ACCESS

Access to essential medicines as a human right


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THE promotion of human rights is one of the principal objectives of the United Nations (UN), and in 1997 the Secretary General placed human rights among the Organization's core activities. However, in 1946 WHO's Constitution preceded the Universal Declaration of Human Rights with the following opening text:

"The States parties to this Constitution declare, in conformity with the Charter of the United Nations, that the following principles are basic to the happiness, harmonious relations and security of all peoples.

Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. 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."

All human rights are interrelated, so that the right to health is related to the exercise of other relevant human rights, such as the right to education, information, privacy, association, equality and participation. All human rights are underpinned by freedom from discrimination, which puts a particular emphasis on vulnerable groups.

Human rights primarily concern the relationship between the state and the individual – they generate state obligations and individual entitlements. As governments also have prime responsibility for public health, they need to combine sound public health practice with fulfilling their obligations on human rights. The realisation of the right to health may be pursued through numerous approaches, which can be used simultaneously, and include formulating health policies, implementing health programmes, or adopting specific legal instruments.

The human right to health is recognised in numerous international instruments. Article 25.1 of the Universal Declaration of Human Rights states (1948): *"Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services"*. It is also recognised in many other international[1,2,3] and regional[4,5,6] instruments. But in particular it is the International Covenant on Economic, Social and Cultural Rights, signed and ratified by over 140 countries, which provides the most comprehensive article on the right to health.

The International Covenant on Economic, Social and Cultural Rights

By the time countries were prepared to turn the provision of the 1948 Declaration into binding law, the Cold War had polarised human rights. The West argued that civil and political rights had priority, and that economic and social rights were mere aspirations, while the Eastern bloc said that rights to food, health and education were paramount, and civil and political rights secondary. So two separate treaties were created in 1966, the *International Covenant on Civil and Political Rights* and the *International Covenant on Economic, Social and Cultural Rights* (ICESCR).

In article 12.1 of the ICESCR, States parties recognise the *"right of everyone to the enjoyment of the highest attainable standard of physical and mental health"*, and article 12.2, by way of illustration, cites a number of steps to be taken by States parties to achieve the full realisation of this right. These include obligations in relation to:

- maternal, child and reproductive health;
- healthy natural and workplace environments;
- prevention, treatment and control of disease;
- health facilities, goods and services.

Essential medicines as part of the right to health

The implementation of the ICESCR is monitored by the Committee on Economic, Social and Cultural Rights and at regular intervals the Covenant is supplemented by authoritative comments. In one, *General Comment no.14* of May 2000,[7] the Committee interprets the right to health, as defined in article 12.1 of the Covenant, as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health. These determinants include access to safe water and sanitation, food, nutrition and housing, a healthy environment, and health education and information. Several sections of the report are particularly relevant to essential medicines.

The Committee states that the right to prevention, treatment and control of diseases in article 12.2.(c) includes the creation of a system of urgent medical care in cases of accidents, epidemics and similar health hazards, and the provision of disaster relief and humanitarian assistance in emergency situations. The right to health facilities, goods and services in article 12.2.(d) includes appropriate treatment of prevalent diseases, preferably at community level; ***and the provision of essential drugs***.[8]

The Committee further specifies the following interrelated and essential components for the fulfilment of the right to health in all its forms, at all levels:

Availability*:* functioning public health and health care facilities, goods and services. The precise nature of the services depends on many factors (see below) but will include water and sanitation, hospitals and clinics, trained professional staff with domestically competitive salaries, and "essential drugs as defined by the WHO Action Programme on Essential Drugs"[9] (since incorporated into the Department of Essential Drugs and Medicines Policy).

Accessibility*:* Accessibility to facilities, goods and services has four components: non-discrimination, physical accessibility, affordability and access to information.

Acceptability*:* Health facilities, goods and services must be respectful of medical ethics, and culturally appropriate and sensitive to gender- and life-cycle requirements.

Quality*:* Health facilities, goods and services must be scientifically and medically appropriate and of good quality.

Obligations to respect, protect, fulfil

The right to health, like all human rights, imposes three levels of obligations on States parties:

Obligation to respect*:* to refrain from interfering directly or indirectly with the enjoyment of the right to health. This includes the obligation to refrain from denying equal access for all persons to preventive, curative or palliative care.

Obligation to protect*:* to take measures that prevent third parties from interfering with guarantees of Article 12. This includes the obligation to ensure equal access to health care provided by third parties, and, for example, to ensure that privatisation of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services.

Obligation to fulfil*:* This in turn contains obligations to facilitate, provide and promote. It requires states to adopt appropriate legislative, administrative, budgetary, judiciary and promotional measures towards the full realisation of the right to health.

International obligations

To comply with international obligations in relation to Article 12, States parties have also to respect the enjoyment of the right to health in other countries, and to prevent third parties from violating that right in other countries. States should facilitate access to essential facilities, goods and services in other countries, and provide the necessary aid when required.[10] This includes their obligations as members of international bodies, such as the International Monetary Fund and the World Bank. States should refrain at all times from imposing embargoes or similar measures restricting the supply of another State with adequate medicines and medical equipment.

Progressive realisation

It is important to note that the right to health cannot be secured immediately – because States may not have the means to do so. This is called "progressive realisation" and acknowledges the limits of available resources. However, the Covenant also imposes on States parties various obligations which have to take effect immediately.

Immediate obligations

States parties have an immediate obligation to guarantee that the right will be exercised without discrimination of any kind (art. 2.2) and to take steps (art. 2.1) towards the full realisation of Article 12. Such steps must be deliberate, concrete and targeted towards the full realisation of the right to health.[11] There is a strong presumption that retrogressive measures taken in relation to the right to health are not permissible.[12]

Core obligations under Article 12

In General Comment no.3 the Committee confirms that States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary care as described in the Alma-Ata Declaration. According to the Committee in General Comment no.14, these core obligations include at least the right to:

- access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups;
- minimum essential food;
- basic housing, water and sanitation;
- essential drugs as defined by the WHO Action Programme on Essential Drugs;[13]
- equitable distribution of health services, goods and services;
- a national public health strategy and plan of action, addressing the health concerns of the whole population with right to health indicators and particular attention to all vulnerable or marginalised groups.

Violations of the right to health

In determining which actions or omissions amount to a violation of the right to health, it is important to distinguish between the *inability* and the *unwillingness* of a State party to comply with its obligations under article 12. However, a State party cannot, under any circumstances whatsoever, justify

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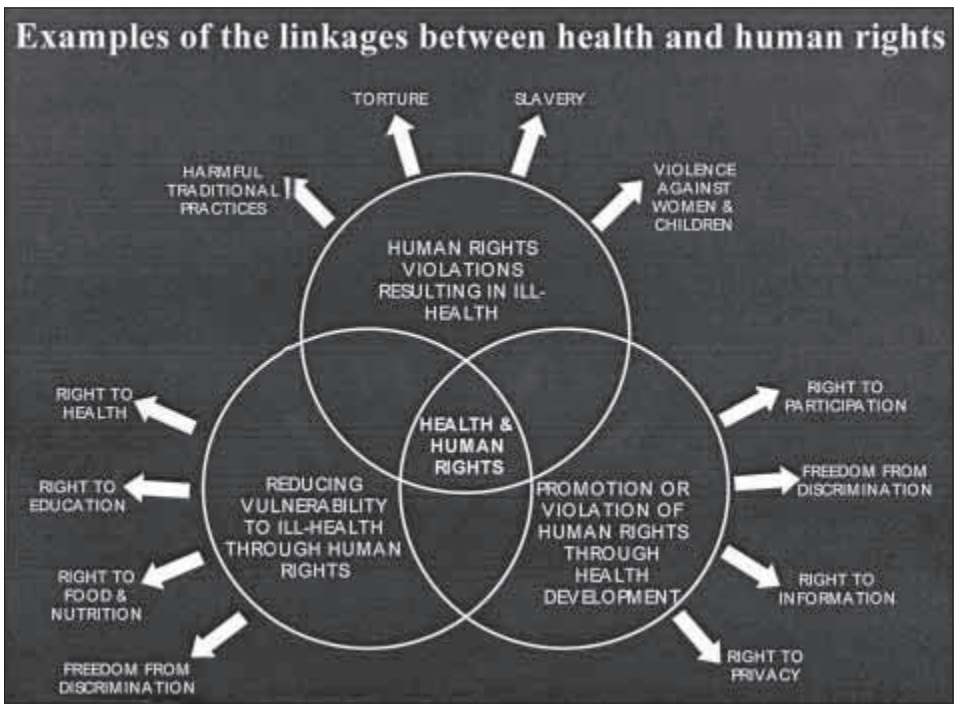
its non-compliance with the core obligations mentioned above, which are non-derogable (i.e. they cannot be suspended or taken away, even in extreme emergency).[14]

Violations can also occur through the failure of States to take all necessary steps to ensure the progressive realisation of the right to health. Examples include: the failure to adopt or implement a national health policy designed to progressively ensure the right to health for everyone; insufficient expenditure or misallocation of public resources; failure to monitor the realisation of the right to health at a national level; and failure to take measures to reduce the inequitable distribution of health facilities, goods and services.



Practical implications of health as a human right

There are several practical implications for the general process of development cooperation, for WHO and for national policies and programmes.

1. Use the Human Rights Approach in policies and programmes

This implies a number of principles in policy and programme development, and international cooperation. Using the Human Rights Approach as a framework for development implies that the human rights implications of any policy or programme are being considered as part of the planning process, and prior to implementation. More specifically, this implies that the policy or programme should focus on maginalised and vulnerable groups (at least the impact on these groups should be considered) and on equity (e.g. by ensuring that health services are available to all). The programme should also include a gender perspective (e.g. by presenting disaggregated statistics) and free and meaningful participation by beneficiaries, and should promote the right to education and to information. The programme should be transparent, using clear indicators and benchmarks. And finally, there should be a system of safeguards and redress (patients and consumers should have the possibility of lodging complaints and appeals).

2. A minimum list of essential medicines?

A concrete implication of Art.12.2(d) on the provision of essential medicines is the need for a list of priority diseases to describe the minimum essential level of primary care; and a cost-effective treatment for each. This can then be translated into a core list of essential medicines. The logical question is then: can the WHO Model List of Essential Medicines serve for this purpose? The answer is that it could in theory; but that the minimum primary health care needs can better be defined on the basis of national lists, using the WHO List and selection procedures as a model.

3. Reporting on progress

The International Covenant includes a provision for States parties to regularly report on progress, for review by the Committee. In the case of access to health care and to essential medicines such reports are not made regularly. The reasons for this could be the lack of time, the limited international interest for this aspect of the Covenant, and/or the fact that no simple indicators or reporting format exist. However, this reporting obligation could be revived by asking States parties to report regularly (e.g. every five years) on certain key aspects of the Covenant such as (1) access to essential medicines, (2) aspects of equity, and (3) documented improvement on access due to Government efforts. Apart from the official government reports, NGOs could also produce their "shadow" reports on the same issues.

To facilitate and standardise such reporting on access, WHO is assisting the Committee and the States parties by developing and promoting the most cost-effective and meaningful indicators for measuring access to essential medicines. These indicators will also help the new Special UN Rapporteur on Health and national NGOs (see below).

4. Empowering national NGOs and individuals

By the end of 2002, 142 States parties had signed and ratified the International Covenant; 109 countries have the right to health incorporated in the constitution, and 83 countries have ratified one or more regional treaties which include aspects of the fundamental right to health. All the world's countries are bound by one or more of these instruments. These commitments can be used as a tool for public pressure on national governments by nationals or national NGOs. As a first step, a schedule of which country has signed and ratified the various treaties is available from the Office of the UN High Commissioner for Human Rights[15] and may be helpful. In addition, WHO is working on the identification and publication of a list of successful national court cases in which individuals or NGOs have successfully secured or improved access to essential medicines on the basis of human rights instruments. Additionally, the simple standardised monitoring tools for access and prices of essential medicines can be made suitable and available for use by NGOs as well.

Conclusion

Health is a human right. The right to health includes the right to emergency care and the right to health facilities, goods and services. The right to health facilities, goods and services specifically includes the provision of essential medicines as defined by WHO. States parties are under immediate obligation to guarantee that the right to health will be exercised without discrimination, and to take deliberate and concrete steps towards its full realisation, with emphasis on vulnerable and marginalised groups.

In practice, the Human Rights Approach should be incorporated in all national medicine policies and programmes, the selection of medicines for essential public health functions should be further refined, States parties' international reporting obligations on access to essential medicines should be strengthened, and national NGOs should be empowered to put pressure on governments to fulfil their commitments and obligations under the international and national human rights instruments they have signed and ratified. ❑

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4. European Social Charter, Article 11 (revised) 1965.
5. African Charter on Human and People's Rights, Article 16 (1981).
6. Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, Article 10 (1988).
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10. Covenant, article 2.1.
11. General Comment 13, para 43.
12. General Comment 3, para 9; General Comment 13, para 45.
13. Committee on Economic, Social and Cultural Rights. The right to the highest attainable standard of health. 11/08/2000. E/.12/2000/4, CESCR General Comment 14, para 43(d).
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15. Status of ratifications of the principal international human rights treaties. Office of the UN High Commissioner for Human Rights (updated regularly).

Box 1

Essential drugs as a human right: summary

Article 25.1 of the Universal Declaration of Human Rights states *"Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services."*

In article 12.1 of the International Covenant on Economic, Social and Cultural Rights, States parties recognise *"the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"*. Article 12.2 enumerates a number of steps to be taken by States parties to achieve the full realisation of this right, which include the *right to prevention, treatment and control of disease, and the right to health facilities, goods and services.*

Article 12.2 of the Covenant is further interpreted and defined in General Comment no.14 by the Committee on Economic, Social and Cultural Rights. The right to prevention, treatment and control of diseases in article 12.2(c) includes the creation of a system of urgent medical care and the provision of disaster relief and humanitarian assistance in emergency situations. The right to health facilities, goods and services in article 12.2(d) includes appropriate treatment of prevalent diseases, preferably at community level; *and the provision of essential drugs.*

While the Covenant provides for progressive realisation and acknowledges the limits of available resources, States parties have an immediate obligation to guarantee that the right to health will be exercised without discrimination of any kind (art. 2.2) and to take deliberate and concrete steps (art 2.1) towards the full realisation of article 12. In General Comment no.3 the Committee confirms that States parties have core obligations, which are non-derogable, to ensure the satisfaction of minimum essential levels of each of the rights enunciated in the Covenant, including essential primary care as described in the Alma-Ata Declaration. These core obligations are further specified in Comment no.14, and specifically include the provision of essential drugs as defined under the WHO Action Programme on Essential Drugs, and a national public health strategy and plan of action with particular attention to vulnerable or marginalised groups.