The right to health

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Colophon

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1 Introduction

There is at least one characteristic that all human beings have in common: the risk of getting ill. The way people deal with their illnesses varies considerably, but treatment in one country should, in essence, not differ from treatment in any other. Everyone knows when it is appropriate to visit a doctor in his or her own country. Differences in the way health care is organised become clear when people are not in their own country and are in need of medical help. In some countries, public health care is free of charge for everyone. However, in most countries people need either money or health insurance to cover the expenses. As these are often lacking for undocumented migrants, seeking medical assistance is often postponed until it is impossible to ignore the symptoms or complaints. This results in consulting a medical professional at too late a stage or in the wrong place (e.g. at the Accident and Emergency department of a hospital instead of a general practitioner). In addition, preventive medical care is also underused by undocumented migrants. Examples of this are vaccination programmes for certain infectious diseases (e.g. hepatitis B) for high risk groups, such as substance users and sex workers. For these groups, the stigma of drug use and sex work may also affect access to health care services when they are in need (e.g. they are vulnerable to contracting a contagious disease) and when they are also undocumented migrants, they face double barriers.

2 The right to the highest attainable standard of health

International agreements conceive the right to health as part of a wider social environment than simply the absence of disease. This extends not only to timely and appropriate health care but also the underlying determinants of health, such as safe working conditions and adequate food and shelter. The basis for an international legal framework of the right to health has been established through the Universal Declaration of Human Rights. This Declaration is not legally binding, but consists of a statement of principles that have been codified in several international instruments and treaties. The most relevant instrument on the right of everyone to the highest attainable standard of physical and mental health, for convenience often shortened to 'the right to health', is the International Covenant on Economic, Social and Cultural Rights (ICESCR), Article 12 (http://www.unhchr.ch/html/menu3/b/a_cescr.htm). This right is inclusive and envisages health care to which people are entitled, rather than privileged, to access, and which is provided in a non-discriminatory manner, respecting diversity and difference. In this chapter, we will highlight Article 12 (the right to health) and Article 2 (obligations of the state).

ICESCR, Article 12

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.

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.

3 Obligations of states

The right to health is often also enshrined in national constitutions and has generated significant jurisprudence. While the right to health includes the right to health care, it goes beyond health care and covers underlying determinants such as adequate access to health-related information. Like other human rights, it has a particular concern for disadvantaged, vulnerable people and those living on the fringes of society. The right requires an effective, inclusive health system of good quality. What 'the right to health' exactly means has been further specified in General Comment 14 (below). This comment asserts that all states have immediate obligations, including minimum core obligations. Core obligations are intended to ensure that people are provided with, at the very least, the minimum conditions under which they can live in dignity, enjoy the basic living conditions needed to support their health and be free from avoidable mortality. They serve, in other words, as a bottom line for responsibilities of states. Here, following the themes addressed by this reader, we confine ourselves to the issues relevant to undocumented migrant drug users and sex workers.

General comment 14 to Article 12, ICESCR

The right to health in all its forms and at all levels contains the following interrelated and essential elements, the precise application of which will depend on the conditions prevailing in a particular State party:

Availability. Functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the State party. The precise nature of the facilities, goods and services will vary depending on numerous factors, including the State party's developmental level. They will include, however, the underlying determinants of health, such as safe drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically competitive salaries, and essential drugs, as defined by the WHO Action Programme on Essential Drugs;

Accessibility. Health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party. Accessibility has four overlapping dimensions:

Non-discrimination: health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds (see paras. 18 and 19);

Physical accessibility: health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS. Accessibility also implies that medical services and underlying determinants of health, such as safe and potable water and adequate sanitation facilities, are within safe physical reach, including in rural areas. Accessibility further includes adequate access to buildings for persons with disabilities;

Economic accessibility (affordability): health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be

disproportionately burdened with health expenses as compared to richer households;

Information accessibility: accessibility includes the right to seek, receive and impart information and ideas concerning health issues. However, accessibility of information should not impair the right to have personal health data treated with confidentiality;

Acceptability. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned;

Quality. As well as being culturally acceptable, health facilities, goods and services must also be scientifically and medically appropriate and of good quality. This requires, inter alia, skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

ICESCR article 2

Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

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.

Developing countries, with due regard to human rights and their national economy, may determine to what extent they would guarantee the economic rights recognized in the present Covenant to non-nationals.

In summary, the obligations of states are to respect the right to health, to protect the realisation of this right and to fulfil this right. To hold a state accountable, it is necessary that disaggregated data are available. These data can be used to influence national health policies. On the other hand, the same data could and should be used by collaborating non-governmental organisations (NGOs) to produce (shadow) reports to the appropriate reporting bodies in, for example, the Council of Europe or the United Nations.

4 Problematic access to health care

For socially excluded populations access to, in addition to the accessibility and acceptability of health care, is often problematic. Even when a state offers harm reduction, a mixture of preventive and curative health care, undocumented migrants are excluded from both local and national programmes. States often leave the responsibility of delivering health care for undocumented migrants to NGOs and those medical professionals who choose to take the risk of not being paid for the services they provide. Few undocumented migrants use regular health care facilities, and, to some extent, this is connected to their lack of knowledge: they simply do not know how health services in the country where they reside are organised. Furthermore, most undocumented migrants have a constant fear of being reported to the police, losing their job, and/or being detained or deported. This means they ignore their health needs until they become absolutely urgent. In the case of HIV/AIDS especially, this fear and ignorance may lead to unnecessary harm.

The accessibility (including economic affordability) of health care services is problematic for undocumented migrants in several European countries. In most of Europe, they access health care only in emergency situations, and most countries provide this. In some countries, essential care is also provided (i.e. care for diseases which are not an immediate health threat, but which may cause serious damage, such as diabetes and hypertension).

The acceptability of health care is another issue. Among other things, this encompasses respect for the culture of individuals. Although there have been enormous efforts to deliver culturally appropriate care in several European countries, only a few examples of good practice are widely-known.

5 Conclusion

To attain 'the right to health' for all, including undocumented migrants, (health) professionals working with this target group should use a 'rights-based approach'. However, to realise 'the highest attainable status of health', one has to be pragmatic too: NGOs delivering health care where states fail to do so is sometimes the best solution. Such NGOs should use their experiences and data to produce reports. A helpful tool for this is Judith Asher's (2004) 'The Right to Health: A Resource Manual for NGOs'. Both legal and health issues are well-elaborated and the work contains properly worked-out field studies that can be used as best practice on how to reach and influence local and (inter)national committees. The great challenge to do so requires a lot of time and effort and, in order to be successful, self-help organisations and NGOs need to cooperate and combine forces and expertise. We wish them success in doing so!

References

Asher, J. (2004) *The Right to Health: A Resource Manual for NGOs.* http://shr.aaas.org/manuals/rth.shtml

Relevant additional resources

www.aidsmobility.org	Especially useful for issues on migrants and HIV/AIDS
www.bayefsky.com	All UN treaties including overviews by state
www.december18.net	Useful human rights portal in different EU languages
www.hhri.org	Health and human rights information (in English and Spanish)
www.mainline.org	NGO focussing on the health and quality of life of drug users
www.pharos.nl	NGO focussing on health care to refugees and asylum seekers.
www.picum.org	I-NGO focussing on undocumented migrants
www.who.int	World Health Organisation website