Safeguarding the Right to Health in an Unequal World

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The right to health

* Universal Declaration of Human Rights art 25
* International Covenant on Economic and Social Rights art 12
  * Elaboration General Comment 14, CESCR Committee
* International Convention on the Elimination of All Forms of Racial Discrimination art 5(e)(iv)
* Convention on the Elimination of All Forms of Discrimination against Women art 10 (h), 11(1)(f), 12, 14(2)(b), 16 (1) (e)
* Convention on the Rights of the Child art 24
* International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families art 28, 43 (1) (e), 45 (1)(c).
* Convention on the Rights of Persons with Disabilities art 25

Framework for the right to health

ICESCR art 12:

1) "The States Parties to the present Covenant recognize the right of **everyone** to the **enjoyment of the highest attainable standard of physical and mental health.**"

2) The steps to be taken by the States Parties to the present Covenant to achieve the **full realization** of this right shall include those necessary for:

* the provision for the **reduction of the stillbirth rate and of infant mortality and for the healthy development of the child;**
* the improvement of all aspects of **environmental and industrial hygiene;**
* the prevention, treatment and control of epidemic, endemic, occupational and other diseases; **the creation of conditions which would assure to all medical service and medical attention in the event of sickness.**"

Framework for realising the right to health

* General Comment 14
  * Progressive realisation
  * Core obligations
  * Non-discrimination and equality, especially for vulnerable groups
  * State must respect, protect, and fulfil the right to health
  * State must make health goods, services and facilities available, accessible, acceptable, and good quality

Framework for realising the right to health

* General Comment 14
  * Freedoms (e.g. autonomy) and entitlements (e.g. access to essential medicines)
  * Include underlying factors and social determinants of health
  * Participation, community involvement and accountability
  * Policies must be evidence-based
  * **International cooperation**

Why take a right to health approach?

* Distinction from traditional public health approaches
* The right to health is distinct because of:
  * The centrality of autonomy and informed consent
  * Its emphasis on non-discrimination and the protection of vulnerable groups
  * The importance of participation and accountability
* i.e. a focus on **empowerment**

Vulnerable and marginalised groups

* Of particular importance is the role of the right to health in safeguarding the rights of vulnerable and marginalised groups
* Including women, minorities, children, MSM, undocumented migrants, asylum seekers, sex workers, HIV+ persons, etc.
  * See: *Naz Foundation* (decriminalised private homosexual conduct via inter alia right to health)
  * See: HIV responses (surveillance vs destigmatization)

Vulnerable groups – the example of HIV

Example:

* Response to HIV can be divided in three stages:
  * Discovery of illness, uncertainty, panic
  * 'Public health rationale' – risk reduction and behavioural change, corresponding discriminatory measures
  * 'Vulnerability' approach – focus on societal factors barring individual control over health
* Most effective in reducing rate of HIV infection was the **vulnerability** approach, which is broadly **rights-based**
* Indicates that rights based approaches are not only **fair**, but also **effective**

Challenges for realising the right to health

* **Only imposes obligations for progressive realisation**
* **Lack of regulation of private parties**
* **Financing and resources**
* **Gap between law and implementation**
* **Absence of right to health considerations in other international treaty regimes**

Progressive realisation

* States need only progressively realise the right to health
  * Except some immediate obligations e.g. non-discrimination
  * Except for core obligations e.g. protection of vulnerable groups
  * Retrogressive measures must be **justified**
* This principle does not exist in constitutional protections of the right to health – e.g. Brazil, South Africa, India
* Draws an **artificial distinction** between economic and social rights and civil and political rights

No regulation of private parties

* **Private entities/corporation** not amenable to the right to health framework
* State obligation to **'protect'** from private party violations – e.g. India's enactment of s 3(d) of the Patents Act sets high bar for patentability, to increase competition and lower prices of essential medicines
* However, private companies wield **increasing power** and resources
* Only **voluntary guidelines** (e.g. Ruggie report, previous UNSR report on access to medicines) exist at present

Financing and Resources

* Resources for realising the right to health are lacking
  * Estimates $40 USD/person for basic health neeeds/Abuja declaration – out of reach for most developing countries
* Currently many global health financing initiatives, e.g.
  * Global Fund for TB, AIDS and Malaria
  * UNITAID
* But dependent on donor or state goodwill, not obligation
* Need for coordinated framework with greater accountability

Absence of right to health in other international regimes

* TRIPS and access to medicines:
  * Some limited TRIPS flexibilities
  * Often developing states have little power or capacity to make full use of TRIPS flexibilities
    * Pressure from developed countries e.g. use of US Trade Law s301
    * Pressure from private sector e.g. Thailand's compulsory licencing of Plavix
  * Many countries further restricting via TRIPS+ agreements

Absence of right to health in other international regimes

* Global drug control regime
  * Primarily a law and order approach
  * Single Convention on Narcotic Drugs, Convention on Psychotropic Substances,
  * Encourage punitive laws and criminalisation (often in excess of treaty requirements)
  * Impacts access to palliative care, harm reduction therapies
  * Drives drug use underground and encourages risky behaviour (e.g. needle sharing)

Gap between law and implementation

* Often law does not translate to improved health on the ground
* E.g. India has very progressive judgments on the right to health
* But has not been able to improve health indicators due to:
  * Lack of investment in/budget for the health care system
  * Increasing privatisation; Poor falling off the table
  * Lack of priority given to preventive and primary health care

Need for a transparent and accountable global governance system

CHALLENGES

* Challenge is to ensure that all persons anywhere in the world has her/his right to health realised.
* How do increase funding available for states that cannot raise budgetary resources?
* Examples of Global Fund on HIV/TB and Malaria, UNITAID to be based on funding by States in a global regime.
* This global regime has to be more participatory, transparent and accountable?