The Human Right to Health

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PHIL COLE, OCT 15 2013

In academic debates around human rights, especially in political theory, the focus has mainly been on political and civil rights, the first two 'generations', and not so much on social rights. In fact cultural rights are generally regarded as the 'third generation', so where social rights fit in is questionable.

However, the United Nations Declaration and the UN Convention on Economic, Social and Cultural Rights make it clear that such rights exist and are central to a decent human life – indeed, some of them seem more fundamental to a decent life than political and civil rights.

One such right is the right to health, and what I want to consider here are not the difficulties political theorists have had with the idea of a right to health – although those difficulties are considerable — but rather what role that right can play in some key political debates.

The human right to health is enshrined in various international instruments. According to Article 25 (1) of the Universal Declaration on Human Rights: "Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control."

Article 12 of the International Covenant on Economic, Social and Cultural Rights states that: "The States Parties to the Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". These steps include: "The prevention, treatment and control of epidemic, endemic, occupational and other diseases" and: "The creation of conditions which would assure to all medical service and medical attention in the event of sickness."[i] The Convention on the Rights of the Child includes the right to health for children under 18. Other international conventions, such as the International Convention on the Elimination of All Forms of Racial Discrimination and the Universal Declaration on the Eradication of Hunger and Malnutrition, all articulate the existence of a human right to health.

The general understanding of the right to health embodied in these international instruments is that it is the right to the highest available standard of health. This itself was expanded upon and interpreted by the Committee on Economic, Social and Cultural Rights, when it adopted General Comment 14 in 2000. General Comment 14 is not itself binding, and remains an interpretation of the right to health embodied in international law. However, General Comment 14 has shaped the work of the United Nations and other organisations in this field.

According to General Comment 14, health is a fundamental human right, and includes certain components which are legally enforceable (paragraph 1). It is not to be understood as a right to be healthy, but is the right to health *care*: "a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health" (paragraph 9).

It is not confined to the right to health care but includes the right to "a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy

working conditions, and a healthy environment" (paragraph 4).

The committee identified four essential elements to the right to health (paragraph 12):

(1) Availability: public health and healthcare facilities, goods, services and programmes have to be available in sufficient quantity. The precise content of what is available may depend on the level of development of the particular state, but it has to include the underlying determinants of health such as safe drinking water, hospitals, clinics, and trained medical staff.

(2) Accessibility: these services have to be accessible to all. Access has to be free of discrimination; these services have to be physically accessible; and they must be affordable.

(3) Acceptability: these services have to be respectful of medical ethics and respectful to the culture of individuals, minorities and communities, and have to be sensitive to gender and age.

(4) Quality: these services have to be scientifically and medically appropriate and of good quality. This requires, amongst other things, skilled medical personnel, scientifically approved and unexpired drugs and equipment, safe water and adequate sanitation.

The Covenant allows for progressive realization of the right to health (paragraph 30), but at the same time it imposes obligations which have immediate effect. Immediate obligations include non-discrimination of any kind, and the obligation to take steps towards the full realization of Article 12. "Such steps must be deliberate, concrete and targeted towards the full realization of the right to health."

Even where progressive realization is allowed, states have a legal obligation to "move as expeditiously and effectively as possible towards full realization…" (paragraph 31). Retrogressive measures are not permissible (paragraph 32).

Three types of general legal obligation fall upon states: to respect, protect and fulfill the right to health (paragraph 33). The obligation to respect requires states to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to protect requires states to prevent third parties from interfering with the right. And the obligation to fulfill requires states to take appropriate measures towards the full realization of the right.

There are many policy issues that could be informed by the right to health, but an important one concerns access to health care systems by irregular migrants. European welfare states such as the United Kingdom are taking steps to exclude irregular migrants from access to public healthcare, but on my reading of the right to health these steps seem to be in violation of their obligations under the ICESCR.

General Comment 14 makes it clear that the Covenant explicitly proscribes any discrimination in access to health care and the underlying determinants of health (paragraph 18). The obligation upon states to respect the right to health means "refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum seekers and illegal immigrants, to preventative, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; and abstaining from imposing discriminatory practices relating to women's health states and needs" (paragraph 34).

This means that the measures taken by the United Kingdom government to exclude certain migrants from access to health care provided by the National Health Service, and any proposals to exclude them further, are a breach of the government's obligation under international law.

General Comment 14 is clear that: "Any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels. All victims of such violations should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition" (paragraph 59).

How irregular migrants go about pursuing a case against the UK government for their exclusion is another question and a very troubling one. But for now, at least, we can see that there is a case to answer, and that, in itself, is a constructive result of approaching this issue through the framework of the human right to health.

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Dr Phil Cole *is Senior Lecturer in Politics at the University of the West of England, Bristol. He is co- author (with Christopher Heath Wellman) of Debating the Ethics of Immigration: Is There a Right to Exclude? (OUP, 2011). Read more from Phil, and others, in UWE Bristol's Politics in Action blog.*

[i] For the full version of the International Covenant on Economic, Social and Cultural Rights, see www.unhchr.ch/html/menu3/b/a_cescr.htm. For other international codes in this area see International Organization for Migration (2005), *World Migration 2005: Costs and Benefits of International Migration* (Volume 3 — IOM Migration Report Series), p.330.

About the author:

Professor Phillip Cole Lectures in Politics and International Relations at the University of the West of England, Bristol. He is co-author of Debating the Ethics of Immigration: Is There a Right to Exclude? (OUP, 2011)