Physicians for Human Rights-UK
Report to the
United Nations Committee on Economic, Social and Cultural Rights

Response to the UK Government's Fourth Report under the International Covenant on Economic, Social and Cultural Rights

Article 12 – the Right to the Highest Attainable Standard of Health

Executive Summary

This report is a response to the UK's Fourth Report under the International Covenant of Economic, Social and Cultural Rights. It draws on the guidance provided by the Committee's General Comment 14 on the Right to the Highest Attainable Standard of Health. It reveals areas where protection of the international right to the highest attainable standard of health falls short of Covenant standards. In particular, the report describes how vulnerable and minority groups are discriminated against in a number of aspects of healthcare.

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[Physicians for Human Rigths-UK has been trading under the name Doctors for Human since 2004]

Contents

1. UK obligations regarding maternal, child and reproductive health

1.1 Respect bound obligations:

1.1.1 To refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health

a. Prison is a high-risk environment for the spread of fatal and potentially fatal diseases, including HIV (human immunodeficiency virus) infection, Hepatitis B and Hepatitis C, which can be transmitted sexually and from mother to child. Prevalence rates for HIV/ AIDS are 13 times higher amongst women in prison than amongst the general population.
b. A large number of people in prison report drug misuse problems. On average 24% of prisoners report that they have injected drugs, of whom 30% continue to inject whilst in prison.
c. Cheap and simple measures such as condoms and clean needles that prevent transmission of infection, are not made available in prison. This creates a two-tier system of protection leaving prisoners with a much lower level of access to basic healthcare prevention measures than other members of the population.
d. The prison service in England and Wales is failing to provide hepatitis B immunisation for prisoners at risk of infection, despite research evidence showing a need for it[1]
e. Prisons, by acting as reservoirs for infection, can facilitate transmission of diseases into the community once prisoners are freed

1.2 Fulfilment bound obligations:

1.2.1 To ensure public health infrastructures that provide for sexual and reproductive health services, (including access to family planning, pre and post-natal and safe motherhood care, emergency obstetric services, access to information and the resources needed to act on that information) particularly in rural areas

See under 1.1.1 in regard to services preventing sexual transmission of fatal and potentially fatal diseases in prison, that can later spread into the community

The government should be asked whether it will make condoms and clean needles for drug users available to prisoners for HIV prevention, and provide appropriate immunisation.

[1] Bird S, (2001) Commentary: efficient research gives direction on prisoners' and the wider public health except in England and Wales. British Medical Journal; 323:1209

2. UK obligations regarding healthy, natural and workplace environments

2.1 Protection bound obligations:

2.1.1 To take measures to protect consumers and workers from practices detrimental to health, and ensure that third parties do not limit people's access to health-related information

See under 1.1.1 in regard to services preventing transmission of fatal and potentially fatal diseases in prison, that can later spread into the community

2.2 Fulfilment bound obligations:

2.2.1 To adopt measures against environment and occupational health hazards and against any other threat as demonstrated by epidemiological data

See under 1.1.1 in regard to services preventing transmission of fatal and potentially fatal diseases in prison, that can later spread into the community.

3. UK obligations regarding the prevention, treatment and control of diseases

3.1. Protection bound obligations:

3.1.1 To ensure that third parties do not limit people's access to health-related information and services for behaviour-related health concerns, such as sexually transmitted diseases, in particular HIV/AIDS, and others adversely affecting sexual and reproductive health

See under 1.1.1 in regard to services preventing transmission of fatal and potentially fatal diseases in prison, that can later spread into the community

3.2 Fulfilment-bound obligations:

3.2.1 To establish and promote prevention and education/information campaigns for behaviour related health concerns such as HIV/AIDS

See under 1.1.1 in regard to services in prisons preventing transmission of the fatal behaviour related disease HIV, and the potentially fatal hepatitis B and C

3.2.2 To promote sexual and reproductive health by discouraging domestic violence, the abuse of alcohol and the use of cigarettes, narcotics and other harmful substances

See under 1.1.1 in regard to discouraging the use of narcotics and other harmful substances in prisons

3.2.3 To ensure the provision of health care, including immunisation programmes against major infectious diseases

See under 1.1.1 in regard to services preventing transmission of the potentially fatal disease hepatitis B in prisons.

4. UK obligations regarding health facilities, goods, and services

4.1. Respect bound obligations :

4.1.1 To take measures to refrain from denying or limiting equal access for all persons including prisoners, detainees, minorities, asylum seekers and illegal immigrants, to preventative, curative, and palliative health services

(i) See under 1.1.1 in regard to services preventing transmission of fatal and potentially fatal infectious diseases such as HIV and hepatitis B and C in prisons.

(ii) Prison health care:

a. Many mentally ill people are held in prison, in conditions inappropriate for their health needs. Over 90% of young offenders in prison show evidence of one, or more than one conditions including personality disorder, psychosis, neurotic disorder or substance misuse. Prevalence rates for functional psychosis such as schizophrenia have been found to be 10% among young male prisoners awaiting sentencing, compared to 0.4% in the general population[2]
b. There have been difficulties in recruiting and in retaining prison doctors[3]
c. Prison doctors, who are uniquely subjected to a dual responsibility to their patients and to the effective running of the prison and frequently find their medical judgments overruled by non-medical personnel for security reasons[4]
d. Whilst the European Committee for the Prevention of Torture recommends that a doctor qualified in psychiatry be attached to the health service of each prison,[5] most prisoners with mental health problems are attended to by doctors lacking such qualifications[6]

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[2] Lader D, Singleton N and Meltzer H (2000) Psychiatric Morbidity Among Young Offenders in England and Wales, TSO

[3] British Medical Association (2001) Prison Medicine: a crisis waiting to break. BMA

[4] ibid

[5] European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment 3rd General Report 1992 (CPT/Inf 93) 12, 13-21

[6] Reed J, Lyne M (1997) The quality of health care in prison: results of a year's programme of semi-structed inspections, British Medical Journal, 315, 1420-42

e. Prisoners are not always allowed access to essential treatment. In 1998, 1300 mentally ill prisoners in England and Wales were denied appropriate transfer to National Health Services (NHS) Hospitals[7]

(iii) Women and access to health care:

a. Substantial evidence of sex inequality for coronary heart disease for access to secondary care exists[8]. Women with angina are less likely to be referred to a specialist[9] or to undergo revascularisation (an operation that renews the blood supply to heart muscles and prolongs life)[10]
b. Research in primary care also suggests a systematic bias towards men compared with women in secondary prevention of coronary heart disease. Women are less likely than men to have cardiovascular risk factors and serum cholesterol concentration recorded and despite women having higher cholesterol concentrations more men are treated with lipid (cholesterol) lowering drugs. Men were more likely to have their height, weight, and body mass index recorded despite women being more likely to be obese. Men were more likely to have smoking status recorded and to be prescribed aspirin (which prevents heart attacks)[11]

(iv) Social gradients and access to health care:

a. Evidence shows that poorer patients have less access to investigations (angiography) and life saving treatment (coronary artery bypass graft operation) for angina and heart attacks, than more affluent patients[12]

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[7] House of Commons Hansard Vol 308 No 142, 19th March 1998, Col 1513

[8] Hippisley-Cox et al, (2001)*S*ex Inequalities in Ischeamic Heart Disease in General Practice: Cross Sectional Survey, British Medical Journal, 832,

[9] Vogels E, Lagro-Janssen A, van Weel C (1999) Sex Differences in Cardiovascular Disease: are Women with Low Socio-economic Status at High Risk? British Journal of General Practitioners 49, 963-66

[10] Kee F, Gaffney B, Currie S, O'Reilly D. (1993) Access to coronary catheterisation: fair shares for all? British Medical Journal, 307, 1305-1307

[11] Hippisley-Cox et al, op cit, 2001

[12] Hippisley-Cox J, et al. (2000) Inequalities in access to coronary angiography and revascularisation: the effect of deprivation and location of primary care services, British Journal of General Practitioner 50, 449-454

(v) People with Learning Disabilities (Mental Retardation) and access to health care:

a. Constituting 2% of the population, people with learning disabilities have much higher prevalence rates of long-term physical and psychiatric disorders than the rest of the population. However, recognition of these conditions may be delayed or prevented due to the individual being unable to interpret a

symptom for what it is, describe it or appreciate its significance. Many studies have demonstrated that throughout their lives, the health needs of people with learning disabilities are often neglected. This has the effect of compromising their quality of life and longevity, as well as social inclusion (integration within society)[13]

b. Despite authoritative institutions recommending anticipatory medical assessment, general practitioners have resisted providing health promotion including regular health checks in this group of people[14]

c. Many general hospitals have insufficient flexibility to provide essential investigations and/or treatment services for some people with learning disabilities, particularly those who do not cooperate because of impaired understanding of health care[15]

d. The complex health needs of children with learning disabilities are often inadequately supported by health and education authorities, preventing such children from receiving suitable education[16]

e. Particular issues also arise for women with learning disabilities. A British Medical Journal editorial commented on the worryingly low rates of cervical screening amongst women with learning disabilities[17]

f. The national strategy for sexual health and HIV fails to mention this group[18]

The government should be asked what steps it will take to ensure the healthcare needs of people with learning disabilities are met.

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[13] Cassidy G, Martin G, Martin D (1998) Health Gain Assessments - How Psychiatrists and GPs can work together to address the needs of people with Learning Disabilities, Personal Communication; Bollard M (1999) Overcoming Social Exclusion through Primary Care Based Health Checks, Journal of Integrated Care, 3 (1) 47-8

[14] Kerr M, Dunstan F, Thepar A (1996b) Attitudes of general practitioners to caring for people with learning disability, British Journal of General Practice, 46, 92-94

[15] MENCAP (1998) Health Care for All? People with Learning Disabilities and Health, London

[16] MENCAP (2001) Don't Count Me Out: The Exclusion of Children with a Learning Disability for Education because of Health Needs, London

[17] Smith R (1999) Medicine and the marginalised, British Medical Journal, 319, 1589-1592

[18] Department of Health (2001) The National Strategy for Sexual Health and HIV London, HMSO

(vi) People living with HIV and access to health care:

a. Discrimination on the basis of HIV status impedes the access to healthcare of people with HIV. As many as one in five gay men have had bad experiences with their GPs because of their sexuality[19]
b. Reports indicate that some dentists refuse to treat people known to be HIV positive. Others dentists only treat people with HIV at the end of the day, justifying it on the grounds that surgical instruments can then be properly sterilised[20]. However, as people with HIV who are not identified as being infected attend dentists, the same sterilisation techniques are needed for everyone.
c. A study showed that infertility clinics are biased against patients infected with HIV with only 44% of units agreeing to treat a couple where the man alone was infected with HIV[21]

The Government should be asked what steps it will take to ensure that people with HIV have adequate access to healthcare, and to protect people with HIV from discrimination in the healthcare system.

d. Levels of HIV infection are particularly high amongst certain ethnic and immigrant groups, in particular those from sub-Saharan Africa. Significant racial differences exist both in the way HIV develops and the treatment offered, with 35% of Black Africans having an AIDS defining illness within a month of diagnosis compared to 13% for non-Africans[22]
e. Black Africans with HIV are also less likely to be referred to specialist mental health services[23]

The government should be asked what measures are being taken to target HIV education at vulnerable groups and provide medical services for communities with high rates of HIV.

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[19] Sigma Research Lesbian and Gay Foundation, National AIDS Trust (2000) Sexual Health for All. Report Commissioned for the Department of Health

[20] Terrence Higgins Trust (2001) Social Exclusion and HIV

[21] Apoola A, ten Hof J, Allan P (2001) Access to Infertility Investigations and Treatment in Couples infected with HIV: Questionnaire Survey, British Medical Journal, 323, 1285

[22] Burns FM, et al (2001) Africans in London continue to present with advanced HIV disease in the era of HAART, accepted for publication in AIDS

[23] Malands S, et al (2001) Are we meeting the psychological needs of Black African HIV-positive individuals in London? Controlled study of referrals to a psychological medicine unit in AIDS Care, Vol. 13, No. 4, pp. 413-41

(vii) Elderly people and access to health care:

a. Older people experience discrimination in relation to access to healthcare. Sixteen per cent of over 65s feel that they have been discriminated against because of their age by the health care or health care insurance sector[24]
b. Three out of four senior health managers surveyed believed that age discrimination existed in their local services, with many feeling that ageism was endemic[25]
c. Half of general practitioners surveyed said they would worry about how the NHS would treat them in old age; 43 per cent said they would have concerns about a frail elderly relative going into their local hospital; 33 per cent said elderly patients did not have the same quality of care as other patients; and 16 per cent said older patients had to wait longer for treatment than other patients[26].
d. Despite the elderly having much higher rates of heart disease, they are less likely than younger people to receive both appropriate investigations[27] and the most effective life saving treatment for heart attacks such as thrombolysis (clot dissolving injections)[28]
e. Eradicating ageism in the NHS may require legislation[29]

The government should be asked what steps are to be taken to avoid discrimination in healthcare against elderly people.

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[24] Survery. Age Concern England. Published Januaruy 15th 2002

[25] Kings Fund (2002) Old Habits Die Hard: Tackling Age Discrimination in Health and Social Care

[26] GPs views on older people and the NHS. Survery. Age Concern England. Published May 17th 2000

[27] Bowling A, et al (1999) The effect of age on the treatment and referral of older people with cardiovascular disease, J Epidemiol Commun Health, 53, 658.

[28] McMechan SR, et al (1998) Age related outcome in acute myocardial infarction, British Medical Journal, 317, 1334-1335

[29] Brahim S. (2000) Do not resuscitate decisions: flogging dead horses or a dignified death? British Medical Journal, 320, 1155-1156

4.2 Protection bound obligations:

4.2.1 To take measures to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct

(i) See under 4.1.1 in regard to service deficiencies resulting from health professionals not meeting required standards of expertise and ethical codes of conduct

(ii) Training/ Employment of Health Care Professionals

a. In the process of selection for medical school certain groups, including ethnic minority groups and male applicants, have been found to be disadvantaged. The disadvantage amongst applicants from ethnic minority groups appears to have been stable over time[30]
b. Evidence suggests that black and Asian doctors, especially those who trained overseas, are more likely to end up working in unpopular specialities and are far less likely to become consultants[31]

The government should be asked what measures it is adopting to eliminate discrimination in the selection for training as, and employment of, doctors from certain groups.

c. A survey shows that 37% of junior doctors reported being bullied in the past 12 months by peers, senior staff, or managers. Black and Asian doctors were more likely to be bullied than other doctors. Women were more likely than men to be bullied[32]

The government should be asked what measures it is adopting to eliminate bullying from the training or the employment of doctors, particularly those from certain groups.

a. The NHS has not given hospices and palliative care services the priority they deserve. Only one third of health authorities within the NHS have developed strategies for specialist palliative care provision with services unevenly distributed[33]
b. The state contribution to independent charitable hospices, which provide 70% of inpatient hospice services, has fallen from 35% to 28% since 1997[34]

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[30] McManus IC, (1998) Factors affecting the likelihood of applicants being offered a place in medical schools in the United Kingdom in 1996 and 1997: prospective study, British Medical Journal, 317, 1111-1117

[31] Racism in medicine.(1999) Kings Fund. London.

[32] Quine L (2002) Workplace bullying in junior doctors. British Medical Journal, 324, 878-879

[33] Department of Health (2000) The NHS Cancer Plan. London HMSO

[34]Letter from Help the Hospices to Secretary of State for Health, 12/03/02

c. The care of all dying patients must improve to the level of the best. The Department of Health has acknowledged that voluntary palliative care services need adequate funding from the NHS[35]

The government should be asked what strategies are in place to ensure access for everyone in need of it to palliative care.

4.3.2 To take measures to ensure the appropriate training of doctors and other medical personnel

(i) See under 4.1.1 in regard to service deficiencies resulting from health professionals not meeting required standards of expertise and ethical codes of conduct

(ii) See under 4.2.1 in regard to racial discrimination and bullying of junior doctors

(iii) Education for medical students in Heath and Human Rights

a. At paragraph 44 (e) of its General Comment 14 on the Right to the Highest Attainable Standard of Health, the Committee confirmed that States parties had an obligation "to provide appropriate training for health personnel, including education on health and human rights."
b. In December 1993, the General Medical Council published its recommendations on undergraduate medical training. This stated that a core objective of an undergraduate degree in medicine included a "knowledge and understanding of ethical and legal issues relevant to the practice of medicine[36] The attitudinal objectives included "the recognition of patients' rights in all respects"[37] as well as an "awareness of the moral and ethical responsibilities involved in individual patient care"[38]. Despite this mandate for the teaching of human rights to medical under graduates, there appears to be no systematic human rights education within the curricula of the UK's twenty-seven medical schools.

The Government should be asked what human rights education currently takes place in medical schools, and what measures it is taking to increase this.

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[35] Dept of Health 2000, op cit

[36] Tomorrow's Doctors: Recommendations on Undergraduate Medical Education, (1993) London, The General Medical Council, Paragraph 40.1 (k) at page 14

[37] Ibid, Paragraph 40.3 (b) at page 15

[38] Ibid, Paragraph 40.3 (e) at page 15

4.3.3 To take measures to ensure health services are culturally appropriate and that health care staff members are trained to recognise and respond to the specific needs of vulnerable or marginalised groups.

(i) See under 4.1.1 with regard to inadequate access to health care for prisoners, women, poor people, people with learning disabilities, people living with HIV, and elderly people.

(ii) Studies indicate a reduced access by black and ethnic minority communities and socially deprived groups to palliative care services which may either be culturally unsuitable or delivered insensitively[39]

The government should be asked what measures are being taken to ensure that palliative services are culturally suitable for all ethnic and socially deprived groups, including people with learning disabilities.

4.3.4 To focus expenditure on rectifying existing imbalances in the provision of health services, goods and facilities

(i) See under 4.1.1 and 4.3.1(ii) regarding service imbalances requiring rectification of imbalances of expenditure

5. UK obligations regarding the formal recognition of the right to the highest attainable standard of health and a formal plan to implement it include:

5.1 Giving sufficient recognition to the Right to the Highest Attainable Standard of Health in national political and legal systems, preferably by way of legislative implementation.

a. The 1998 Human Rights Act has impacted health related cases, such as those involving decisions regarding the right to die with dignity, the detention of mentally ill people and the separation of conjoined twins when this would inevitably lead to the death of one of them.
b. Article 13 of the Council of Europe's revised European Social Charter (1996) obliges States Parties to provide the care necessitated by sickness to persons without adequate resources.
c. Article 35 of the European Union's Charter of Fundamental Rights (2000) recognises the right of everyone to preventive health care and medical treatment under conditions established by national laws and practices.
d. However, the UK Government has yet to enact legislation that allows recognition of the right to the highest attainable standard of health in domestic law.

The government should be asked when it will enact legislation that allows the recognition of the Right to the Highest Attainable Standard of Health in domestic law.

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[39] Dept of Health 2000, op cit

6. UK obligations with regard to the Right to the Highest Attainable Standard of Health in other countries

a. In its general comment 14 on the Right to the Highest Attainable Standard of Health, the Committee confirmed that states parties, to comply with their international obligations in relation to Article 12, have to respect the enjoyment of the right to the highest attainable standard of health in other countries, to prevent third parties from violating the right in other countries if they are able to influence these third parties by way of legal or political means, and to ensure that their actions as members of international organisations take due account of the right to the highest attainable standard of health[40]

b The UK Chancellor of the Exchequer sits on the management committee of the IMF and the UK Secretary of State for International Development sits on the development committee of the World Bank.

The government should be asked how UK international policy takes regard of this obligation, and to what extent the UK has sought to influence IMF and World Bank lending policies so as to prevent them adversely affecting the Right to the Highest Attainable Standard of Health in other countries.

[40] General Comment 14, Paras 38 and 39