

Honouring the Human Rights to Health and Freedom of Movement

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INTRODUCTION

There is a growing need to make explicit that which we together believe to be ethical in global development.¹ This is readily apparent with regard to the migration of health workers, as evidenced by the burgeoning of both international and transnational voluntary codes of practice related to the processes surrounding their international recruitment.² Internationally agreed upon human rights help to identify the shared principles that we hope to make explicit and provide clarity on the potential forms that recommended practices can take in order to mitigate the negative effects resulting from the migration of health workers.

A number of voluntary codes of practice on the issue of health worker migration suggest policies around self-sufficiency, limitation on active recruitment, and placement of government trained health workers in rural areas,³ as a means to temper the adverse consequences of the migration of health workers. These proposed practices have brought forward the potential tension between the human right to health and the human right to freedom of movement, and the need to balance the two. This paper will explore these two

¹ See Sigrun Mogedal, "The Responsibility Faced by Developed Countries towards the New Ethical Challenges Related to Development", presented at the Inter-American Development Bank meeting on Social Capital, Ethics, and Development, 2001. Available at http://www.iadb.org/ETICA/documentos/dc_mog_respo-i.htm. Date last visited, February 20, 2009.

² The Commonwealth Code of Practice for the International Recruitment of Health Workers, the Pacific Code of Practice for the Recruitment of Health Personnel, the Who Draft Code of Practice on the International Recruitment of Health Workers, the EPSU-HOSPEEM Code of Conduct, and the Voluntary Code of Ethical Conduct for the Recruitment of Foreign Educated Nurses to the United States and the EPSU-HOSPEEM Agreement are examples of the recent emergency of voluntary codes of practice in this area.

³ See, for example, the Commonwealth Code of Practice. Available at http://www.thecommonwealth.org/shared_asp_files/uploadedfiles/%7B7BDD970B-53AE-441D-81DB-1B64C37E992A%7D_CommonwealthCodeofPractice.pdf. Date last visited February 20, 2009.

rights and their relationship within the context of the global health workforce crisis and the migration of health workers. We will focus particularly on the duties of states to fulfill the right to health and the individual health worker's right to freedom of movement and how the realization of both these human rights can be honoured.

THE RIGHT TO HEALTH

The right to health is fundamental and universal. First articulated in the preamble to the WHO Constitution⁴ in 1946, the right to health was soon after assured internationally through the Universal Declaration of Human Rights and later recognized as a distinct human right in the International Covenant on Economic, Social and Cultural Rights (“ICESCR”).⁵ The right to health or the more limited right to healthcare is affirmed in a wide range of other international and regionally agreed upon instruments, as well as in over a hundred national constitutions. Every country has indeed ratified at least one agreement that protects the right to health.⁶ The human right to health has perhaps most comprehensively been examined in the context of the ICESCR and its associated General Comment. 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.”⁷ General Comment 14, adopted by the UN Committee on Economic, Social, and Cultural Rights, though not legally binding, provides an authoritative interpretation of Article 12. It acknowledges that the materialization of the right to health cannot be fully achieved overnight but is in fact subject to progressive realization and resource availability.⁸ However, General Comment 14 also stipulates that State parties have “a core obligation

⁴See Preamble of the WHO constitution. Available at http://www.who.int/governance/eb/who_constitution_en.pdf. Site last visited February 25, 2009.

⁵ See ICESCR. Available at http://www.unhchr.ch/html/menu3/b/a_ceschr.htm. Site last visited February 25, 2009.

⁶ WHO. 25 Questions and Answers on Health and Human Rights. Health and Human Rights Publication Series. July 2002(1). Geneva: World Health Organization; 2002. Available at <http://www.who.int/hhr/NEW37871OMSOK.pdf>. Site last visited February 26, 2009.

⁷ See Article 12 of the International Covenant on Economic, Social and Cultural Rights. Available at <http://www2.ohchr.org/english/law/cescr.htm>. Site last visited February 20, 2009.

⁸ See ICESCR, article 2. Available at http://www.unhchr.ch/html/menu3/b/a_ceschr.htm. Site last visited February 20, 2009.

to ensure the satisfaction of [...] essential primary health care”⁹ which consists of the duty to ensure the right to non-discriminatory access to health facilities, goods, and services, minimum essential food, basic shelter, essential drugs as well as ensuring the equitable distribution of all health facilities and the adoption and implementation of a national public health strategy.¹⁰ Governments have the duty to immediately fulfill these core obligations. In addition they have a “continuing obligation to expeditiously and effectively”¹¹ move towards the full realization of the right to health.¹² In order to promptly provide essential primary healthcare, an efficient health system is vital, itself depending in large part on a qualified workforce.¹³ The presence of and equitable access to health workers is thus central to the full realization of the right to health. This is just as true for destination countries as it is for source countries, with both requiring health workers to realize the right to health for their populations. In the context of a global health workforce crisis, this creates the dilemma where adherence simply to national duties might jeopardize the achievement of the central goal of the ICESCR - observance of human rights for all. Indeed, partly due to an efflux of health workers from many developing countries, realizing the right to health has become all the more challenging for their governments.

The right to health does importantly make prominent not only a national duty but also an international one. Article 2 of the ICESCR asserts that States capable of providing “international assistance and cooperation”¹⁴ to enable developing countries to accomplish their core obligations should do so. Hunt and Backman thus point to the responsibility of high-income countries to “provide appropriate international assistance and cooperation in health in low-income countries”¹⁵ and for low-income countries to “seek appropriate

⁹ See General Comment 14, paragraph 43. Available at [http://www.unhcr.ch/tbs/doc.nsf/\(symbol\)/E.C.12.2000.4.En](http://www.unhcr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En). Site last visited February 27, 2009.

¹⁰ Id.

¹¹ Id, paragraph 31.

¹² Id.

¹³ See Gunilla Backman and Paul Hunt, “Health Systems and the Right to Health: An Assessment of 194 Countries” *Lancet*; 372 (2008): 2047-2085.

¹⁴ See ICESCR, article 2.1

¹⁵ Id.

international assistance and cooperation to help them strengthen their health systems.”¹⁶ The right to health thus demands a productive dialog between high-income and low-income countries and coordinated action to address the consequences from the asymmetric migration of health workers. Moreover, States must not only “respect, protect and fulfill”¹⁷ the right to health within their own borders, they are also called to “respect the enjoyment of the right to health in *other* countries and prevent third parties from violating the right in other countries.”¹⁸ Paul Hunt and Gunilla Backman understand this as a commitment to ‘do no harm’ to their neighbors.¹⁹ The responsibility of doing no harm to the enjoyment of the right to health in other countries, albeit an interpretation of the above mentioned scholars, is relevant when analyzing the complex issue of health worker migration, especially so when discussing policies of active and passive recruitment.

THE RIGHT TO THE FREEDOM OF MOVEMENT

The human right to freedom of movement, like the right to health, is fundamental and universal. In addition to being present in numerous national laws, it is protected through the Universal Declaration of Human Rights²⁰ and the International Covenant on Civil and Political Rights (“ICCPR”).²¹ Article 12 of the ICCPR provides that “everyone lawfully within the territory of a State shall, *within that territory*, have the right to liberty of movement”. It further states that “everyone shall be free to leave any country, including his own”.²² Unlike the right to health, the *full* realization of the right to freedom of movement must be achieved immediately. The right to free movement, as contained in the ICCPR, has been authoritatively interpreted by the Human Rights Committee in

¹⁶ Id.

¹⁷ General Comment 14, Paragraph 33

¹⁸ GC 14, para 39

¹⁹ See Paul Hunt and Gunilla Backman, “Health Systems and the Right to the Highest Attainable Standard of Health” Health and Human Rights; 10 (2008)

²⁰ See Universal Declaration of Human Rights. Available at <http://un.org/Overview/rights.html>. Site last visited February 25, 2009.

²¹ See ICCPR. Available at http://www.unhchr.ch/html/menu3/b/a_ccpr.htm. Site last visited February 25, 2009

²² See Article 12 of the International Covenant on Civil and Political Rights. Available at <http://www2.ohchr.org/English/law/ccpr.htm>. Site last visited February 20, 2009.

General Comment 27 as placing a duty on the state of residence or nationality to not unduly restrict the internal movement of persons lawfully within the country, or to place barriers on their leaving the country.²³ Critically, the right to freedom of movement does not in any significant way impose duties on the receiving states.

Within the context of health worker migration, the human right to freedom of movement is often raised as an argument against policies that might place restrictions on the movement of labor. The international movement of health professionals, unlike other aspects of globalization such as the movement of capital and goods, is indeed centrally linked to human rights.²⁴ However, the right to freedom of movement is limited internationally as it does not place a duty on the receiving state to grant entry to those wishing to work and reside within the receiving state's territory. With specific regard to health worker migration, no duty is placed on destination countries to facilitate the movement of health workers. Indeed it would seem incongruous should human rights law require such a duty of receiving states with specific regard to health workers, but a duty that would not otherwise be extended for their fellow citizens.²⁵ The "fast tracking" of visas for nurses and other health care workers by destination countries raises ethical questions surrounding such policies, particularly when viewed in conjunction with potential state responsibility "to do no harm" to the right to health in source countries. It is additionally important to note that at the same time that the world has seen an increase in the cross-border movement of goods, services, and high-skilled labor, there have been strong efforts by the national governments in many developed countries to limit the entry

²³ See generally Human Rights Committee, General Comment No. 27 on the Freedom of Movement. Available <http://www.unhchr.ch/tbs/doc.nsf/8e9c603f486cdf83802566f8003870e7/6c76e1b8ee1710e380256824005a10a9?OpenDocument#5%2F%20See%20general>. Site last visited February 20, 2009.

²⁴ See Bob Sutcliffe, "Freedom to Move in the Age of Globalization", in *Globalization and Progressive Economic Policy*, ed. By Baker, D., Epstein, G., Pollin, R. Cambridge University Press, 1998.

²⁵ See Nir Eyal and Samia Hurst, "Physician Brain: Can Nothing Be Done?" *Public Health Ethics* 1 (2008): 180-192. The contention could be made that protecting the human right to health creates first and foremost a national duty. Based on the global shortage of health workers, the principles enshrined in the UDHR, Article 2 of the ICESCR speaking to international cooperation, as well as General Comment 14 provision to respect the right to health in other countries, a strong counterargument could be made that human rights law does not demand that movement of health workers be facilitated.

of low-skilled labor.²⁶ The ability to restrict the movement of individuals is indeed very much part and parcel of the concept and exercise of national sovereignty.

Moreover, the human right to freedom of movement, both within and between countries, can be restricted based on certain conditions articulated in Article 12 of the ICCPR. For our purposes, the human right to freedom of movement can and often is restricted based on public health concerns. Article 12 of the ICCPR affirms that the right to freedom of movement can be restricted if necessary to protect public health, as long as it is provided by law and consistent with other rights recognized in the Covenant.²⁷ This limitation on the freedom of movement, for example, provides the basis for quarantining or isolating those who are infected with tuberculosis.²⁸ It is perhaps not too great a leap to contend that restricting the movement of an infectious individual based upon public health concerns may also justify the temporary restriction of movement of individuals whose specific skills are necessary to prevent, identify, and treat the infectious disease and patient, based upon the very same concern. This would be of particular relevance in the case of government trained health workers who are required to reside and practice in rural areas for specific periods of time. Such examples would appear to fit within the restrictions permitted in the ICCPR, if provided by law and consistent with other civil and political rights.²⁹

CONCLUSION

The human rights to health and freedom of movement are fundamental, universal, and both create immediate obligations on states. The existence of these two rights in the context of managing health worker migration, particularly recommendations which limit

²⁶ See supra note 17.

²⁷ See ICCPR, article 12, paragraph 2. Available at http://www.unhchr.ch/html/menu3/b/a_ccpr.htm. Site last visited February 26, 2009.

²⁸ See Geneviève Pinet, “Good Practice in Legislation and Regulations for TB Control: An Indicator of Political Will”, World Health Organization document. Available at http://whqlibdoc.who.int/hq/2001/WHO_CDS_TB_2001.290.pdf. Site last visited February 20, 2008.

²⁹ The Siracusa Principles provide further guidance on this balance. See Andrea Boggio et al., “Limitations on Human Rights: Are they justifiable to reduce the burden of TB in the era of MDR – and XDR – TB”. *Health and Human Rights*, 2008. Available at <http://hhrjournal.org/blog/perspectives/limitations-on-human-rights-are-they-justifiable/>. Site last visited February 20, 2009.

active recruitment or promote self-sufficiency policies as part of an ethical code of practice, does not compromise a state's ability to honour both rights. As mentioned earlier, receiving states bear do not bear any significant human rights related duty to enable or facilitate the movement of foreign health workers into its borders. Even where a conflict might arise in the fulfillment of these two human rights, as perhaps in the case of temporary domestic government bonding of health workers, restriction to the freedom of movement could be permitted under the exception provided for public health.³⁰ In sum, the tension between the two internationally accepted human rights remains in large part that of perception rather than one strictly dictated by human rights law.

³⁰ As long as provided by law and consistent with other civil and political rights.