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VIEWPOINT

The Evolution of the Right to Health in the Shadow of COVID-19

LISA FORMAN

As a graduate student in the early 2000s coming to grips with the meaning and interpretation of the right to health, few publications had as great an impact on me as the Harvard Law School and Francois-Xavier Bagnoud (FXB) Center's 1993 "Interdisciplinary Discussion on Economic and Social Rights and the Right to Health."[1] It captured a discussion between multiple heavy hitters of the field, including Jonathan Mann, then head of the FXB Center, Philip Alston, chair of the UN Committee on Economic, Social and Cultural Rights, Martha Minow, a Harvard Law School professor, Albie Sachs, soon to be a member of South Africa's first Constitutional Court, and Paul Farmer, at that point an assistant professor at Harvard Medical School. The discussion transformed my understanding of human rights from laws found in 'black-letter' texts and court judgments, to a far more socially-generated, dynamic model of norms and standards. My light-bulb moment came when Martha Minow quoted Judith Shklar's insight that "civilization advances when what was perceived as misfortune is perceived as injustice."[2] In a seemingly impossible fight to expand the right to health to include universal access to affordable antiretroviral medicines during a global pandemic, Shklar articulated the social and political processes necessary for a radical transformation to take place. That global access to antiretrovirals subsequently shifted so dramatically and rapidly deeply underscored for me, as a junior scholar, that global crises could transform both our conceptions of health rights and justice and material outcomes.

It is poignant to revisit that insight in the context of the COVID-19 pandemic. As I write in early April 2020, extraordinary lockdowns and isolation measures affecting billions of people worldwide are in place to stop the explosive spread of SARS-CoV-2. The scale and impact of these measures are such that health and human rights scholars will likely be exploring their legitimacy, necessity, and proportionality for years to come. Some on social media are suggesting these steps show that for once policy-makers have placed health above the economy. But the rampant global spread of COVID-19 is likely a result of many governments' reluctance to take the necessary steps at a far earlier stage, including because they did not want to spook markets. Those steps would have included wide-spread testing, contact tracing, and more adequately preparing health care settings for COVID-19 patients. Health care systems throughout Europe and North America have struggled to mount adequate public health and clinical responses, with facilities overwhelmed, basic testing and protective gear in short supply, and care triaged to those with the best chance of survival.[3] These failures are exposing deep vulnerabilities and inequities within universal health care systems in high-income countries, raising tremendous concerns about what this pandemic will mean for health systems in low and middle-income countries and for the roll-out of universal health coverage (UHC).

Lisa Forman is an associate professor at the Dalla Lana School of Public Health, University of Toronto, where she holds a Canada Research Chair Tier 2 in Human Rights and Global Health Equity, Canada. Email: lisa.forman@utoronto.ca.

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In many respects, this pandemic is deepening crises of social, economic, and health inequities created by decades of neoliberal economic supremacy. The neoliberalism which was only nascent 25 years ago now dominates global decision-making, manifesting in reduced health spending for all countries (including under austerity) and the growing deregulation, privatization, and commodification of health care like other social sectors.[4] These tensions play in relation to interpretations and implementation of UHC, in particular between whether to focus on strengthening comprehensive health systems or support discrete, vertical, selective pro-poor interventions.[5] Many health and human rights scholars had already been contemplating critiques that a right to health that did not directly address these conflicts risked becoming a 'handmaiden' to a neoliberally-inflected global health policy which reinforced rather than remediated health inequities.[6] Such tensions are being brought clearly to the surface during this pandemic which is ravaging economies, and exposing the inadequacies of universal health care systems, social safety nets and precarious employment. Indeed, just as HIV/AIDS did, COVID-19 is exposing the fault-lines and vulnerabilities of the current social and economic system, with infection rates already mapping income gradients in some places.[7]

How policy-makers respond will fundamentally shape key right to health questions, including how we understand government responsibilities towards health and well-being, and the practical meaning of an entitlement to the highest attainable standard of physical and mental health and to living conditions conducive to their health and wellbeing. Government responses are also raising concerning questions about the impact of the pandemic on civil and political rights. For over 13 years Freedom House has documented a global democratic retreat, marked by rising nationalist populism and civil society crackdowns.[8] Governments around the world, in response to COVID-19 have been rushing to expand emergency powers of surveillance and detention, and to place restrictions on human rights for political purposes.[9] There is a risk that regressive responses to COVID-19 could move us even closer to a 21st century defined by 'neo-illiberalism', in which economic neoliberalism combines with political illiberalism and xenophobic nationalism to erode human rights, deepen health inequalities, and undermine the realization of global health policies like UHC.

COVID-19 as a systemic shock that could bring health and human rights to the fore

COVID-19 infections and responses underscore that the indivisibility of health and a range of human rights is not just a theoretical proposition: effective public health measures rely on public trust and the existence of affordable and accessible testing and health care for those who need it. Now, more than ever, scholars and practitioners of health and human rights must move quickly to assert human rights standards to guide policy and protect those most vulnerable to both infection and neglect. This crisis reinforces the pre-existing challenge for the right to health to evolve to meet the health challenges of our time.

Before COVID-19, I had thought of this evolution in the true Darwinian sense of incremental biological processes of natural selection where organisms must either successfully adapt to shifting external conditions or face extinction. My concern for some time has been that if the post-World War II project of human rights were not to land (like natural law) on the litter-heap of history, it must transform itself from within and adapt to a vastly changed global environment from that in which the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, and even General Comment 14 were written. Yet in the early stages of a global health pandemic which is affecting us where we live and work, and where we are most vulnerable, it seems likely this evolution will be not so much slow and incremental than dramatic and precipitous.

British sociologist Graham Scambler suggests that COVID-19 is functioning as a 'breaching experiment': that disrupting the normal social order allows us to see its rules more clearly.[10] Already the dark unspoken rules of economic supremacy are

becoming visible, including intimations from policy-makers and media that the cure for COVID-19 cannot be worse than the problem itself, and that saving the economy might require sacrificing those most vulnerable, including the elderly.[11] For those who have long worked in HIV/AIDS, on LGBTQI rights, for the disabled, on racial and indigenous justice, to name a few, this rhetoric is familiar. The global pandemic can help expose such truly disturbing priorities and built-in inequities within our social and political systems.

From a human rights perspective, a 'breaching incident' like COVID-19 could generate tremendous change. Oona Hathaway has suggested that major shifts in human rights practices have often occurred because of "[m]ajor shocks to the system [which] provide limited windows of opportunity for effecting large changes in the system."[12] Indeed, the shock-response impact of crisis is embedded within the genesis of the United Nations and international human rights law, created in response to the atrocities of World War II.

In exposing the shadowy biases of our current economic and health systems and underscoring government responsibilities to assure COVID-related prevention and treatment, this pandemic may illuminate the value and meaning of the right to health: that inaccessible and unaffordable health care for many desperately ill and dying people is less a misfortune than injustice. That sacrificing the poor, elderly, ill, and marginalized for the sake of economic growth is wrong. And that in this moment of global crisis, countries should not turn inwards to self-protection at all costs but should also engage in the acts of solidarity, innovation, and assistance urgently needed to meet the grave health and humanitarian needs of this pandemic.[13]

The imperative to evolve human rights also requires our field to engage in some uncomfortable self-inquiry. We need to identify and eradicate the inequities inherent in our essential precepts, and 'de-colonize' global health and human rights.[14] An illustrative example: when I first read the 1993 Harvard Roundtable discussion, it never occurred to me that of the seventeen participating scholars, only three were women and only two were from outside the United States. That these disparities are so obvious today reflects a significant sea-change in our ability to recognize certain types of inequities, including the startling lack of racial and gender representation in key institutions of public and global health.[15] As Shklar intimates, we have advanced by being able to recognize that these inequities are not misfortunes of nature but inequities socialized into the fabric of social and political life that drive even well-intentioned global health and human rights institutions.

This pandemic may catalyze responses to pre-existing challenges within health and human rights, changing our understanding of the responsibilities governments have to protect domestic and global health. It may also promote a deeper inquiry into the ways that inequities are reinforced by our institutions, systems, and actors, including within human rights and health.

The challenge for our field is to counter regressive policies that do not meet the human rights standards of non-discrimination, accountability, necessity, and proportionality; to consistently push for accessible, affordable care for those who need it; and to bolster and transform the standards, guidance, and protections that human rights offers when it comes to health writ small and large, especially when it comes to regressive and illiberal social and economic policies. Now more than ever we need to transform the right to health to meet the challenges of this moment and to push towards a far different understanding of health justice for the many millions of people who will be infected and affected by this pandemic.

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