Part II *Moving towards action:* Focussing on obligations arising from the right to health

Chapter 4 Focus on Core Obligations

Keys to Chapter 4

key information:

- Core obligations define a minimum standard of essential health-related services and conditions that states are responsible for ensuring to all sectors of the population;
- All states, irrespective of their economic resources, have an immediate duty to comply with core obligations.

key questions:

- To what extent is the government meeting its core obligations arising from the right to health?
- To what extent does the government accord priority to implementing its core obligations?
- In the case of developing countries, to what extent does health-related international development aid prioritise the implementation of core obligations?

This is the very least that governments must do immediately

CESCR General Comment 14 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 *minimum* or *bottom line* for responsibilities of states. They require governments to take the basic measures that are needed to enable people to achieve minimum standards of health, including the provision of essential primary health care. They also take into account the fact that health problems associated with poverty and inequity pose the main obstacles to attaining minimal standards of health and well-being for most of the world's population. (See chapter 2.)

Minimum core obligations cannot be subjected to progressive realization. All states, regardless of their level of development, are required to take immediate action to implement them. This can include legislation; the regulation, design and enforcement of policies; and mobilization of the necessary resources.

CESCR General Comment 14 identifies the core obligations that arise from the right to health as including at least the following obligations.[1]

In the case of *health care*, governments must provide:

- immunization against the major infectious diseases;
- measures to prevent, treat and control epidemic and endemic diseases;
- essential medicines, as defined by WHO's Action Programme on Essential Medicines;
- reproductive, maternal (pre-natal and post-natal) and child health care;
- essential primary health care;
- right of access to health facilities without discrimination, especially for the poor, and otherwise vulnerable and disadvantaged groups;
- equitable distribution of all health facilities, goods and services; and

In the case of *underlying determinants of health*, governments must provide:

- access to the minimum amount of food that is sufficient, nutritionally adequate and safe, to

ensure their freedom from starvation and malnutrition; and

- access to basic shelter, housing and sanitation, together with an adequate supply of safe and potable water.

In the case of *health education and information*, governments must provide:

- education and access to information about the main health problems in the community, including methods of prevention and control; and
- appropriate training for medical and other health professionals, including education in health and human rights.

When formulating a *national health policy*, governments must:

- adopt and implement a national public health strategy and plan of action, which is based on epidemiological evidence, and which takes into account the health concerns of the whole population. The strategy and plan of action must be developed through a participatory and transparent process and subject to regular review. Specific objectives and a cost-effective strategy must be adopted for using available resources, as well as methods such as right to health indicators and benchmarks, by which progress can be closely monitored. The process by which the strategy and plan of action are formulated, as well as their content, shall pay particular attention to all the vulnerable or marginalized groups in the population.

Core obligations: a framework for monitoring the right to health in developing countries

Monitoring core obligations is particularly important in developing countries, where basic resources and infrastructures (upon which realization of the right to health depends) are often inadequate and sometimes do not even exist. Moreover, many governments in developing countries make inappropriate decisions on investment in health despite resource constraints.

Minimum core obligations require governments to assign priority to public health measures, comprehensive primary health care, and preventive services, and expect them to invest their available resources in an equitable manner. They also require governments to give priority to correcting existing inequities and imbalances in the distribution of health sector resources in order to improve services for the poor and otherwise vulnerable and disadvantaged groups in the community. Many developing countries need to take incremental steps (over a period of time) towards implementing the comprehensive health policies that core obligations stipulate, and for this purpose they are required to design a systematic plan, which must include the adoption of goals and a timeframe.

In keeping with this, a human rights approach entails that health-related development aid should be directly linked to the fulfilment of core obligations, as a matter of priority. CESCR General Comment 14 stipulates that it is incumbent on States parties and other actors in a position to assist, to provide international assistance and cooperation, particularly economic and technical, which enable developing countries to fulfil their core obligations.[2] (See Chapter 6.)

Minimum core obligations provide concrete standards for adoption of the public health measures needed to improve the health status of the population, including primary health care and health education. They also provide a formula for a legal framework, a public policy agenda, and effective government action that can promote the enhancement of health as an integral part of development.

Core obligations acknowledge that the poor, vulnerable, or otherwise disadvantaged groups in the community carry the greatest burden of disease in the world. (See chapter 5.) In developing countries, where resources are limited, many governments make policy choices and allocate public funds in ways that are both unwise and unjust. Many of them misallocate their scarce resources, in particular by funding tertiary health care facilities and higher specialist training when investment in primary and preventive health measures would benefit a far greater proportion of the population. Another common example is when enormous public resources, often many times higher than that expended on basic health care services, are spent by poor countries on their armed forces (and are usually presented as being needed for purposes of defence).

> *'… good health and economic prosperity tend to support each other. Healthy people can more easily earn an income, and people with a higher income can more easily seek medical care, have better nutrition, and have the freedom to live healthier lives.'*
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> *Amartya Sen*[3]

Even when economic conditions are bad, governments can still achieve major health improvements by using their available resources more wisely. They can do so by investing in programmes that benefit the greatest number of people living within their jurisdiction, and in particular, the needy. The issue here is one of policy and allocation of resources rather than level of spending. The reason why some rich countries, such as the USA, do not implement some of their core obligations is because they allocate spending on health inequitably, and without due regard to areas such as public health and primary health care.

Many of the core obligations included in CESCR General Comment 14 were derived from the minimum standards of a 'basic needs strategy' that was agreed upon by experts in the international health and development community. This strategy was designed to ensure that populations could share in the economic development of their countries. The *Declaration of Alma Ata* on Health for All by the Year 2000 emphasized the importance of providing comprehensive primary care as part of that strategy. In this way, core obligations can promote the basic features necessary for improved health and sustainable development. Moreover, they carry the added authority of being legally binding, as they are based on internationally accepted standards and principles of human rights, and are derived from people's human rights entitlements.

This reflects the fundamental difference between a 'classic' needs-based approach to health and development, on the one hand, and a human rights approach to health, on the other. Unlike the development perspective, core obligations are not about benevolence or charity, and cannot be argued away for reasons of financial constraint, or more pressing state priorities. A human rights approach is based on the inherent dignity of all individuals, on people's entitlements, and on corresponding state obligations. States that have freely agreed to take on obligations (by ratifying human rights instruments) can, therefore, be held accountable for not doing so.

Core obligations provide an important framework for NGOs in all countries to monitor the right to health as they identify a *bottom line* for the minimum essential services and conditions that are necessary to be healthy and to continue to be so. The fact that they do so from a human rights perspective means that they focus as much on the process as the outcome, and they deal with inequities in health status between social groups and between men and women. They set out what should be a government's highest priorities in making policy, programme, and budgetary choices on health issues.

From the NGO perspective, they provide legally enforceable and internationally recognised standards against which existing health-related laws, policies, budgets, programmes, and administrative practices can be evaluated. Furthermore, CESCR General Comment 14 makes it clear that a state's failure to implement core obligations constitutes a violation of the right to health. There are simply no circumstances that can justify a government's failing to take immediate action to implement its core obligations.

Chapter 7 contains a checklist of questions to guide health-concerned NGOs in evaluating the extent to which their government is complying with its core obligations. This checklist should be read in conjunction with chapter 9, which gives detailed examples of some of the most common ways in which governments violate core obligations.

Notes

1 Committee on Economic, Social and Cultural Rights. General Comment 14, The right to the highest attainable standard of health. E/C.12/2000/4: paras 43-44.

2 Ibid:para 45.

3 Amartya Sen. Keynote address to World Health Assembly, May 1999.