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Using the Right to Health to Promote Universal Health Coverage: A Better Tool for Protecting Non-Nationals' Access to Affordable Health Care?

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Abstract

Five years ago, the World Health Assembly adopted a resolution on universal health coverage, followed a year later by a resolution from the United Nations General Assembly. In these resolutions, states promised to deliver affordable health care for everyone, referring to notions of equity and human rights law, particularly a human right to health. However, the explosion of migration coupled with the post-2008 bleak economic climate have led societies worldwide to restrict, or at least challenge, the affordability of access to national health systems for non-nationals. It is in this light that the claims of universality made by universal health coverage should be challenged. This article, therefore, will question the effectiveness of this global health policy in guaranteeing access to affordable health care for non-nationals and will ask whether and how legal avenues such as the right to health should be used to address potential weaknesses.

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Introduction

Four years ago, states agreed to provide universal health coverage (UHC) to their populations in a resolution of the United Nations (UN) General Assembly, finally answering calls from the World Health Organization (WHO).[1] By committing themselves to provide good-quality health care to everyone without exacerbating users' risk of financial ruin or impoverishment, states made a promise which Dr. Margaret Chan, director-general of WHO, believes to be "the single most powerful concept that public health has to offer" and the "ultimate expression of fairness."[2] However, its inherent claims of "universality" must urgently be verified.

The international community is currently facing an era of migration. Whether asylum seekers, refugees, stateless persons, or undocumented and documented migrants, the number of persons living in a country other than their country of birth amounted to 244 million in 2015—71 million more than in 2000.[3] Estimates suggest that the number of undocumented migrants, often victims of sex trafficking or workplace exploitation, represent 10–15% of such figures.[4] Furthermore, the number of refugees and asylum seekers worldwide hit a sad record of 21 million in 2014, the highest figure since World War II.[5] The situation of individuals finding themselves in a country other than their country of birth, whom this article refers to as "non-nationals" for purposes of comprehensiveness, thus deserves particular attention.

In addition to encompassing an increasingly large number of vulnerable individuals, non-nationals have also become victims of legislation and policies that limit free or subsidized access to health care to citizens only. The bleak economic climate following the 2008 economic crisis has led societies worldwide to restrict access to national health systems, endangering populations' health as well as the availability and affordability of health care.[6] However, academics, nongovernmental organizations, and human rights institutions have all highlighted the particularly negative impact that such austerity policies have had on undocumented migrants, asylum seekers, and refugees.[7]

Therefore, this article challenges the effectiveness of UHC in guaranteeing non-nationals' access to affordable health care and asks whether legal avenues such as the human right to health, mentioned in UHC documents, should be explored to address insufficiencies. Various authors have examined the inherent relation between UHC and international human rights law, in particular the right to health, while others have discussed the impact of austerity policies on human rights, in particular on economic, social, and cultural rights.[8] Nonetheless, little research has combined both aspects or applied them to the protection of non-nationals. The question I explore in this article contributes to current debates on UHC, access to health care, international migration, citizenship requirements, international human rights law, and the right to health. However, my focus is on whether and how the goals of UHC should be promoted through the right to health in order to better protect non-nationals. To this end, I use doctrinal methods that enable me to formulate an analysis based on a study of primary sources of law alongside relevant scholarly commentaries.

The limited protection of non-nationals' access to affordable health systems under universal health coverage

In order to discuss whether and how the goals of UHC should be promoted through the right to health to better protect non-nationals, it is essential to first demonstrate that the protection afforded by UHC in that regard is limited.

The shaky protection of non-nationals under UHC

UHC, as its name suggests, aims at ensuring that "everyone" can access affordable health systems without increasing the risk of financial ruin or impoverishment.[9] Both the UN General Assembly and WHO recognize the goal as being directed toward an equitable distribution of health care for all individuals by taking into account the needs of vulnerable groups.[10]

However, the formulation of UHC remains unclear regarding non-nationals. In 2005 and 2011, WHO urged states to move toward universal health

coverage for all "citizens" in two resolutions on sustainable health financing, while its 2010 annual report and its 2012 discussion paper on UHC refer to "everyone."[11] In its 2010 annual report, WHO goes even further, by declaring that UHC represents a commitment to cover "100% of the population" and by encouraging states to pay particular attention to vulnerable groups such as "migrants."[12] Nevertheless, the same report also notes that none of the high-income countries that supposedly fulfill the UHC requirements provide 100% of the services to 100% of their populations for 100% of the costs, with no waiting list.[13] Therefore, it is uncertain whether countries that fail to guarantee access to affordable health systems to non-nationals could still be identified as providing UHC.

In addition to its ambiguous language, UHC has been criticized on other grounds having the potential to impede demands for further protection of non-nationals' access to affordable health systems. As argued by Gorik Ooms et al., UHC does not rely on any legally binding treaties and does not demand that decision-making processes in health care prioritize vulnerable groups (for example, refugees).[14] UHC was officially recognized in resolutions of the World Health Assembly and the UN General Assembly, but international law generally considers such documents to be mere "recommendations" for states.[15] Furthermore, Millennium Development Goals 1, 4, 5 and 6, as well as Sustainable Development Goals 1 and 3.8, from which UHC stems, are not legally binding since they are formulated in resolutions from the UN General Assembly.[16] The protection of non-nationals' access to affordable health systems is thus left to states' goodwill, as exemplified by research on the Association of Southeast Asian Nations, where member states take different approaches to UHC implementation for migrants.[17] This leap of faith is particularly problematic in contexts of economic inequalities, fueled by states' failures to ensure equitable provision of services and associated with the resurgence of nationalism, which often results in hostility toward immigrants.[18] Such hostility may trigger the election of leaders opposed to facilitating non-nationals' access to services such as health care, which would be compounded by low levels of non-nationals' participation in decision-making processes.

The shaky protection of non-nationals under UHC is therefore not only problematic as such but also insufficient to fight the rise of health discrimination against non-nationals, as shown by the example of Europe below.

The rise of health discrimination against non-nationals: The example of Europe

As expected by systematic reviews examining the effect of economic crises on populations' health, the 2008 recession has been coupled with a decrease in access to health systems.[19] This decrease is clearly documented by Marina Karanikolos et al. in the case of Europe.[20] However, the negative effects of the economic crisis tend to be exacerbated for non-nationals, who represent an important part of the population following recent increases in migration.[21] Non-nationals often face unique obstacles in accessing health care, such as restricted legal entitlements, administrative difficulties, and language barriers.[22] In 2013, the organization Médecins du Monde found that more than half of the 8,412 patients it treated and interviewed in Europe—mainly non-nationals—had expressed difficulties in accessing national health systems.[23] The organization reported that such difficulties were often associated with a lack of knowledge or understanding of their rights, with administrative problems, or with language barriers.[24] Furthermore, Médecins du Monde highlighted that in the case of undocumented migrants, fears of being reported or arrested often discouraged individuals from seeking medical assistance.[25] It is nonetheless important to note that the extent of legal protection from which non-nationals benefit in the area of health care depends heavily on their migration status. In the European Union, for instance, citizens from member states tend to enjoy higher protection due to the principle of free movement of persons.[26] However, other groups of individuals, such as refugees and undocumented migrants, tend to enjoy a more minimal protection, often limited to emergency services only.[27] Furthermore, each group

faces obstacles specific to its migration status (e.g., fear of deportation for undocumented migrants). It is not my intention here to specify which type of health care protection each group should be able to benefit from. However, a more general question ought to be asked regarding the rationale for—and thus the legitimacy of—policies excluding non-nationals from accessing health care services on the same basis as nationals.

What must be stressed in the context of UHC, nonetheless, is the connection between the various obstacles faced by non-nationals when trying to access national health systems and affordable health care. If states do not invest in raising awareness of health rights or in organizing administrative and linguistic assistance that enables non-nationals to access health care, the affordability of services is irrelevant. That is not to say that health care affordability for non-nationals is not a concern. Carin Cuadra, for instance, has put forward disturbing figures regarding access to health care for undocumented migrants in Europe, highlighting different degrees of protection among states.[28] She argues that only five European Union states provide undocumented migrants with "more than minimum rights of access health care" (though administrative procedures are still required). Twelve European Union states provide undocumented migrants with "minimal rights" to access health care (i.e., free emergency care), and ten guarantee "less than minimum rights" (i.e., the costs of emergency care are unclear, must be paid upfront, or depend on an affiliation to a conditioned insurance system).[29] Considering that undocumented migrants are often exposed to high-risk working and living environments, their exclusion from national health systems is particularly worrying.[30]

Finally, while data on migrants' health is often scattered and missing, as is the case in Europe, research clearly highlights this population's vulnerability to diabetes, certain communicable diseases, and maternal, child, occupational, and mental health problems.[31] However, how can such vulnerabilities be taken into consideration if states do not collect data to monitor and protect migrants' health?

To conclude, while the very essence of UHC is to guarantee everyone's access to affordable national health systems, the ambiguity of its scope and the absence of binding texts provide insufficient protection to non-nationals. This is particularly problematic in light of rising health discrimination against non-nationals in a post-2008 era, as exemplified by the case of Europe. Therefore, it is crucial to discuss whether and how the use of legal tools such as the right to health can improve demands for further protection and promote the goals of UHC for non-nationals.

The right to health: An opportunity to promote universal health coverage for non-nationals

In order to discuss whether and how the goals of UHC should be promoted through the right to health to better protect non-nationals' access to affordable health systems, this section will explore the opportunities offered by this right.

A legally binding tool intertwined with UHC

The connection between the right to health and UHC is unambiguous. Academics such as Gorik Ooms et al. and Audrey Chapman have discussed interactions between both concepts, while the UN General Assembly's 2012 resolution on UHC and WHO's annual reports and policy briefs explicitly refer to the right to health.[32]

The right to health, first recognized in WHO's 1946 Constitution and in the Universal Declaration of Human Rights of 1948, is now enshrined in numerous legally binding instruments at the international and regional levels.[33] The most authoritative among these is the International Covenant on Economic, Social and Cultural Rights (ICESCR).[34] Article 12 of the ICESCR defines the right to health as "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health," a definition to which the UN General Assembly explicitly referred in its 2012 resolution on UHC.[35]

While article 12 of the ICESCR does not clarify what a right to health entails, the human rights body monitoring its realization (the UN Commit-

tee on Economic, Social and Cultural Rights) has interpreted it extensively in its General Comment No. 14.[36] This document, which is not legally binding but has authoritative force, outlines what states parties to the ICESCR ought to do to realize the right to health. General Comment No. 14 establishes that states ought to respect, protect, and fulfil each dimension of the right to health, which include the availability, accessibility, acceptability, and quality of health facilities, goods, and services.[37] Interestingly, some of the requirements set forth in General Comment No. 14 under the dimension of "accessibility" are very similar to the requirements (later) established in UHC instruments. For instance, the UN Committee on Economic, Social and Cultural Rights declares that the element of economic accessibility is fundamental to the realization of the right to health. It stresses that "health facilities, goods and services must be affordable for all,"[38] while WHO defines UHC as "ensuring that all people can use the health services they need without risk of financial hardship."[39]

The right to health is nonetheless in a more advantageous situation than UHC in various respects to effectively protect non-nationals' access to affordable health systems. The provisions in which it is enshrined are legally binding for the states that have ratified the relevant human rights treaties. In the case of the ICESCR, this concerns 164 states.[40] International organizations, nongovernmental organizations, and individuals can thus press states to fulfill their obligations on that basis. Furthermore, the implementation of the right to health tends to be periodically monitored by human rights bodies mandated to supervise the application of treaties by states parties. This often takes place through reporting or complaints procedures involving states, nongovernmental organizations, and individuals. Finally, since the right to health has been on the international scene for nearly 70 years, it benefits from a wealth of literature and case law clarifying (to a certain extent) states' obligations toward non-nationals.

As a result, the right to health has the potential to promote UHC goals by legally demanding non-nationals' access to affordable health systems. Such a statement is particularly true when examining this right's universal scope and its principle of non-discrimination.

The universality and non-discrimination standards to protect non-nationals

The Universal Declaration of Human Rights declares that "all members of the human family" are entitled to "equal and inalienable rights" based on their "inherent dignity" as human beings.[41] The universality of rights and their cross-border effects are often recognized as cornerstones of international human rights law, including in the context of the right to health.[42] This is often reflected by wording such as "everyone" or "every human being" in right to health provisions, whether they appear in international and regional human rights treaties, or in the preamble of the WHO Constitution.[43] Similar wording can also be found in global health instruments adopting a human rights-based approach to fight health inequities, including those promoting UHC.[44] The promise of universality borne by the right to health could, therefore, strengthen the claim according to which UHC should apply to non-nationals.

However, declaring that everyone is entitled to the same rights is not sufficient. As argued by Martha Fineman, such a formal concept of equality, embedded in the Western philosophy of liberal individualism, fails to combat persistent forms of domination and, consequently, to address social disparities.[45] This is critical in the area of health care, where costs can often exacerbate the vulnerability of certain groups. Undocumented migrants, for instance, are at particular risk of being excluded from national health systems either because of upfront costs which they cannot afford, or because of complex procedures to access free treatment which they are unfamiliar with or unable to navigate due to language barriers.[46] It is therefore crucial that states consider the difficulties faced by certain groups of individuals in accessing health care, in order to effectively guarantee affordable national health systems for all.

Historically rooted in fights against exclusion and clearly echoing calls for substantive equality,

international human rights law prohibits discrimination, including in health.[47] Key human rights treaties (including those recognizing a right to health) prohibit discrimination on grounds such as "race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth."[48] However, the list is not exhaustive since the same treaties also prohibit discrimination "of any kind" or "based on "other status."[49] International human rights law therefore protects non-nationals' access to affordable health systems by explicitly prohibiting discrimination based on "national origin" or, more implicitly, discrimination based on migration or citizenship status. This is confirmed by General Comment No. 14. In this document, the UN Committee on Economic, Social and Cultural Rights declares that states' obligation to not discriminate not only applies to non-nationals such as asylum seekers and undocumented migrants but is also a core obligation from which states cannot derogate.[50] Furthermore, the committee takes a clear stance for substantive equality in health by asking that states design and implement measures fitting with the special needs of vulnerable groups.[51]

To conclude, while the right to health and UHC share an inherent connection recognized by the international community, the right to health offers legal avenues to protect non-nationals' access to affordable health systems, which UHC does not. Its universal scope and its non-discrimination clause are particularly promising. However, limits should also be highlighted with regard to the legal nature and ambiguity of its interpretation.

The right to health: A limit to promoting universal health coverage for non-nationals

In determining whether and how the goals of UHC should be promoted through the right to health to better protect non-nationals' access to affordable health systems, it is important to highlight the limits of such a protection. To this end, this section examines the key provisions restricting the scope of protection of the right to health to citizens, thus conflicting with the universal scope of international human rights law and weakening UHC goals.

International provisions restricting the scope of the right to health to nationals

At the international level, two legally binding provisions are particularly problematic. Article 28 of the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families explicitly restricts migrant workers' right to health to emergency care.[52] Furthermore, article 2(3) of the ICESCR allows developing countries to determine to what extent they wish to guarantee economic rights to non-nationals. [53]

Before article 28 of the UN Convention on Migrant Workers was drafted, the UN had already started to differentiate the type of health care that individuals were entitled to according to their nationality and migration status. In 1985, the UN adopted the Declaration on the Human Rights of Individuals Who Are Not Nationals of the Country in Which They Live.[54] Its article 8 recognizes the existence of a right to health for non-nationals, albeit under strict conditions. It declares that non-nationals can benefit from right to health protection and medical care only if they lawfully reside on the territory of the state and if they respect its regulations for participation. Furthermore, article 8 grants non-nationals a right to health only if the state's resources are not experiencing "undue strain," which could be broadly interpreted in the current economic climate.[55] This instrument, however, is not legally binding. In 1990, the UN adopted the UN Convention on Migrant Workers, a legally binding treaty that came into force in 2003.[56] While this treaty has been ratified by only 48 states, which excludes major areas of destination for migrants such as European and North American states, it remains open to signature to all UN member states and may one day gain further popularity.[57] Its article 28 declares that migrant workers and members of their families, whether in a "regular" or "irregular situation" (namely, whether they fulfill a state's conditions for entry, stay or residence or not), have a right to health. Yet it also restricts this right to emergency care.[58] Therefore, several issues arise

when reading article 28 of the UN Convention on Migrant Workers together with article 12 ICESCR, since the latter recognizes that "everyone" has a right to the highest standard of health.[59] Which provision prevails when a state is party to both treaties? Will this conflict of norms affect the possibility for the right to health to protect non-nationals' access to affordable health systems and weaken its promotion of UHC goals?

Furthermore, the scope of protection of the ICESCR is unclear. Despite the universalist aspirations of article 12, article 2(3) of the same covenant allows developing countries to determine the scope of protection guaranteed to non-nationals when it comes to "economic rights."[60] The right to health, often recognized as a social right, also encompasses the right to access affordable health care, which could be labeled as an economic right. More importantly, such a statement highlights that a distinction can be made between nationals and non-nationals in the implementation of the ICESCR. Emmanuel Victor Oware Dankwa argues that when the ICESCR was drafted, developing countries that had recently gained independence wished to protect their economies from nationals of former colonial states, and proposed the inclusion of what is now article 2(3).[61] No explicit relevance can be established with the issues discussed in this article—that is, access to affordable health care for non-nationals in times of economic crisis. However, the UN Committee on Economic, Social and Cultural Rights has not yet indicated how it wishes to interpret article 2(3), if at all, leaving various questions unanswered. Which provision—article 2(3) or article 12—prevails for states that are party to this treaty? Will the conflicting scopes of these two articles affect the protection of non-nationals' access to affordable health systems, thus weakening UHC goals?

While the universal approach entitles all human beings to a right to health, it is unclear under the UN framework whether everyone has a right to *similar* health care. This is particularly problematic in the context of UHC since the prospect of using the right to health as a legal tool to promote non-nationals' access to affordable health care may not bear fruit under this ambiguity.

Regional provisions restricting the scope of the right to health to nationals

At the regional level, all instruments but the Protocol of San Salvador can be read as restricting the scope of the right to health to nationals.[62] The appendix of the European Social Charter (ESC) explicitly excludes from its scope of protection nationals from states not party to the charter, as well as Europeans illegally working or residing within other states parties.[63] The African Charter on Human and Peoples' Rights is more implicit but potentially restrictive nonetheless. Its article 16 declares that states must ensure the health of "their people," and article 13(2) states that every "citizen" has the right of equal access to the public services of the country.[64] Such restrictions are particularly confusing when reading UN instruments, in which, despite a degree of uncertainty, a universal approach tends to be preferred. Which provisions should prevail?

In order to analyze the implications of a potential clash between UN and regional standards, I will focus on the European example, for it has generated promising case law on the matter. Contrary to article 12 of the ICESCR, the scope of article 11 of the ESC is limited to certain individuals. The charter's appendix specifies that article 11 (among other provisions) protects refugees, stateless persons, and "foreigners only in so far as they are nationals of other Parties lawfully resident or working regularly within the territory of the Party concerned."[65] Therefore, article 11 does not apply to documented migrants from non-states parties, except refugees and stateless persons; and it does not apply to undocumented migrants in general. However, the text of the ESC is confusing. Its article E prohibits discrimination on the grounds of national extraction, national minority, birth, or "other status," which could be interpreted as migration status.[66] Furthermore, part I of the ESC describes article 11 as the right of "everyone" to benefit from the highest attainable standard of health.[67] In this light,

the ESC could potentially protect the right of all non-nationals to access affordable health systems, thus promoting the goals of UHC. Nevertheless, uncertainty remains.

The *travaux préparatoires* of the ESC in the 1950s clearly stress the drafters' intention to restrict the scope of the charter to European nationals.[68] However, this intention was explicitly rooted in the desire to promote freedom of movement among Europeans and to protect states parties' nationals against discrimination based on nationality.[69] It is unclear whether, at that time, drafters purposefully wanted to exclude other non-nationals from the scope of the ESC.[70] Nevertheless, when the charter was amended in 1996, states parties did not use this occasion to clarify their position on migrants' rights, reflecting perhaps a more conscious desire to differentiate nationals from non-nationals. The European Committee of Social Rights, nonetheless, has dismissed such an interpretation by extending the protection of article 11 to all non-nationals in recent case law.

To conclude, human rights treaties are sending mixed signals at both the international and regional levels. While clearly recognizing the universal scope of the rights they enshrine, including the right to health, these treaties also differentiate nationals from non-nationals. It is therefore essential to examine how such obstacles may be overcome, in order to enable UHC advocates to use the right to health as a legal tool to promote non-nationals' right to access affordable health systems.

Looking ahead: Advocating non-nationals' right to affordable health systems through supranational monitoring

Discussing whether and how the goals of UHC should be promoted through the right to health in order to better protect non-nationals' access to affordable health systems raises one final question: how can the aforementioned conflicts of norms be addressed? This section explores the potential of supranational human rights bodies to interpret the right to health inclusively, thus strengthening UHC goals.

Advocacy through international human rights bodies

Supranational human rights bodies are mandated to supervise the implementation of human rights treaties, including those recognizing a right to health. Therefore, when having to decide whether the right to health is realized and when justifying why during their monitoring procedures, supranational human rights bodies have the potential to clarify what it entails.[71]

At the international level, the body mandated to supervise the ICESCR—the UN Committee on Economic, Social and Cultural Rights—has clearly interpreted the scope of protection of article 12 of the ICESCR as being universal. As reported by Audrey Chapman and Benjamin Carbonetti, the committee often reviews the situation of foreigners, asylum seekers, refugees, and displaced persons in its reporting procedure.[72] This is relevant under article 12, as the committee frequently highlights health discrimination committed against migrants in regular situations, undocumented migrants, asylum seekers, refugees, and stateless persons. Such monitoring subsequently disregards the differentiation made by article 2(3) (and article 28 of the UN Convention on Migrant Workers) and could promote UHC goals for all.

This is particularly true when examining the committee's comments on European states' reports from its 2016 reporting cycle. For instance, in its 2016 concluding observations on France, Sweden, and Macedonia, the committee called on these governments to provide better access to health care for asylum seekers and refugees, given restrictions in place (for example, administrative barriers in France).[73] In the case of Sweden, it even requested that access to basic health care be facilitated for "vulnerable foreigners," which it understood as including citizens of other European countries, notably Roma people.[74] Finally, in its 2016 concluding observations on the United Kingdom, the committee reminded the state that it was legally obliged to guarantee access to health care for everyone, following the enactment of a piece of legislation restricting access to health care for some non-nationals. This includes, the committee

noted, "temporary migrants and undocumented migrants, asylum seekers, refused asylum seekers, refugees and Roma, Gypsies and Travellers."[75] Furthermore, the committee has repeatedly declared that austerity measures should not adversely or disproportionately affect vulnerable groups.[76] Such an inclusive interpretation could promote the goals of UHC.

However, the Committee on Economic, Social and Cultural Rights fails to systematically review non-nationals' right to access affordable health care when monitoring article 12 of the ICESCR. In its 2016 reporting cycle, for instance, the committee referred to this issue only when commenting on European countries' and Canada's reports. Its concluding observations on Angola, Burkina Faso, Honduras, and Kenya do not examine this issue.[77] While these states may not experience the same migration flux or may not have the same income as European states, they too ought to protect non-nationals' right to health. Denying this would otherwise give life to article 2(3) of the covenant. Moreover, even when European states badly hit by the economic crisis are at stake, the committee does not always monitor non-nationals' access to (affordable) health care. For instance, it failed to discuss this issue in its 2014 concluding observations on Portugal.[78] Finally, for those states in which the committee verifies the affordability of health care for non-nationals, its comments tend to focus on asylum seekers and refugees, leaving the situation of migrants (documented or not) sometimes unsupervised.

Advocacy through regional human rights bodies

At the regional level, the European Committee of Social Rights (which monitors the implementation of the ESC) has greatly mitigated the conflicts arising between the appendix and article 11 of the ESC, through its jurisprudence on migrants' health. In *International Federation of Human Rights Leagues v. France*, it recognized undocumented migrants' right to minimal medical assistance and established that their children had the right to access health care on a similar basis as the rest of the population.[79] It grounded this decision on the principle of good faith, enshrined in the Vienna Convention on the Law of Treaties, by declaring that the ESC was based on the values of dignity, autonomy, equality, and solidarity and that "health care [was] a prerequisite for the preservation of human dignity." [80] In *Médecins du Monde International v. France*, and in its 2013 conclusions on Spain, the committee further extended the scope of protection of article 11.[81] It recognized that adult migrants, whether in regular or irregular situations, had the right to access adequate health care and that this was not limited to emergency services. The committee explicitly stressed that states had "positive obligations in terms of access to health care for migrants, 'whatever their residence status,'" referring to standards of "universal accessibility" laid down by the UN in General Comment No. 14.[82] It even specified that states could not use the economic crisis as a pretext to restrict or deny access to health care in a manner that affected the substance of the right to health.[83] As a result, article 11 (the right to protection of health) and article 13 (the right to medical assistance) of the ESC now apply to undocumented migrants.[84]

In the African context, it is unclear whether the African Commission on Human and Peoples' Rights interprets the right to health as entitling non-nationals to access affordable health care on the same basis as nationals. None of its four merits decisions involving article 16 of the African Charter on Human and Peoples' Rights concerns non-nationals' access to health care, and its 2015 concluding observations are inconclusive. Moreover, little research has been carried out with regard to the protection of non-nationals by the African Charter on Human and Peoples' Rights except in the context of mass expulsions.[85] However, in two merits decisions on article 16 and in various concluding observations, the commission recognizes the right to health of the "citizens" of the state.[86] Such a formulation is more restrictive than article 16 of the African Charter on Human and Peoples' Rights, which requires that states protect the health of their "people," and not solely their "citizens."[87] This does not necessarily mean that the commission wishes to exclude non-nationals from the scope of protection of the right to health. In *Institute for Human Rights and Development in Africa v. Angola*, for in-

stance, it held that the absence of medical attention to migrants in detention camps constituted cruel, inhuman, and degrading treatment.[88] Nevertheless, nothing was said regarding their right to health. It is therefore desirable that the commission, in future jurisprudence, extend the scope of protection of the right to health to non-nationals. Such an inclusive interpretation could protect non-nationals' right to access affordable health systems and promote the goals of UHC.

To conclude, notwithstanding the potential of supranational human rights bodies to address conflicts of norms and discrepancies on non-nationals' right to health in human rights law, their contributions remain ad hoc and unprincipled. Consequently, the reliance of UHC on the right to health as a legal tool to promote non-nationals' right to access affordable health care offers uncertain opportunities.

Conclusion

According to Dr. Chan, WHO's director-general, by promising access to affordable health systems to all without exacerbating poverty, UHC is "the single most powerful concept that public health has to offer" and represents the "ultimate expression of fairness."[89] In order for this policy to be effective, it is essential that it reach all individuals whose access to health is under threat. However, asylum seekers, refugees, stateless persons, and undocumented or documented migrants are being increasingly denied access to affordable health care and often remain forgotten at the negotiating table.

This article has explored whether and how UHC should be promoted through the right to health to better protect non-nationals' access to affordable health systems. The first section argued that the protection of non-nationals' access to affordable health care was limited under UHC. Notwithstanding its "universal" quality, UHC provides limited guarantees to non-nationals given its ambiguous scope of protection and its non-legally binding nature. Such limits are problematic since non-nationals often experience difficulties in accessing national health systems, including that of affordability, following the 2008 economic crisis. The second section then explored the opportunities offered by the right to health as a vehicle to promote UHC for non-nationals. The legally binding nature of the right to health, its worldwide recognition, and the linkages between its goals and those set by UHC represent considerable opportunities to promote non-nationals' access to affordable health systems. Furthermore, the universalist aspirations of the right to health and its inherent principle of non-discrimination provide important legal guarantees for non-nationals. However, as the third section highlighted, the right to health could weaken the promotion of UHC for non-nationals, for its scope of protection is unclear. The restrictive scope of article 28 of the UN Convention on Migrant Workers and the ambiguous meaning of article 2(3) of the ICESCR clash with the universalist aspirations of the right to health. Regrettably, similar restrictions and ambiguity can also be found in regional human rights systems, such as Europe and Africa. Therefore, the fourth section suggested advocating non-nationals' right to affordable health systems through supranational monitoring in order to reinforce the goals of UHC. The monitoring procedures of both the UN Committee on Economic, Social and Cultural Rights and the European Committee of Social Rights clearly show the intention to protect non-nationals' right to access affordable health systems on the same basis as nationals.

The problems discussed in this paper further highlight the urgent need for human rights law to address the conflicts of norms generated by the increasing and fragmented number of treaties at the international and regional levels. This is all the more crucial when such conflicts question the universality of human dignity, reflecting instead states' political interests. Both UHC and human rights advocates would agree that affordable access to health care should be provided to all, regardless of national migration policies.

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References

1. United Nations General Assembly (UNGA), Res. 67/81, UN Doc. A/RES/67/81 (2012). Previous calls from the World Health Organization (WHO) can be noted in World Health Assembly, *Resolution 58.33: Sustainable health financing, universal coverage and social health insurance* (2005); WHO, *The world health report: Health systems financing* (Geneva: WHO, 2010); World Health Assembly, *Resolution 64.9: Sustainable health financing structures and universal coverage* (2011).

2. WHO, *Address by Dr Margaret Chan, director-general, to the sixty-fifth World Health Assembly*, WHO Doc. A65/3 (2012), p. 4.

3. United Nations Department of Economic and Social Affairs, *International migration report 2015: Highlights* (New York: United Nations, 2016), p. 1.

4. International Organization for Migration, *World migration report 2010: The future of migration; Building capacities for change* (Geneva: International Organization for Migration, 2010), pp. 29–44.

5. United Nations High Commissioner for Refugees, *Global trends report 2014: World at war* (Geneva: United Nations High Commissioner for Refugees, 2015), p. 5.

6. M. Karanikolos, P. Mladovsky, J. Cylus, et al., "Financial crisis, austerity, and health in Europe," *Lancet* 381/9874 (2013), p. 1323.

7. For example, Médecins du Monde, *Access to healthcare in Europe in times of crisis and rising xenophobia* (Paris: Médecins du Monde, 2013); Office of the United Nations High Commissioner for Human Rights, *The economic, social and cultural rights of migrants in an irregular situation* (Geneva: United Nations, 2014), p. 35; Council of Europe Commissioner for Human Rights, M*aintain universal access to health care* (2014). Available at http://www.coe.int/en/web/commissioner/-/maintain-universal-access-to-health-care.

8. On UHC and human rights law, see, for example, G. Ooms, C. Brolan, N. Eggermont, et al., "Universal health coverage anchored in the right to health," *Bulletin of the World Health Organization* 91/1 (2013); G. Ooms, L. Latif, A. Waris, et al., "Is universal health coverage the practical expression of the right to health care?" *BMC International Health and Human Rights* 14/3 (2014); D. Sridhar, M. McKee, G. Ooms, et al., "Universal health coverage and the right to health from legal principle to post-2015 indicators," *International Journal of Health Services* 45/3 (2015), p. 495. On austerity and economic, social and cultural rights, see, for example, A. Nolan (ed), *Economic and social rights after the global financial crisis* (Cambridge: Cambridge University Press, 2014); D. Flanigan, "More human rights, not less: Why we need economic, social and cultural rights," *Scottish Human Rights Journal* 70 (2015), p. 1; B. Warwick, "Socio-economic rights during economic crises: A changed approach to non-retrogression," *International and Comparative Law Quarterly* 65/1 (2016), p. 249.

9. WHO, *The world health report: Research for universal health coverage* (Geneva: WHO, 2013), p. 5.

10. UNGA (2012, see note 1); WHO (2013, see note 9), pp. 19–20.

11. World Health Assembly (2005, see note 1), para. 1(4); World Health Assembly (2011, see note 1), para. 1(2) and (3); WHO (2010, see note 1), p. xvi; WHO, *Positioning health in the post-2015 development agenda: WHO discussion paper* (2012), p. 3.

12. WHO (2010, see note 1), pp. xvi, xviii, 88.

13. Ibid., pp. xv–xvi.

14. Ooms et al. (2014, see note 8), pp. 2, 5.

15. L. Gostin, *Global health law* (Cambridge, MA: Harvard University Press, 2014), pp. 64–67; Constitution of the World Health Organization (WHO Constitution), UN Doc. E/155 (1946), art. 23; Charter of the United Nations, as amended (1945), art. 10.

16. UNGA, Res. 55/2, UN Doc. A/RES/55/2 (2000); UNGA, Res. 70/1, UN Doc. A/RES/70/1 (2015).

17. R. Guinto, U. Curran, R. Suphanchaimat, et al., "Universal health coverage in 'one ASEAN': Are migrants included?" *Global Health Action* 8/25749 (2015).

18. F. Solt, "Diversionary nationalism: Economic inequality and the formation of national pride," *The Journal of Politics* 73/3 (2011), pp. 821–30.

19. M. Suhrcke, D. Stuckler, J. Suk, et al., "The impact of economic crises on communicable disease transmission and control: A systematic review of the evidence," *PLOS ONE* 6/6 (2011), p. 1.

20. Karanikolos et al. (see note 6).

21. United Nations Department of Economic and Social Affairs (see note 3), p. 6 (figure 2).

22. M. Nørredam and A. Krasnik, "Migrants' access to health services," in B. Rechel, P. Mladovsky, W, Devillé, et al. (eds), *Migration and health in the European Union* (Maidenhead: Open University Press, 2011), pp.71–72.

23. Médecins du Monde (see note 7).

24. Ibid., p. 18.

25. Ibid., p. 19.

26. European Parliament and Council of the European Union, Directive 2011/24/EU on the application of patients' rights in cross-border healthcare (2011); see also Council of Europe, European Convention on Social and Medical Assistance, ETS No. 014 (1953).

27. On refugees, see European Parliament and Council of the European Union, Directive 2013/33/EU laying down standards for the reception of applicants for international protection (2013), art. 19; see also Council of Europe,

Protocol to the European Convention on Social and Medical Assistance, ETS No. 014A (1953). On undocumented migrants, see European Parliament and Council of the European Union, Directive 2008/115/EC on common standards and procedures in member states for returning illegally staying third-country nationals (2008), arts. 5(c), 14(1)(b), 16(3); see also Parliamentary Assembly of the Council of Europe, Resolution 1509 on the human rights of irregular migrants (2006), art. 13(2).

28. C. Björngren Cuadra, "Right of access to health care for undocumented migrants in EU: A comparative study of national policies," *European Journal of Public Health* 22/2 (2012), pp. 267–71.

29. Ibid., p. 269.

30. B. Rechel, P. Mladovsky, D. Ingleby, et al., "Migration and health in an increasingly diverse Europe," *Lancet* 381/9873 (2013), p. 1236.

31. B. Rechel, P. Mladovsky, and W. Devillé, "Monitoring migrant health in Europe: A narrative review of data collection practices," *Health Policy* 105/1 (2012) p. 14–15; Rechel et al. (2013, see note 30), p. 1238.

32. Ooms et al. (2014, see note 8); A. Chapman, *Global health, human rights and the challenge of neoliberal policies* (Cambridge: Cambridge University Press, 2016), pp. 283–326; UNGA (2012, see note 1), p. 2; WHO (2013, see note 9), p. 5; WHO, *Anchoring universal health coverage in the right to health: What difference would it make?* (2015). Available at http://apps.who.int/iris/bitstream/10665/199548/1/9789241509770_eng.pdf.

33. WHO Constitution (see note 15), preamble; Universal Declaration of Human Rights (UDHR), G.A. Res. 217A (III) (1948), art. 25.

34. International Covenant on Economic, Social and Cultural Rights (ICESCR), G.A. Res. 2200A (XXI) (1966), art. 12.

35. UNGA (2012, see note 1), preamble.

36. Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. No. E/C.12/2000/4 (2000).

37. Ibid., paras. 12, 33.

38. Ibid., para. 12.

39. WHO 2013 (see note 9), p. 5.

40. UN Treaty Collection, *Status of the International Covenant on Economic, Social and Cultural Rights.* Available at https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en.

41. UDHR (see note 33), preamble.

42. For example, R. Hammonds and G. Ooms "Realising the right to health: Moving from a nationalist to a cosmopolitan approach," in G. Backman (ed), *The right to health: Theory and practice* (Lund: Studentlitteratur, 2012), pp. 73–92.

43. For example, at the UN level: ICESCR (see note 34), preamble, art. 12. For example, at the regional level: European Social Charter, as amended (ESC), ETS No. 163 (1996), preamble, art. 11 (see also European Social Charter (ESC 1961), ETS No. 035 (1961), preamble, art. 11, for states parties that still refuse to ratify the revised version of the ESC); African Charter on Human and Peoples' Rights, (African Charter) 21 ILM 58 (1981), preamble, art. 16; Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador), OAS Treaty Series No. 69 (1988), preamble, art. 10; WHO Constitution (see note 15), preamble.

44. For example, UNGA (2012, see note 1), preamble, para. 10.

45. M. Fineman, "The vulnerable subject: Anchoring equality in the human condition," *Yale Journal of Law and Feminism* 20/1 (2008).

46. Cuadra (see note 28).

47. See, for example, A. Grear, *Redirecting human rights: Facing the challenge of corporate legal humanity* (New York: Houndmills, 2010); C. O'Cinneide, "The right to equality: A substantive legal norm or vacuous rhetoric," *UCL Human Rights Review* 1/80 (2008); M. Nussbaum and A. Sen, *The quality of life* (New York: Clarendon Press, 1993); S. Venkatapuram, *Health justice: An argument from the capabilities approach* (Cambridge: Polity Press, 2011).

48. UDHR (see note 33), art. 2; ICESCR (see note 34), art. 2(2). See also International Covenant on Civil and Political Rights (ICCPR), G.A. Res. 2200A (XXI) (1966), art. 2(1).

49. UDHR (see note 33), art. 2; ICESCR (see note 34), art. 2(2). See also ICCPR (see note 48), art. 2(1).

50. UNCESCR (see note 36), paras. 34, 43(a).

51. For example, ibid., para. 37; Committee on Economic, Social and Cultural Rights, General Comment No. 22, Right to Sexual and Reproductive Health, UN Doc. E/C.12/GC/22 (2016), paras. 24, 31.

52. International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICMW), G.A. Res. 45/158 (1990), art. 28.

53. ICESCR (see note 34), art. 2(3).

54. UNGA, Declaration on the Human Rights of Individuals Who Are Not Nationals of the Country in Which They Live, UN Doc. A/RES/40/144 (1985).

55. Ibid., art. 8(1)(c).

56. UN Treaty Collection, *Status of the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families.* Available at https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-13&chapter=4&lang=en.

57. Ibid. See also United Nations Department of Economic and Social Affairs (see note 3), p. 6 (figure 2).

58. ICMW (see note 52), art. 28.

59. ICESCR (see note 34), art. 12.

60. Ibid., art. 2(3).

61. E. Dankwa, "Working paper on article 2(3) of the International Covenant on Economic, Social and Cultural Rights," *Human Rights Quarterly* 9/2 (1987), pp. 231–36. See

also Report from the Third Committee, UN Doc. A/5365 (1962) (agenda item 43), para. 68.

62. Protocol of San Salvador (see note 43), preamble.

63. ESC (see note 43), art. 11, appendix. See also ESC 1961 (see note 43), art. 11, appendix.

64. African Charter (see note 43), arts. 13(2), 16.

65. ESC (see note 43), appendix. See also ESC 1961 (see note 43), appendix.

66. ESC (see note 43), art. E. See also ESC 1961 (see note 43), preamble.

67. Ibid., part I (11). See also ESC 1961 (see note 43), part I (11).

68. Council of Europe, Collected Travaux Préparatoires of the European Social Charter, Volume III (1956); Council of Europe, Collected Travaux Préparatoires of the European Social Charter, Volume V (1958).

69. Council of Europe, Collected Travaux Préparatoires of the European Social Charter, Volume I (1953–1954), p. 5 (Memorandum by the Secretariat-General, April 16, 1953, para. 14).

70. Ibid., p. 6.

71. C. Lougarre, "Clarifying the right to health through supranational monitoring: The highest standard of health attainable," *Public Health Ethics* (December 22, 2015).

72. A. Chapman and B. Carbonetti, "Human rights protections for vulnerable and disadvantaged groups: The contributions of the UN Committee on Economic, Social and Cultural Rights," *Human Rights Quarterly* 33/3 (2011), p. 704 (table 2).

73. Committee on Economic, Social and Cultural Rights, Concluding Observations on France's Fourth Periodic Report, UN Doc. E/C.12/FRA/CO/4 (2016), para. 19(d); Committee on Economic, Social and Cultural Rights, Concluding Observations on Sweden's Sixth Periodic Report, UN Doc. E/C.12/SWE/CO/6 (2016), para. 31; Committee on Economic, Social and Cultural Rights, Concluding Observations on The Former Yugoslav Republic of Macedonia's Combined Second to Fourth Periodic Report, UN Doc. E/C.12/MKD/CO/2-4 (2016), para. 21.

74. Committee on Economic, Social and Cultural Rights (2016, Sweden, see note 73), para. 20.

75. Committee on Economic, Social and Cultural Rights, Concluding Observations on the United Kingdom of Great Britain and Northern Ireland, UN Doc E/C.12/GBR/CO/6 (2016), paras. 55–56.

76. Committee on Economic, Social and Cultural Rights, Open Letter to States Parties on Economic, Social and Cultural Rights in the Context of the Economic and Financial Crisis, UN Doc. CESCR/48th/SP/MAB/SW (2012). Available at

http://www2.ohchr.org/english/bodies/cescr/docs/LetterCESCRtoSP16.05.12.pdf. For example, Committee on Economic, Social and Cultural Rights (2016, United Kingdom, see note 75), paras. 18–19.

77. All documents relevant to the reporting procedure of the UNCESCR can be found at http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/SessionsList.aspx?Treaty=CESCR

78. Committee on Economic, Social and Cultural Rights, Concluding Observations on Portugal's Fourth Periodic Report, UN Doc. E/C.12/PRT/CO/4 (2014).

79. *International Federation of Human Rights Leagues (FIDH) v. France* (2004), Complaint No. 14/2003, Decision on the Merits (European Committee of Social Rights).

80. Vienna Convention on the Law of Treaties, 1155 U.N.T.S. 331 (1969), art. 31(1); *FIDH v. France* (see note 79), paras. 26–32.

81. *Médecins du Monde – International v. France* (2012), Complaint No. 67/2011, Decision on the Merits (European Committee of Social Rights); European Committee of Social Rights, Conclusions XX-2 (2013) on Spain, pp. 12–14.

82. European Committee of Social Rights (2013, Spain, see note 81), pp. 12–14.

83. Ibid., pp. 12–14.

84. ESC (see note 43), arts. 11, 13(1) and (4). See also ESC 1961 (see note 43), arts. 11, 13(1) and (4).

85. G. Bekker, "Mass expulsion of foreign nationals: A special violation of human rights – Communication 292/2004 Institute for Human Rights and Development in Africa v. Republic of Angola," *African Human Rights Law Journal* 9/1 (2009), p. 262.

86. *Egyptian Initiative for Personal Rights and INTERIGHTS v. Egypt* (2013), Communication No. 323/06, Decision on the Merits (African Commission on Human and Peoples' Rights), paras. 258, 264; *Social and Economic Rights Action Center (SERAC) and Center for Economic and Social Rights (CESR) v. Nigeria* (2001), Communication No. 155/96, Decision on the Merits (African Commission on Human and Peoples' Rights), para. 52; African Commission on Human and Peoples' Rights, Concluding Observations and Recommendations on Malawi's Initial Periodic Report (2015), para. 77.

87. African Charter (see note 43), art. 16.

88. *Institute for Human Rights and Development in Africa (on behalf of Esmaila Connateh & 13 others) v. Angola* (2008), Communication No. 292/04, Decision on the Merits (African Commission on Human and Peoples' Rights), paras. 51, 87.

89. WHO (2012, see note 2), p. 4.