POLICY BRIEF

The Government's response to COVID-19: how to further realise the right to health

Submission to the Joint Committee on Human Rights: Inquiry into the human rights implications of the Government's response to COVID-19

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THE UK'S OBLIGATIONS TOWARD THE RIGHT TO HEALTH IN THE COVID-19 PANDEMIC

The United Kingdom ("UK") has legally binding obligations towards the right to the enjoyment of the highest attainable standard of physical and mental health ("right to health"), deriving from its ratification of international human rights treaties including the International Covenant on Economic, Social and Cultural Rights 1966 ("ICESCR") and the European Social Charter 1961.

The United Nations (UN), the World Health Organization (WHO) and the UN Special Rapporteur on the right to health have emphasised that the right to health should be at the forefront of state responses to COVID-19 (UN, 2020; WHO, 2020a; Puras et al., 2020).

ICESCR recognises States parties must take steps for the '*prevention, treatment and control of epidemic, endemic, occupational and other diseases*' (ICESCR, Article 12(2)(c); see also European Social Charter, Article 11(1), (3)).

In this context, in realising the right to health, States must guarantee cross-cutting human rights principles of: equality and non-discrimination, participation, transparency and accountability.

SUMMARY OF RECOMMENDATIONS

We recommend that the UK comply with its international obligations to realise the right to health, including by:

- Taking immediate steps to avert future high mortality and a disproportionate burden on marginalized and vulnerable groups (i.e. older persons, BAME and poor communities);
- Enhancing its pandemic preparedness strategy, based on evidence from public health experts and guidance from the WHO, and through a participatory process, in order to prevent or better manage a second wave, including for marginalized groups;
- Ensuring an adequate supply of PPE for health workers and care home workers, including cleaners, to prevent or better manage a second wave;
- Enhancing its capacity to test suspected cases and trace their contacts to ensure public surveillance and prevent future waves;
- Managing localised lockdowns in a timely and transparent fashion to prevent or better manage a second wave;
- Restoring as much as possible access to essential health services for vulnerable non COVID patients including with the creation of COVID free hubs;
- Supporting the development and distribution of a vaccine in compliance with standards of the right to health, including the WHO criteria for COVID 19 vaccine prioritization;
- Providing human and material resources to the NHS and social care system to cope with the long term effects of the disease, with particular attention to vulnerable groups;
- Fostering international cooperation by sharing data on COVID 19, supporting the UN Comprehensive Response to COVID 19, and providing assistance to low and middle income countries on the DAC list; and
- A public inquiry into the UK's COVID 19 response should be framed by the full range of the UK's international human rights obligations including the right to health, and led by an independent body of experts.

In General Comment 14, the Committee on Economic Social and Cultural Rights ("CESCR") highlighted obligations that States are required to fulfil to realise the right to health, including:

- To adopt, implement and regularly review a public health strategy based on epidemiological evidence, participation and transparency, in order to address the health concerns of the whole population, particularly vulnerable groups;
- To realise the social determinants of health;
- To realise available, accessible, acceptable and good quality health care;
- To provide access to health information;
- To provide access to essential drugs as well as immunisation against major infectious diseases (CESCR, 2000).

These obligations must be realised at the domestic level and the transboundary level, through international cooperation (ICESCR, Article 2(1)). Additionally, the UK is a party to the International Health Regulations (WHO, 2005) which aim to prevent the spread of infectious diseases, with due attention to the protection of human rights.

Reflecting on the UK's response during and since the first wave, as well as the UK's international obligations to realise the right to health, this submission highlights some of the steps that the UK need to take in order to ensure that the measures adopted by its Government to address the COVID-19 pandemic are compliant with the right to health.

SPECIFIC AREAS OF CONCERN IN RELATION TO COVID-19 AND RECOMMENDATIONS

Minimising preventable deaths, and addressing the disproportionate risk of infection and death for marginalized and vulnerable groups

The fact that the UK has the highest number of deaths from COVID-19 and second highest excess death rate in Europe suggests that many deaths in the UK could have been prevented had the Government followed WHO guidelines in the early stages of the outbreak, learned from international experience, and acted upon earlier pandemic preparedness recommendations of UK bodies.

Research suggests that people from low socio-economic background are at higher risk of mortality, which cannot be explained by other risk factors such as underlying health conditions (Williamson et al, 2020). Incidence and mortality are also higher in Black, Asian and minority ethnic (BAME) communities, as well as in older people, especially those living in care homes (PHE, 2020a; PHE, 2020b).

RECOMMENDATION

The UK must protect everyone's right to health, on the basis of equality and non-discrimination (ICESCR, Articles 12(1) and 2(2); European Social Charter, Article 11), including through targeted measures where required (CESCR, 2020). We recommend that the UK take immediate steps to avert future high mortality and a disproportionate burden on marginalized and vulnerable groups. This should be done through the adoption and implementation of appropriate public health strategies, based on participatory processes, and which address the factors and social determinants that bear upon disparities.

Enhancing pandemic preparedness: learning lessons for the future

Despite the risks of an influenza-type pandemic identified by the National Risk Register for Civil Emergencies (Cabinet Office, 2015), the limitations of the UK's preparedness revealed by Exercise Cygnus (PHE, 2017) and the WHO Joint External Evaluation mission (WHO, 2019), findings from these reviews (including on PPE shortages, surge capacity preparedness, lab testing services and entry procedures for international travellers) were reportedly not communicated to key stakeholders or adequately acted on.

In the absence of a vaccine, the likelihood of a second wave is high. In an open letter, leaders of the medical, nursing and public health professions have recently highlighted that the UK is not adequately prepared for this; as it has failed to procure sufficient PPE, to step up national efforts to track and trace effectively, and to increase scrutiny in care homes (Adebowale et al, 2020).

RECOMMENDATION

The UK must prevent epidemic and endemic diseases (ICESCR, Article 12(2)(c)); and must adopt, implement and regularly review a public health strategy based on epidemiological evidence, participation and transparency, in order to address the health concerns of the whole population, particularly vulnerable groups (CESCR, 2000). We recommend that the UK conduct a public inquiry to learn lessons from its failures to comply with this obligation during the first wave. We also recommend that the UK enhance its pandemic preparedness strategy, based on evidence from public health experts and guidance from the WHO, and through a participatory process, in order to prevent or better manage a second wave and thereby, further realise the right to health for all.

Ensuring adequate supply of essential medical goods

From March to late April, during the peak of the pandemic, several testimonies showed a lack of PPE for healthcare workers. In May, the government announced that over 300 health workers and social workers had died of COVID-19 since March 2020. Care homes also lacked the necessary equipment because suppliers prioritised the NHS, whilst PPE guidance for care home workers deviated from WHO's recommended standards in several respects (Lewis, 2020).

RECOMMENDATION

The UK must protect everyone's right to health (ICESCR, Article 12(1); European Social Charter, Article 11), including health workers and care home workers (CESCR, 2020; European Committee of Social Rights, 2020). We recommend that the UK conduct a public inquiry to learn lessons from its failures to comply with this obligation during the first wave; and that it ensure an adequate supply of PPE for health workers and care home workers (including cleaners) to prevent or better manage a second wave and thereby, further realise the right to health.

Testing, contact tracing and surveillance

Testing and contact tracing are a mainstay of infectious disease control (Sekalala and Harrington, 2020). Despite interim guidance from WHO issued on 7th March (WHO, 2020b) to test all suspected cases and trace contacts, as well as positive experiences of widespread testing from other jurisdictions such as Germany, Singapore and South Korea, the UK government halted community testing on 12th March. Continuing testing could have saved lives.

Further, testing was also not available in care homes, and until mid-April, there was no requirement for persons discharged from hospitals into care homes to have a COVID-19 test. Testing shortcomings continued during the lockdown. Despite limited capacity, Public Health England restricted the conduct of tests to its own laboratories and ignored help from universities. Testing capacity scaled up slowly and did not allow NHS workers and social care workers to be tested regularly, diminishing the human capacity in the health sector due to self-isolation amongst its workforce. The Test and Trace service was only launched on 28th May, after the first eases on the lockdown were implemented.

There have also been significant shortcomings in terms of communicating second pillar testing data with local public health authorities and primary and secondary care (UK Statistics Authority, 2020).

RECOMMENDATION

The right to health requires the prevention of epidemic and endemic diseases (ICESCR, Article 12; CESCR, 2000). The WHO evidences that this is best achieved through public health surveillance, by testing suspected cases and tracing their contacts (WHO, 2020b). We recommend that the UK conduct a public inquiry to learn lessons from its failures to complywith this obligation during the first wave; and that it guarantees robust testing and contact tracing capacity and surveillance in order to prevent or better manage a second wave and thereby, further realise the right to health (European Committee Social Rights, 2020).

Adopting lockdown measures

The Government's strategy prior to lockdown on 23 March would have costed an estimated 260,000 lives and overwhelmed the NHS (Ferguson et al, 2020). It ignored WHO interim advice issued on 7 March to consider cancelling mass gatherings and closing schools, public transportation and workplaces (WHO, 2020b). The week preceding the lockdown, while the official advice was to stay at home, employers had the power to decide who should travel to the office, social venues remained open, and sporting events were not forced to close. Strong compulsory measures were only implemented on 25 and 26 March by the Coronavirus Act 2020 and the Health Protection (Coronavirus, Restrictions) Regulations 2020. The UK was also very late in coming with a plan for quarantining people who were coming from countries in which COVID-19 was already endemic.

The UK only implemented a national lockdown on 23 March. By that time, lockdowns were already in force for several weeks in other European countries. Former SAGE member Neil Ferguson, and Chief Medical Officer Chris Whitty, have subsequently suggested that locking down one week earlier would have halved the death toll (Stuart, Sample, 2020).

Furthermore, the only localised lockdown to date (Leicester) highlights a lack of transparency from the Government for not providing data in a timely fashion and not communicating the threshold for localised lockdowns.

RECOMMENDATION

The right to health requires the UK to adopt, implement and regularly review a public health strategy based on epidemiological evidence, participation and transparency (CESCR, 2000). We recommend that the UK conduct a public inquiry to learn lessons from its failures to comply with this obligation during the first wave; and that it adopt

lockdown measures (at a local or national level), if required, in a timely, participatory and transparent fashion, providing support to avoid undermining social and economic rights, to prevent or better manage a second wave and thereby, further realise the right to health.

Managing the disrupted access to other health services due to COVID-19

Access to both general and acute care services has been severely affected since the beginning of the pandemic, with a significant impact on individuals with underlying health conditions. Whilst recognising the exigencies of the COVID-19 outbreak, we are particularly concerned that cancer screening programmes in the UK were paused from mid March to mid-June. New estimates predict a 20% increase in cancer deaths in the next 12 months among new diagnoses, as well as additional deaths due to late diagnoses and delayed treatments (Wise, 2020). We are also concerned that all elective surgeries were suspended on 17 March, carrying risks of significant harm to patients.

RECOMMENDATION

The UK must protect everyone's right to health, ensure access to health care facilities and services on a non-discriminatory basis, and guard against retrogression in service provision (ICESCR, Article 12; CESCR, 2000). We recommend that the UK immediately implement additional measures to minimise the disruption of essential health services for non-COVID patients, including with the creation of COVID-free hubs to treat these patients.

Planning for vaccine development and distribution

In the event of a successful COVID-19 vaccine, decisions about distribution, within the UK and globally, must be compliant with relevant right to health obligations. Therefore, the UK should: make it available in sufficient quantity; distribute it in priority to individuals who are more likely to contract COVID-19 and those whose health is at higher risk of being seriously compromised by COVID-19. The UK should also ensure that a COVID-19 vaccine is: distributed within safe physical reach for all; affordable for all; respectful of key medical ethics concepts such as patients' protection, consent and confidentiality; safe and of a quality acceptable by clinical standards (CESCR, 2000). Finally, a COVID-19 vaccine should be distributed globally on an equitable basis and for free, through use of flexibilities in intellectual property regimes (CESCR, 2020).

RECOMMENDATION

It is fundamental that the UK prepares immediately for the deployment of a COVID-19 vaccine in order to facilitate a speedy, efficient and right to health-compliant process. Therefore, we welcome the independent report from the UK Joint Committee on Vaccination and Immunisation (JCVI) on the groups that should be prioritised for vaccination (18 June 2020) and remind the UK of the WHO criteria for COVID-19 vaccine prioritization (WHO, 2020c).

Coping with the long-term health effects of COVID-19

While uncertainty remains on the long-term effects of COVID-19, preliminary observations suggest damage to the lungs, heart, brain, kidneys, gastrointestinal tract and the nervous system; as well as effects on mental health. We welcome the £8.4 million research into the long-term effects of the disease, and the launch of the COVID-19 rehab service.

RECOMMENDATION

The UK must devote maximum available resources to realise the right to health for all (ICESCR, Articles 2(1) and 12). We recommend that the UK provide human and material resources to the NHS and social care system to cope with the long-term effects of the disease, with particular attention to vulnerable groups.

Complying with transboundary obligations under the right to health

The UN Secretary-General, the WHO and the CESCR have called for international cooperation and solidary in the response to COVID-19 (WHO, 2020a; CESCR, 2020). The CESCR has clarified that this should include: "*sharing of research, medical equipment and supplies, and best practices in combating the virus; coordinated action to reduce the economic and social impacts of the crisis; and joint endeavours by all States to ensure an effective, equitable economic recovery. The needs of vulnerable and disadvantaged groups as well as fragile countries, including least developed countries, countries in conflict and post-conflict situations, should be at the centre of such international endeavours*" (CESCR, 2020).

In this statement, the CESCR has also emphasised the importance of sharing the best scientific knowledge to expedite the discovery of effective treatments and vaccines, and the promotion of flexibilities in intellectual property regimes to allow universal access to the benefits of scientific advancements relating to COVID-19 such as diagnostics, medicines and vaccines (CESCR, 2020; also see Harrington and Sekalala, 2020; and Bueno de Mesquita and Mason Meier, 2020).

RECOMMENDATION

These obligations are particularly important considering the leading role of the UK in the development of a COVID-19 vaccine, as the vaccine researched by the University of Oxford/AstraZeneca is at the most advanced stage of clinical trials worldwide. Therefore, the UK should ensure that its actions are guided by the promotion and protection of the right to health worldwide, in line with its obligations under the ICESCR as discussed above. The UK should also fully support the UN Comprehensive Response to COVID-19, and provide assistance to low- and middle-income countries on the DAC list.

ACCOUNTABILITY AND INQUIRY

Accountability is a central preoccupation of human rights law and will be central to assess responses as well as improve health systems and related services in the face of COVID-19. Accountability, which requires monitoring, independent review, remedies and redress, can only be achieved where there is transparency surrounding decision making (Bueno de Mesquita, Evans and Fuchs, 2018). Assessing the UK's compliance with right to health standards will entail reviewing the adequacy of its health system, by examining its attempts to protect human dignity, to not discriminate, and to integrate fast-moving public health expertise (Lougarre, 2015) in the face of COVID-19.

RECOMMENDATION

We recommend that a future public inquiry into COVID-19 must be framed with reference to the full range of international human right obligations of the UK, including the right to health. Review, through an inquiry, must be performed by an independent body.

AUTHORS

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