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Human rights and health

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Key facts

- The WHO Constitution (1946) envisages “...the highest attainable standard of health as a fundamental right of every human being.”
- Understanding health as a human right creates a legal obligation on states to ensure access to timely, acceptable, and affordable health care of appropriate quality as well as to providing for the underlying determinants of health, such as safe and potable water, sanitation, food, housing, health-related information and education, and gender equality.
- A States’ obligation to support the right to health – including through the allocation of “maximum available resources” to progressively realise this goal - is reviewed through various international human rights mechanisms, such as the Universal Periodic Review, or the Committee on Economic, Social and Cultural Rights. In many cases, the right to health has been adopted into domestic law or Constitutional law.
- A rights-based approach to health requires that health policy and programmes must prioritize the needs of those furthest behind first towards greater equity, a principle that has been echoed in the recently adopted 2030 Agenda for Sustainable Development and Universal Health Coverage. (1)
- The right to health must be enjoyed without discrimination on the grounds of race, age, ethnicity or any other status. Non-discrimination and equality requires states to take steps to redress any discriminatory law, practice or policy.
- Another feature of rights-based approaches is meaningful participation. Participation means ensuring that national stakeholders – including non-state actors such as non-governmental organizations – are meaningfully involved in all phases of programming: assessment, analysis, planning, implementation, monitoring and evaluation.

“The right to the highest attainable standard of health” implies a clear set of legal obligations on states to ensure appropriate conditions for the enjoyment of health for all people without discrimination.

The right to health is one of a set of internationally agreed human rights standards, and is inseparable or 'indivisible' from these other rights. This means achieving the right to health is both central to, and dependent upon, the realisation of other human rights, to food, housing, work, education, information, and participation.

The right to health, as with other rights, includes both freedoms and entitlements:

- Freedoms include the right to control one's health and body (for example, sexual and reproductive rights) and to be free from interference (for example, free from torture and non-consensual medical treatment and experimentation).
- Entitlements include the right to a system of health protection that gives everyone an equal opportunity to enjoy the highest attainable level of health.

Focus on disadvantaged populations

Disadvantage and marginalization serve to exclude certain populations in societies from enjoying good health. Three of the world's most fatal communicable diseases – malaria, HIV/AIDS and tuberculosis – disproportionately affect the world's poorest populations, and in many cases are compounded and exacerbated by other inequalities and inequities including gender, age, sexual orientation or gender identity and migration status. Conversely the burden of non-communicable diseases – often perceived as affecting high-income countries – is increasing disproportionately among lower-income countries and populations, and is largely associated with lifestyle and behaviour factors as well as environmental determinants, such as safe housing, water and sanitation that are inextricably linked to human rights.

A focus on disadvantage also reveals evidence of those who are exposed to greater rates of ill-health and face significant obstacles to accessing quality and affordable healthcare, including indigenous populations. While data collection systems are often ill-equipped to capture data on these groups, reports show that these populations have higher mortality and morbidity rates, due to noncommunicable diseases such as cancer, cardiovascular diseases, and chronic respiratory disease. These populations may also be the subject of laws and policies that further compound their marginalization and make it harder for them to access healthcare prevention, treatment, rehabilitation and care services.

Violations of human rights in health

Violations or lack of attention to human rights can have serious health consequences. Overt or implicit discrimination in the delivery of health services – both within the health workforce and between health workers and service users – acts as a powerful barrier to health services, and contributes to poor quality care.

Mental ill-health often leads to a denial of dignity and autonomy, including forced treatment or institutionalization, and disregard of individual legal capacity to make decisions. Paradoxically, mental health is still given inadequate attention in public health, in spite of the high levels of violence, poverty and social exclusion that contribute to worse mental and physical health outcomes for people with mental health disorders.

Violations of human rights not only contribute to and exacerbate poor health, but for many, including people with disabilities, indigenous populations, women living with HIV, sex workers, people who use drugs, transgender and intersex people, the health care setting presents a risk of heightened exposure to human rights abuses – including coercive or forced treatment and procedures.

Human rights-based approaches

A human rights-based approach to health provides a set of clear principles for setting and evaluating health policy and service delivery, targeting discriminatory practices and unjust power relations that are at the heart of inequitable health outcomes.

In pursuing a rights-based approach, health policy, strategies and programmes should be designed explicitly to improve the enjoyment of all people to the right to health, with a focus on the furthest behind first. The core principles and standards of a rights-based approach are detailed below.

Core principles of human rights

Accountability

States and other duty-bearers are answerable for the observance of human rights. However, there is also a growing movement recognising the importance of other non-state actors such as businesses in the respect and protection of human rights. (2)

Equality and non-discrimination

The principle of non-discrimination seeks ‘...to guarantee that human rights are exercised without discrimination of any kind based on race, colour, sex, language, religion, political, or other opinion, national or social origin, property, birth or other status such as disability, age, marital and family status, sexual orientation and gender identity, health status, place of residence, economic and social situation’.

Any discrimination, for example in access to health care, as well as in means and entitlements for achieving this access, is prohibited on the basis of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, and civil, political, social or other status, which has the intention or effect of impairing the equal enjoyment or exercise of the right to health.

The principle of non-discrimination and equality requires WHO to address discrimination in guidance, policies, and practices, such as relating to the distribution and provision of resources and health services. Non-discrimination and equality are key measures required to address the social determinants affecting the enjoyment of the right to health. Functioning national health information systems and availability of disaggregated data are essential to be able to identify the most vulnerable groups and diverse needs.

Participation

Participation requires ensuring that all concerned stakeholders including non-state actors have ownership and control over development processes in all phases of the programming cycle: assessment, analysis, planning, implementation, monitoring, and evaluation. Participation goes well beyond consultation or a technical addition to project design; it should include explicit strategies to empower citizens, especially the most marginalized, so that their expectations are recognised by the State.

Participation is important to accountability as it provides “...checks and balances which do not allow unitary leadership to exercise power in an arbitrary manner”.

Universal, indivisible and interdependent

Human rights are universal and inalienable. They apply equally, to all people, everywhere, without distinction. Human Rights standards – to food, health, education, to be free from torture, inhuman or degrading treatment – are also interrelated. The improvement of one right facilitates advancement of the others. Likewise, the deprivation of one right adversely affects the others.

Core elements of a right to health

Progressive realization using maximum available resources

No matter what level of resources they have at their disposal, progressive realisation requires that governments take immediate steps within their means towards the fulfilment of these rights. Regardless of resource capacity, the elimination of discrimination and improvements in the legal and juridical systems must be acted upon with immediate effect.

Non-retrogression

States should not allow the existing protection of economic, social, and cultural rights to deteriorate unless there are strong justifications for a retrogressive measure. For example, introducing school fees in secondary education which had formerly been free of charge would constitute a deliberate retrogressive measure. To justify it, a State would have to demonstrate that it adopted the measure only after carefully considering all the options, assessing the impact and fully using its maximum available resources.

Core components of the right to health

The right to health (Article 12) was defined in General Comment 14 of the Committee on Economic, Social and Cultural Rights – a committee of Independent Experts, responsible for overseeing adherence to the Covenant. (4) The right includes the following core components:

Availability

Refers to the need for a sufficient quantity of functioning public health and health care facilities, goods and services, as well as programmes for all. Availability can be measured through the analysis of disaggregated data to different and multiple stratifiers including by age, sex, location and socio-economic status and qualitative surveys to understand coverage gaps and health workforce coverage

Accessibility

Requires that health facilities, goods, and services must be accessible to everyone. Accessibility has four overlapping dimensions:

- non-discrimination
- physical accessibility
- economical accessibility (affordability)
- information accessibility.

Assessing accessibility may require analysis of barriers – physical financial or otherwise – that exist, and how they may affect the most vulnerable, and call for the establishment or application of clear norms and standards in both law and policy to address these barriers, as well as robust monitoring systems of health-related information and whether this information is reaching all populations.

Acceptability

Relates to respect for medical ethics, culturally appropriate, and sensitivity to gender. Acceptability requires that health facilities, goods, services and programmes are people-centred and cater for the specific needs of diverse population groups and in accordance with international standards of medical ethics for confidentiality and informed consent.

Quality

Facilities, goods, and services must be scientifically and medically approved. Quality is a key component of Universal Health Coverage, and includes the experience as well as the perception of health care. Quality health services should be:

- **Safe** – avoiding injuries to people for whom the care is intended;
- **Effective** – providing evidence-based healthcare services to those who need them;
- **People-centred** – providing care that responds to individual preferences, needs and values;
- **Timely** – reducing waiting times and sometimes harmful delays.
- **Equitable** – providing care that does not vary in quality on account of gender, ethnicity, geographic location, and socio-economic status;
- **Integrated** – providing care that makes available the full range of health services throughout the life course;
- **Efficient** – maximizing the benefit of available resources and avoiding waste

WHO response

WHO has made a commitment to mainstream human rights into healthcare programmes and policies on national and regional levels by looking at underlying determinants of health as part of a comprehensive approach to health and human rights.

In addition, WHO has been actively strengthening its role in providing technical, intellectual, and political leadership on the right to health including:

- strengthening the capacity of WHO and its Member States to integrate a human rights-based approach to health;
- advancing the right to health in international law and international development processes; and
- advocating for health-related human rights, including the right to health.

Addressing the needs and rights of individuals at different stages across the life course requires taking a comprehensive approach within the broader context of promoting human rights, gender equality, and equity.

As such, WHO promotes a concise and unifying framework that builds on existing approaches in gender, equity, and human rights to generate more accurate and robust solutions to health inequities. The integrated nature of the framework is an opportunity to build on foundational strengths and complementarities between these approaches to create a cohesive and efficient approach to promote health and well-being for all.

(1) [Transforming our World: The 2030 Agenda for Sustainable Development](#). UN General Assembly. 2015. 21 October. UN Doc. A/RES/70/1.

(2) [General comment No. 20: Non-discrimination in economic, social and cultural rights](#)

Committee on Economic, Social and Cultural Rights. 2009.

(3) [Guiding principles for business and human rights, Implementing the United Nations “Protect, Respect and Remedy” Framework](#)

Office of the high Commissioner for Human Rights, Geneva, 2011.

(4) [CESCR General Comment No. 14: The Right to the Highest Attainable Standard of Health \(Art. 12\)](#)

CESCR (Committee on Economic, Social, and Cultural Rights). 2000.). 11 August. Doc. E/C.12/2000/4.

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