International and national legal provisions law european essay

Law

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International and national legal provisions

International legal provisionsSeveral international treaties and declarations provide legal backing for the right to health. Most of them also contain additional paragraphs listing fundamental obligations of states parties to ensure the fulfillment of the right. Although the UDHR is not a treaty, most of its provisions have already gained the status of Customary International Law (Leary, 1994). Article 25 of the UDHR states: Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control. The WHO Constitution (1946) also described the right to health in the second paragraph of its Preamble as: “ The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.” The discourse “ the highest attainable standard of health” of the WHO has thereafter inspired provisions of many international treaties such as: The ICESCR (1966), Article

12(1): “ The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.” Convention on the Rights of the Child (1989), Article 24(1): “ States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health.” The WHO Declaration of Alma-Ata on Primary Health Care (1978), also used similar language reiterating that health, which is a state of complete physical, mental and social wellbeing, and not merely the absence of disease or infirmity, is a fundamental human right and that the attainment of the highest possible level of health is a most important world-wide social goal whose realization requires the action of many other social and economic sectors in addition to the health sector. The WHO Constitution also emphasizes the principle of non-discrimination on the grounds of race, religion, political belief, economic, or social conditions. This emphasis on non-discrimination with respect to health is reaffirmed in the following international conventions: Convention on the Elimination of All Forms of Racial Discrimination (1969), Article 5(e) (iv) provides that “ States Parties undertake to prohibit and eliminate racial discrimination in the enjoyment of the right to public health, medical care, social security and social services.” Convention on the Elimination of All Forms of Discrimination against Women (1979), Article 11 (l) (f) provides that “ States Parties shall take all appropriate measures to eliminate discrimination against women in the enjoyment of the right to protection of health and to safety in working conditions, including the safeguarding of the function of reproduction.” Correspondingly, Article 12 of the same convention provides that “ States Parties shall take all appropriate measures to eliminate discrimination

against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.” National legal provisionsIn addition to ratifying all of the abovementioned international Conventions and Declarations, the government of Ethiopia has also explicitly stated its obligation to ensure the right to health and other social rights in its constitution (1995), Article 41 as: “ The State has the obligation to allocate an ever increasing resource to provide to the public health, education and other social services”. In the past 15 years, the government has been relentlessly working on designing and implementing macro and sector-specific policies, strategies and programs aiming to improve the health system of the country, and the health status of its citizens[1]. In 1998, the government endorsed the Health Care and Financing (HCF) Strategy with the purpose of increasing resources to the health sector, improving efficiency in resource allocation and utilization, enhancing quality and equity, and ensuring financial sustainability as well as in delivery of health care services. Improving health equity through providing financial protection for the poorest segment of the population is one of the major goals of the HCF reform. Accordingly, the government has established new “ fee-waiver system” based on the HCF Strategy, which is aimed at enhancing equity of and access to health services by offering clinical services to the core poor, completely free of charge. Even though there had already been such provision of free health care service for the poor, the system was so disorganized that it was widely open for abuse by the well-off segment of the population, and that the cost remained unreimbursed. The new fee waiver system is however, a strongly systematized one whose

implementation will be discussed in section 6 of the present paper. The guiding principle of this fee waiver system is founded on the Health Policy (1993) of the country which stipulates that no individual shall be denied of medical services in public health facilities due to his/her inability to pay. Subsequently, the regions of the country adopted the HCF Strategy and step wisely enacted the Health Service Delivery and Administration (HSDA) legal framework: proclamation, regulation, and directive. These legal documents encompass six[2]main components of the reform one of which is fee waiver system. Among other things, the HSDA clearly explains the underlying principles upon which the fee waiver system is based, the eligibility criteria to select beneficiaries of the system, the main actors of the system, and the implementation procedure to be followed.

Governmental obligations

Beitz (2011) explained the role of governments in human rights by proposing a two-level model, which expresses the division of labor between states and the international community. In his model, he delineates states as the bearers of the primary responsibility in respecting and implementing human rights, while he explained the international community as outside agents that serve as guarantors of these responsibilities. The ICESCR also states the obligation of states parties in its Article 2 (1) as: Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of

legislative measures. According to this article, states bear the primary responsibility to progressively achieve the full realization of the rights under the Covenant. The phrase “ progressive realization” mentioned in the article implicitly recognizes the resource constraints of states and the fact that it takes time to implement provisions in the treaty. The phrase “ available resources” mentioned in the article refers to both the existing resources within a state and the resources mobilized from the international community through international cooperation and assistance. International assistance and cooperation is not something that substitutes governmental obligations, but it only comes as a remedy in particular situations wherein the government fails to implement its responsibilities and requires assistance from other states. States in general have the responsibility of international assistance and cooperation, and thus are expected to provide economic and technical assistance to enable needy states to meet their obligations in relation to the right to health (General Comment 3, 1990). Beitz (2011) reflected his concern that this two-level model “ may seem objectionable for the prominent role it assigns to states” or in other words, it “ might prompt the question whether the model is excessively state-centric” (p. 122). He also mentioned the possibility that one might also question whether states can be relied upon to protect their residents against the human rights threat by non-state actors. He then commented on these objections arguing that: The human rights treaties all place the primary responsibility for compliance on states and rely on states to regulate the behavior of non-state actors. The formal mechanisms for monitoring human rights violations are overwhelmingly constituted of states and their reporting procedures rely

primarily on states (nongovernmental organizations have an important but subsidiary role) (p. 124). In harmony with Beitz’s opinions, the Committee has also imposed three categories of obligations on states parties regarding the right to health, namely the obligation to respect, to protect, and to fulfill. The obligation to “ respect” requires states to refrain from interfering with or violating directly or indirectly the right to health by its own actions such as committing torture by states organs. It is also emphasized that states parties are also expected to respect the enjoyment of the right to health in other countries. The obligation to “ protect” requires states to prevent third parties (non-state actors) from interfering with or violating the right to health. It may be to prevent such actions as preventing tobacco companies’ promotion of tobacco use. The Committee further noted that, states parties should take appropriate measures when negotiating international or multilateral agreements to ensure that these instruments will not bring an adverse impact on the right to health of their citizens. Finally, the obligation to “ fulfill” requires states to take measures necessary to ensure the right such as to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health. It may be requiring a state to adopt a Primary Health Care strategy and to emphasize on preventive rather than curative services (General Comment 14, 2000, para. 33; Leary, 1994). Cognizant of the fact that different states parties have different capacities to fulfill their obligations in ensuring the right to health, the Committee specifies core obligations that must be fulfilled irrespective of a state party’s resources. These core obligations are to: ensure the right of access to health facilities, goods and

services on a non-discriminatory basis; ensure access to the minimum essential food that is nutritionally adequate and safe; ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water; provide essential drugs, as defined under the WHO Action Program on Essential Drugs; ensure equitable distribution of all health facilities, goods and services; and adopt and implement a national public health strategy and plan of action addressing the health concerns of the whole population (General Comment 14, 2000, para. 43). In its Declaration of Alma-Ata on Primary Health Care (1978), the WHO also elaborated the means that can be used both by developed and developing countries to achieve their obligations in providing the " highest attainable standard" of health mentioned in article 12 of the ICESCR. The main points of this Primary Health are approach can be summarized as: emphasis on maternal and child health, significance of community participation in the planning and implementation of health care, importance of health education, emphasis on preventive health services more than curative measures, priority to vulnerable and high risk groups (such as women and children) as well us to underprivileged segments of the society, and equal access to health care at an affordable price to the community. It is remarkable that this approach emphasizes many elements that are fundamental to any rights such as equality, participation, and inclusion of the society's vulnerable groups, which are partly discussed in the second section of this paper.

Fee-waiver system in Ethiopia

In order to ensure the full enjoyment of " the right to health" by its citizens without any discrimination based on their economic status, the government

of Ethiopia has established the new fee-waiver system since the adoption of its HCF Strategy in 1998. The fee waiver system is aimed at ensuring health equity by providing clinical services to the poorest segment of the population completely free of charge. The implementation of the system involves three core processes: selection of beneficiaries (indigents) by local selection committee, certification of the selected beneficiaries by an authorized entity, and reimbursement of service providers' cost by the waiver granting entity. The fee waiver system is established based on the national legal provisions mentioned in section 4 of this paper. The Health Service Delivery and Administration (HSDA) proclamation, which is adopted by various regions of the country at different times, has identified the authorized entities to implement the system, whose mandates enable them to ensure health equity. These entities are namely: the District/City Administration office, the Community Mobilization office, the Labor and Social Affairs office, the Food Security office, and the Disaster Prevention and Preparedness office. These organizations are responsible to implement the waiver system for different categories of target groups in such a manner that the District/City Administration office is responsible for indigents that are registered as permanent residents of the district/city; the Community Mobilization office, and the Labor and Social Affairs office are responsible for people without permanent address such as homeless/street and abandoned children; the Food Security office, and the Disaster Prevention and Preparedness office are responsible for people affected by natural/manmade calamities. Among other things, the major roles and responsibilities of these organizations include creating awareness on the waiver system to the community, setting

selection criteria based on the specific context of their respective target groups, establishing fee waiver selection and approving committees from among the community, issuing/granting waiver certificate for the selected beneficiaries, allocating budget to reimburse service providers, signing contractual agreement with public health facilities (service providers), and monitoring the proper implementation of the system for their respective target groups. The community, the Bureau of Finance and Economic Development (BoFED), and the public health facilities are also among the main actors in implementing the waiver system. BoFED and its extended structure play a key role in implementing the waiver system by facilitating the budget allocation process for the system, by providing technical assistance to ensure appropriate financial recording as well as reporting, and by facilitating reimbursement to service providers. The beforehand selection and certification of beneficiaries during a fixed period of time in a year rather than at the spot of sickness is one of the basic changes and advantages introduced by the new fee waiver system over the previous one. To this effect, the District/City Administration cabinet is responsible to set selection criteria, and to establish selection committee at village level, and to establish approval committee at district/city level; both committees are composed of members who represent the government structure and the community. The key role of the village selection committee is to create awareness among the community and to carry out primary selection of beneficiaries based on the criteria set by District/City Administration. The selection criteria may probably vary from village to village based on their specific contexts, but it must be based on the ability to pay of an individual

or a household. No any criterion that leaves a space for adverse selection such as disease type or profession is used in selecting beneficiaries. The selection committee is also expected to conduct meetings with the community of the village so as to ensure their participation and to make appropriate amendments on the primary selection if required, and then to send the list of selected beneficiaries to the district level approving committee along with the minute of the meetings. The approving committee reviews the proposed list of beneficiaries and approves/disapproves the village level selection, and finally proposes for the issuance of the waiver certificate for qualified beneficiaries. It also proposes for the budget allocation to be approved by the District/City Administration cabinet. In addition, the approving committee is also supervise the proper implementation of the fee waiver system in the district/city administration, hears complaints from beneficiaries, and proposes solutions for further improvement. The purpose of this section is to show that the government of Ethiopia has taken the primary responsibility of ensuring the right to health and enhancing health equity through its abovementioned organs. However, like many poor countries, Ethiopia’s health sector is also highly supported the international cooperation. According to the National Health Accounts (NHA, 2010) of Ethiopia, only 21% of the country’s health expenditure is covered by the government treasury, while the lion share (40%) is covered by rest of the world. This is in harmony with Beitz’s two-level model of human rights and the provision of the ICESCR, article 2 (1) which requires each state party to participate in international assistance and cooperation in order to achieve the full realization of social rights.

Conclusion

The human rights approach to health recognizes the joint interests of the state on the one hand, and users on the other, in realizing the right to health. As explained in the previous sections, every human being is entitled with the right to health without discrimination on the basis of any ground. This right is firmly established by several international legal instruments, most of which were mentioned in this paper. Despite their firm legal backing, however, the practical implementation of social rights including the right to health has been questioned by many scholars and writers. Some writers argue that social rights are not strong enough to be rights because they cannot be implemented by judges. With this argument, they put due process rights way apart from real rights. According to Nickel (2007), however, due process rights have a prominent place in historic bills of rights, and hence, such an argument which concludes due process rights as unreal rights is implausible. Besides, the successful implementation of rights can be achieved only through the combined effort of judges and legislators. Once they have been legislatively defined and funded, social rights can be implemented by judges. Hence, every social right including the right to health is a real human right. Other writers argue that social rights are not real rights because their implementation calls for international cooperation and assistance from outside agents, which cannot be relied up on. According to their opinion, putting outside agents as the second-level addressees of social rights makes the practical implementation of social rights highly questionable. This is mainly because of the difficulty to identify which outside agents have reasons to act, and the difficulty to decide what kinds of

reasons are strong enough for outside agents to act. Beitz (2011) defended such kind of objections by arguing that even if there is no single reason that applies to all cases and to all outside agents, in today's world of interdependence, there are always different possibilities that suggest a reason for an external action depending on the context of the needy state and depending on the pattern of the interaction between needy states and relatively affluent ones. Beitz's two-level model of human rights which assigns the primary responsibility to states and which puts the international community as guarantors of the rights through international cooperation has also been criticized by some scholars. In the real world, however, the practice of many developing countries in implementing human rights is usually in harmony with this two-level model. The ICESCR also states the same division of labor between states and the international community in its article 2 (1). As explained in the previous section, Ethiopia's experience in implementing the right to health and in enhancing health equity shows the fact that the state has taken the primary responsibility, but it still depends on financial as well as technical assistance of the international community to meet its obligations.