969, 1155 UNTS 331 (entered into force 27 January 1980) art 31.

³³ 'Status of Ratification Interactive Dashboard ICESCR' *United Nations Human Rights Office of the High Commissioner* (30 September 2019) <<http://indicators.ohchr.org/>>.

³⁴ Ibid.

³⁵ CESCR (n 2) [53].

As there is no express mention of T&CM, it is not immediately clear whether the duty imposed on each State includes taking whatever steps are necessary to ensure that everyone has access to T&CM health care facilities, goods and services. Nonetheless, millions of people use T&CM to realise their right to health. Dr Margaret Chan, the immediate past Director-General of the World Health Organisation ('WHO'), stated:

Across the world, T&CM is either the mainstay of health care or serves as a complement to it. ... T&CM is an important and often underestimated part of health care ... is found in almost every country in the world and the demand for its services is increasing. T&CM ... contributes to the goal of ensuring ... all people have access to care.³⁶

Dr Tedros Adhanom Ghebreyesus, the current WHO Director-General, states: 'In an ideal world, traditional medicine would be an option offered by a well-functioning, people-centred health system that balances curative services with preventive care.'³⁷ Accordingly, the WHO has set the course for expanding access to T&CM for the next decade in the *WHO Traditional Medicine Strategy 2014-2023* ('*WTMS*').³⁸ The *WTMS* has two key goals:

1. To support Member States in harnessing the potential contribution of T&CM to health, wellness and people centred health care and
2. promoting safe and effective use of T&CM through the regulation, evaluation and integration of products, practices and practitioners into health systems, as appropriate.³⁹

Despite extensive and increasing global use of T&CM, there is little in the way of international human rights discourse regarding the right to health and T&CM. For this reason alone, there may be a need to establish an express and legally binding right for ensuring safe and equitable access to T&CM from an international human rights perspective.

III The Scope of the Right to Health

A *Article 12 ICESCR*

The legally binding and 'most important formulation of the right to health is contained in art 12 *ICESCR* which provides the cornerstone protection of the right to health in international law.'⁴⁰ Article 12(1)

³⁶ Margaret Chan, 'Foreword' in WHO (n 15) 7.

³⁷ Tedros Adhanom Ghebreyesus, 'Foreword' in WHO (n 24) 5.

³⁸ WHO (n 15) 16.

³⁹ *Ibid* 57.

⁴⁰ Grover (n 27) 6.

ICESCR provides a definition of the right to health as the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Article 12(2) states

... steps to be taken by ... State Parties ... shall include those necessary for:

- (a) The provision for the reduction of the stillbirth-rate and 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.

In analysing art 12, and whether its scope arguably includes T&CM, four important points can be made. First, none of the terms contained within art 12 are defined by the instrument. This includes the terms ‘medical service and medical attention’ only referred to in art 12(2)(d). Without a clear indication as to what medical service and medical attention means, an interpretation inclusive of T&CM service and attention is arguably possible.

Second, ‘the idea of health under international law reflects a multidimensional construct that includes psychosocial, physical, mental’⁴¹ and environmental elements. Third, art 12 neither explicitly mentions nor proscribes T&CM. Fourth, art 12(2)(c) refers to prevention and treatment but does not specify how this is to be achieved. This potentially enables an interpretation inclusive of T&CM prevention and treatment. Regarding inclusions in the scope of the right to health, Tobin highlights that

where there is no explicit textual basis to support their inclusion ... if a persuasive account is to be made for their inclusion, it must be derived from an argument that they are necessary to ensure the effective enjoyment of the right to health ... they must fill an ‘effectiveness gap’ in the implementation of the right to health ...⁴²

In endorsing Tobin’s view, an argument can be made that for millions of people, T&CM is necessary to ensure the effective enjoyment of the right to health. This includes the millions of people who have limited or no access to conventional Western medicine (also referred to as biomedicine) and the millions who, for a multitude of reasons, including effectiveness gaps in health care, choose T&CM as part of their preferred health care regime.

⁴¹ Tobin (n 21) 245 quoting Jennifer Prah Ruger ‘Toward a Theory of a Right to Health: Capability and Incompletely Theorized Arguments’ (2006) 18 (2) *Yale Journal of Law and the Humanities* 273.

⁴² Tobin (n 21) 247.

As explained by the late Dr Peter Fisher, who was director of research at University College London Hospital's Royal London Hospital for Integrated Medicine, and physician to Her Majesty The Queen, 'an effectiveness gap, is a clinical area where available treatments are not fully effective or satisfactory for any reason, including: lack of efficacy, adverse effects, acceptability to patients, compliance, economic or any other reason'.⁴³ One UK report found 'Evidence indicates that many of the most effective CM therapies correspond to 'effectiveness gaps' in National Health Service treatment. The main areas comprise chronic and complex conditions, anxiety, stress, depression and palliative care.'⁴⁴ Although criticized by Ernst,⁴⁵ the main areas of CM efficacy have largely been reiterated by two recent studies in the UK⁴⁶ and Australia.⁴⁷ The UK study concluded that 'CAM has the potential to help the NHS in treating the burden of musculoskeletal/mental health comorbid patients.'⁴⁸ The Australian study highlighted 'that whole-system multi-modality naturopathic medicine is effective for treating a range of conditions, including cardiovascular disorders, musculoskeletal pain, type 2 diabetes, polycystic ovarian syndrome, depression, and anxiety.'⁴⁹

However, whether the scope of the right to health in international law includes T&CM to ensure the effective enjoyment of the right to health, remains open to interpretation. As far as can be ascertained, no courts, either internationally or domestically, have interpreted the scope of art 12 to either include or exclude T&CM. The most authoritative interpretation of the right to health within the UN system is *General Comment No. 14: The Right to Highest Attainable Standard of Health (Art. 12) ('GC14')*. *GC14* reflects the present state of international law on the right to health. It was issued by the Committee on Economic, Social and Cultural Rights ('CECSR'), established to monitor the *ICESCR*, in 2000. Although General Comments are not legally binding, 'they are quasi-legislative, authoritative interpretations of the scope and

⁴³ Peter Fisher et al, 'Effectiveness Gaps: A New Concept for Evaluating Health Service and Research Needs Applied to Complementary and Alternative Medicine' (2004) 10 (4) *Journal of Alternative and Complementary Medicine* 628.

⁴⁴ Christopher Smallwood, *The Role of Complementary and Alternative Medicine in the NHS An Investigation into the Potential Contribution of Mainstream Complementary Therapies to Healthcare in the UK* (Report, October 2005) 17.

⁴⁵ Ezard Ernst, 'The "Smallwood Report" – Method or Madness' (2006) 56 (522) *British Journal of General Practice* 64-5.

⁴⁶ Sharp et al (n 18) 2.

⁴⁷ Stephen Myers and Vanessa Vigar, 'The State of the Evidence for Whole-System, Multimodality Naturopathic Medicine: A Systematic Scoping Review' (2019) 25 (2) *Journal of Complementary and Alternative Medicine* 121.

⁴⁸ Sharp et al (n 18) 12.

⁴⁹ Myers and Vigar (n 47) 166.

normative content of Covenant rights ... and are one of the potentially most significant and influential tools available to treaty bodies.⁵⁰

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

First, *GC14* states the definition of the right to health contained in art 12(1) is broad⁵¹ and that art 12(2) enumerates illustrative, non-exhaustive examples of States parties' obligations.⁵² A broad definition of the right to health, coupled with non-exhaustive examples arising from this broad definition, points to the scope of the right being inclusive rather than exclusive of T&CM, arguably enabling a right to T&CM to potentially be inferred from art 12.

Second, the proposition that T&CM falls within the scope of the right to health is significantly strengthened by the opening paragraph of *GC14* which states that '[t]he realization of the right to health may be pursued through numerous, complementary approaches, such as ... the implementation of health programmes developed by the WHO ...'⁵³ The current *WHO Traditional Medicine Strategy* ('*WTMS*') is a health programme, developed by the WHO, focussed on global implementation of T&CM. Therefore, the *WTMS* is evidence of a WHO programme that is supportive of T&CM contributing to the right to health and is central to the argument that a right to T&CM is within the ambit of the right to health.

Third, 'the right to health contains freedoms and entitlements. Freedoms include the right to control one's health and body.'⁵⁴ Indeed, 'private individuals in a just society should be entitled to choose [their health care] and to be afforded appropriate protection for that choice.'⁵⁵ To this end, the *WTMS* is 'to help health care leaders develop solutions that contribute to a broader vision of improved health care and patient autonomy.'⁵⁶ Exercising the freedom and having an ability to choose T&CM is a fundamental expression of the right to control one's health and body.

Fourth, 'the right to health must be understood as a right to the enjoyment of a variety of facilities, goods and services ... necessary for the realization of the highest attainable standard of health.'⁵⁷ The

⁵⁰ Phillip Alston, 'The Historical Origins of the Concept of "General Comments" in Human Rights Law' in L Boisson de Chazourmess and V Gowlland-Debbas (eds) *The International Legal System in Quest of Equity and Universality* (Martinus Nijhoff, 2001) 763, 773.

⁵¹ CESCR (n 2) [13].

⁵² Ibid [7].

⁵³ Ibid [1].

⁵⁴ Ibid [8].

⁵⁵ Weir (n 5) 19.

⁵⁶ Chan, 'Foreword' in WHO (n 15) 8.

⁵⁷ CESCR (n 2) [9].

plethora of T&CM facilities, goods and services, whether sourced locally or from the internet, significantly attests to a large variety of these available to the global population in their pursuance of health. Indeed, issues of quality and safety regarding a large variety of online T&CM goods and services has been an ongoing concern for the WHO since 1999.⁵⁸

Fifth, ‘the right to health in all its forms and at all levels contains the following interrelated and essential elements - availability, accessibility, acceptability and quality.’⁵⁹ A 2014 literature review, conducted by Stuttaford and colleagues, revealed a gap in international law in terms of defining the right to health *in all its forms* beyond biomedicine.⁶⁰ Although *GC14* does not explicitly define the right to health in all its forms, this articulation allows for a broad interpretation of what constitutes the right and is not limited to a particular form or level to satisfy the right. These broad parameters make it plausible that T&CM are manifestations of the right to health in many of its forms and therefore must also contain the elements of availability, accessibility, acceptability and quality.

Sixth, *GC14* articulates special topics of broad application in interpreting the *ICESCR*. These include non-discrimination and equal treatment. By virtue of art 2(2) and art 3 *ICESCR*, the Covenant proscribes any discrimination in access to health care on multiple grounds. *GC14* stipulates, ‘States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health-care facilities, and to prevent any discrimination in ... the provision of health care and health services.’⁶¹ As T&CM are forms of health care and services, the argument can plausibly fall within the scope of art 2(2) and art 3.

Further *GC14* clarifies, ‘Inappropriate health resource allocation can lead to discrimination that may not be overt. Investments should not disproportionately favour expensive curative health services rather than primary and preventative health care.’⁶² Investments in health care should therefore value primary and preventative health care, and potentially be inclusive of primary and preventative health care offered by T&CM. As highlighted by Hollenberg and colleagues, TM has provided and continues to provide direct forms of primary health care (‘PHC’) to global communities with low physician-to-population ratios

⁵⁸ World Health Organisation, *Medical Products and the Internet: A Guide to Finding Reliable Information* (World Health Organisation, 1999).

⁵⁹ CESCR (n 2) [12].

⁶⁰ Stuttaford et al (n 25) 3-4.

⁶¹ CESCR (n 2) [19].

⁶² *Ibid.*

and access to western biomedicine.⁶³ As stated by the WHO, TM also has a long history of use in health maintenance and in disease prevention and treatment, particularly for chronic disease.⁶⁴ Previous Director-General of the WHO Margaret Chan stated ‘TM stands out as a way of coping with the relentless rise of chronic non-communicable disease.’⁶⁵ The *WTMS* effectively addresses this point by articulating a fundamental redirection of resources towards non-discriminatory, universal coverage inclusive of T&CM.

These top heavy services (curative, hospital-based, disease orientated services) are responsible for huge inefficiencies that could be redirected towards achieving universal coverage. Instead of these existing barriers, qualified T&CM could be a positive contribution to universal health care coverage.⁶⁶

Multiple reports have articulated the cost effectiveness of preventative T&CM as a means to combating unsustainable health care costs, running into the billions of dollars in savings through avoiding potential hospital costs.⁶⁷ As the Covenant proscribes discrimination in access to health care, because T&CM are forms of health care, it can therefore be inferred that the Covenant may also proscribe discrimination in access to T&CM care. As investments in health care should value primary and preventative health care, and as T&CM provides significantly cost effective primary and preventative health care, T&CM should also be valued.

In continuing the non-discrimination in health care theme, *GCI4* states, ‘the Committee stresses ... that not only the public sector but also private providers of health services ... comply with the principle of non-discrimination in relation to persons with disabilities.’⁶⁸ One study revealed that

a significant proportion of people with physical disabilities (19%) consult CM practitioners because it fits their lifestyle and they perceive it to be

⁶³ Daniel Hollenberg et al, ‘Repositioning the Role of Traditional Medicine as Essential Health Knowledge in Global Health: Do They Still Have a Role to Play?’ in Jon Adams et al, *Traditional, Complementary and Integrative Medicine: An International Reader* (Palgrave Macmillan, 2012) 240.

⁶⁴ WHO (n 15) 11.

⁶⁵ Margaret Chan (Speech given at the International Conference on Traditional Medicine for South East Asian Countries, New Delhi, India, 13 February 2013) quoted in WHO (n 15) 16.

⁶⁶ WHO (n 15) 35.

⁶⁷ Access Economics, *Cost Effectiveness of Complementary Medicines* (Report, August 2010); Carl Gibson, *Complementary Healthcare Council of Australia’s 2014-15 Federal Pre-Budget Submission* (Report, January 2014); Frost and Sullivan, *Smart Prevention – Health Care Cost Savings Resulting from the Targeted Use of Dietary Supplements* (Report, September 2013); Smallwood (n 44).

⁶⁸ CESCR (n 2) [26].

more effective than conventional medicine for treating common symptoms including pain and decreased functioning.⁶⁹

Furthermore, perhaps the most compelling evidence for the inclusion of T&CM within the scope of the right to health is the *GC14* explicit statement:

indigenous peoples have the right to specific measures to improve their access to health services ... [that] should be culturally appropriate, taking into account traditional preventive care, healing practices and medicines. ... The vital medicinal plants, animals and minerals necessary to the full enjoyment of health of indigenous peoples should also be protected.⁷⁰

Finally, the committee stipulates, ‘obligations to respect include a State’s obligation to refrain from prohibiting or impeding traditional preventive care, healing practices and medicines.’⁷¹ This section of *GC14* gives unequivocal clarification that the scope of the right to health imposes all three levels of obligations on States parties to respect, protect and fulfil the right to specific measures that are inclusive of T&CM. The obligation to respect requires States from interfering with the enjoyment to the right to health,⁷² including T&CM. The obligation to protect requires States to take measures that prevent third parties interfering with the right,⁷³ including T&CM.

The obligation to fulfil the right requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health,⁷⁴ inclusive of T&CM. Despite these obligations, countries like Australia are failing to fully realise their obligations in terms of T&CM and some of these have recently been repealed.

C Other International Treaties - Understanding the Scope of the Right to Health

Beyond art 12 and *GC14*, ‘additional right to health protections are contained in international treaties that address issues specific to marginalized groups.’⁷⁵ These include *CEDAW* art 12, *CRC* art 24, *ICERD* art 5(e)(iv), *ICRMW* arts 28, 43(1)(e) and 45(1)(c) and *CRPD*

⁶⁹ M J Carlson and G Krahn, ‘Use of Complementary and Alternative Medicine Practitioners by People with Physical Disabilities: Estimates from a National US Survey’ (2006) *Disability Rehabilitation* 1, 1.

⁷⁰ CESCR (n 2) [27].

⁷¹ *Ibid* [34].

⁷² *Ibid* [33].

⁷³ *Ibid*.

⁷⁴ *Ibid*.

⁷⁵ Paul Hunt et al, ‘The Right to the Highest Attainable Standard of Health’ in Roger Detels et al (eds), *Oxford Textbook of Global Public Health* (Oxford University Press, 6th ed, 2015) 278.

art 25. The *ICERD* has been ratified by 182 States Parties, the *CEDAW* is ratified by 189 States Parties, the *CRC* is ratified by 196 States Parties, and the *CRPD* is ratified by 181 States Parties. Although Australia has ratified all these treaties, only some rights under these conventions have been incorporated into domestic law. Currently the new Queensland *Human Rights Act 2019*⁷⁶ is the only domestic legislation implementing the right to health services into any Australian jurisdiction. The *ICRMW* is ratified by 55 States Parties but is neither signed nor ratified by Australia.⁷⁷

As with art 12, none of these international treaties explicitly provide for nor prohibit T&CM. Nonetheless, the contents of the treaties themselves, the General Comments, General Recommendations and Concluding Observations by the UN treaty bodies, the work of the WHO and commentary by the Special Rapporteurs on the right to health, significantly enhance the understanding of what the legal scope of the right to health is for vulnerable groups.

An understanding of the scope of the right to health beyond art 12 *ICESCR* is *CEDAW* art 12(1) which states, ‘States parties should take all appropriate measures to eliminate the discrimination against women in the field of health care ... to ensure ... access to health care services, including those related to family planning.’⁷⁸ Family planning is not expressly mentioned in art 12 *ICESCR*. However, the right to reproductive freedom,⁷⁹ including access to family planning⁸⁰ is mentioned in *CESCR GC14*. The *CEDAW* Committee has further specified in General Recommendation 24 (*‘GR24’*) ‘that access to health care, including reproductive health, is a basic right under the *CEDAW*.’⁸¹ The concept of reproductive health as a basic right is not mentioned in art 12 *ICESCR*. Therefore, increased understanding of the scope of art 12 *ICESCR* is achieved by the *CEDAW*, *GR24* and *GC14*. *GR 24* further articulates that

States parties should report on ... how policies ... address the health rights of women from the perspective of women’s needs ... and how it addresses distinctive features and factors that differ for women in comparison with

⁷⁶ *Human Rights Act 2019*(Qld) s 37.

⁷⁷ ‘Status of Ratification Interactive Dashboard CEDAW, ICERD, CRC, CRPD, ICRMW’ *United Nations Human Rights Office of the High Commissioner* (30 September 2019) <<http://indicators.ohchr.org/>>.

⁷⁸ *Convention on the Elimination of All Forms of Discrimination against Women*, opened for signature 18 December 1979, 1249 UNTS 13 (entered into force 3 September 1981) art 12(1).

⁷⁹ *CESCR* (n 2) [8].

⁸⁰ *Ibid* [14].

⁸¹ *CEDAW, General Recommendation No 24 (Twentieth Session): Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women— Women and Health*, as contained in *Report of the Committee on the Elimination of Discrimination against Women: Twentieth Session*, UN GAOR, 54th sess, UN Doc A/54/38 (Part I) (2 May 1999) [1].

men such as: (a) biological factors such as their menstrual cycle, their reproductive function and menopause.⁸²

Although art 12 *CEDAW* or *GR24* do not make any reference to T&CM, it is important to note that the above articulation of how States Parties should report on how policies address the health rights of women should also potentially include T&CM as ‘large cohort studies reveal CM users are more likely to be women than men and CM does appear to lend itself to a number of women’s health issues including pregnancy, menstruation and menopause’.⁸³ *GR24* also states that

acceptable services are those that are delivered in a way that ensures that a woman gives her fully informed consent, respects her dignity, guarantees her confidentiality and is sensitive to her needs and perspectives.⁸⁴

Studies supporting that T&CM services should be considered acceptable services as ‘when women accessed care, they often chose traditional healers ... on account of privacy, anonymity, accessibility and the provision of more patient-centred care.’⁸⁵ The *CEDAW* Committee has also expressly mentioned the key importance of the use of TM in women’s healthcare in their Concluding Observations, Uganda 1995 which stated:

Members believed that traditional healers and traditional medicine were the key to making assisted childbearing a financial possibility. Had Uganda made an effort to systematize its network of traditional birth attendants and traditional healers? Were development strategies making use of traditional knowledge, as opposed to imposing foreign approaches?⁸⁶

Similarly, *General Comment No 15* by the Committee on the Rights of the Child clarifies the scope of the right to health as it pertains to children. It states, ‘The Committee interprets the children’s right to health ... extends ... also to a right to grow and develop to their full potential ... through the implementation of programmes that address underlying determinants of health.’ The CRC have also acknowledged TM practitioners in facilitating greater access to health services for children. One example is the Concluding Observations: Tanzania 2001 which stated:

⁸² Ibid [12a].

⁸³ Jon Adams et al, ‘Complementary and Alternative Medicine throughout the Lifecycle’ in Adams et al (n 63) 33.

⁸⁴ *CEDAW* (n 81) [22].

⁸⁵ Valoshnee Govenda and Loveday Penn-Kakkana, ‘Gender Biases and Discrimination – A Review of Health Care Interpersonal Interactions’ (Background paper prepared for the Women and Gender Equity Knowledge Network of the WHO Commission on Social Determinants of Health, June 2007) 14.

⁸⁶ *CEDAW, Concluding Observations of the Committee on the Elimination of Discrimination against Women: Uganda*, 270th and 273 mtg, UN Doc A/50/38 (3 February 1995) [319].

... the State party should take all effective measures to facilitate greater access to health services by ... increasing the number of trained medical and other health personnel, including traditional healers, facilitate cooperation between trained medical personnel and traditional healers ...⁸⁷

T&CM strategies are used by children's parents in realising their child's highest attainable standard of health, and use of CM therapies by children and adolescents appears to be increasing.⁸⁸ In outpatient care settings, paediatric CM use ranges from 20-40 per cent, while use in children with recurrent, chronic or incurable conditions can be much higher.⁸⁹ Therefore, it is not unreasonable to suggest that T&CM is within the scope of the right to health as it pertains to children.

It is important to note that harmful traditional practices and practitioners have also been identified by the CRC in its Concluding Observations regarding Nepal⁹⁰ and Madagascar.⁹¹ Although this issue is beyond the scope of this paper, this issue highlights the importance of T&CM being recognised as part of the right to health. In this way States Parties could lessen public harm through more effective regulatory measures to improve the quality and safety of T&CM products, practices and practitioners as articulated in the *WTMS* goals.

Another example of the understanding of the right to health is art 5(e)(iv) *ICERD*. It provides:

States Parties undertake to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction ... notably in the enjoyment of ... (e) Economic, social and cultural rights, in particular: (iv) The right to public health, medical care, social security and social services.⁹²

Public health is not defined by the *ICERD* or the CERD committee. However, 'the widely accepted definition of public health is 'the science and art of preventing disease, prolonging life and promoting health through the organized efforts of society.'⁹³ *General*

⁸⁷ CRC, *Concluding Observations of the Committee on the Rights of the Child, Tanzania*, 27th sess, UN Doc CRC/C15/Add 156 (8 June 2001) [47].

⁸⁸ Denise Adams, Kahi Kemper and Sunita Vohra, 'Complementary and Alternative Medicine Use Among Infants, Children and Adolescents' in Adams et al (n 63) 44.

⁸⁹ See *ibid*.

⁹⁰ CRC, *Consideration of Reports Submitted by State Parties under art 44 of the Convention. Concluding Observations: Nepal*, 39th sess, UN Doc CRC/C/15/Add.261 (21 September 2005) [60(e)].

⁹¹ CRC, *Consideration of Reports Submitted by States Parties under Article 44 of the Convention. Concluding Observations: Madagascar*, 34th sess. UN Doc CTC/C/15/Add.218 27 (27 October 2003) [47].

⁹² *International Convention on the Elimination of All Forms of Racial Discrimination*, opened for signature 21 December 1965, 660 UNTS 195 (entered into force 4 January 1969) art 5(e)(iv).

⁹³ Roger Detels and Chorh Chuan Tan, 'The Scope and Concerns of Public Health' in Detels et al (eds) (n 75) 3 quoting Donald Acheson, *Public Health in England Report of the Committee of Inquiry into the Future Development of the Public Health Function* (Report, 1988) 1.

Recommendation XX ('GRXX') states that 'the rights and freedoms mentioned in art 5 do not constitute an exhaustive list.'⁹⁴ This points to rights and freedoms not expressly articulated in art 5, like the right to T&CM potentially being within its scope. Evidence that TM falls within the ambit of the ICERD is the 2005 *Conclusions and Recommendations of the CERD to Venezuela*, where the Committee expressly acknowledged the *right* of indigenous persons to TM in the Venezuelan Constitution. 'The Committee welcomes with satisfaction the rights ...in the Constitution of ... Venezuela of 1999, in particular article 21 and chapter VIII which guarantees the rights of indigenous peoples ... the right to TM.'⁹⁵ Understanding the right to health to be specifically inclusive of public health is also emphasised by the UN Special Rapporteur for the Right to Health, because to equating the right to health to mean a right to medical care only, is inconsistent with and a misinterpretation of international human rights law, because the right to health is more than access to medical care as it encompasses medicine, public health and the underlying determinants of health.⁹⁶

D WHO and T&CM

The *WTMS 2014-2023* is the latest offering in the WHO's long term commitment in recognising T&CM as a legitimate public health strategy in the realisation of the right to health. The WHO first asserted TM as the major source of health care for more than two thirds of the world's population in 1977.⁹⁷ TM has been the subject of some sixteen World Health Assembly resolutions across a fifty year period.⁹⁸ For over 25 years, WHO has consistently validated the importance of T&CM to global health by extensively publishing across multiple

⁹⁴ CERD, *General Recommendation XX on article 5 of the Convention*, 48th sess, UN Doc A/51/18 (15 March 1996) [1].

⁹⁵ CERD, *Conclusions and Recommendations of the Committee on the Elimination of Racial Discrimination: Venezuela*, 67th sess, UN Doc CERD/C/VEN/CO/18 (19 August 2005) [4].

⁹⁶ Paul Hunt, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*. Human Rights Council, 62nd sess, UN Doc A/62/214 (8 August 2007) [46]-[47].

⁹⁷ WHO, *The Promotion and Development of Traditional Medicine* (WHO, 1978) 36.

⁹⁸ 'Traditional, Complementary and Integrative Medicine', *World Health Organisation* (2019) <<https://www.who.int/traditional-complementary-integrative-medicine/about/en/>>.

T&CM topics⁹⁹ including benchmarks for training in seven T&CM practices.¹⁰⁰

The current *WTMS* is an example of the WHO use of a ‘soft’ instrument in norm setting for the international community. Despite being empowered to do so, the WHO has mostly chosen ‘soft’ law in the form of guidelines, codes, or recommendations rather than ‘hard’ binding international law.¹⁰¹ Exceptions to this are the *WHO Regulations No. 1*, the *International Health Regulations* and more recently the *Framework Convention on Tobacco Control*. Gostin and colleagues have proposed that ‘soft instruments, more-over, can become the building blocks for subsequent treaties, with greater enforcement and accountability.’¹⁰² They make this assessment in the context of epidemic infectious disease. It is also relevant to the epidemic of chronic, lifestyle driven, ‘non-communicable diseases, such as heart disease, stroke, cancer, chronic respiratory diseases and diabetes, that are the leading cause of mortality in the world’¹⁰³ and where ‘T&CM stands out as a way of coping with the relentless rise of chronic non-communicable disease.’¹⁰⁴

E Special Rapporteurs on the Right to Health, UN and WHO Declarations

The Special Rapporteurs for the right to health have consistently advocated ‘for the proper use of TM and its integration into health care systems’¹⁰⁵ and that ‘training in some traditional medicine practices

⁹⁹ WHO, *Research Guidelines for Evaluating the Safety and Efficacy of Herbal Medicine* (WHO, 1993); WHO, *Guidelines for Clinical Research on Acupuncture* (WHO, 1995); WHO, *Guidelines for the Appropriate Use of Herbal Medicines* (WHO, 1998); WHO, *Guidelines on Training and Safety in Acupuncture* (WHO, 1999); WHO, *Guidelines on Training Traditional Health Practitioners in Primary Health Care* (WHO, 1999); WHO, *General Guidelines for Methodologies on Research and Evaluation of Traditional Medicine* (WHO, 2000); WHO, *Guidelines on Developing Consumer Information on the Proper Use of Traditional and Complementary Medicine* (WHO, 2004); WHO, *WHO Guidelines for Safety Monitoring in Pharmacovigilance Systems* (WHO, 2004); WHO, *Guidelines on Training and Safety in Chiropractic* (WHO, 2005); WHO, *WHO Guidelines for Assessing Quality of Herbal Medicines with Reference to Contaminants and Residues* (WHO, 2007); WHO, *WHO Guidelines on Good Manufacturing Practices (GMP) for Herbal Medicines* (WHO, 2007).

¹⁰⁰ WHO, *Benchmarks for Training in Naturopathy* (WHO, 2010); WHO, *Benchmarks for Training in Ayurveda* (WHO, 2010); WHO, *Benchmarks for Training in Nuad Thai* (WHO, 2010); WHO, *Benchmarks for Training in Osteopathy* (WHO, 2010); WHO, *Benchmarks for Training in Traditional Chinese Medicine* (WHO, 2010); WHO, *Benchmarks for Training in Tuina* (WHO, 2010); WHO, *Benchmarks for Training in Unani Medicine* (WHO, 2010).

¹⁰¹ Laurence O Gostin, Devi Sridharb, Daniel Hougendobler, ‘The Normative Authority of the World Health Organization’ (2015) *XXX Public Health* 1, 4.

¹⁰² *Ibid* 5.

¹⁰³ WHO, ‘Global Health Observatory (GHO) Data’, *World Health Organisation* (2019) <<https://www.who.int/gho/ncd/en/>>.

¹⁰⁴ Chan (n 65) quoted in WHO (n 15) 16.

¹⁰⁵ Paul Hunt, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*. Human Rights Council, 61st sess, UN Doc A/61/338 (13 September 2006) [50].

should also be encouraged.¹⁰⁶ The Special Rapporteur on the right to health has highlighted the need for non-discriminatory, culturally sensitive health care provision for migrant workers.¹⁰⁷ It is reasonable to infer that in order to reduce barriers to accessing health care, migrant workers and their families should enjoy equality of treatment with nationals of the State of employment in relation to accessing T&CM services that may be more culturally sensitive to their health needs. Again, Special Rapporteur recommendations are not legally binding on Member States.

The express *right* to T&CM has been recognised in a wide range of ‘soft’ international documents, including declarations. An analysis of these provides further evidence for establishing a legal foundation for the inclusion of T&CM within the body of international law pertaining to the right to health. Express mention of T and/or CM and the right to health are included in the non-legally binding but authoritative and aspirational soft law *United Nations Declaration on the Rights of Indigenous Peoples* (‘*UNDRIP*’)¹⁰⁸ and in key global health agreements including the *Declaration of Alma-Ata* (‘*DAA*’)¹⁰⁹ the *Beijing Declaration* (‘*BD*’)¹¹⁰ and the *Declaration of Astana*.¹¹¹ Article 24(1) *UNDRIP* states:

Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.¹¹²

Article 24(1) *UNDRIP* expressly provides the right for indigenous people to their TM, and for protection of their TM. It also provides the right to access, without discrimination, all health services. As T&CM are types of health services, this provision could reasonably apply to other types of T&CM beyond their own indigenous TM.

¹⁰⁶ Paul Hunt, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*. Human Rights Council, 77th sess, UN Doc A/HRC/7/11 (31 January 2008) [44].

¹⁰⁷ Anand Grover, *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health*. Human Rights Council, 23rd sess, UN Doc A/HRC/23/41 (15 May 2013) [44].

¹⁰⁸ *United Nations Declaration on the Rights of Indigenous Peoples*, GA Res 61/295, UN Doc A/RES/61/295 (2 October 2007, adopted 13 September 2007).

¹⁰⁹ *Declaration of Alma-Ata* (International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978) [1].

¹¹⁰ *Beijing Declaration* (‘*BD*’) (Adopted by the WHO Congress on Traditional Medicine, Beijing, China, 8 November 2008).

¹¹¹ *Declaration of Astana* (International Conference on Primary Health Care, Astana, Kazakhstan, 25 – 26 October 2018) V.

¹¹² *United Nations Declaration on the Rights of Indigenous Peoples*, GA Res 61/295, UN Doc A/RES/61/295 (2 October 2007, adopted 13 September 2007) 24(1).

In 1978, the *DAA* was the first formal recognition by the WHO and its Member States of the importance of TM and TM practitioners in primary healthcare.¹¹³ The *DAA* expressly affirmed

health is a fundamental human right¹¹⁴ ... the people have a right and a duty to participate ... in the planning and implementation of health care¹¹⁵. ... Primary health relies, ...on health workers ... including ... traditional practitioners ... suitably trained ... to work as a health team to respond the expressed health needs of the community.¹¹⁶

The CESCR in *GCI4* also explicitly state ‘the *DAA* provides compelling guidance on the core obligations arising from art 12.’¹¹⁷ The *DAA* was recalled and extended upon thirty years later in the *BD*. The *BD* was adopted by the WHO Congress on TM in Beijing, China, in 2008. After four years’ implementation of the *WTMS 2002-2005*, ‘the WHO Congress on TM was convened to further assess the role of T&CM, to review the progress of countries and to help Member States integrate T&CM into their national health systems.’¹¹⁸ The *BD* highlighted that people have a right to participate in health care which may include access to TM and reiterated T&CM as a resource of primary health care services.

Recalling... Alma Ata thirty years ago ... noting ... people have the right and duty to participate ... in the planning and implementation of their health care, which may include access to TM. ...

Noting that the term “TM” ... may also be referred to as ... CM. Recognizing TM as one of the resources of primary health care services to increase availability and affordability and to contribute to improve health outcomes ...¹¹⁹

In 2018, on the fortieth anniversary of the *Declaration of Alma-Ata*, the *Declaration of Astana* declared

The success of primary health care will be driven by: Knowledge and capacity-building. We will apply knowledge, including scientific as well as traditional knowledge, to strengthen PHC, improve health outcomes and ensure access for all people to the right care at the right time and at the most appropriate level of care, respecting their rights, needs, dignity and autonomy... Technology. We support broadening and extending access to

¹¹³ WHO, ‘Background of WHO Congress on Traditional Medicine’, *World Health Organisation* (2019) <http://www.who.int/medicines/areas/traditional/congress/congress_background_info/en/>.

¹¹⁴ *Declaration of Alma-Ata* (International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978) [I].

¹¹⁵ *Declaration of Alma-Ata* [III].

¹¹⁶ *Declaration of Alma-Ata* [VII] [7].

¹¹⁷ CESCR (n 2) [43].

¹¹⁸ WHO (n 113).

¹¹⁹ *Beijing Declaration* (Adopted by the WHO Congress on Traditional Medicine, Beijing, China, 8 November 2008).

a range of health care services through the use of high-quality, safe, effective and affordable medicines, including, as appropriate, traditional medicines ...¹²⁰

Despite the legally non-binding and aspirational nature of these declarations, they all articulate the right of people to participate in their health care which is expressly inclusive of T&CM. As far as the WHO is concerned, the application of traditional knowledge and the inclusion of traditional medicines will drive the success of primary health care. From these it can be inferred that the scope of the right to health necessarily includes a right to T&CM. A future express and binding right to T&CM may assist governments in the provision of national policy and regulations to ensure quality, safe, affordable and culturally appropriate access to T&CM for their populations.

IV Policy and Regulation of T&CM in Australia

A recent Australian study reported that T&CM services are being used by a substantial proportion of the Australian population.¹²¹ ‘The estimated number of practitioner visits to CAM practitioners ... was almost identical to the number of visits to medical practitioners,’¹²² although ‘in some areas of Australia, CM practitioners providing primary care services outnumber conventional primary care physicians.’¹²³

Despite this, the Australian Government has no national policy on T&CM.¹²⁴ Instead, Australia has what has been described as a mixed level recognition of T&CM – that is, consumer led with little government support at the service delivery level.¹²⁵ Although Australia recently reported to the WHO that the national policy for T&CM is integrated into the *National Medicines Policy 2000*,¹²⁶ the content of that policy is limited to an almost twenty year old, one sentence

¹²⁰ *Declaration of Astana* (International Conference on Primary Health Care, Astana, Kazakhstan, 25 – 26 October 2018) V.

¹²¹ Rebecca Reid et al, ‘Complementary Medicine Use for the Australian Population: A Critical Mixed Studies Systematic Review of Utilisation, Perceptions and Factors Associated with Use’ (2016) 16 (176) *BMC Complementary and Alternative Medicine* 1.

¹²² Charlie C L Xue et al, ‘Complementary and Alternative Medicine Use in Australia: A National Population–Based Survey’ (2007) 13(6) *Journal of Alternative and Complementary Medicine* 643, 648.

¹²³ Jon Wardle et al, ‘Distribution of Complementary and Alternative Medicine (CAM) Providers in Rural New South Wales, Australia: A Step Towards Explaining High CAM Use in Rural Health?’ (2011) 19 *Australian Journal of Rural Health* 197, 197.

¹²⁴ WHO and Australian Institute of Health and Welfare, ‘Health Service Delivery Profile Australia 2012’, *WHO Western Pacific* (2019) <http://www.wpro.who.int/health_services/service_delivery_profile_australia.pdf> 9.

¹²⁵ Yu Lee Park and Rachel Canaway, ‘Integrating Traditional and Complementary Medicine with National Healthcare Systems for Universal Health Coverage in Asia and the Western Pacific’ (2019) 5(1) *Health Systems and Reform* 24, 26.

¹²⁶ WHO (n 24) 157.

statement that ‘the term “medicine” includes prescription and non-prescription medicines, including complementary healthcare products.’¹²⁷ While T&CM products in Australia are highly regulated by the *Therapeutic Goods Act 1989* (Cth) and the *Australian Regulatory Guidelines for Complementary Medicine 2018* (ARGTC) (currently under review), regulation of some T&CM practitioners and practices has been stalled for around fifteen years. Currently only chiropractic, osteopathy and traditional Chinese medicine are registered health professions. Of note, the Australian government recently reported to the WHO that the practice of naturopathy remains unregulated in all jurisdictions.¹²⁸ This is despite an extensive government report¹²⁹ and multiple professional association and national register submissions recommending that both naturopathy and Western herbal medicine become statutory regulated.¹³⁰

Instead of statutory registration for naturopaths and Western herbalists, State based *Codes of Conduct*, which are a form of negative licencing, have been enacted in some Australian jurisdictions.¹³¹ However, the State based *Codes of Conduct* are manifestly ineffective in regulating naturopaths and Western herbalists, especially when compared with protections provided by the *Health Practitioner Regulation Law*¹³² (‘*National Law*’) for registered health practitioners. The *National Law* sets a protective high bar that ensures that only health

¹²⁷ Australian Government, Department of Health and Ageing, *National Medicines Policy 2000* (Commonwealth Government, 1999) 1.

¹²⁸ WHO (n 24) 160.

¹²⁹ Vivian Lin et al, *The Practice and Regulatory Requirements of Naturopathy and Western Herbal Medicine* (Department of Human Services, 2006).

¹³⁰ ‘ANPA Submission - Options for Regulation of Unregistered Health Practitioners to the Australian Health Ministers Advisory Council’, *ANPA Australian Naturopathic Practitioners Association* (2019) <<https://anpa.asn.au/anpa-submission-options-for-regulation-of-unregistered-health-practitioners-to-the-australian-health-ministers-advisory-council/>>; ‘Submission to Consultation on Options for Regulation of Unregistered Health Practitioners 2011’, ARONAH Australian Register of Naturopaths and Herbalists (2019) <http://www.aronah.org/wp-content/uploads/ARONAH_AHMAC_Submission.pdf> 5; Michael Weir, ‘Australian Natural Therapists Association Submission to Chair Health Workforce Principal Committee Registration of Naturopathy, Western Herbal Medicine and Nutritional Medicine September 2016’, *ANTA Australian Natural Therapists Association* (2019) <https://www.australiannaturaltherapistsassociation.com.au/Public/Resources/Statutory_Registration/Public/Resources/Statutory_Registration.aspx?hkey=8c990abf-14a0-4a1b-9665-ecb161912c00> 44; National Herbalists Association Australia, ‘Submission AHMAC Australian Health Ministers’ Advisory Council (AHMAC) by National Herbalists Association of Australia (NHAA) Regarding the Options for Regulation of Unregistered Health Practitioners’ *NHAA Naturopaths and Herbalists Association Australia* (April 2011) <<https://www.nhaa.org.au/docs/Submissions/AHMAC%20Unregulated%20Health%20Practitioners%20Submission%20v2%201.pdf>>.

¹³¹ *Public Health Regulation Act 2012* (NSW) sch 3 Code of Conduct; *Health Ombudsman Act Regulation 2014* (Qld); *National Code of Conduct for Health Care Workers 2015* (Qld); *Health and Community Services Complaints Regulations 2005* (SA) sch 2 Code of Conduct for Unregistered Health Practitioners; *Health Complaints Act 2016* (Vic) sch 2 General Code of Conduct in Respect of General Health Services.

¹³² *Health Practitioner Regulation Law 2009* (NSW).

practitioners who are suitably trained and qualified to practise in a competent and ethical manner are registered.¹³³ With no barriers to limit entry, currently anyone is free to practice in any of the unregistered professions, such as naturopathy or Western herbal medicine. Failure to adequately regulate CM in Australia has and continues to cause harm to Australians¹³⁴ and is currently a barrier to people realising their right to health.

There are no policies that address the integration of T&CM services into national health service delivery.¹³⁵ ‘Due to (lack of) government policy, CM is generally unsupported by Medicare ... For this reason, access to CM is primarily through the private sector. This excludes many potential clients on a financial basis and may offend the principle of (distributive) justice.’¹³⁶ Further, despite Australia reporting to the WHO that ‘health insurers are free to determine the services that attract general treatment benefits and that T&CM practices fall under,’¹³⁷ from 1 April 2019:

the following natural therapies will be excluded from the definition of private health insurance general treatment and will no longer receive the private health insurance rebate as part of a general treatment policy: Alexander technique, aromatherapy, Bowen therapy, Buteyko, Feldenkrais, Western herbalism, homeopathy, iridology, kinesiology, naturopathy, Pilates, reflexology, Rolfing, shiatsu, tai chi, and yoga.¹³⁸

Although the government will commission an updated review of certain natural therapies including a five year update to its 2014-15 review of natural therapies, a final report will not be available until 2020.¹³⁹ Lack of policy provisions inclusive of T&CM in Australia has resulted in the exclusion of CM from adequate health practitioner regulation, national health service delivery and private health insurance rebates. This directly impacts many people’s ability to access CM, which offends the principle of distributive justice and limits some Australian’s ability to realise their right to health.

¹³³ Ibid pt 1 s 3(2)(a).

¹³⁴ Weir (n 130) 42-9.

¹³⁵ National Institute of Complementary Medicine, ‘Integrative Medicines Directions Report A Report Commissioned by the National Institute of Complementary Medicine 2009’, *NICM Health Research Institute* (2009) 14 <https://www.westernsydney.edu.au/__data/assets/pdf_file/0008/760715/NICM_Integrative_Medicine_Directions_Report.pdf>.

¹³⁶ Weir (n 5) 19.

¹³⁷ WHO (n 24) 160.

¹³⁸ ‘Private Health Insurance Reforms: Changing Coverage for Some Natural Therapies’, *Australian Government Department of Health* (17 April 2019) <<https://www.health.gov.au/internet/main/publishing.nsf/Content/private-health-insurance-reforms-fact-sheet-removing-coverage-for-some-natural-therapies>>.

¹³⁹ ‘Review of Natural Therapies for Private Health Insurance’, *Ministers Department of Health* (7 April 2019) <<https://beta.health.gov.au/ministers/the-hon-greg-hunt-mp/media/review-of-natural-therapies-for-private-health-insurance>>.

It is similarly concerning that across a thirty-year period, all four Australian government reports submitted to the CESCR under the *ICESCR* have been silent regarding any T&CM in health care and health services,¹⁴⁰ particularly for Indigenous Australians. The only mention of TM has been made in the context of intellectual property patent protection for traditional knowledge and medicine in the most recent report.¹⁴¹ This is of particular concern considering the ongoing failure of the Australian Government's *Closing the Gap* policy reform. The latest report states that both health targets to close the gap on Aboriginal life expectancy and infant mortality rates are not on track.¹⁴² An analysis of the *Closing the Gap* legal and policy framework has identified a foundational flaw: the neglect of Aboriginal traditional medicine in the current national Aboriginal and Torres Strait Islander health policy agenda.¹⁴³ The report highlights:

The current Australian government Closing the Gap policy reform agenda fails to acknowledge the same existence of Aboriginal traditional medicine; it dismisses the body of traditional medical knowledge embedded within the Aboriginal system of medicine passed down from generation to generation for thousands of years; it fails to consider the potential role that the promotion of Aboriginal traditional medicine can have on the health status of Aboriginal and Torres Strait Islander people and their communities; it does not consider the potential contribution that the inclusion of Aboriginal traditional medicine in a two-way health care model can make in 'closing the gap'.¹⁴⁴

The author of the report also submits that Australia's disregard of Aboriginal traditional medicine in the national Indigenous health policy agenda contravenes articles 24(1) and 31 of the *United Nations Declaration on the Rights of Indigenous Persons*.¹⁴⁵ She also states that 'Many countries have established regulatory systems with formal recognition, promotion and financing of TCAM. At the other end of the spectrum, there are countries in which the process of recognition and

¹⁴⁰ *Fourth Periodic Report Submitted by States Parties under Articles 16 and 17 of the Covenant (Australia)* UN Doc E/C.12/AUS/4 (7 Jan 2008); *Third Periodic Report Submitted by States Parties under Articles 16 and 17 of the Covenant (Australia)* UN Doc E/1994/104/Add.22 (23 July 1998); *Second Periodic Report Submitted by States Parties to the Covenant Covered by Articles 6 to 9 : Australia* UN Doc E/1984/7/Add.22 (10 Mar 1985); *Reports submitted in Accordance with Council Resolution 1988 (LX) by States Parties to the Covenant on Economic, Social and Cultural Rights concerning Articles 6 to 9 Australia* UN Doc E/1978/8/Add.15 (29 Mar 1978).

¹⁴¹ *Fifth Periodic Report Submitted by States Parties under Articles 16 and 17 of the Covenant (Australia)* UN Doc E/C.12/AUS/5 (1 Feb 2016) 39.

¹⁴² Australian Government Office of the Prime Minister and Cabinet, 'Closing the Gap Report 2019', *Australian Government Office of the Prime Minister and Cabinet* (2019) <<https://ctgreport.pmc.gov.au/sites/default/files/ctg-report-2019.pdf?a=1>> 10.

¹⁴³ Francesca Panzironi, *Hand in Hand Report on Aboriginal Traditional Medicine* (Anangu Ngangkari Tjutaku Aboriginal Corporation, 2013) 15.

¹⁴⁴ *Ibid* 16.

¹⁴⁵ *Ibid*.

regulation has not yet begun, including in Australia.¹⁴⁶ Indeed, there is a lack of data on the use of indigenous TM in Australia.¹⁴⁷

A new global treaty which explicitly recognises the importance of T&CM in health care and health services would go a long way to effectively harness T&CM contribution to the realization of the right to health for both the Australian and global populations. Countries like Australia, might at some future time, be held specifically accountable under the international obligations for failing to ensure safe and equitable access to T&CM products, practitioners and services. Whether this strategy will result in the effective implementation of the right to T&CM in the realization of the right to health will depend on a myriad of factors beyond the scope of this article. 'First do no harm is as relevant for ... policymakers as it is for clinicians.'¹⁴⁸ Therefore, 'in addition to expected benefits, proposals for reform should also be assessed for their potential costs, limitations and unintended consequences and should be compared with benefits and competing alternatives before they are implemented.'¹⁴⁹ In the interim, we submit there is a solid legal foundation in international law that the scope of the right to health includes a right to T&CM and that this right may more effectively be realised by being expressly articulated in the *FCGH*.

V Framework Convention on Global Health ('*FCGH*')

There have been many recent calls for international treaties to address health challenges following the perceived success of the *Framework Convention on Tobacco Control (2002)*.¹⁵⁰ Proposed in 2008, the *FCGH* has seen growing momentum.¹⁵¹

Existing treaties ... establish commitments to the right to health. Yet vast gaps exist between commitments and realities ... Effective structures and processes to secure action and accountability are largely absent. The right to health and other related rights are often poorly implemented and

¹⁴⁶ Emily Cook, 'How Traditional Aboriginal Medicine can Help Close the Health Gap' *University of Sydney News* (27 April 2016) <<https://sydney.edu.au/news-opinion/news/2016/04/27/how-traditional-aboriginal-medicine-can-help-close-the-health-ga.html>>.

¹⁴⁷ WHO (n 24) 160.

¹⁴⁸ Stephen J Hoffmann and John-Arne Rottingen, 'Dark Sides of the Proposed Framework Convention on Global Health's Many Virtues: A Systematic Review and Critical Analysis' (2013) 15(1) *Health and Human Rights Journal* 118.

¹⁴⁹ Ibid.

¹⁵⁰ Stephen J Hoffmann and John-Arne Rottingen, 'Assessing the Expected Impact of Global Health Treaties: Evidence from 90 Quantitative Evaluations' (2015) 105(1) *American Journal of Public Health* 1523.

¹⁵¹ Eric A Friedman et al, 'Realizing the Right to Health through a Framework Convention on Global Health? A Health and Human Rights Special Issue' (2013) 15(1) *Health and Human Rights Journal* 1.

enforced. The *FCGH* would establish precise, enforceable human rights obligations.¹⁵²

A *FCGH* based on the right to health has been described as well within WHO's constitutional powers, with the *Framework Convention on Tobacco Control* demonstrating proof of concept.¹⁵³ There has been a call for the next WHO Director-General to make the right to health their foremost priority, with the *FCGH* as the "centrepiece,"¹⁵⁴ incorporating it into a bold vision for WHO.¹⁵⁵

Key research questions regarding whether the scope of the *FCGH* should address traditional/alternative medicines and if so, how, were proposed on the Joint Action Learning Initiative (JALI) website.¹⁵⁶ One group of researchers have previously proposed that traditional and alternative medicines are essential components of a *FCGH*.¹⁵⁷ The preceding part of this article provides evidence that the scope of the right to health includes the right to T&CM and for the same reasons, the scope of the *FCGH* should also address the right to T&CM. Although it has been noted that 'treaties are high-profile, powerful tools, but they are laborious and expensive to produce and resource-intensive to administer and implement,'¹⁵⁸ the *FCGH* has been described as at the intersection of global health policy and human rights law and presents a path to advance public health systems as a means to realize human rights.¹⁵⁹

A draft article proposal activating a right to T&CM might be achieved by inserting an express articulation that the right to health includes a right to T&CM and then inserting the three strategic objectives of the *WTMS* into the *FCGH*, along the following lines:

¹⁵² Platform For A Framework Convention on Global Health (FCGH): Realizing the Universal Right to Health Fundamental Principles and Joining the Platform 14 May 2014', *FCGH Alliance* (2014) <<https://www.jalihealth.org/documents/platform-for-an-fcgh-march-2014-full-4-7-14.pdf>>.

¹⁵³ Lawrence O Gostin et al, 'The Next WHO Director-General's Highest Priority: A Global Treaty on the Human Right to Health' (2016) 4 *The Lancet* 890, 891.

¹⁵⁴ Eric A Friedman and Lawrence O Gostin, 'Global Health: A Pivotal Moment of Opportunity and Peril' (2017) 36 *Health Affairs* 1159, 1159.

¹⁵⁵ Gostin (n 153) 891.

¹⁵⁶ *JALI Research Introduction, Questions and Responses. Scope of the FCGH* (JALI Joint Action and Learning Initiative on National and Global Responsibilities for Health) <<http://jalihealth.org/research/index.html>>.

¹⁵⁷ Emmanuel Kabengele Mpinga et al, 'Traditional/alternative Medicines and the Right to Health: Key Elements for a Convention on Global Health' (2013) 15(1) *Health and Human Rights Journal* 44.

¹⁵⁸ G Lien and K DeLand, 'Translating the WHO Framework Convention on Tobacco Control (FCTC): Can We Use Tobacco Control as a Model for Other Non-communicable Disease Control?' (2011) 125 *Public Health* 848, 848

¹⁵⁹ Lance Gable and Benjamin Mason Meier, 'Global Health Rights: Employing Human Rights to Develop and Implement a Framework Convention on Global Health' (2013) 15(1) *Health and Human Rights Journal* 17, 17.

The Right to Traditional and Complementary Medicine (T&CM)

1. The Parties recognize the right to health includes a right to T&CM.
2. Each party shall build the knowledge base for active management of T&CM through appropriate national policies.
3. Each party shall strengthen quality assurance, safety, proper use and effectiveness of T&CM by regulating products, practices and practitioners.
4. Each party shall promote universal health coverage by integrating T&CM services into health care service delivery and assist T&CM consumers make informed self-health care choices.

An advantage of this proposal is that Member States already compliant with the strategic objectives will automatically be compliant with this aspect of the *FCGH*. By shifting the objectives out of the realm of soft law into binding obligations, States Parties may be encouraged to view these objectives as mandatory rather than optional. This approach could provide an impetus for States Parties to develop national key performance indicators relevant to their specific needs, addressing expected outcomes and critical indicators previously articulated in the soft law strategy. A lack of effective implementation of the soft law policy regarding T&CM has and continues to effectively preclude some people from realizing their right to health. The urgency of implementing quality, safe, effective, culturally appropriate, respectful, adequately regulated and equitably accessible T&CM health care products and services into national health care systems, especially for marginalized groups whose health and wellbeing may be contingent upon access to these, cannot be overstated.

As the utilisation and prevalence of complementary medicines increases, public protection and safety around the use of CM are emerging as a significant public health issue, because in many countries, like Australia, the regulatory and legislative protections for consumers of CM have not kept pace with CM use.¹⁶⁰ For many sick and vulnerable members of the public, the failure of Member States to effectively implement national T&CM policy results in harm and is the antithesis to the realisation of the basic human right to health.

¹⁶⁰ Jon Wardle et al, 'Regulatory and Legislative Protections for Consumers in Complementary Medicine: Lessons from Australian Policy and Legal Developments' (2014) *European Journal of Integrative Medicine* 423, 423; David Sibritt et al, 'The Failure of Contemporary Law and Regulation to Keep Pace with Growing Complementary Medicine (CM) Use: The Significance of Examining 'Hidden' Gaps in Australia's Current Regulatory and Legislative Infrastructure' (2016) *Advances in Integrative Medicine* 43, 43; J Wardle et al 'Is Health Practitioner Regulation Keeping Pace with the Changing Practitioner and Health Care Landscape? An Australian Perspective' (2016) (4) 91 *Frontiers in Public Health* 1, 1.

VI Conclusion

Health care has undergone significant evolutionary change to the point where in many countries like Australia, the products and services of T&CM have become central to the realization of health for many members of the public. Despite this, in international human rights law, the right to health codified in multiple legally binding treaties, fails to expressly include the right to T&CM.

Although not expressly provided for in the international right to health treaties, this analysis finds substantial evidence in the evolution in the understanding of the scope of the right to health includes the right to T&CM whilst relating T&CM to the effective enjoyment of the highest attainable standard of health. This is of most pivotal significance for the realization of the right to health for the world's indigenous peoples. By building on this existing body of international law, this article has argued that the *FCGH* could provide an express and legally binding right to T&CM. In this way, a clear duty would be imposed on States Parties, including the Australian Government, to ensure everyone including indigenous people have access to quality, safe, culturally appropriate and effective T&CM health care facilities, goods and services.

This would necessarily include suitable regulation, evaluation and integration of T&CM products, practices and practitioners into national, universal health care systems. This would go some way to addressing the policy, legislative and regulatory gaps that currently exist in a world that has failed to keep pace with the T&CM use of global populations. States Parties might then more effectively harness the potential contribution of T&CM, and fundamentally reorientate health systems towards significantly more cost-effective wellness and people centred health care in realising the right to health for all.