The Right to Health

Joanne Csete†

Among the "14 Principles" for protection of migrants, refugees and displaced persons in the COVID-19 pandemic is that all persons have a right to health, which, in essence, means an equal right to basic health services. In more than a year of COVID-19 challenges, it has become clear that migrants, refugees and displaced persons are easily left behind in access to basic health services. Stigma and entrenched discrimination, regulatory exclusions from health services based on immigration status, and lack of access to user-friendly information about COVID-19 services have impeded migrants' ability to enjoy health rights in the current emergency. States must make special efforts to overcome these barriers.

I. The Core of the Right to Health

The right to health is the right to a progressively realized package of health services that are available, accessible, affordable and of good quality and that are of the highest standard that can be attained with available resources. The articulation of this right in the International Covenant on Economic, Social and Cultural Rights (ICESCR) includes the right to "prevention, treatment and control of epidemic, endemic, occupational and other diseases" (Art. 12.2(c)). The same treaty enshrines the state's responsibility to ensure access to "medical service and medical attention in the event of sickness" (Art. 12.2(d)), a provision many countries have established in national law.

The committee overseeing compliance with the ICESCR in a 2000 General Comment (no. 14) defined minimum "core" state duties on health rights, including ensuring non-discrimination in services; access to essential drugs; immunization against major infectious diseases; ensuring access to information about health concerns; and efforts at progressive realization of adequate water, food, sanitation and housing (paragraphs 43, 44). As with all progressively realized rights, defining "core" commitments helps to ensure that, even with resource constraints, certain services will be available, sometimes with international assistance. Ensuring universal core services is challenging in the best of times; the COVID-19 crisis has shone a light on inequities in access to services affecting many populations, including migrants and refugees.

Health-related rights are also included in treaties focusing on the rights of women, children, persons with disabilities and migrant workers. Virtually

---

† Joanne Csete, Ph.D, is an Associate Professor in the Heilbrunn Department of Population and Family Health of the Mailman School of Public Health, Columbia University. She was the founding director of the Health and Human Rights Division at Human Rights Watch and the executive director of the HIV Legal Network in Toronto. Her research has focused on health services for criminalized persons and rights-based reform of policy on illicit drugs.

all UN member states have ratified at least one treaty with provisions on health-related rights.

II. The Right to Health of All Migrants

The right to health of migrants is recognized in a number of international treaties and guidelines. ICESCR General Comment no. 14 on the right to health notes that states must refrain from "denying or limiting equal access for all persons, including. . .asylum-seekers and illegal immigrants, to preventive, curative and palliative health services. . ." (paragraph 34). The same Committee, in a 2020 statement about COVID-19 cites refugees, persons affected by conflict and undocumented migrant workers as particularly vulnerable groups for which states should make special efforts to ensure access to all prevention and treatment services.

The World Health Organization (WHO) draft global action plan for 2019-2023 entitled "Promoting the health of refugees and migrants" is based on the premise that "nationality should never be a basis for determining access to health care." The plan asserts the responsibility of governments to ensure that no migrants are left behind in health services, including during emergencies. It urges the integration of refugee and migrant health into global, regional and country health programs and policies. Attention to legal and social protection is promoted as a necessary complement to health services. The plan also notes the central importance of providing migrants and refugees "appropriate, factual, timely, culturally-sensitive, user-friendly information" on services available to them (paragraph 35a).

Realizing the right to health is partly about the "what"—the components of a core package of services—but also about the "how" of service delivery. As the Committee on Economic, Social and Cultural Rights has noted, meaningful participation of the population using the services is central to the design, implementation and evaluation of rights-based health services. Delivery of health services to refugees and migrants has too often been top-down with little effort at any level of consultation. In stable refugee settlements, health committees comprised of refugees themselves can be organized. For more mobile populations, "meaningful participation" may be difficult, but rapid participatory assessments and consultations may still be possible. Accountability is another feature of rights-based health services. Migrants and refugees should have the means of notifying authorities of cases of exclusion from health care or other complaints, and there should be functioning means of follow-up and redress.

III. Barriers to Migrants Realizing the Right to Health

The ability of migrants and refugees to claim their right to health services may hinge on their ability to cross borders. The 2005 International Health Regulations (IHR) of WHO are meant, among other things, to minimize non-essential closing of borders during health emergencies when there are "reasonably available alternatives that would achieve the appropriate level of health protection". (Art. 17) Where it is decided that a border must be closed, member states are in theory, required to "provide to WHO the public health

rationale and relevant scientific information" behind the decision. (Art. 43.3) In practice, these justifications are often not provided. During COVID-19, travel restrictions based on nationality have been widely, almost cavalierly, imposed, contributing to discrimination, especially against Asians. That nearly all countries imposed nationality-based travel restrictions of some kind in 2020 is virtually unprecedented in recent decades.

Even if they are able to reach an amenable host country, migrants and refugees often face enormous impediments to realizing their right to health services. Xenophobic or stigmatizing attitudes in the host population may make it politically easy to exclude migrants from national health schemes. Migrants may fear deportation or other consequences of seeking health care even if they are in desperate need. They may face high user fees and administrative barriers. They may not have been able to travel with their medical records. Without special efforts on the part of a host state, migrants are often without access to linguistically and culturally appropriate information on health problems and services.

Migrants are often in need of special and intensive care; they may arrive at a host country's borders undernourished or having contracted foodborne or waterborne diseases. The post-traumatic psychosocial support they may need is often inaccessible. Treatment for chronic diseases may have been interrupted in the course of migration, which may lead to the development of resistant strains of infectious diseases. Unaccompanied children require special care. Young children, even with parents, may suffer the effects of disruption of regular feeding practices and care. Pregnancy and lactation also raise the need for special health and nutritional care.

A few countries have endeavored to meet these special needs. Portugal announced in April 2020 that it would temporarily regard all persons seeking asylum and visas as citizens for the purpose of gaining access to health services during the COVID-19 emergency. Ireland also extended resident permits during COVID-19 for persons awaiting immigration decisions. In both cases, however, the lack of preventive measures in lodging intended for some migrant groups has been criticized in the media. On-paper policy changes are clearly insufficient.

IV. COVID-19 Has Dramatically Affected Migrants' Ability to Enjoy their Right to Health

International consensus on the expansive health rights of migrants and refugees, then, is not easily translated into a realization of these rights, especially at a moment when immigration policy has been highly politicized and "populist" nationalism reigns. Even before COVID-19, migrant "invasions" were portrayed as a national security threat to invoke emergency measures to undermine asylum rights and in some cases return asylum-seekers to situations of danger, as at the southern border of the US. It is especially heinous for a respected public health authority such as the US Centers for Disease Control and Prevention to use COVID-19 as an excuse to deny people the right to initiate an asylum claim when there are less restrictive case management practices that could be invoked without denying

asylum rights.

Vaccine access is also a particular challenge. UN officials have called for COVID-19 vaccination for refugees as a high priority, recognizing however that 85% of refugees are hosted by low- and middle-income countries where vaccine rollouts have been slow or non-existent. If vaccine supplies materialize, immunization of refugees in relatively stable living situations may be logistically manageable, but for migrants and refugees on the move, vaccine programs are very difficult to access, especially where vaccines require two doses. In many countries, low-income workers in jobs deemed essential include many undocumented immigrants who may be ineligible for vaccines even if vaccine programs target "essential" workers.

There is an international consensus that the detention of immigrants who await asylum hearings and have not committed crimes should be a measure of last resort. Article 31 of the UN Refugee Convention protects refugees and asylum seekers from restrictions imposed based on illegal entry, including detention. But immigration detention has flourished, and detention facilities in many parts of the world have proven to be very dangerous for the health of detainees. With respect to COVID-19, facilities may be overcrowded with poor access to protective equipment and sanitation and no possibility for physical distancing. In the US, many immigration detention facilities are operated by for-profit companies that provide poor-quality health services and, in the worst cases, have engaged in practices such as forced labor. Exacerbating the health problems of migrants through cruel and degrading conditions of detention is a gross violation of international law and standards.

The WHO ideal of integration into regular primary care systems of health services that meet the special needs of migrants, refugees and displaced persons is far from reality. Most states have made commitments to well-defined universal health rights and to legal protections for migrants and refugees. But in the face of a health emergency, the targeted efforts to ensure access to core prevention and care services for these vulnerable populations—let alone in a manner that ensures meaningful participation—have been largely absent. COVID-19 has shown the political ease with which the health rights of migrants and refugees can be denied.