Submission to the UN Committee on the Elimination of Racial Discrimination in light of the call for inputs "Issues for consideration during the thematic discussion in preparation for a General Recommendation on article 5 (e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination "

By the Global Initiative for Economic, Social and Cultural Rights

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Introduction

The Global Initiative for Economic, Social and Cultural Rights (GI-ESCR) welcomes the opportunity to contribute to the consultation process initiated by the UN Committee on the Elimination of Racial Discrimination in relation to its 'General Recommendation n°37 on racial discrimination and the right to health under Article 5 (e)(iv) of the International Convention on the Elimination of All Forms of Racial Discrimination (ICERD).'

Our response to the questionnaire clarifies the normative framework applicable to private actors in health drawing on our previous work. Likewise, we discuss the importance of paying attention to the different types of healthcare actors within a system, going beyond a simple public-private division and adding nuances to the analysis, drawing on research from an upcoming paper that we will publish.

Following article 5 (iv) of ICERD, the States Parties are obliged to prohibit and to eliminate racial discrimination in all its forms and to guarantee the right of everyone, without distinction as to race, colour, or national or ethnic origin, to equality before the law, in the enjoyment of the right to public health, medical care, social security and social services.[1]

Article 2.2 and 3 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) also prohibit any form of discrimination in the enjoyment of the right to health and the underlying determinants of health, including on grounds of race.

[1] In connection with article 25 of the Universal Declaration on Human Rights and article 12 of the International Covenant of Economic Social and Cultural.

States are also responsible to take all steps to protect the right to health of individuals within their jurisdictions from infringements of the right to health by third parties. The Committee on Economic, Social and Cultural Rights (CESCR) has specified that violations of the obligations to protect include omissions such as the failure to regulate the activities of individuals, groups, or corporations to prevent them from violating the right to health of others,[2] or for the non-availability of redress mechanisms.

As the COVID-19 pandemic showed, it is urgent to strengthen public healthcare services to realise the right to health of all, including marginalised populations that are at substantial risk of suffering from discrimination, including indigenous people, minorities and those living in marginalised areas, such as urban informal settlements.[3]

Private actors

32. How should States classify actors interfering with the prohibition of racial discrimination in health? Is the division between public and private actors sufficient or should actors follow a typology reflecting their role in health?

The right to health requires that everyone has access to quality healthcare services without discrimination on any grounds.[4] States must ensure that all health facilities, staff, and goods are of high quality and culturally acceptable. States should take affirmative steps to remove geographical, socio-economic, and other barriers to access healthcare while also monitoring and regulating private health actors involved in healthcare.[5] The right to health also includes a right to the underlying determinants of health, including access to food, water and housing.[6]

A healthcare system consists of all the organisations, institutions, resources, and people whose primary purpose is to improve health, including core inpatient and outpatient medical services, public health promotion, and preventative care.[7] Within this context, States have an obligation to ensure that healthcare goods, services and facilities are accessed without discrimination. While some obligations are subject to progressive realisation,

[2] CESCR, 'General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12 of the Covenant)' (11 August 2000) E/C.12/2000/4.
[3] Global Initiative for Economic, Social and Cultural Rights, 'Patients or Customers? The impact of Commercialised Healthcare on the Right to Health in Kenya during the COVID-19 pandemic (2021) DOI: 10.53110/RPCN4627.
[4] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966, entered into force 3 January 1976) 999 UNTS 3 (ICESCR) Art. 12.
[5] See note 2.
[6] Ibid.
[7] See note 3 (p. 15-16).

States have an immediate obligation to guarantee that the right to health will be exercised without discrimination of any kind.[8]

While only States are parties to the Covenant and thus ultimately accountable for compliance with it, all members of society - individuals, including health professionals, families, local communities, intergovernmental and non-governmental organizations, civil society organizations, as well as the private business sector - have responsibilities regarding the realization of the right to health. States parties should therefore provide an environment which facilitates the discharge of these responsibilities.[9] The State must ensure that healthcare services in public and private settings are provided without discrimination, including on racial grounds.

The report 'Private actors in health services: towards a human rights impact assessment framework', provides a first review of the existing standards on the right to health in the context of private actors' involvement. Building on an analysis of the jurisprudence, it lists the main human rights obligations with regard to the right to health, including the following State obligations: to protect the right to health when a third party is involved; to ensure that any private involvement in healthcare does not undermine the accessibility, availability, acceptability and quality of healthcare; to assess privatisation plans to ensure that that they do not interfere with the fulfilment of the right to health at the maximum of their available resources; to ensure that healthcare privatisation does not reduce the level of the enjoyment of the right previously granted; to strictly regulate and monitor private healthcare actors. When private actors provide services in areas that correspond to the public sector, they should be 'subject to strict regulations that impose on them so-called 'public services obligations': (…) private healthcare providers should be prohibited from denying access to affordable and adequate services, treatments or information.'[10]

While the normative framework under international human rights law relates to private actors in general, from our work of research and advocacy at GI-ESCR, we have learnt that the distinction between public and private actors in healthcare is not sufficient to conduct adequate human rights impact assessments and analysis in practice. We recommend that any human rights analysis of private actors in healthcare should to the very least distinguish between for-profit (or 'commercial') private actors who provide healthcare services to make a profit and non-profit private actors, such as non-governmental organisations, faith-based organisations, or other forms of private non-commercial actors. We suggest the following categories and sub-categories:

- Commercial (or for-profit) actors. This can include individual healthcare businesses,

8 ICESCR, Art. 2.2
9 CESCR, 'General Comment No.14' (see note 2), para 42.
10 GI-ESCR, ISER, University of Essex, 'Private Actors in Healthcare: Towards a Human Rights Impact Assessment Framework' (2019) accessed 3 December 2021.

- Non-commercial actors (of non-profit). This can include, but it is not limited to:
    - faith-based
    - NGOs
    - Foundations
    - Sickness funds
    - Self-organised, grassroot initiatives in communities
    - other
- public actors[11]

It is GI-ESCR's view that it is highly recommended that human rights practice and research in civil society, academia, and institutions pay attention to these typologies, as they might have tremendous human rights implications. For instance, in reports we published on Italy,[12] Kenya[13] and Nigeria[14] during COVID-19, we show that the right to health is undermined when States excessively rely on for-profit actors to deliver healthcare services. Additionally, we noticed how private for-profit insurance companies can create barriers and discrimination when it comes to access to healthcare insurance in social healthcare insurance systems.[15] At the same time, faith-based and non-profit organisations operate in different ways than for-profit providers and might have, in some cases, positive effects on the enjoyment of the right to health, for example in easing struggles resulting from lack of access to healthcare services although they cannot substitute public healthcare provisions.[16]

One key driver of privatization and commercialization of healthcare is the dominant narrative and policies perpetuated by the global economic system, which itself embodies racial inequalities. Scholars have highlighted the racist dynamics within the World Bank and International Monetary Fund (IMF),[1] and the racial imbalance in the decision-making power within these institutions,[2] which are two of the most important players in the global economy. The World Bank and IMF are responsible for the widespread adoption of structural adjustment

[11] Global Initiative for Economic, Social and Cultural Rights, 'Typologies of healthcare actors and the right to health: a Guide', (forthcoming, September 2022).
[12] GI-ESCR, 'Italy's Experience during COVID-19: the Limits of Privatisation in Healthcare [Policy Brief]' (2 June 2021) available at: https://static1.squarespace.com/static/5a6e0958f6576ebde0e78c18/t/60b78462b0e35034a1394630/1622639715294/2021-05-Policy-brief-italy-during-COVID-19-healthcare-privatisation.pdf.
[13] Global Initiative for Economic, Social and Cultural Rights, 'Patients or Customers? The impact of Commercialised Healthcare on the Right to Health in Kenya during the COVID-19 pandemic (2021) DOI: 10.53110/RPCN4627.
[14] Global Initiative for Economic, Social and Cultural Rights and Justice & Empowerment Initiative (2022) 'The failure of commercialised healthcare in Nigeria during the COVID-19 pandemic. Discrimination and inequality in the enjoyment of the right to health. DOI: 10.53110/ZYQT7031.
[15] See note 8-10.
[16] Ibid.

programs (SAPs) in the 1980s. In Kenya for example, following the express inclusion of the SAPs through Sessional Paper 1 of 1986 as preconditions to receiving loans and financial support from the World Bank and IMF, access to quality public healthcare was limited by the introduction and increase of user fees in healthcare, and the constrained State capacity to invest in healthcare, including the construction of more public health facilities and employment of health workers.[3]

We thus recommend the Committee to not only make use of the existing legal framework on private actors in healthcare, but also to emphasize the differentiated impacts of private actor both commercial and non-commercial, in the enjoyment of the right to health, without discrimination including racial discrimination.

33. Taking into account the UN Guiding Principles on Business and Human Rights, what sort of standards should States adopt in matters involving private parties and to promote respect for human rights by private parties?

GI-ESCR would like to remind that the Committee on Economic on Social and Cultural Rights has stated that "Businesses play an important role in the realization of economic, social, and cultural rights, inter alia by contributing to the creation of employment opportunities and — through private investment — to development. However, the Committee on Economic, Social and Cultural Rights has been regularly presented with situations in which, because of States' failure to ensure compliance, under their jurisdiction, with internationally recognized human rights norms and standards, corporate activities have negatively affected economic, social and cultural rights."[17]

States have an obligation to protect everyone's right to health when non-state actors provide medical services or are involved in other forms of activities related to healthcare. The right to the highest attainable standard of physical and mental health also includes access to healthcare that is scientifically and medically appropriate and of good quality. Quality healthcare requires, among other factors, services that are provided through skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.[18] Hence, it is particularly important that States ensure that all private providers offer safe, quality healthcare to all, without discrimination based on race, gender, income, or any other ground of discrimination. States' obligations of regulation and monitoring are thus also fundamental in ensuring that all health establishments provide quality healthcare.

[17] Committee on Economic, Social and Cultural Rights General Comment No. 24 (2017) on State obligations under the International Covenant on Economic, Social and Cultural Rights in the context of business activities, para. 1.
[18] CESCR, 'General Comment No. 14: The Right to the Highest Attainable Standard of Health' (adopted on 11 August 2020) E/C.12/2000/4.

States also must ensure that private involvement in healthcare does not undermine the cross-cutting principles of non-discrimination. Non-discrimination and equality are fundamental components of international human rights law and essential to the exercise and enjoyment of economic, social and cultural rights, such as the right to health.[19] States must ensure equality between everyone, in form and substance, by eliminating legal, policy and practical barriers to enjoying the right to health.[20] United Nations treaty bodies have highlighted how privatisation in healthcare can undermine equal access to healthcare, urging States not to implement privatisation when it may result in higher health inequalities impacting marginalised groups.[21] For instance, in relation to women, the Committee on the Elimination of All Forms of Discrimination against Women has urged State Parties to: 'monitor the privatization of health care and its impact on the health of poor women and provide such information in its next periodic report'.[22] It is urgent that these standards are applied. GI-ESCR's empirical research in the context of COVID-19 show that in urban informal settlements in Kenya and Nigeria unregulated for-profit private businesses are widespread, leading to unnecessary treatments, unsafe medical care, lack of referral to the appropriate level of care and use of expired drugs and reagents.[23]

Finally, States have an obligation to prevent, respond and control public health emergencies such as pandemics, in line with WHO International Health Regulations.[24] GI-ESCR's policy brief on Italy has shown how in the Italian region of Lombardy, one of the wealthiest regions in the world, the progressive privatisation of the healthcare system has contributed to the weak pandemic response.[25] Specifically, the brief shows how reliance on for-profit healthcare provision leads to the neglect of relatively less remunerative sectors, such as family medicine and prevention.[26]

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[19] CESCR, 'General Comment No. 20: Non-discrimination in economic, social and cultural rights (art. 2, para. 2, of the International Covenant on Economic, Social and Cultural Rights)' (2 July 2009) E/C.12/GC/20.
[20] CESCR, 'General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12 of the Covenant)' (11 August 2000) E/C.12/2000/4.
[21] GI-ESCR, 'Compendium of United Nations Human Rights Treaty Bodies' Statements on Private Actors in Healthcare' (June 2021) accessed 25 February 2022.
[22] CEDAW, 'Concluding observations on the combined second and third reports of India' (2 February 2007) CEDAW/C/ IND/2-3.
[23] See note 8
[24] WHO, International Health Regulations (adopted by the 58th World Health Assembly in 2005 through Resolution WHA58.3).
[25] GI-ESCR, 'Italy's Experience during COVID-19: the Limits of Privatisation in Healthcare [Policy Brief]' (2 June 2021) available at: https://static1.squarespace.com/static/5a6e0958f6576ebde0e78c18/t/60b78462b0e35034a1394630/1622639715294/2021-05-Policy-brief-italy-during-COVID-19-healthcare-privatisation.pdf.
[26] Enrico Lavezzo et al., 'Suppression of a SARS-CoV-2 Outbreak in the Italian Municipality of Vo'', (2020) Nature 584 7821 425,29.

It is urgent that the Committee takes all steps to push for higher regulation and monitoring of private actors in healthcare in line with the enjoyment of the right to health without discrimination.

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