

# Health as a human right

The right to health is included in international human rights conventions. The UN monitors national implementation, while the resources targeted at health measures by the member states are allocated in very different ways. Increased focus has been directed at the question of global co-responsibility for securing the basic elements of the right to health for the world's poor. In the last decade important steps have been taken to safeguard this responsibility.

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The right to health as a universal human right was first declared by the World Health Organization in 1946 at its first meeting after the Second World War. The text, which was later incorporated in the preamble to WHO's constitution is as follows: «The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition» (1).

In 1966 the UN adopted the two main conventions on human rights, one on civil and political rights (International Covenant on Civil and Political Rights (ICCPR)) and the other on economic, social and cultural rights (International Covenant on Economic, Social and Cultural Rights (ICESCR)). (For all major conventions cited in this article, see website (2)).

Article 12 of the ICESCR is of key importance for the right to health. The majority of states have ratified this convention, with the exception of the US and some smaller states. Article 12 formulates the right to «the highest attainable standard of health» in the same way as the preamble to WHO's constitution.

## Interpreting and applying the right to health as set out in the convention

Article 12 obviously does not imply that the state should guarantee good health for everyone. However, it requires the state to make adequate provision to ensure that its

inhabitants enjoy the best possible health based on individual potential.

The ICESCR sets long-term objectives and therefore incorporates a provision (in article 2.1) which prescribes that the States Parties undertake to take steps individually, and through international development assistance and cooperation, with a view to *progressively* achieving by all appropriate means the full realization of the rights recognized in the ICESCR.

Obviously countries with small resources will be unable to accomplish as much as more affluent countries. Nonetheless, all states are obliged to build up a health system and *progressively* to achieve the full realization of the right to health. Some countries do so while others prioritize their resources in a manner that is unacceptable from the standpoint of human rights. However, the sanctions against states that do not comply with the provision are weak.

## The UN monitors compliance

The UN has established a separate committee to monitor that the States Parties comply with their obligations under the ICESCR. The monitoring is effected by the states submitting periodic reports to the committee via the UN's General Secretary. On the basis of the states' own report and other data, the committee summons the individual state to take part in a dialogue on whether the implementation is good enough in relation to what is possible in the state in question. Moreover, the UN's Human Rights Council has appointed a Special Rapporteur on the Right to Health, who reports annually to the Human Rights Council and to the UN General Assembly on problems and progress related to the realization of the right to health (3).

Some states have used the provision in article 2.1 of the ICESCR on progressive implementation of the rights as an excuse for neglecting or postponing their commitments. Therefore the ICESCR Committee requires that the states set benchmarks that are achievable, step by step, for the individual state. The committee further stipulates

that the states prepare detailed health statistics which clearly show which groups suffer the greatest health problems. On this basis the states must present concrete plans specifying the measures they will take, grouped into realistic phases with a clear indication of the instruments and time frames (4, 5).

Furthermore, the states must indicate what will be prioritized at all times within the framework of the limited resources available. This demands that priorities must be made which may be politically challenging but which are necessary from the human rights perspective (1, 6, 7).

## The Convention on the Rights of the Child and the Convention on the Elimination of all Forms of Discrimination against women (CEDAW)

Of equal importance for the right to health as article 12 of the ICESCR, is article 24 of the Convention on the Rights of the Child, in which the States Parties acknowledge responsibility for ensuring the child's right to enjoy the highest attainable standard of health and treatment for illness and rehabilitation (2). The States Parties have pledged that no child shall be deprived of his/her right of access to such health services. The article also contains detailed requirements for measures to be taken on the part of the state. Article 12 of the Convention on the Elimination of Discrimination against Women is also important. Article 12.1 requires states to abolish discrimination of women and to ensure access to health care services, including those related to family planning, on the basis of the equality of men and women. Article 12.2 requires states to ensure that women are offered appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

In Norway these conventions are currently directly applicable law by virtue of the Human Rights Act of 1999 (2).

Many more provisions on the right to health can be found in global and regional

conventions and declarations. The right to health has received increased prominence in the global protection of human rights.

### International collaboration

The responsibilities of states for the health of their own inhabitants can be at threat from external forces. Some years ago WHO played a key role in stopping the spread of severe acute respiratory syndrome (SARS). The initial indications of a pandemic began in China in the autumn of 2002. Internationally this caused alarm because of the gravity of the situation and serious outbreaks of the disease in several countries, mainly related to people who had visited China or Hongkong. The epidemic receded after a couple of years, but the fear it inspired had a strong impact on international collaboration under the auspices of WHO aimed at preventing pandemics. The most important result was the preparation of the International Health Regulations (IHR), which are now a legally binding instrument acceded to by practically every state in the world (adopted in 2007, now acceded to by 194 states) (8).

WHO has pointed out that the justification for international health regulations lies in the fact that in today's globalized world, disease can spread swiftly and widely due to international travel and trade. A health emergency in one country can quickly impact on living conditions and the economy in many parts of the world. These emergencies include infectious diseases such as SARS but also chemical emissions, oil spills or nuclear melt-downs with the ensuing danger of radiation.

Many other examples could be given to indicate that to a growing extent the defence and protection of the right to health in the individual country demand international collaboration. Our economies and global trade make it increasingly essential to ensure that health is not endangered by visiting other countries.

The effect of globalization can also be experienced the other way round. Refugees, asylum-seekers and immigrant workers come to our countries, and the right to health must also apply to them. Some may also bring with them diseases that are more or less eradicated in Western countries. In June 2011 there was an outbreak of measles in Oslo among children who had visited the emergency medical service. The infection was carried by Somali children and was unexpected in Norway where measles is now a rare condition. Others may carry tuberculosis, sometimes caused by multi-resistant bacteria. In order to fulfil their health commitments vis-à-vis people in Norway, the Norwegian authorities must participate in international collaboration to improve the health situation in other countries, for example by reducing the incidence of infectious diseases.

International cooperation can also apply to the prevention of chronic diseases that are not infectious, but are a result of lifestyle. This can be achieved through cooperation on the marketing and sale of tobacco products, or on the marketing of undesirable food and drink products that can contribute to overweight and malnourishment. Active participation in international collaboration to regulate such conditions forms part of every individual state's

commitment to safeguard the right to health.

WHO's framework convention on tobacco control is the first international treaty successfully negotiated under WHO's auspices. It was adopted in 2003 and entered into force in 2005. Since then it has become one of the international conventions that has received speedy and broad support. On 21 June 2011 the convention received its 174<sup>th</sup> ratification.



Illustration Supernøtt Popseløyd

## The responsibility of affluent countries

As mentioned previously, countries have extremely different resources at their disposal for health initiatives. When the UN adopted the ICESCR it was clear that many countries would be unable to accomplish these tasks on their own. Therefore article 2.1 of the ICESCR stipulates that the States Parties are obliged to implement these rights «individually and through international assistance and co-operation, especially economic and technical». The achievement of a reasonably good standard of health in poor countries demands development assistance and cooperation on the part of rich countries.

The examples mentioned above stem from countries' self-interest in healthcare, which is increasingly secured through international collaboration. For example, the foreign ministers of a number of countries have adopted a declaration stating that global health is a vital and major area of commitment for foreign policy in our time. The initiative was taken by the foreign ministers of Norway, Brazil, France, Indonesia, Senegal, South-Africa and Thailand, and was presented in 2007 as «The Oslo Ministerial Declaration – global health: a pressing foreign policy issue in our time». It has received substantial support.

Although this is well and good, it is not good enough. No satisfactory solution has been offered for one major contentious issue – the responsibility of affluent countries, over and above their self-interest – to improve the health situation of poor people in low-income countries. The prime responsibility is still invested in the national state; each individual state is first and foremost responsible for the health of its own inhabitants. If the right to health is to constitute a universal right, the health of people in the least developed countries cannot merely be left to the country's own resources. Many states lack well-functioning institutions and a satisfactory legal system, a system for the redistribution of wealth, and appropriate national health institutions. Moreover, there is a considerable degree of corruption in the management of public funding in many countries, and this also applies to the health service. Nation-building has not been successful in a large number of conflict-ravaged countries. Conflict destroys the possibilities of building up the health system and it creates large flows of internally-displaced persons and refugees across national borders. International society – in practice rich countries – has developed substantial cooperation on emergency help to internally-displaced persons and refugees and therefore helps to ensure that the right to health becomes a universal co-responsibility. But there are many more tasks. Rich countries must have a co-responsibility for

reducing widespread child and maternal mortality, and must help to stop epidemics.

## Initiatives and coordination

Even though major international campaigns such as the Global Alliance for Vaccines and Immunization (GAVI) and the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) are well under way in their efforts to improve the health situation among the very poor, the work is uncoordinated and unsystematic. Many people are making efforts to increase global management of this work. A ground-breaking initiative was taken by

Lawrence Gostin in 2007, when he proposed the preparation of a framework convention on global health (9). This aroused great interest and promoted the establishment of a broad international network called Joint Action and Learning Initiative, in which the management of global health is discussed and clarified in greater detail. The network has several Norwegian members. The group presented its proposals in an appendix to WHO's «World Health Report» 2010 (10). Different interpretations of the concept «global health» are discussed by Ooms (11).

It will take a long time to achieve solutions that secure everyone the «highest attainable standard of health» as pledged in WHO's constitution and in the ICESCR. However, through international collaboration we can perhaps achieve minimum health levels for everyone at the end of the next two decades.

WHO has taken the initiative to organize a global health forum, which is to meet for the first time in 2012. The biggest task will be to develop guidelines ensuring that everyone enjoys at a minimum the basic elements of the universal right to health, as formulated by the ICESCR committee (5).

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