



Guest Editorial

Is Health a Fundamental Right for Migrants?

PASCALE ALLOTEY

In the last decade or so, the links between health and human rights have been increasingly promoted as an additional advocacy tool to address the protection of human rights and health care for marginalized populations. While the notion of health as a human right may seem intuitive, and is indeed supported by several of the international human rights instruments that arise from the Universal Declaration of Human Rights, the implementation of a rights-based approach in health is not without its problems. Most health practitioners in various speciality areas deal with disease rather than *health*. The field of public health, closest in its mandate to a broad focus on health and not merely the absence of disease, remains largely within a paradigm of 'dynamic disease within a status quo society' (Mann, 1995: 230). So what exactly does a right to health mean?

General Comment 14 of the International Covenant on Economic Social and Cultural Rights comments on the right to the highest attainable standard of health (Committee on Economic Social and Cultural Rights, 2000). This has been largely translated as a right to health *care* and has enabled a focus on ensuring that the rights of individuals are not violated through the creation of structural and other barriers to the access to healthcare facilities. The approach has had some success with patients who are HIV positive, where stigmatization and discrimination have been particularly problematic within healthcare delivery. The application of the principles in international law to remind governments and relevant authorities of their obligations to their populations is of great value. Obligations towards migrants,¹ however, introduce a further challenge.

As Castles points out in this issue, populations have always and will always move for a range of reasons. The World Bank figures for people living outside their country of birth in 1995 were estimated at 125 million (World Bank,

1995). In 2000, the International Organization for Migration (IOM) revised this figure upwards to 150 million. Globalization, conflict and environmental disasters have all contributed to the need for populations to be mobile. However, while governments, particularly those of developed countries, have promoted globalization for economic and (arguably) development reasons, they have become increasingly reluctant to accept migration as one of the consequences of opening up markets for the exchange of goods and services. Restrictive migration policies in many countries have been open to the scrutiny of human rights organizations and have revealed a plethora of human rights violations of migrants in general and refugees in particular (Human Rights Watch, 2002; Taran, 2002; Allotey and Reidpath, 2003). In spite of significant gains in the human rights area, states have resisted the adoption of any global standards for non-nationals so that there are countries that take pride in their human rights record notwithstanding violations of the rights of non-nationals within their borders (Helton, 2002).

The marginalization and health of migrant populations are a growing public health concern as they represent one of the most 'at need' groups in the world. Compared with the dominant population of richer host countries migrants generally have worse physical and mental health outcomes and this has in fact been cited as a reason for restrictive immigration policies. There is a concern about the spread of communicable diseases; some that would be new to host countries if endemic in the migrants' countries of origin, and others which are re-emerging, having previously been controlled, due to poor health and hygiene conditions in crowded refugee and internal displacement camps. In addition, countries like Australia reject applications for migration, even for family reunion, if the applicant presents with a health problem that is likely to impose an excessive cost on the country's healthcare system. One may recall an incident a few years ago in Australia when a migrant father set himself alight outside the parliament in protest against the department of immigration's continued rejection of his disabled child's application to join him. For refugees in particular, there is the potential for long-term

physical and mental health problems as a consequence of traumatic experiences prior to and during the process of migration. In addition, migrant workers predominate in the lower income labour market with higher risks of exposure to unsafe working conditions. Women migrants have a higher risk of being victimized in the work place and of being subjected to sexual exploitation with its associated reproductive and mental health consequences. The health needs of migrant groups are often reflected in the high level of support required for healthy resettlement and 'integration'.

Restrictive immigration policies to prevent the entry of migrants from particular countries or particular categories are, arguably, the prerogative of sovereign states. However, for migrants or non-nationals within the borders of countries that are signatories to the international human rights instruments, governments are obliged to ensure the protection of their rights from the point of arrival within their borders. These human rights instruments include the Universal Declaration of Human Rights (UDHR), the International Covenant on Economic Social and Cultural Rights (ICESCR), the International Covenant on Civil and Political Rights (ICCPR), the Convention on the Status of Refugees, and the Convention on the Rights of the Child (CRC) among others. Under these instruments are contained rights that are fundamental and non-derogable. These include, for instance, the right to life and to freedom (Tiburcio, 2001). Others, such as political rights that grant the right to participation in the political process and to vote are often granted to citizens to the exclusion of migrants. The controversy arises in two areas: in the determination of which rights can be legally formulated to exclude non-citizens when human rights are incorporated into domestic legislation and in the definition of the legal status of the migrant with regard to immigration policy and in some cases with regard to citizenship. Bhabha, in this issue, highlights the complexities of citizenship and rights with some interesting conclusions. However, with the exception of developing countries that may deny some economic rights to non-nationals as a result of limited resources (ICESCR article 2(3)), the general rule is that human rights must be

guaranteed without discrimination between citizens and non-citizens (Knight, 1995).

In this issue, Johnston and Allotey elaborate on some of the specific restrictions on access to health care for particular migrant groups. In addition, lack of access to schools, support for housing and authorization to engage in lawful employment all constitute violations of human rights and all have a direct impact on the health of individual migrants and family groups. A recent review of the mandatory detention policy for unauthorized arrivals in Australia found that the period of detention was punitive and conditions within the detention centres breached the International Covenant Relating to Torture and Other Cruel or Degrading Treatment. The detention of children in particular was a clear violation of the CRC (Bhagwati, 2002). Children had limited access to recreational facilities and education and were subject to solitary confinement as punishment for minor misdemeanours. The effect on the normal development and mental health of the children has been well documented.

Increasing xenophobia and the resulting discrimination discussed by Quraisy in this issue also constitutes a violation of the human rights of migrants. Again while most countries have some legislative framework to counter racism and discrimination, it is very rarely used in the case of migrants because of their lack of knowledge of their rights and the legal system, and the uncertainty in their legal status. There are also clear power differentials created by the need for the expression of gratitude for the opportunity of 'the better life' offered in the host country and the reluctance therefore to appear ungrateful by making waves. Unfortunately, discrimination, neglect and/or violations of human rights are widespread in both developed and developing countries in spite of criticism from human rights organizations and ultimately the persistent barrier is the ability to balance international treaties against states' rights. More recent efforts towards global action culminated in The Hague Declaration with the expectation of a more humane approach to migrants and migration, the process of which is described in this issue by the Secretary General of the United Nations, Kofi Annan, and Philip Rudge.

So do migrants have a right to health? Where there are clear guiding principles about the entitlements of citizens and non-citizens or non-nationals, *access to health care* can be argued as an issue of resource allocation, giving states the right to decide the nature of access. The rights required to ensure health invariably put the onus on governments to provide the social goods, infrastructure and services. As a result, access to many of these social goods is treated by many governments as a privilege and not a right, a privilege provided by citizenship from which various categories of migrant groups are excluded. The morality of that argument is a separate issue.

In ensuring the right to *health*, the human rights framework would be much more effective with a reconceptualization of what health is. There is a need for an acknowledgement that health extends to the underlying determinants including adequate nutrition, housing, healthy environmental and occupational conditions, access to health-related education and information as well as access to health care and education. The human rights framework requires an increased focus on the societal and contextual conditions within which people live, recognizing the rapid and continuous changes in society, culture, environment and political influences, as well as in disease and health technology. Programmes for migrant health need to incorporate these areas and include them in the indicators for the evaluation of the success of interventions. In addition, interventions that address stigmatization, racism and discrimination need to target not only the migrant groups, but also the wider population with critical involvement of the media.

The late Jonathan Mann suggested:

... that a society in which human rights are promoted and protected, and in which human dignity is respected is a healthy society; that is, a society in which people can best achieve physical, mental and social well-being. While a healthy society may not preclude disease, within the limits of available resources, all people, [including migrants] could enjoy the 'highest attainable standard of health'. (Mann, 1995: 230)

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Note

1 Migrant is used here to refer to populations outside their countries of birth voluntarily or through the complex process of forced migration (see Castles). Much of the vulnerability and the health problems raised here relate to those who move from developing to more developed host countries and are minorities within the host country setting. There is also usually some uncertainty about their status as citizens of the host country (Taran, 2000; Duckett, 2001).

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