justfair

The right to health in the UK

Rossella De Falco
Head of Right to Health Campaign
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Just Fair

Established in 2010, Just Fair is a charity which works across the UK to achieve positive social change using human rights.

Just Fair's vision is for a fairer and more just society for all, and its mission is to use economic, social and cultural rights (ESCR) as a tool for social change, leading and inspiring work to respect, protect and fulfil ESCR in the UK.

In 2024, Just Fair launched a campaign on the right to health.

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Just Fair: Jess McQuail, Director; Kate Ewing, Researcher and Helen Flynn, Head of Policy, Research and Campaigns.

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Executive summary

The right to health

Achieving the right to health is about creating a world where everyone can access quality healthcare throughout their life, regardless of where they live, how much they earn, their gender, age, ethnicity, or any other personal characteristic.

The right to health is also about people enjoying universal access to a range of factors that improve physical and mental health, like adequate housing, sufficient and nutritious food, green spaces, fair working conditions, healthy relationships, and a healthy environment.

The problem

The right to health is being eroded across the UK.

In the UK, health inequalities continue to widen, and health injustice is pervasive, for four main reasons:

1. The UK Government has not been sufficiently resourcing the provision of quality healthcare that meets the needs of all.[1]

2. The availability, accessibility and quality of publicly provided healthcare are deteriorating.[2]

3. Privatisation and commercialisation are having negative effects on the provision of quality health and social care that meets the needs of all.

4. Increasing racism, poverty, exposure to poor housing conditions, and the effects of migration status and climate change are negatively impacting certain groups and communities' access to both healthcare and healthy living environments.

While these factors can potentially impact everyone, they are affecting some marginalised groups more than others, further compounding differences in health outcomes.

This situation is unacceptable.

The solution

To start to address this situation, the right to health needs to be at the centre of health legislation, regulation, policy and governance.

Currently, we have indirect and limited accountability mechanisms for the protection of human rights in health and social care in UK domestic law. Civil and political rights do have important domestic protection through the Human Rights Act (HRA); however, these do not sufficiently cover the majority of economic, social and cultural rights, including the right to health.

The UK ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR) in 1976, which includes the right to health in article 12, and is a signatory to other treaties that contain health related provisions. However, it has not initiated a full process of incorporation of ICESCR.[3]

Lastly, while the UK Government has committed to enactment of Section 1 of the Equality Act 2010 - the socio-economic duty - in the current Parliament, this process has not yet been completed, and much will depend on how it ultimately operates in practice.

To address these issues, international law provides some solutions. As we can learn from elsewhere, incorporating the right to health can promote the right to health for all.

For our rights to be protected we need to build the practical measures and policies set out in Just Fair's five principles of everyday rights: rights knowledge, rights frameworks, rights resourcing, rights accountability and rights enjoyment.[4]

To address health inequalities and injustice in the UK, we need:

- economic, social and cultural rights, including the right to health, to be fully incorporated into UK domestic law and effectively implemented.

In addition, we need:

- full commencement and effective implementation of Section 1 of the Equality Act 2010 - the socio-economic duty. This is an important step on the road to incorporation and building a rights culture which is critical to rights incorporation more generally.

It is time for everyone in the UK to enjoy quality healthcare, access to adequate living and working conditions, and a healthy environment, not as a privilege but as a right.

The right to health is also about people enjoying universal access to a range of factors that improve physical and mental health, like adequate housing, sufficient and nutritious food, green spaces, fair working conditions, healthy relationships, and a healthy environment.

1. Introduction

Achieving the right to health is about creating a world where everyone can access quality healthcare throughout their life, regardless of where they live, how much they earn, their gender, age, ethnicity, or any other personal characteristic.

It is also about people enjoying universal access to a range of factors that improve physical and mental health, like adequate housing, sufficient and nutritious food, green spaces, fair working conditions, healthy relationships, and a healthy environment.

However, this is not the reality for many across the UK.

This might be surprising, with the National Health Service (NHS), established in 1948, being one of the first centrally funded healthcare systems in the world to provide everyone with comprehensive, free and quality healthcare.[5]

However, the NHS is now struggling due to decades of underfunding, coupled with an aging population and increases in costs associated with advances in technology.[6]

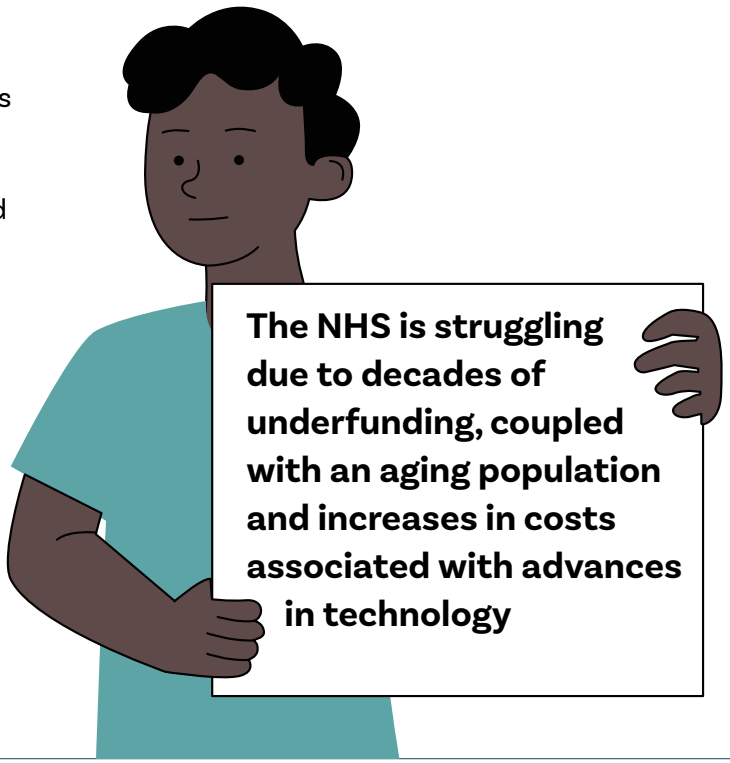
At the same time, the UK is lagging behind on preventing and treating life-threatening illnesses such as cardiovascular diseases and cancer, when compared to similar countries.[7] Health inequalities also continue to widen, exacerbated by climate change and the aftermath of the Covid-19 pandemic.[8]

This report analyses these issues using a human rights lens and proposes solutions.

1.1. Methods and structure

This report is based on analysis of qualitative and quantitative indicators over the period between 2021 and 2024.

This includes findings from one focus group, and open-ended interviews with its participants, with lived experience of barriers to accessing healthcare.



2. Health as a human right

Our physical and mental health is dependent upon the realisation of all human rights. When discussing health as a human right, the starting point is the right to the highest attainable standard of physical and mental health (right to health).

First recognised in 1948, as part of the Constitution of the World Health Organisation (WHO),[9] the right to health is well-protected under international law.

These protections are explained below.

2.1. The right to health under International law

In 1966, the right to health was also enshrined in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR).[10] ICESCR has been ratified or acceded to by 171 States at the time of writing, including the UK.[11]

As specified by the Committee on Economic, Social and Cultural Rights (CESCR), the right to health under ICESCR includes both freedoms, such as the right to control one's body, to be free from torture and from non-consensual medical treatment; as well as entitlements, like the right to a system that protects and promotes health.[12]

In particular, the right to health means that everyone is entitled to the full range of healthcare services that are necessary to live a healthy life. In fact, CESCR specifies that the right to health includes 'the provision of equal and timely access to basic preventive, curative, rehabilitative health services, and health education.'[13]

CESCR further specifies that healthcare services should be available, accessible, acceptable and of the highest possible quality,[14] a framework referred to as the AAAQ Framework, explained in Box 1 below. The right to health also encompasses the fundamental principles of equity, equality and non-discrimination; participation; and transparency.[15]

BOX 1: THE AAAQ FRAMEWORK

A rights-based approach to healthcare includes four dimensions:

- **Availability:** healthcare facilities, goods and services must be available in adequate quantity, equipped with sufficient and trained medical staff and essential medicines.
- **Accessibility,** which has four elements:
  - non-discrimination: discrimination in accessing healthcare is not permitted on any prohibited grounds.
  - economic accessibility: healthcare services have to be affordable.
  - physical accessibility: healthcare services need to be physically accessible.
  - information accessibility.
- **Acceptability**: healthcare must comply with medical ethics and be 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 health status.
- **Quality:** healthcare must be scientifically and ethically approved. This requires trained staff, unexpired medicines, quality hospital equipment, potable water and sanitation.

Table 1: Health-related provisions in international human rights law.

	Year	Monitoring body	Article
Charter of the United Nations	1945		
Universal Declaration of Human Rights	1948		
International Covenant on Economic, Social and Cultural Rights	1966	CESCR	12
International Covenant on Civil and Political Rights	1966	HRC	6
International Convention on the Elimination of all forms of Racial Discrimination	1969	CERD	5
Convention on all forms of Discrimination against Women	1979	CEDAW	12
Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment	1987	CAT	3, 14
Convention on the Rights of the Child	1990	CRC	24
International Convention on Protection of the Rights of All Migrant Workers and Members of their Families	1990	CRMW	28
Convention on the Rights of People with Disabilities	2006	CRPD	25, 26

As further specified by CESCR, the right to health also relies upon the universal enjoyment of the underlying determinants of health.[16] These are the non-medical factors that influence our physical and mental health. Examples of these determinants are access to potable water, sufficient and nutritious food, adequate housing, healthy relationships, and fair working conditions.[17]

The right to health is even more important at times of health emergencies, as the Covid-19 pandemic demonstrated.[18] Recently developed expert principles have further clarified how States can protect the right to health and other interconnected human rights during health emergencies.[19]

Beyond ICESCR, health-related provisions are contained in several other international human rights treaties, as summarised in Table 1. Each of these international human rights treaties is monitored by a committee of experts, which monitors the implementation and works to advance the interpretation of the treaties.

2.2. The right to health in UK domestic law

The UK ratified ICESCR in 1976. However, it has not yet incorporated the Covenant into UK domestic law. This means that the right to health is not enforceable in domestic courts. A similar situation applies to the other human rights treaties that contain health-related provisions.

Despite this, human rights law is having some influence on health law and policy across the UK, as will be highlighted below.

2.2.1. Regional level

At the regional level, the UK is a member of the Council of Europe. As such, it has ratified the European Convention on Human Rights (ECHR), which entered into force in 1953.

However, the UK has signed but not yet ratified the revised version of the European Social Charter (ESC), which protects health in article 11. Furthermore, the UK has not signed the additional protocol providing for a collective complaints procedure to the ESC.[20]

Finally, since the UK's exit from the European Union, people in the UK have largely lost protection of the rights contained in the EU Charter of Fundamental Rights.[21]

2.2.2. UK level

At UK level, the Human Rights Act 1998 (HRA) sets out fundamental rights and freedoms that everyone in the UK is entitled to.[22] The HRA, which came into force in October 2000, incorporates many of the provisions of the ECHR into domestic UK law.

The HRA mainly provides for civil and political rights. An important exception is the right to education (article 2, Protocol 1).[23] Nonetheless, the HRA is being increasingly extended to economic, social and cultural rights protection.[24]

In fact, while there is no health-specific provision in the convention, the European Court of Human Rights (ECtHR) has dealt with a wide range of issues related to health.[25] For instance, the ECtHR has already decided that the lack or the denial of access to healthcare may constitute a breach of article 2 (right to life) and article 3 (prohibition of torture, inhuman or degrading treatment) of the ECHR in several cases.[26]

Consequently, the HRA also contains several provisions that directly relate to health,[27] including articles 2 (the right to life), 3 (the prohibition on torture and inhuman or degrading treatment), 5 (the right to liberty and security), and 8 (the right to respect for private and family life).[28]

2.2.3. Devolution

In the UK, health is a devolved function. Thus, it is important to look at differences between the legal systems of the four nations/jurisdictions when it comes to health rights' protection.

Importantly, Scotland has, within the limits of devolution, incorporated the UN Convention on the Rights of the Child (CRC), which includes key protections for the health of children.[29]

Article 24 of the CRC says that children and young people have the right to be both physically and mentally fulfilled.[30]

In Wales, the Healthcare Inspectorate is committed to the principles of equality, human rights and diversity, and it supervises whether NHS services meet the National Minimum Standards for Independent Healthcare Services in Wales (2011).[31]

In 2021, the Welsh Government indicated its intention to incorporate the Convention on the Rights of Persons with Disabilities (CRPD), which contains important health and care provisions.[32]

In Northern Ireland, the Northern Ireland Executive and the Northern Ireland Assembly make law and policy in health and social care.[33]

Devolution has key implications for how the healthcare system is organised and how the right to health is protected.

The UK's four health systems were created very similarly in 1948.[34] However, since devolution in 1998, they have increasingly diverged.[35] For instance, in Scotland, Wales and Northern Ireland, most aspects of healthcare are largely free, whereas in England some are subject to charges in certain instances.[36] Scotland's health and care system is the only one in the UK which provides free personal social care for people over 65.[37]

3. The problem

The right to health is being eroded across the UK.

Below, the main themes are analysed: resourcing; access to healthcare; privatisation in healthcare; health inequalities and the social determinants of health.

3.1. Resourcing

The NHS has a key role in promoting fair and equitable access to healthcare in the absence of a legally enforceable right to health.[38] However, an ageing population, combined with a gradual decline in health spending since the 2008 financial crisis, are putting the NHS under pressure.[39]

In 2024, the UK Government commissioned an independent investigation of the NHS in England (the *Darzi Review*). The review found that the NHS is in 'critical condition' because of austerity and constrained funding; the impact of the Covid-19 pandemic; a lack of patient voice and staff engagement; and inefficient management structures.[40]

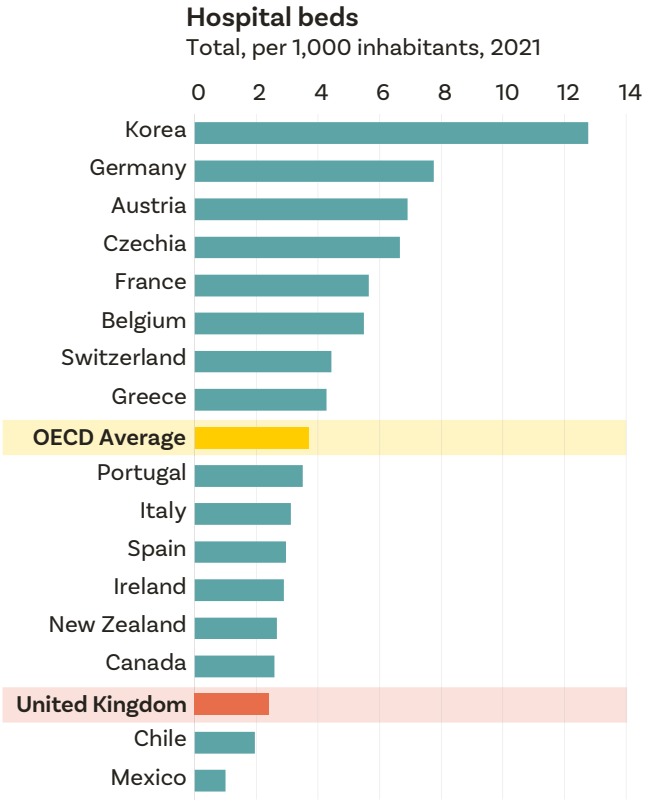
3.2. Healthcare services

As a result of the lack of funding, across the UK, there are not enough healthcare services, staff, goods and facilities to provide healthcare to everyone. This results in widespread problems in accessing healthcare services.

In fact, the UK has fewer practicing doctors (3.2 per 1,000 population) than the OECD average (3.7 per 1,000 population).[41] Similarly, the UK has only 2.4 hospital beds per 1,000 people, as against, for instance, the 7.8 per 1,000 people in Germany.[42]

There are also not enough general practitioners (GPs). In Scotland, the situation is particularly troubling. Between 2013 and 2024, the number of GP practices fell by 11 per cent.[43] At the same time, GP vacancies are increasing.[44] Concerningly this decrease in GP services corresponds with rising numbers of prospective patients placing the system under further strain. [45]

Fig. 1: Hospital beds per 1,000 Inhabitants



Source: Own elaboration based on: OECD Data, 'Hospital Beds per 1,000 inhabitants' (2021) <https://www.oecd.org/en/data/indicators/hospital-beds.html?oecdcontrol-00b22b2429-var3=2021> accessed 05 December

As a result, considerable numbers of people are struggling to access healthcare when they need it. In England, nine out of ten NHS dental practices are not accepting new adult patients as of 2022;[46] and an estimated 13 million people (28 per cent of those seeking dental care) are not able to secure NHS dentistry.[47]

Likewise, waiting times, which are an essential indicator of quality in healthcare, are excessive across the UK.[48] In England, between 2022 and 2024, not a single hospital with an Accident

and Emergency Department (A&E) was meeting performance standards.[49]

In April 2024, almost 7.57 million individuals were waiting for NHS treatment in England.[50] In Scotland, as of March 2024, there were 690,000 waits for appointments or treatment for non-urgent care.[51]

Such long waits are estimated to be the cause of 14,000 preventable deaths per year in the UK.[52]

At the same time, the lack of hospital beds discussed above, combined with a very high occupancy rate, may determine a decline in healthcare safety and efficiency.[53] Inadequate staffing puts pressure on existing healthcare workers, increasing dissatisfaction about working conditions.[54]

Problems in social care exacerbate the crisis. For instance, in England, insufficient capacity in adult social care contributes to delays in discharging people from hospitals.[55]

3.3. Privatisation in healthcare

In the UK, as in many other countries, private actors are increasingly involved in health and social care financing, provision and governance.

For example, there is increasing use of NHS funding for private provision (outsourcing)[56] as well as financialization.[57]

Tellingly, the proportion of NHS budgets spent on private providers rose from 3.9 per cent in 2008/09 to 7.3 per cent in 2018/19.[58] A recent study suggests that this is an underestimate, and that when looking at spending at local levels, the NHS budget spent on private providers is at least 18 per cent.[59]

This may have human rights impacts. During the Covid-19 pandemic, 2020-2022, on average one in four patients had to pay to access treatment. The number of, for example, paid for knee surgeries, rose from 13 per cent to 23 per cent.[60]

Recent research has found that 98 per cent of adult care homes that the Care Quality Commission in England forced to close[61] due to problems of abuse, neglect and negligence between 2011 and 2023 were operated by the private, for-profit sector.[62]

The UN Guiding Principles on Business and Human Rights detail States' duty to *respect*, *protect*, and *fulfil* human rights when third parties are involved in sectors such as health and social care, as well as a *corporate responsibility* to respect human rights.[63] Under these principles, States are obliged to strictly monitor and regulate private providers in a meaningful way.

Furthermore, while international human rights law does not prohibit private involvement in healthcare *per se*, there is now consensus that any private actors' involvement in healthcare, if needed, it must at the very least meet minimum standards. It must not: decrease the accessibility, availability, and quality of healthcare; result in discrimination of any group or higher inequalities; result in sub-optimal use of maximum available resources; decrease a healthcare system's capacity to prevent, respond and control pandemics.[64]

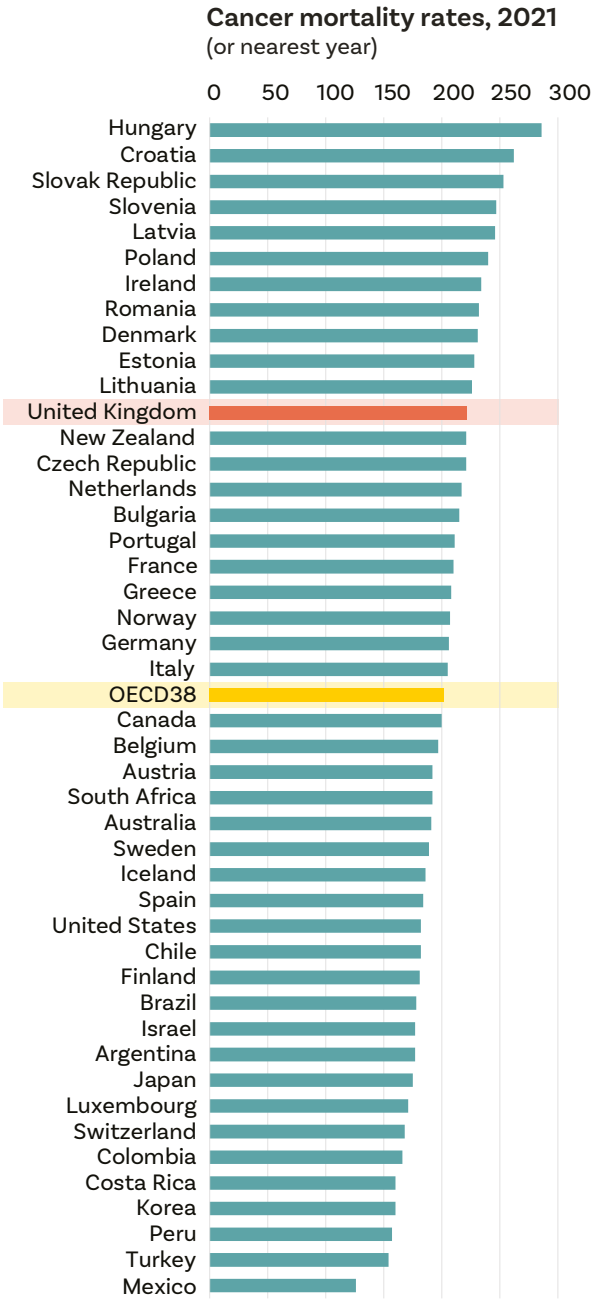
3.4. Inequalities and the social determinants of health

Former UN Special Rapporteur on the right to health, Paul Hunt, underlines that the right to health means that States need to ensure that 'disadvantaged individuals and communities enjoy, in practice, the same access as those who are more advantaged.'[65]

This is highly relevant in the UK, which, as of 2021, was amongst the countries in Europe with the highest income inequality.[66] By 2023, the richest 50 families in the UK held more wealth than the poorer half of the UK population.[67]

In this context, people's health and well-being varies based on multiple interacting factors such as income, gender, place of residence, or education level. In other words, the social determinants of health, which are the non-medical conditions in which we live, play, and work, shape our health and well-being.[68]

Fig. 2: Cancer mortality rates (2021)



Source: Own elaboration based on: OECD 'Cancer mortality rates per sex (2021 or nearest year)' (2023) *Health at a Glance 2023: OECD Indicators*, OECD Publishing: Paris, <https://doi.org/10.1787/7848b810-en> accessed 05 December 2024.

Below, we look at health inequalities in the context of issues such as racism, poverty, homelessness, or inadequate living and working conditions.

We use intersectional and gender lenses, which allow us to understand how different sources of discrimination reinforce each other, creating unique experiences of oppression.[69]

Refugees, people seeking asylum and other migrants

International human rights law protects the right to health of everyone, including people that might have left their homes for a variety of reasons.[70]

In England, Scotland, and Wales, everyone is entitled to register with a GP practice, see a primary care doctor, or receive primary care services free of charge, regardless of nationality or immigration status.[71]

In Northern Ireland, entitlement to primary care is normally dependent on ordinary residence. However, refugees and those who have claimed asylum, including people who have had their asylum claim refused, are granted certain exemptions.[72]

However, in practice, obstacles to access are common.

According to a recent study, 13 per cent of migrants who attempted to register with a GP were incorrectly refused because of their immigration status.[73] Moreover, people seeking asylum often find the healthcare system difficult to navigate, including because of absence of linguistic assistance when registering with GP services and through digital exclusion.[74]

There are also structural barriers that deter migrants from seeking secondary healthcare across the four nations.[75] England has the most restrictive environment, in which undocumented migrants and people who have had their asylum claim refused are charged for secondary healthcare.[76]

Moreover, since 2017, all hospitals are legally required to check patient eligibility for free NHS healthcare,[77] a policy that often creates confusion amongst healthcare workers and fear amongst migrants.[78] During Covid-19, migrants were deterred from seeking healthcare due to this policy.[79]

I felt so drained: lived experience of the asylum system

People seeking asylum often go through extreme physical and mental stress due to unstable housing and living conditions. This situation is particularly concerning for the health of the health of those who are pregnant, as this interview below illustrates:

'I lived in hotels for 5 months and I was pregnant with my second baby, I could not cook, I became so stressed and affected by the situation, during the lockdown, my daughter lost weight, many families struggle. With small babies the mum stresses a lot. They can struggle mentally and physically. They became homeless during Covid-19.

'Accommodation is a hard journey for people, you need to move from place to place, also for children they move schooling each time, instability, uncertainty, if you can't plan your life or feel stable, this can affect you.

*'We applied to [the] Home Office, and they sent us to hotels. It's hard to access support, imagine [being] in [a] hotel pregnant. Without support, I felt depressed, it was the hardest experience for me when I came here. [I am] still struggling now. [In] the same situation, living in hotels and hostels. I think we should be campaigning about not allowing children under 5 in hotels. Not allowed to move families with children in the hotel.'**

*Person interviewed by Just Fair (November 2024)

In England, charging rates can often act as a deterrent to seeking healthcare, with some categories of migrants being charged 150 per cent of the cost of regular NHS care,[80] decreasing healthcare accessibility for a specific group.[81]

In addition, people seeking asylum struggle to afford medicines, with a report finding that, as of 2022, 75 per cent of people in this group stating that they could not always afford the medicines they needed, a percentage that has increased from the previous report.[82]

Even more concerningly, at UK level, NHS qualifying debts must be reported to the Department of Health and Social Care (DHSC), who will inform the Home Office; and such debts may influence decisions on immigration applications.[83]

Disabled people

Article 25 of the Convention on the Rights of Persons with Disabilities (CRPD) obliges States to ensure that access for persons with physical or intellectual disabilities to gender-sensitive health services and rehabilitation.[84]

Importantly, while the CRPD is not incorporated in UK law, it was ratified in 2009 and there is a UK-wide mechanism to promote it and monitor its implementation.[85]

Despite progress, much remains to be done. In 2017, the Committee on the Rights of Persons with Disabilities expressed concerns about the 'systemic, physical, attitudinal and/or communicative barriers' that disabled people face in accessing general healthcare services in the UK.[86]

In 2024, disabled people remain more likely to suffer discrimination, poor access to some health services, and worse employment prospects, hindering their health.[87]

During Covid-19, it was particularly complex for disabled people to access healthcare services.[88] For example, people with learning disabilities[89] were six times more likely to die during the pandemic than the general population in England.[90] In Wales, disabled people's access to ongoing medical treatment was severely disrupted, leading to deterioration of pre-existing conditions or death.[91]

Furthermore, disabled people are more likely to live in poor housing conditions, which negatively affects their health.[92]

Lastly, the Committee on Civil and Political Rights (CCPR) has expressed concerns over detention of individuals with learning disabilities or autism under the Mental Health Act 1983, and that average detention was over 2 years.[93]

Minority ethnic people

In the UK it is often the case that minority ethnic people have disproportionately poorer health outcomes. It is concerning, for example, that Black women are four times more likely, and Asian women twice as likely, to die in childbirth than white women in the UK.[94]

Furthermore, minority ethnic people are often living in conditions that negatively impact their health. For example Gypsy, Roma and Traveller sites in England present health and safety risks for residents, with lack of accountability mechanisms to challenge these issues.[95]

Gypsy, Roma and Traveller communities also experience significant barriers to accessing healthcare[96] and poorer maternal health outcomes.[97] Likewise, they were amongst the groups most impacted by the Covid-19 pandemic and its aftermath.[98]

These inequalities do not happen in a vacuum: unequal health outcomes are the result of structural racism that impacts health in direct and indirect ways.[99]

Trans people

Trans people continue to experience discrimination when accessing healthcare: for example, trans people may wait up to 5 years for trans-specific treatment.[100]

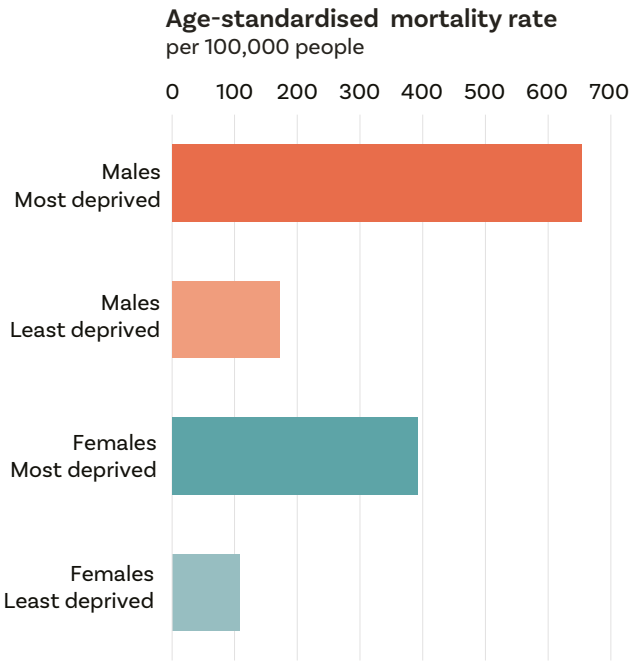
A civil society survey also found that 14 per cent of trans respondents were refused GP care on account of being trans at least once; that 70 per cent reported being impacted by transphobia in healthcare settings; and 57 per cent declared that they would avoid going to the doctor when unwell.[101]

People experiencing poverty

As of 2023, 18 per cent of people in the UK were living in conditions of absolute poverty after housing costs.[102] Concerningly, this includes 3.6 million children (25 per cent).[103]

Poverty has a profound negative impact on health and well-being. In England, life expectancy for the poorest 10 per cent of women has declined.[104] People living in poorer areas of Scotland are three times more likely to die earlier or have more years of ill health than those in richer areas.[105]

Fig. 3: Avoidable mortality rates by sex and selected deciles, England (2020)



Source: Own elaboration based on: Office for National Statistics (ONS), 'Age-standardised avoidable mortality rates by sex and selected deciles, England, 2001 to 2020' (March 2022) <https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/bulletins/socioeconomicinequalitiesinavoidablemortalityinengland/2020> accessed 05 December 2024.

In Northern Ireland, between 2020 and 2022, the suicide mortality rate in the most deprived areas was more than two and a half times the rate observed in the least deprived areas.[106]

Similarly, people experiencing homelessness have a life expectancy of 47 years (for women experiencing homelessness this is only 43). This compares to a life expectancy of 77 years for the general population (74 for men and 80 for women).[107]

Finally, the Covid-19 pandemic had the most significant negative impact upon people living in poverty.[108]

The unequal impacts of climate change

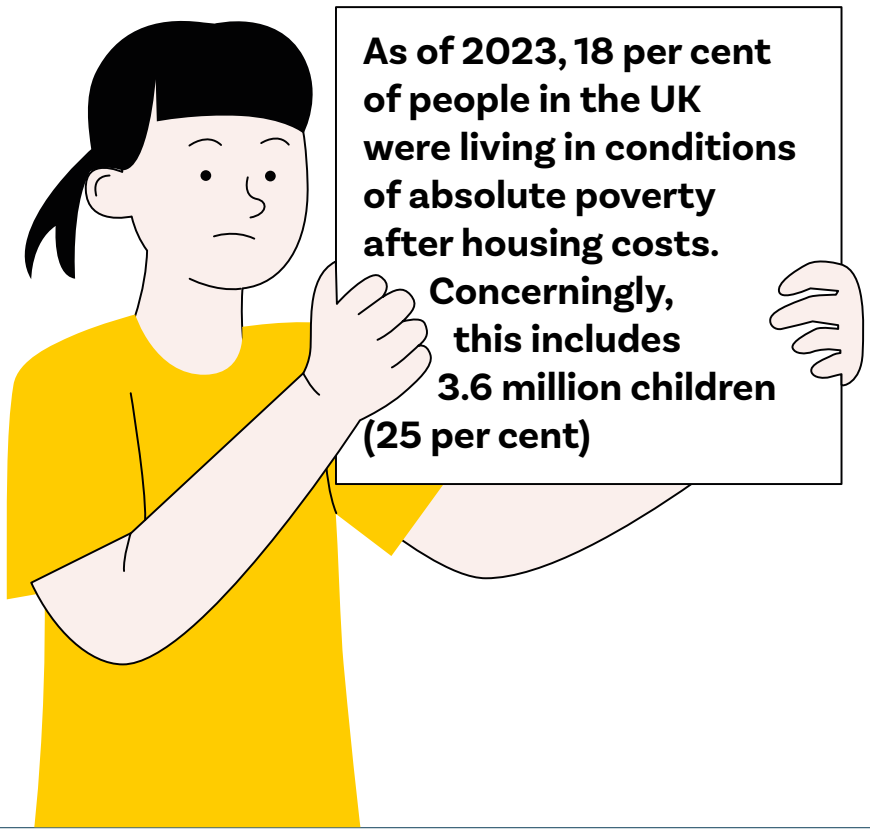
Climate change is one of the most pressing threats to health in the UK. While this impacts everyone, marginalised groups and those with pre-existing health conditions are suffering the most, leading to higher physical and mental health inequalities.

For example, as the UK endured record high temperatures of 40°c in the summer of 2022, the total excess mortality (excluding Covid-19) in England was approximately 3,000 for the most vulnerable age group (those aged 65 years and over), the highest number since the introduction of the Heatwave Plan for England in 2004.[109]

Overheating also increases health inequalities indirectly. Half of the poorest households in England live in homes that are the most likely to overheat.[110]

Overheating and flooding can cause damage to private and public facilities, including hospitals and clinics, often at the times when they are most needed.[111]

Climate change may also increase age-related mental health inequalities, with eco-anxiety being on the rise amongst the youngest.[112]



4. Solutions

To start to address this situation and achieve the right to health for everyone, the right to health needs to be at the centre of health legislation, regulation, policy and governance.

Currently, we have indirect and limited accountability mechanisms for the protection of human rights in health and social care in UK domestic law.

We explain these below.

4.1. Current mechanisms

The Human Rights Act (HRA)

Human rights protections have the potential to improve the problems highlighted in this report.

For instance, this can be seen from the way in which civil and political rights protections in the Human Rights Act (HRA) are being expanded to try to better protect elements of the right to health. Examples include cases of medical negligence, life-prolonging treatment, access to information in health settings, access to treatment, long term care for older people, and regulation of healthcare professionals.[113]

As well as this, the HRA is an important accountability tool, which can indirectly provide remedies and redress when elements of the right to health are violated.[114]

Furthermore, the HRA influences regulations and policies in healthcare.[115]

UN human rights treaty bodies

UN human rights treaty bodies are committees of experts that monitor the implementation of human rights treaties. They can issue statements and recommendations to countries regarding their human rights obligations.

Treaty body processes have already brought positive change in the UK. In 2018, the UN Committee on the Elimination of Discrimination against Women (CEDAW) stated that restrictive abortion laws in Northern Ireland amounted to a 'grave and systematic violation of rights', including Article 12 on women's sexual and reproductive rights.[116]

The CEDAW findings, coupled with mounting civil society pressure,[117] helped to persuade MPs at Westminster, in July 2019, to vote for the decriminalisation of abortion in Northern Ireland and for the creation of new laws which implemented the recommendations of the UN Committee.[118] A new legal framework for abortion came into effect in Northern Ireland on 31 March 2019.[119]

In some cases, individuals can also bring individual complaints to UN human rights committees. This also applies to the UK in limited circumstances.[120]

As the landmark case *Alyne de Silva Pimental v Brazil* brought before CEDAW in 2008, demonstrates, these direct accountability measures can advance health justice.[121]

The case involved the death of a 28-year-old woman during pregnancy, due to a series of failures. These included delays in surgery and ambulance transportation, and inaccurate diagnosis.[122] Similar problems, as shown in this report, have also been experienced in the UK.

CEDAW concluded that 'the lack of appropriate maternal health services in the State party … clearly fails to meet the specific, distinctive health needs and interests of women'[123] and thereby violates article 12 under CEDAW.[124] The case established that governments have human rights obligations to give women access to appropriate maternal healthcare services regardless of

their background, including when the service is outsourced to private providers. The Brazilian Government also reaffirmed their commitment to CEDAW and agreed to make reparations to the family involved.[125]

Human rights frameworks and narratives

Finally, the UK Government could be making better use of existing tools to apply a rights-based approach to health policy. These include: a national health plan that is grounded in international human rights law; meaningful human rights impact assessments before, during and after policies are implemented; human rights indicators and benchmarks; the collection of disaggregated data to understand and tackle inequalities of outcomes; and human rights frameworks to inform policy-making.

4.2. Advancing health rights

However, existing protections are not enough. To advance health rights, we need: the incorporation of the right to health into UK domestic law, and the commencement and effective implementation of Section 1 of the Equality Act 2010 - the socio-economic duty.

Incorporation: international evidence

The UK ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR) in 1976, which includes the right to health in article 12. The UK is also a signatory to other treaties that contain health related provisions. However, it has not initiated a full process of incorporation of ICESCR into domestic law across all of the UK. [126]

Incorporation would lead to a range of direct accountability measures, such as judicial remedy for violations of the right to health.[127] These remedies should be supported by inclusive access to justice mechanisms so that those most in need of the remedy are not subjected to additional barriers.

For example, South Africa's constitution recognises the right to health as justiciable and measurable.[128] Given the enabling legal framework, the Treatment Action Campaign (TAC) was able to successfully sue the South African Government for restricting access to a new anti-retroviral drug (Nevirapine) to women in 18 sites.[129] This judgment and the access to treatment that it allowed is estimated to have saved thousands of lives.[130]

Likewise, in Kenya, where the right to health is also incorporated in domestic law,[131] the High Court of Kenya found that the government violated the constitutional and international human rights of a woman by failing to provide free quality maternal healthcare when she gave birth in a public hospital in August 2013.[132]

The woman was granted remedies for the damage, and the case set the precedent that women must be provided quality maternal healthcare, and that government failure is a direct violation of health rights and dignity.[133]

The socio-economic duty

While the UK Government has committed to the enactment of Section 1 of the Equality Act 2010 - the socio-economic duty - in the current Parliament, this process has not yet been completed, and much will depend how it ultimately operates in practice.

The socio-economic duty is intended to reduce socio-economic disadvantage. When enacted, it will require local and public authorities to consider the ways in which their decisions increase or decrease inequalities that result from socio-economic disadvantage, in much the same way as they are required to consider inequalities resulting from 'protected characteristics' such as gender or disability.

The duty came into force in Scotland in 2018,[134] and in Wales, in March 2021.[135] In addition, over the last few years, local authorities across England have voluntarily adopted the duty, showing its potential.[136]

For example, Hackney Council voluntarily adopted the duty in 2013 and relied on it as a basis for its successful community-oriented response to tackle health and other inequalities during the Covid-19 pandemic.[137]

Similarly, Harborough Council voluntarily adopted the duty in 2021 and used it to frame actions in support of people experiencing poverty, with a focus on health.[138]

When the Welsh Government enacted the duty, it was used to co-create its 2022 National Immunisation Framework.[139]

Expanding the duty to the whole of the UK and ensuring that it is well implemented has the potential to have a positive impact on the right to health for people across the UK.

Expanding the socio-economic duty to the whole of the UK and ensuring that it is well implemented has the potential to have a positive impact on the right to health for people across the UK.

5. Conclusion

The evidence in this report shows that the right to health is being eroded across the UK, and that there are several deteriorating trends for the following four main reasons:

1. The UK Government has not been sufficiently resourcing the provision of quality healthcare that meets the needs of all.[140] In fact, the UK has lower levels of health spending and capital investment as a share of GDP relative to comparable high-income countries.[141]

2. The availability, accessibility and quality of publicly provided healthcare are deteriorating.[142] This means that millions of people are waiting for NHS treatment or are struggling to afford charges and prescriptions.[143] Marginalised groups bear the heaviest burden, as they struggle to navigate the healthcare system due to stigma, discrimination, cost, information, language and digital access barriers.[144]

3. Privatisation and commercialisation are having negative effects on the provision of quality health and social care that meets the needs of all. For example, during the Covid-19 pandemic a study found that, between 2020 and 2022, on average, one in four patients had to pay to access treatment.[145]

4. Increasing racism, poverty, exposure to poor housing conditions, the effects of migration status and climate change are negatively impacting certain groups and communities' access to both healthcare and healthy living environments. For example, for the first time in 100 years, life expectancy has failed to increase in England and has declined for the poorest 10 per cent of women.[146]

To address these issues, international law provides some solutions. As we can learn from elsewhere, incorporating the right to health can promote the right to health for all.

For our rights to be protected we need to build the practical measures and policies set out in Just Fair's five principles of everyday rights: rights knowledge, rights frameworks, rights resourcing, rights accountability and rights enjoyment.[147]

To address health inequalities and injustice in the UK, we need:

- economic, social and cultural rights, including the right to health, to be fully incorporated into UK domestic law and effectively implemented.

In addition, we need:

- full commencement and effective implementation of Section 1 of the Equality Act 2010 - the socio-economic duty. This is an important step on the road to incorporation and building a rights culture which is critical to rights incorporation more generally.

Human rights cannot solve health inequalities and injustice overnight but can provide an important framework to address them in a fair, transparent and participatory way.[148]

It is time for everyone in the UK to enjoy quality healthcare, access to adequate living and working conditions, and a healthy environment, not as a privilege but as a right.

Endnotes

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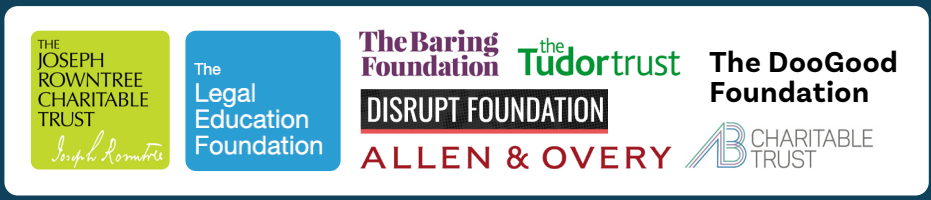

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