Framework Convention on Global Health Background Briefing: The Right to Health

August 2014

The Right to Health

Encompassing FCGH key principles

o) Define state responsibilities for the health of all its inhabitants on an equal basis, regardless of gender, race, nationality, ethnicity, religion, age, sexual orientation, gender identity and expression, or socioeconomic, migration, disability, disease, or other status, and to promote equality through equity, ensuring equal access to good quality and responsive health services, including by removing financial barriers and ensuring physical accessibility and dignified treatment.

p) Remove all discrimination and other barriers in law, policy, and practice that undermine the right to health.

x) Strengthen global leadership on the right to health, including that of WHO.

Background

The right to health is already codified through numerous global and regional treaties, most prominently the International Covenant on Economic, Social and Cultural Rights (ICESCR) ("the right of everyone to the enjoyment of the highest attainable standard of physical and mental health") (article 12). An analysis of national constitutions adopted through 2011 found that 105 guaranteed everyone the right to health or specifically the right to medical care or public health.[1] The right's principles are detailed most prominently in General Comment 14 of the UN Committee on Economic, Social and Cultural Rights,[2] as since elaborated upon through reports on the UN Special Rapporteurs on the right to health – and related rights such as those on food and on water and sanitation[3] – along with general comments and recommendations from other treaty bodies[4] and national and regional court cases.

Yet, major gaps and shortcomings exist in both international right to health law as it exists and in its implementation:

1. Clarity of key principles: General Comment 14 and other elucidations of the right to health have gone far towards developing its normative principles. Indeed, many of these – such as equality and non-discrimination, participation in health-related decisions, and accountability – are foundation elements of an FCGH. However, there remain several key principles of the right to health (and economic, social, and cultural rights more broadly) that lack clarity. In particularly, how to determine whether a state is meeting its obligation to spend the maximum of its available resources towards fulfilling health and other human rights,[5] and what are the appropriate benchmarks and metrics for progressive realization?[6]

Greater precision on these obligations could lead to faster and fuller achievement of the right to health. Meanwhile, there remains the question of the exact meaning of the right itself – what is the "highest attainable standard of physical and mental health"? For example, is it what a country has achieved for the most well off portion of its population? Or is the standard to be measured internationally, and if so, how?

Further, the Committee on Economic, Social and Cultural Rights introduced the importance concept of "a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care."[7] However, General Comment 14 leaves many questions about the precise nature of the "core obligation" unanswered.[8]

Along with elements of the right to health that may benefit from further definition, many of the key concepts of the right – such as equal treatment and the focus on marginalized and vulnerable population, participation in health-related decisions, and accountability – have been explained in General Comment 14 and elsewhere, but are not part of binding treaty law (other than equal treatment with respect to specific populations subject to separate treaties, such as on race, women, children, and people with disabilities). Would it be valuable to codify these principles in binding law?

2. Globalization: General Comment 14's elucidation of the right to health, following the basic structure of the ICESCR, with vague language on international responsibility and a focus on providing health services, is poorly attuned to a globalized world, and the many ways globalization affects the right to health. For example, states agree to trade agreements that can reduce access to medicines, encourage health worker migration that pulls health workers from countries where health personnel shortages are a significant obstacle to realizing the right to health, and international drug controls impede countries from accessing morphine and other opioids needed for pain relief. Responding to these international dimensions of the right to health would be a major aspect of the FCGH.

   States parties should ensure that the right to health is given due attention in international agreements and, to that end, should consider the development of further legal instruments. In relation to the conclusion of other international agreements, States parties should take steps to ensure that these instruments do not adversely impact upon the right to health.

   Meanwhile, many countries still require international support to meet even the most basic right to health obligations, yet international assistance obligations are only vaguely defined in the ICESCR ("Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical…") (article 2) and elaborated by the Committee on Economic, Social and Cultural Rights ("Depending on the availability of resources, States should facilitate access to essential health

facilities, goods and services in other countries, wherever possible and provide the necessary aid when required") (para. 39).[9]

The right to health, like other ICESCR rights, is also imprecise in establishing responsibility for regulating transnational corporations, though these may significant impact the right. General Comment 14 explains that countries have a general obligation "to take measures that prevent third parties from interfering with article 12 guarantees," as part of their obligation to protect against rights violations.[10] They must also "prevent third parties from violating the right in other countries, if they are able to influence these third parties by way of legal or political means, in accordance with the Charter of the United Nations and applicable international law."[11]

More recently, some non-binding law has been developed in this area. In 2011, HR Council adopted the "Guiding Principles on Business and Human Rights: Implementing the United Nations "Protect, Respect and Remedy" Framework," which were developed by UN Special Rapporteur on the issue of human rights and transnational corporations and other business enterprises, John Ruggie.[12] These charge states with protecting against human rights abuses in their territory, including those of business enterprises (principle 1), and "set out clearly the expectation that all business enterprises domiciled in their territory and/or jurisdiction respect human rights throughout their operations" (principle 2). Implementation of the extraterritorial measures may range from standard-setting to direct legal enforcement of legislation with extraterritorial reach. Overall, the principles focus on the responsibility of businesses to respect human rights.

3. Implementation and accountability: The above gaps in the development of the right to health notwithstanding, international binding and non-binding law, along with national right to health laws and policies provide a rich basis for implementing the right to health today. Yet as with so many human rights, implementation is weak in many countries, and effective accountability mechanisms lacking. A major goal of the FCGH would be to establish the strategies and accountability mechanisms to greatly accelerate state measures to implement the right to health. These could range from widespread education to ensure that people are aware of and understand their right to health, as well as ways to hold their governments accountable where this right is not being fulfilled; educating health workers and government officials on their responsibilities under this right as well as how they can contribute to fulfilling it in their communities and countries; requirements on integrating the right and its components in its strategies and continually analyzing obstacles to implementing these strategies and developing actions to overcome them; enabling courts to enforce the right; increasing participation community members (especially marginalized populations) and civil society in health-related decision-making, including budgeting, as well as monitoring and evaluation, and; developing community-level accountability strategies, linked to higher-level policymaking. Some of

measures are described more in separate briefings, including on equity and accountability.

4. Non-discrimination: The ICESCR creates a binding obligation to avoid discrimination ("The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status") (article 2(2)). Other treaties further detail this obligation for certain populations, including women, racial minorities, children, and people with disabilities. The Committee on Economic, Social and Cultural Rights added additional statuses where discrimination violates the right to health, namely physical or mental disability, health status (including HIV/AIDS), civil or political status, and sexual orientation.[13]

   Discrimination in these areas persists, such as in laws that criminalize homosexuality and drive members of the LGBT population underground, and laws that discriminate against women by limiting their access to health care that is primarily or exclusively needed by women. Even where unlawful, many marginalized populations, such as people living with HIV/AIDS, people with disabilities, women, and indigenous people face discrimination and other forms of mistreatment in the health care setting.

   Meanwhile, populations with less explicit international human rights protection are frequently subjects of nationally lawful discrimination that is highly suspect internationally. Immigrants, especially those without proper documentation, are often entitled to fewer health services than nationals. This despite General Comment 14's stipulation that "States are under the obligation to [refrain]…from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventive, curative and palliative health services."[14] Internal migrants may also face obstacles to equal health care.

   Very frequently, people receive different levels of health services based on wealth and employment status. People who are poor may receive only a basic package of health services at no cost (though even then there may be informal fees or other costs, such as transportation or medicine), while those who are economically better off can afford health services to more comprehensively meet there needs. And health insurance packages are sometimes linked to employment status, with people employed in the formal sector receiving more benefits than people who are unemployed or working in the informal sector.

   Discrimination outside of the health sector may also prevent people from enjoying their right to health. Prominently, laws that criminalize homosexual behavior may cause members of the LGBT community to avoid health services because they fear that they may face criminal sanctions (and other discrimination) if health

workers learn their sexual orientation and report them to authorities, or if seeking certain forms of health services will lead others in the community to believe that they are LGBT. They may also receive lower quality of care because of the stigma attached to their behavior.

Discrimination against women similarly undermines their right to health. Cultural practices may dictate that a woman may be unable to leave home without permission of her husband, even when she needs to seek medical care. Discrimination in the education sector – whether cultural biases against girls' education or discriminatory laws and policies do (e.g., prohibiting pregnant girls from attending school) – harm the health of women and their families, as higher educational status is strongly associated with better health outcomes for both women and their children.[15]

5. Full meaning of respect for the right to health: Policies and practices outside the health sector may have a significant impact on people's ability to enjoy their right to health but are not assessed for how they might affect this right, such as educational, economic, and environmental policies. The FCGH could elevate this aspect of the right to health through provisions on right to health assessments and other means. Please see background briefing on intersectoral actions for health for more on this subject and how an FCGH could further respect for the right to health.

6. WHO human rights leadership: Despite highly capable staff in its Gender, Equity, and Rights Office in Geneva and regional and programmatic human rights officers, WHO is not structured for right to health leadership. One could envision a WHO that provided clear guidance to countries on developing and implementing the right to health throughout their health programming and health systems, that develops and supports widespread rollout of human rights curricula for health workers, that intervenes closely with other sectors to elevate the right to health, that supports public education on the right to health, and that closely monitors national right to health implementation. An FCGH could provide WHO the mandate, funding, and member state support required to assume such leadership.

Possible ways for the FCGH to operationalize its right to health principles (outside the scope of this briefing is FCGH operationalization of other right to health principles, such as accountability, equity, and integrating the right to health into non-health sector policies)

1. Precision on key right to health elements: The FCGH could further define maximum resources and other aspects of the right to health, codifying (or empowering a designated body to codify) common benchmarks, indicators, and targets, while also codifying basic right to health principles such as equal treatment and participation.

2. Transnational corporations: The FCGH could clarify state responsibility with respect to regulating transnational corporations, along with particular areas of regulation to prevent them from undermining the right to health (e.g., mining, toxic waste dumping, marketing unhealthy foods and beverages).

3. Non-discrimination: The FCGH could codify additional categories where discrimination is prohibited (e.g., based on migration status, disease status, or sexual orientation), and include the principles that countries will reform or repeal non-health sector laws that are discriminatory and undermine public health.

4. Respect for the right to health: Provide clarity that states have an obligation to avoid measures that would undermine the right to health extraterritorially.

5. Right to health capacity fund: The FCGH could establish a right to health capacity fund to enhance the capacity of communities, civil society, and governments to implement the right to health, including through funding civil society organizations to monitor government actions,; local participation and accountability mechanisms (e.g., village health committees); health worker, government official, and public education on the right to health, and; public health and human rights organizations (e.g., right to health units of national health commissions, health and human rights parliamentary subcommittees).[16]

6. WHO right to health leadership: The FCGH could establish a WHO-led multi-sector right to health forum, with a prominent role for civil society as well, to empower WHO to align other global institutions and regimes with the right to health.[17]

Key questions

1. Should the FCGH further define maximum available resources, progressive realization, the highest attainable standard of health, and the core obligations? What should these definitions be?

2. What would it take for WHO to become a leading force for the right to health? What would this look like?

3. Would a right to health capacity development fund help empower civil society, the public, and even government human rights institutions and actors to better secure and ensure the right to health?

Possible right to health champions

UN agencies and actors: UN human rights special rapporteurs, including;

Office of the High Commissioner for Human Rights

NGOs: Human Rights Watch, Amnesty International

States: States with a constitutional right to health and commitment to its implementation (e.g., Brazil); States with a foreign policy that prioritizes human rights (e.g., Norway, Sweden)

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[1] Jody Heymann, Adèle Cassola, Amy Raub, and Lipi Mishra, "Constitutional rights to health, public health and medical care: The status of health protections in 191 countries," 8(6) *Global Public Health* (2013): 639-653, http://www.tandfonline.com/doi/abs/10.1080/17441692.2013.810765#.U-jygs-Ybcv. See also "Constitutional protections of health," WORLD Policy Forum, http://worldpolicyforum.org/tables/constitutional-protections-health/ (accessed August 11, 2014).

[2] Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, U.N. Doc. E/C.12/2000/4 (August 11, 2000), http://www1.umn.edu/humanrts/gencomm/escgencom14.htm.

[3] UN Office of the High Commissioner for Human Rights, "Thematic mandates," http://www.ohchr.org/EN/HRBodies/SP/Pages/Themes.aspx (accessed August 10, 2014).

[4] Committee on the Elimination of Discrimination Against Women, General Recommendation 24: Women and Health, U.N. Doc. A/54/38 at 5 (1999), http://www1.umn.edu/humanrts/gencomm/generl24.htm. Committee on the Rights of the Child, *General Comment 15: The right of the child to the highest attainable standard of health*, CRC/C/GC/15 (March 13, 2013), http://www.crin.org/docs/CRC-C-GC-15_en-1.pdf.

[5] Perhaps the most developed effort to define this obligation is: Radhika Balakrishnan, Diane Elson, James Heintz, and Nicholas Lusiani, *Maximum Available Resources and Human Rights: Analytical Report* (June 2011), http://www.cwgl.rutgers.edu/publications/economic-a-social-rights/154-publications/esr/380-maximum-available-resources-a-human-rights-analytical-report-. The report draws on previous analyses, including from UN human rights treaty bodies and special rapporteurs, highlight such key aspects of their analysis as the need to look to all resources (beyond financial), both domestic and international; to compare state economic, cultural, and social spending with its peers, with international benchmarks, and to non-rights spending; to spend money efficiently and avoid corruption, and; to have a progressive taxation system. The analysis focuses on five levers for increasing resources for economic, social and cultural rights: 1) government expenditure; 2) government revenue; 3) development assistance; 4) debt and deficit financing, and; 5) monetary policy and financial regulation. See also Fundar – Centro de Análisis e Investigación, International Budget Project, and International Human Rights Internship Program, *Dignity Counts: A Guide to Using Budget Analysis to Advance Human Rights*

(2004), http://www.internationalbudget.org/wp-content/uploads/Dignity-Counts-A-Guide-to-Using-Budget-Analysis-to-Advance-Human-Rights-English.pdf.

[6] The Committee on Economic, Social and Cultural Rights has added some clarity. Progressive realization creates a "specific and continuing obligation to move as expeditiously and effectively as possible towards the full realization of" the right to health, and "there is a strong presumption that retrogressive measures taken in relation to the right to health are not permissible." Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, U.N. Doc. E/C.12/2000/4 (August 11, 2000), paras. 31, 32, http://www1.umn.edu/humanrts/gencomm/escgencom14.htm.

[7] Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, U.N. Doc. E/C.12/2000/4 (August 11, 2000), para. 43, http://www1.umn.edu/humanrts/gencomm/escgencom14.htm.

[8] Lisa Forman et al., "What could a strengthened right to health bring to the post-2015 health development agenda?: Interrogating the role of the minimum core concept in advancing essential global health needs," 13:48 *BMC International Health & Human Rights* (2013), http://www.biomedcentral.com/content/pdf/1472-698X-13-48.pdf.

[9] A statement of human rights experts that is intended to capture the current state of international human rights law states: "States, acting separately and jointly, that are in a position to do so, must provide international assistance to contribute to the fulfilment of economic, social and cultural rights in other States…." *Maastricht Principles on Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights* (2011), principle 33, http://www.etoconsortium.org/nc/en/library/maastricht-principles/?tx_drblob_pi1%5BdownloadUid%5D=23. The principles also include other aspects of this obligation, such as prioritizing disadvantaged groups and prioritizing the core obligations.

[10] Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, U.N. Doc. E/C.12/2000/4 (August 11, 2000), para. 33, http://www1.umn.edu/humanrts/gencomm/escgencom14.htm.

[11] Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, U.N. Doc. E/C.12/2000/4 (August 11, 2000), para. 39, http://www1.umn.edu/humanrts/gencomm/escgencom14.htm.

[12] UN Human Rights Council, *Report of the Special Representative of the Secretary-General on the issue of human rights and transnational corporations and other business enterprises, John Ruggie; Guiding Principles on Business and Human Rights: Implementing the United Nations "Protect, Respect and Remedy" Framework*, U.N. Doc A/HRC/17/31, March 21, 2011, http://business-humanrights.org/sites/default/files/media/documents/ruggie/ruggie-guiding-principles-21-mar-2011.pdf.

[13] Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, U.N. Doc. E/C.12/2000/4 (August 11, 2000), para. 18, http://www1.umn.edu/humanrts/gencomm/escgencom14.htm.

[14] Committee on Economic, Social and Cultural Rights, *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, U.N. Doc. E/C.12/2000/4 (August 11, 2000), para. 34, http://www1.umn.edu/humanrts/gencomm/escgencom14.htm. See

also International Organization for Migration, WHO, and UN Office of the High Commissioner for Human Rights, *International Migration, Health and Human Rights* (2013), http://publications.iom.int/bookstore/index.php?main_page=product_info&cPath=41_7&products_id=976.

[15] WHO, *World Health Statistics 2014* (2014), at table 8, p. 153-163, http://www.who.int/gho/publications/world_health_statistics/EN_WHS2014_Part3.pdf.

[16] See Eric A. Friedman, Lawrence O. Gostin, and Kent Buse, "Advancing the Right to Health through Global Organizations: The Potential Role of a Framework Convention on Global Health," 15(1) *Health and Human Rights* (June 2013): 71-86, at 83-84, http://www.hhrjournal.org/wp-content/uploads/sites/13/2013/06/Friedman-FINAL.pdf.

[17] See Eric A. Friedman, Lawrence O. Gostin, and Kent Buse, "Advancing the Right to Health through Global Organizations: The Potential Role of a Framework Convention on Global Health," 15(1) *Health and Human Rights* (June 2013): 71-86, at 83, http://www.hhrjournal.org/wp-content/uploads/sites/13/2013/06/Friedman-FINAL.pdf.