
Covid-19: An Inconvenient Truth? Re-evaluating Progress and Confronting Challenges for the Right to Health

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I. Introduction

As the global crisis of Covid-19 has unfurled, a grating dissonance can be observed between many States' responses and their right to health obligations under international human rights law. This began with the initial cover-up of the Covid-19 outbreak in China, conflicting with the right to access health information and the principle of transparency. Following on, the "keep calm and carry on" approach of governments of the UK, USA and Brazil, influenced by perceived economic imperatives and a belief that the cure would be worse than the disease,¹ failed to put in place timely protective measures for the right to health, contrary to advice and warnings from the World Health Organization (WHO). There have been particularly high rates of infection and deaths in these three countries. There is anxiety about limited capacity of health systems in low and middle income (and indeed high income) countries to mount an effective response to Covid-19, on the back of long-standing austerity and structural adjustment policies that have eaten away at the very core of structures required for an effective rights-based public health response,² whilst many States have adopted protectionist measures in conflict with right to health obligations of international assistance and cooperation. This is not to mention the use by some countries of the public health emergency of Covid-19 as a smokescreen for erosions of human rights, including restrictions on reproductive freedoms and civil society space. Even as public health imperatives have become increasingly central to Governments' actions worldwide, a shared global experience has been the disproportionate risks faced by vulnerable and marginalised populations, who are exposed to the double jeopardy of a significantly higher risk of catching and dying from Covid-19, and shouldering the burden of deprivations arising from social distancing measures which fail to protect their livelihoods and health and expose them to hunger and domestic violence, with significant implications in terms of equality and non-discrimination. A lack of accountability thus far for these shortcomings is also highly problematic.

Infringing on almost all of its attributes, Covid-19, is a perfect storm for the right to health, a fundamental human right protected under international human rights law. The United Nations (UN), the WHO and UN human rights procedures have clearly articulated that the right to health should be at the frontline of responses.³ This makes the comparative absence of the right to health from States' responses even more striking. States have largely embraced public health whilst eschewing the right to health. At the same time, predominantly, human rights scrutiny has honed in on derogations and legitimacy of

¹ Juan Pablo Bohoslavsky, 'COVID-19 Economy v Human Rights: a Misleading Dichotomy,' *Health and Human Rights Journal Blog*, 29 April 2020.

² Lisa Forman, 'The Evolution of the Right to Health in the Shadow of COVID-19,' *Health and Human Rights Journal Blog*, 1 April 2020.

³ UN, *We are All in this Together: COVID-19 and Human Rights* (United Nations: April 2020); WHO, 'Addressing Human Rights as Key to the COVID-19 Response', 21 April 2020; Committee on Economic, Social and Cultural Rights (CESCR), 'Statement on the Coronavirus Disease (COVID-19) Pandemic and Economic, Social and Cultural rights', UN Doc. E/C.12/2020/1, 9 April 2020.

limitations on civil liberties, rather than considering socio-economic rights impacts, including the right to health.

Why has the right to health received so little attention beyond the UN system and what are the lessons to be learned by the human rights community? In this paper, I argue that this dearth of attention is firstly symptomatic of continued marginalisation of the right to health, particularly in the policy making context. Whilst the health and human rights community has celebrated progress of the right to health in recent years, particularly in terms of improving legal protections and the production of rights-based guidance for policy makers, there has been a conflicting and simultaneous erosion of a supportive policy environment. Health and other social support systems have been weakened by structural adjustment and austerity, which have also entrenched and exacerbated inequalities in the social and economic determinants of health. Weak health systems and inequalities are exposed by the catastrophic impact of Covid-19, highlighting the need for the health and human rights community to rethink how to measure and bring about progress. Secondly, it is also reflective of the limited attention of human rights oversight bodies and the broader health and human rights community to unpacking the right to health in contexts of pandemics, which raise unique and often complex questions for human rights. These are questions which the human rights community has scrambled to grapple with but without always producing a clearly articulated positions and guidance. Human rights oversight bodies, and the health and human rights community more broadly, will need to clarify more specifically how the right to health, and other human rights, apply in the context of pandemics, if they are to have a meaningful impact on responses. Thirdly, whilst the pandemic has, at least in most quarters, refocused acceptance of the importance of science and evidence-based approaches, which have been challenged particularly by populist right-wing politicians in recent years, it has not only revealed their importance in many respects, but also their limits when it comes to securing the rights and well-being of all people everywhere. The human rights community can learn from the science and must take it on board; at the same time it can contribute important analysis and tools to support policy makers to promote and protect the well-being of all people. The health and human rights community must put efforts into ensuring its insights meaningfully shape government responses, including from the outset of crises.

II. The Effects of Neoliberalism and Health Inequalities Call for a Re-evaluation of Progress in, and New Strategies for, Vindicating the Right to Health

The right to health is centrally protected in international law by the International Covenant on Economic, Social and Cultural Rights (ICESCR), which obligates States parties to, amongst others, take steps for the 'prevention, treatment and control of epidemic, endemic, occupational and other diseases' and create conditions to assure 'medical service and medical attention in the event of sickness.'⁴ This requires health services and goods, such as medicines, to be available in adequate numbers; financially and physically accessible, and accessible on the basis of non-discrimination; acceptable including respectful of medical ethics; and good quality.⁵ Extending beyond health care, the right to health also embraces social determinants of health such as safe and healthy working conditions, food and nutrition, housing, and water, sanitation and hygiene. With obligations to respect

⁴ International Covenant on Economic, Social and Cultural Rights (ICESCR), G.A. Res. 2200A (XXI) (1966), article 12.

⁵ CESCR, 'General Comment No. 14, The Right to the Highest Attainable Standard of Health', UN Doc. No. E/C.12/2000/4, 11 August 2000, para. 12.

(refrain from harm), protect (from third parties), and fulfill (promote) the right to health, States must adopt legislative, administrative, judicial, promotional and other measures and devote maximum available resources to progressively realise the right to health. Further, the right to health must be realized on the basis of cross-cutting human rights principles, including non-discrimination and equality, participation and accountability.⁶ These obligations have a central relevance in Covid-19 responses, to minimise mortality and morbidity and prevent retrogression in the enjoyment of a swathe of other human rights.⁷

Historically marginalised, there has been much progress in terms of increasingly extensive legal recognition of the right to health, and greater oversight provided by the international human rights system. With 170 State ratifications of the ICESCR, as well as even more widespread ratification of other international human rights treaties protecting the right to health, all States have assumed internationally binding legal obligations towards the right to health. Constitutional protections of the right to health are now found in the majority of countries worldwide, some of which are generating a flourishing jurisprudence.⁸ Legal positivists, including within the human rights community, have celebrated these legal gains as significant milestones for the right to health, yet it is acknowledged that in practice the transformative potential of international law, constitutional protections and litigation has varied significantly between countries.⁹

Whilst, on the one hand, States have been prepared to ratify international treaties and adopt constitutional protections recognising the right to health, on the other hand, many States have simultaneously adopted austerity and structural adjustment policies, resulting in the reduction or suppression of spending for healthcare and the erosion of social determinants of health, thus undermining the right to health in practice.¹⁰ With entrenched and widening inequalities in social determinants of health, the right to health situation has been particularly precarious for marginalised and vulnerable groups, including people living in poverty. Covid-19 has shone a torch on the underlying fragility of health systems in the face of sudden, widespread and acute need, with many systems experiencing shortages of equipment including ventilators, oxygen, protective clothing and testing capacity, denials of treatment by some private institutions, and interruptions to other essential healthcare, including cancer treatment, sexual and reproductive health care and immunisations.¹¹ In the earliest weeks of the pandemic, there was strong messaging from governments, and the UN, that Covid-19 does not discriminate.¹² Yet, with the passage of time, it has become clear that marginalised and vulnerable groups are at significantly higher risk of catching Covid-19, are more likely to die from it, and are more likely to suffer adverse consequences to their well-being and human rights from social distancing policies.

⁶ Ibid.

⁷ Dainius Pūras, Judith Bueno De Mesquita, Luisa Cabal, Allan Maleche, and Benjamin Mason Meier, 'The Right to Health Must Guide Responses to COVID-19', *The Lancet*, 29 May 2020.

⁸ Alicia Ely Yamin and Siri Gloppen, *Litigating Health Rights: Can Courts bring more Justice to Health?* (Cambridge, Massachusetts: Harvard University Press, 2011).

⁹ Audrey Chapman, *Global Health, Human Rights and the Challenge of Neoliberal Policies* (Cambridge: Cambridge University Press, 2016); Matthias Goldman, *Contesting Austerity: Genealogies of Human Rights Discourse* (Berlin: Max Planck Institute, 2020).

¹⁰ Timon Forster, Alexander E. Kentikelenis, Thomas Stubbs, and Lawrence P. King, 'Globalization and Health Equity: The Impact of Structural Adjustment Programs on Developing Countries', (2019) 80(5) *Social Science & Medicine* 83-113.

¹¹ See, for example, UNICEF, 'As COVID-19 Devastates Already Fragile Health Systems, over 6,000 Additional Children Could Die a Day, Without Urgent Action', 13 May 2020.

¹² See, for example, UN Network on Migration, 'COVID-19 Does Not Discriminate; Nor Should Our Response', 20 March 2020.

As well as older persons, racial and ethnic minorities and people with underlying health conditions, people living in poverty (a category which has disproportionate representation of groups marginalised on other grounds, e.g. racial and ethnic minorities and older persons) are at particular risks of infection where they live in overcrowded conditions, lack access to sanitation and lack access to protective measures in the workplace, whilst they are also particularly affected by social distancing policies which threaten their livelihood. Further, the World Bank has estimated that Covid-19 will push 71 million more people into poverty worldwide.¹³

Neoliberalism, which promotes a small role for the State, reliance on the market, and privatisation in health and other sectors, has provided the ideological underpinning of austerity and structural adjustment. The strain this approach has placed on the right to health is increasingly recognised.¹⁴ Yet, despite overwhelming evidence of harm, international human rights law, as currently interpreted, does not prescribe any particular type of economic system.¹⁵ Whilst some academics, NGOs and UN Special Procedures have taken an anti-neoliberal stance, other UN human rights bodies, such as the UN Committee on Economic, Social and Cultural Rights (CESCR), which oversees the ICESCR, have refrained from adopting a principled position against neoliberalism, preferring to consider the provision of care and services on a case-by-case basis.¹⁶ Further, the vast economic inequalities that are, at least in part, a product of neoliberalism (which has failed to redistribute economic gains),¹⁷ and which raise questions in terms of the obligation of States to devote maximum available resources to the right to health, have also not been robustly addressed by human rights bodies as questions of equality and non-discrimination. Interpretations of equality and non-discrimination under international human rights law have, to date, precluded the concept of economic inequalities, a position challenged by MacNaughton who describes income, wealth and social inequalities as the 'greatest human rights challenge of our time.'¹⁸ The impact of Covid-19 on low income groups suggests very clearly that these groups are experiencing inequality and discrimination. A further apposite criticism comes from Moyn, who has also lamented the failure of the human rights community to fully engage with economic inequalities, and who is particularly critical of the contentment of human rights bodies to elaborate and hold States accountable for minimum entitlements, often called "core obligations", at the expense of the more challenging and redistributive goal, within and between countries, of economic equality.¹⁹ Covid-19 illustrates how economic inequality matters, not only intrinsically, but also for securing core obligations that are vital for dignity and well-being and which the human rights community purports to uphold.

In recent years, the health and human rights community has increasingly engaged with the policy making context as well as with constitutionalism and litigation, particularly through elaborating human rights-based approaches to a range of different health issues and

¹³ Daniel Gerszon Mahler, Christoph Lakner, R. Andres Castaneda Aguilar, and Haoyu Wu, 'Updated Estimates on the Impact of COVID-19 on Global Poverty,' *World Bank Data Blog*, 8 June 2020.

¹⁴ Chapman (n. 9).

¹⁵ Ibid.

¹⁶ Paul O'Connell, 'On Reconciling Irreconcilables: Neo-liberal Globalisation and Human Rights,' (2007) 7(3) *Human Rights Law Review* 483–509.

¹⁷ Thomas Piketty, *Capital in the Twenty First Century* (Cambridge, Mass: Harvard University Press, 2014).

¹⁸ Gillian MacNaughton, 'Vertical inequalities: are the SDGs and human rights up to the challenges?', (2017) 21(8) *International Journal of Human Rights* 1-23.

¹⁹ Samuel Moyn, *Not Enough: Human Rights in an Unequal World* (Cambridge, Mass: Belknap, 2018).

issuing many sets of guidelines for policy makers.²⁰ Whilst this clarification is important and welcome, Covid-19 raises questions about the scale of the mainstream impact of this enterprise. This sends an unequivocal message to the human rights community that, despite litigation and guidelines – both of which are playing an important role in Covid-19 responses²¹ but have not have a widespread impact for all - bolder approach are needed to secure the right to health for the most marginalised, including challenging the institutions, and economic models that underpin weak health systems and global inequalities.²²

III. The Human Rights Community Must Clarify Right to Health Obligations in the Context of Pandemics

The devastating effects of pandemic diseases have been recorded across centuries. Plague was one of the first documented pandemics, with two major outbreaks during the middle ages, the Plague of St Justinian, which struck in 542 AD, and the Black Death which resulted in an estimated 100 million deaths between the 14th and 17th centuries in Eurasia, and which led to some of the earliest approaches at international health control, including quarantine and the *cordon sanitaire*.²³ The 1918-19 influenza (Spanish Flu) epidemic led to an estimated 50-100 million deaths worldwide. More recent pandemic influenza outbreaks occurred in 1957, 1968 and 2009 (H1N1/Swine Flu), whilst outbreaks and spread of other novel infectious diseases, notably the HIV pandemic, and the SARS (2002-3), MERS (2016) and Ebola epidemics (2014-16) have continued to remind us of a continuing global threat.

Nascent international health collaborative engagements emerging in the nineteenth and early twentieth centuries were, indeed, spawned by fears of the spread of infectious disease, including cholera, yellow fever (in the Americas) and plague. Whilst the field of international, and more recently global, health has long since expanded to new areas, the remaining commitment to infectious disease control is reflected in the WHO's Constitution, which sets out a long list of duties, amongst which is stimulating and advancing work to 'eradicate epidemic, endemic and other diseases'.²⁴ In the context of this work, the WHO has not lost sight of this vitally important mandate. Whilst its response to infectious diseases has not been without fault,²⁵ it has consistently warned of the threat posed by epidemics and pandemics, and spearheaded a number of relevant initiatives, most notably the legally binding International Health Regulations (IHR).²⁶ As discussed in the chapter by Bueno de Mesquita and Meier in this publication, the International Health Regulations, which are grounded in human rights, require States to, amongst others: notify the WHO of

²⁰ Paul Hunt, Judith Bueno De Mesquita, Joo-Young Lee, and Sally-Anne Way, 'Implementation of Economic, Social and Cultural Rights', in Nigel Rodley, and Scott Sheeran (eds), *Routledge Handbook of International Human Rights Law* (London: Routledge, 2013).

²¹ WHO, 'Addressing Human Rights as Key to the COVID-19 Response' (n. 3); Aoife Nolan, 'Symposium: Constitutional Social Rights Litigation and Adjudication in a Time of COVID-19', *International Association of Constitutional Law Blog*, 28 May 2020.

²² Forman (n. 2).

²³ Anne-Emanuelle Birn, Yogan Pillay, and Timothy H. Holtz, *Textbook of International Health: Global Health in a Dynamic World* (New York: Oxford University Press, 2017), 4.

²⁴ Constitution of the WHO, International Health Conference (1946).

²⁵ Sarah Boseley, 'Experts Criticise WHO Delay in Sounding Alarm Over Ebola Outbreak', *The Guardian*, 22 November 2015.

²⁶ WHO, Fifty-eighth World Health Assembly Resolution WHA58.3: 'Revisions of the International Health Regulations', 23 May 2005.

events that may constitute a public health emergency of international concern; and develop the capacity to respond promptly and effectively to public health risks and public health emergencies of international concern.

Whilst States have been criticised for failures to notify of, and prepare for pandemics, it is also the case that human rights bodies have been neglectful in attending to the delineation of right to health obligations in the context of pandemics, or addressing States compliance with the right to health, in terms of their preparedness for pandemics. The ICESCR clearly sets out that '[t]he prevention, treatment and control of epidemic, endemic, occupational and other diseases' is a central right to health obligation.²⁷ More recent international human rights standards do not include such specific language on epidemics, although this is not to say that their provisions cannot be interpreted as requiring State actions in this area. General Comment 14 on the right to health of the CESCR sets out, in prescient albeit sketchy terms, that States must put in place a system of urgent medical care in the event of epidemics or, more generally, for infectious disease control; they should: make available relevant technologies; improve epidemiological surveillance and data collection on a disaggregated basis; and enhance and implement immunization programmes and other strategies.²⁸ However, beyond this, little interpretive guidance had been promulgated by human rights procedures.

Moreover, a search of the Universal Human Rights Index database revealed just 17 recommendations made to States by treaty bodies or the Universal Periodic Review making explicit reference to pandemics and 22 to epidemics: these were reactive and almost all responding to the HIV pandemic, with a small number focused on Ebola (west Africa) and cholera (Haiti), rather than focused on pandemic preparedness.

In the aftermath of the outbreak, almost all international human rights bodies and experts have rapidly elucidated concerns about the impact of the crisis on human rights, yet many recommendations remain quite broad and generic,²⁹ phrased in terms of overarching principles, leaving some of the most challenging textual aspects of addressing Covid-19 unclear. For example, what positive obligations for the right to health apply in the context of pandemics?³⁰ What is the specific relationship of restrictions of other human rights and the protection of the right to health in the context of a pandemic?³¹ In times of acute need and scarce resources, for example for ventilators, personal protective equipment and vaccinations (when available), who should receive treatment as a priority?³² What is the relationship between restrictions of rights under the Convention on the Rights of the Child with the core principles of this treaty, including non-discrimination, the right to survival and development and the right of children to express their views in all matters affecting them?³³ These are all conceptual questions that require clarification by the CESCR, the Committee

²⁷ ICESCR, article 12.

²⁸ CESCR, 'General Comment No. 14' (n. 5).

²⁹ CESCR, 'Statement on the Coronavirus Disease', (n. 3); Commissioner for Human Rights of the Council of Europe, 'Learning from the Pandemic to Better Fulfil the Right to Health', 23 April 2020; WHO, 'Addressing Human Rights as Key to the COVID-19 Response' (n. 3).

³⁰ See, the paper by Koldo Casla in this publication.

³¹ Nina Sun, 'Applying Siracusa: A Call for a General Comment on Public Health Emergencies,' *Health and Human Rights Journal Blog*, 23 April 2020.

³² See, the paper by Sabine Michalowski in this publication.

³³ Aoife Nolan and Judith Bueno de Mesquita, 'Of Limitations and Retrogression: Assessing COVID-19's Impact on Children's ESC Rights,' *Global Initiative for Economic, Social and Cultural Rights Blog*, 26 May 2020.

on the Rights of the Child and other UN human rights bodies charged with overseeing and interpreting core international human rights treaties, to support States to make decisions on complex issues which are compatible with their international human rights obligations. With this in mind, there have been calls for treaty bodies to update guidance, including through adopting new General Comments to flesh out some of these concerns.³⁴

IV. Science, Human Rights and Evidence

Having worked on human rights in the field of public health for almost twenty years, one of the most frequent questions I have been asked by experts within that community, and which I have been rarely asked about by human rights lawyers, is what evidence is there that human rights can improve public health? This preoccupation is indicative of the overriding concern with evidence in public health (not to mention scepticism in some quarters about human rights).³⁵ In recent years there has been an increasing focus on the evidence of impact of a human rights-based approach for health. Whilst methodological challenges of measurement persist, research does suggest positive correlations, including in terms of promoting a more equitable approach to the right to health that secures inclusion for vulnerable and marginalised groups.³⁶ With impacts of Covid-19 disproportionately borne by marginalised and vulnerable groups, and with policy makers engaging particularly with scientists in formulating responses, the emerging evidence of impact of human rights suggests that more should be done to persuade policy makers to adopt human rights-based approaches, including for effective pandemic responses. Conveying the evidence of impact of human rights through more research and awareness raising will be an important part of strategies of political engagement by the human rights community, and will complement efforts to implement human rights in Covid-19 responses through constitutional social rights litigation to remedy and review policies or other measures that have harmed human rights.³⁷

Turning to the field of international human rights law, interpretation of the law is principally guided by normative considerations, yet that evidence also has a role to play is also clearly acknowledged. For example, the adoption and implementation of a 'national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population,' is considered a core obligation of the right to health.³⁸ Thus, strategies must be guided by both norms and evidence of how to achieve them.

The emergence and rapid global spread of Covid-19, a novel strain of coronavirus not previously identified in humans, has posed a series of urgent evidentiary questions surrounding transmission, severity of symptoms, the effectiveness and appropriateness of control measures in different settings, treatment and vaccines. Findings which suggest answers to some of these questions are emerging in an increasingly extensive, though not always coherent, patchwork of research. Whilst it is important that the public health community considers the evidence of impact of human rights, it is equally important that in interpreting international human rights law, the human rights community closely scrutinises

³⁴ See, for example, Sun (n. 31).

³⁵ Birn, Pillay and Holtz (n. 23).

³⁶ Paul Hunt, Alicia Ely Yamin, and Flavia Bustreo, 'Making the Case: What is the Evidence of Impact of Applying Human Rights-based Approaches to Health?' (2015) 17(2) *Health and Human Rights Journal*.

³⁷ Nolan (n. 21).

³⁸ CESCR, 'General Comment No. 14,' (n. 5), para. 43(f).

the public health evidence, taking into account the reliability of evidence, as well as what is still unknown.

The Covid-19 outbreak provides a range of insights about questions of evidence. Firstly, it highlights the range of fields from which evidence can be drawn. As well as the already acknowledged importance of epidemiological evidence, Covid-19 has illustrated that research from a much broader raft of disciplines should also be drawn on. Like human rights, public health is an inter-disciplinary endeavour, and - in addition to epidemiology - economics, statistics, medicines, anthropology, political science, sociology, law and behavioural science are key disciplines generating research that contributes valuable evidence to shape pandemic, and other public health responses. Secondly, Covid-19 has highlighted the great importance of international scientific collaboration, which is reflected by the ICESCR which obligates States parties to recognise the benefits 'derived from the encouragement and development of international contacts and co-operation in the scientific and cultural fields'.³⁹ A lack of scientific collaboration of China with the WHO hindered the pandemic responses at the outset, whilst countries, including the UK, have been reluctant to learn from experiences, including the evidence of impact of good practices, from other countries such as Taiwan or South Korea,⁴⁰ such as their successful approaches to testing and contact tracing. Thirdly, transparency surrounding public health strategies and the evidence informing them is another critical consideration illustrated by Covid-19. Where a lack of transparency surrounds the scientific evidence shaping public health policies, this obstructs preparedness, and stymies participation and accountability.⁴¹

In conclusion, the Covid-19 outbreak reveals that the development of an evidence-based public health policy demands critical engagement from human rights oversight bodies in terms of which fields of evidence are used to inform public health policy, political processes surrounding the development of policy, and whether policies engage with international as well as domestic public health guidance, whilst the evidence of impact of human rights must also guide responses to Covid-19.

V. Conclusion

Covid-19 has created a situation of global and national disorder for the right to health. Touching on all of its attributes, and raising many seemingly intractable problems, the pandemic casts light on obstacles to realising? the right to health and provides an opportunity to evaluate the past work of, and think about new directions for, the health and human rights community. Now is the moment for the community to refine interpretations of the right to health and think strategically about how to effectively address challenges embedded in society and the global order to achieve health justice and well-being for populations worldwide.

³⁹ ICESCR, Article 15.4.

⁴⁰ Toby Helm, Emma Graham-Harrison, and Robin Mackie, 'How Did Britain Get its Coronavirus Response So Wrong?' *The Guardian*, 19 April 2020.

⁴¹ Richard Coker, 'Coronavirus can only be Beaten if Groups such as Sage are Transparent and Accountable,' *The Guardian*, 27 April 2020.