

# Addressing health inequalities in times of COVID-19

Minorities and indigenous peoples between deeply rooted and new, emerging forms of discrimination

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## Abstract

In numerous countries, the spread of the COVID-19 epidemic has affected ethnic, racial and religious minorities most severely, along with indigenous peoples. On one hand, the pandemic is laying bare the presence of deeply rooted patterns of discrimination in access to health; on the other hand, for some states and non-state actors, it also represents a useful opportunity to persecute particular ethnic and religious minorities through additional forms of discrimination, labelling, stigmatization and scapegoating.

## Keywords

COVID-19, right to health, minorities, indigenous peoples.

## 1. Introduction

From the early stages of the spread of the COVID-19 epidemic in different parts of the world, the disaggregated data collected in various countries have shown that ethnic and religious minorities and indigenous peoples have been at higher risk of contracting and dying from the virus. The more severe impact of the virus on these population groups can be explained by several factors, but it is indisputable that the current pandemic has contributed to further deepening the conditions of discrimination and vulnerability faced by those groups. In general, the health impact of COVID-19 reflects deeply rooted patterns of discrimination in access to health services that, in turn, reflect the presence of a broader system

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of multi-sectoral discrimination based on ethnic, racial or religious affiliation. Furthermore, since the outbreak of the pandemic an increase in other forms of discrimination has been reported, such as stigmatization, labelling and scapegoating, which have often resulted in discriminatory acts, violence and denial of access to healthcare.

This article explores how minorities and indigenous people have experienced the COVID-19 pandemic, focusing on the egregious combination of pre-existing systems of discrimination and new forms of discrimination directly related to the spread of the pandemic. It examines types of discrimination in health against those specific population groups from an international law perspective, and more specifically through the lens of the human rights approach. The current pandemic is indeed highlighting the fundamental conflict between (recent and less recent) discriminatory practices in health and several fundamental international law provisions on human rights, particularly those concerning the right to health.

## **2. The role played by the social determinants of health and barriers to health in creating and consolidating health disparities against minorities and indigenous peoples**

A vast literature has extensively documented the existence, in multi-ethnic and multiracial states, of a serious gap in disease incidence and life expectancy between people belonging to minorities and indigenous peoples, on one hand, and the rest of the national population on the other hand.<sup>2</sup> Especially in developing countries but also in developed countries, the status of health among people belonging to those groups is different from that of the rest of the population. The causal factors fall into two categories: social determinants of health (SDH) and barriers to health. These two distinct but related concepts both describe non-medical factors which have a direct impact on health status.

The existence of this link was stressed by the United Nations World Health Organization (WHO) Conference convened in Alma Ata in 1978, and by the Declaration adopted at the end of that conference. From that point onward, both the UN – in particular through the adoption of the Millennium Development Goals

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<sup>2</sup> Institute of Medicine, 'Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care', The National Academies Press, Washington, DC, 2003; Leonard E. Egede, 'Race, Ethnicity, Culture, and Disparities in Health Care', *Journal of General Internal Medicine*, 2006, 21(6):667-669; Jason Schnittker, Mehul Bhatt, 'The role of income and race/ethnicity in experiences with medical care in the United States and United Kingdom', *International Journal of Health Services*, 2008, 38(4):671-95; Lindsey Konkel, 'Racial and Ethnic Disparities in Research Studies: the Challenge of Creating More diverse Cohorts', *Environmental Health Perspectives*, 2015, 123 (12):297-302; Odette Mazel, 'Indigenous Health and Human Rights: A Reflection on Law and Culture', *International Journal of Environmental Research & Public Health*, 2018, 15:789.

and more recently the Sustainable Development Goals<sup>3</sup> – and WHO, with its 2011 Rio Political Declaration, have recognized the central role played by SDH. According to the definition given by WHO’s Commission on the social determinants of health, SDH are “the conditions in which people are born, grow, live, work and age” and the fundamental drivers of these conditions.<sup>4</sup> These factors have been defined as “the cause of the causes of health disparities”<sup>5</sup> since they create the conditions for the origin of health disparities and contribute to creating a vicious cycle: the poorest, most vulnerable and most marginalized segments of the population have no access to health services because they are poor and marginalized, and their condition of marginalization and poverty is a primary source of illness and disease.<sup>6</sup>

Although the interrelationship between poverty, marginalization and the burden of disease seems obvious, it is actually more complex than it appears. What seems uncontroversial is that health generally improves as social position increases. In this respect, the interaction between SDH and the above-mentioned barriers to health plays a central role in creating and consolidating disparities. A number of social and economic factors such as education, employment opportunities, income, and possessions impact each individual’s access to various material resources (such as proper housing, food, and sanitation and a healthy workplace) on which health depends. These factors interact with barriers to health such as the geographical location or absence of health facilities and structures, or the incompatibility of health services with the prospective recipient’s cultural and religious background, to make healthcare unaffordable, unacceptable or unavailable for some segments of the national population.

Access to health is also basically affected by the functioning of national health systems. In numerous countries where access to health services – most significantly, hospitalization – is determined by the ability to pay out of pocket, the ability to receive adequate treatment in case of illness is almost nil for those who cannot afford the cost. A pernicious combination of environmental and personal factors can therefore substantially impair access to treatment, hospitalization and basic health services which could be essential for health or even survival.

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3 Michel Marmot, Ruth Bell, ‘The Sustainable Development Goals and Health Equity’, *Epidemiology*, 2018, 1:5-7; Ahmad Reza Hosseinpoor, Nicole Bergen, Anne Schlottheuber, John Grovea, ‘Measuring health inequalities in the context of sustainable development goals’, *Bulletin of World Health Organisation*, 2018, 654-659.

4 WHO, World Conference on Social Determinants of Health, Rio Political Declaration on Social Determinants of Health, 2011, at para 6.

5 Paula Braveman, Laura Gottlieb, ‘The Social Determinants of Health; It’s Time to Consider the Cause of the Causes’, *Public Health Rep.* 2014, 129 (Suppl. 2):19-31.

6 Paul Farmer, ‘Social Inequalities and Emerging Infectious Diseases’, *Emerging and Infectious Diseases*, 1996 Oct-Dec., 259-269.

Clearly, the underlying problem is the unequal distribution of social and economic factors that make healthcare inaccessible and unavailable.<sup>7</sup> In this respect, policy choices and the government strategies can make a difference. Usually, the combination of SDH and barriers to health, and the resulting discriminatory practices, are the direct consequence of policy choices, economic programmes and bad governance. In 2008, the WHO Commission on SDH pointed out that “where systematic differences in health are judged to be avoidable by reasonable action, they are, quite simply, unfair.”<sup>8</sup> The Commission also stressed that the unequal distribution of health-damaging experiences “is not in any sense a natural phenomenon but is a result of a toxic combination of poor social policies and programmes, unfair economic arrangements and bad politics.”<sup>9</sup> In the Commission’s view, action on SDH is therefore essential “to create inclusive, equitable, economically productive and healthy societies.”<sup>10</sup>

The dimensions of inequality differ from one country to another. However, although in general the presence of more disadvantaged segments of the national population and the consequential problem of health inequities are pervasive issues, the problem takes on a further dimension in countries characterized by the presence of ethnic, racial and religious minorities and indigenous peoples, regardless of the level of that country’s development.<sup>11</sup> Very often, even in developed countries, the condition of belonging to ethnic or racial groups or indigenous peoples and the condition of economic and social marginalization coincide;<sup>12</sup> ethnic and minority groups are indeed disproportionately affected by socio-economic

7 Hilary Graham, ‘Social determinants and their unequal distribution: clarifying policy understandings’, *Milbank Quarterly*, 2004, 82 (1):101-124.

8 WHO, *Closing the gap in a generation: health equity through action in the social determinants of health – Final report of the Commission on social determinants of health, 2008*, WHO/IER/CSDH/08:4.

9 *Ib.*:5.

10 WHO, *Rio Declaration*, cit., para 6.

11 Angela Durey, ‘Reducing racism in Aboriginal healthcare in Australia: where does cultural education fit?’ *Australian and New Zealand Journal of Public Health*, 2010, 34 (1):87-92; European Commission, *Roma Health Report*, Brussels, 2014; Phyu Phyu Thin Zaw, Thant Sin Htoo, Ngoc Minh Pham, Karen Eggleston, ‘Disparities in health and health care in Myanmar’, *The Lancet*, 21 Nov 2015, 386 (10008):2053; Shawnita Sealy-Jefferson, Jasmine Vickers, Angela Elam, M. Roy Wilson, ‘Racial and Ethnic Health Disparities and the Affordable care Act: a Status Update’, *Journal of Racial and Ethnic Health Disparities*, 2015, 2:583-588; Kun Tang, Yingxi Zhao, ‘Health as a bridge to peace and trust in Myanmar: The 21st Century Panglong Conference’, *Globalisation and Health*, 2017, 13:40; United Nations, *State of the World’s Indigenous Peoples: Indigenous Peoples’ Access to Health Services*, New York, 2018; UNDP, *Health deprivation among Roma in the Western Balkans*, 2018; Wang, Y.J., Chen, X.P., Chen, W.J. et al. ‘Ethnicity and health inequalities: an empirical study based on the 2010 China survey of social change (CSCS) in Western China’, *BMC Public Health*, 2020, 20:637; Veena Raleigh, Jonathon Holmes, ‘The health of people from ethnic minority groups in England’, 2021. Available at: <http://bit.ly/3F6UJ3q>; Oxfam, *India Inequality Report 2021: India’s Unequal Healthcare Story*, 20 July 2021. Available at: <http://bit.ly/3h2sTgL>.

12 UNDP, *Marginalised Minorities in Development Programming*, 2010; United Nations, *Indigenous peoples and ethnic minorities: Marginalization is the norm*, *The Report on the World Social Situation 2018. Promoting Inclusion Through Social Protection*, September 2018, 97-108; The World Bank, *Everyone Equal: Making Inclusive Growth a Priority for Ethnic Minorities*, 13 July 2020. Available at: <http://bit.ly/3Fzb8z4>.

deprivation, with the result that these groups are more vulnerable and exposed to illness and mortality.

Racial and ethnic health disparities can therefore be the consequence of a complex combination of low socio-economic status, less healthy lifestyles and poor access to care. Even in countries where access to care is guaranteed to the vast majority of the population, recourse to healthcare is prevented by other factors, such as lack of documentation of residential status. The lack of access to healthcare could be a consequence of the fact that some segments of the population are invisible; for example, the lack of documents attesting to citizenship or permanent residence excludes numerous people, particularly those belonging to ethnic and religious minorities as well as irregular migrants, from all sorts of state-subsidized social benefits, including healthcare. This problem, in different ways, is shared by various developed nations, including the United States, Canada, Australia and European countries.<sup>13</sup> Even in Europe, although most health systems cover nearly the whole population, the problem of health disparities remains challenging. The European Union has long been focusing on the problem of unequal access to health services and the need to outline specific policies to handle this issue and meet the needs of vulnerable groups.<sup>14</sup>

### **3. The spread of the COVID-19 pandemic, minorities and indigenous peoples: a spotlight on inequality**

The problem of health disparities is not confined to special circumstances or phases. The combination of SHD and barriers to health plays a primary role in shaping these disparities under normal conditions; these factors become even more important in times of emergency. In such situations, it can indeed produce extremely pernicious effects. In this respect, the ongoing pandemic is not only putting national health systems under exceptional pressure but is also laying bare their shortcomings, revealing the existence of deeply rooted patterns of discrimination, and exacerbating existing inequalities in health and living conditions.

From the earliest stages of the pandemic's spread, data showed that in both developed and developing countries, ethnic minorities and indigenous peoples were (and still are) generally at higher risk of contracting and dying from the

<sup>13</sup> 'Stateless. No legal identity. Few rights. Hidden from society. Forgotten', *Forced Migration Review*, Issue 32, April 2009; Timon Forster, Alexander Kentikelenis, Clare Bambra, *Health Inequalities in Europe: Setting the Stage for Progressive Policy Action*, Dublin, 2018; UNDP, *Health deprivation among Roma in the Western Balkans*, 2018; Rasha Al-Saba, 'COVID-19, Minorities, and Indigenous peoples: The Litmus Test of Equality', *VerfBlog*, 2021/4/24. Available at: <http://bit.ly/3Pa8EdG>.

<sup>14</sup> European Commission Staff Working Document, *Report on health inequalities in the European Union*, SWD (2013) 328 final; European Commission, *Inequalities in access to healthcare. A study in national policies*, 2018.

virus. Disease incidence and mortality rates were higher among black communities in the USA<sup>15</sup> and United Kingdom<sup>16</sup> – the so-called BAME communities – as well as among indigenous peoples in the Amazon subregion<sup>17</sup> and Afro-descendants in various Latin-American countries.<sup>18</sup> A comparable situation of ethnicization of the COVID-19 epidemic was found in several European countries. European institutions – in particular the European Commission and the European Fundamental Rights Agency – pointed out that Roma communities were facing a much higher risk of contracting the virus and of dying once infected.<sup>19</sup> In the same vein, several studies carried out in European countries including Norway and Denmark showed that the highest risk of COVID-19 infection was among people born in Somalia, Afghanistan, Iraq, Ethiopia, Morocco and Lebanon.<sup>20</sup>

The pandemic is highlighting the importance of the role played by SDH and barriers to health in preventing the most marginalized segments of the population not only from having access to health services, but also from taking basic and fundamental measures to protect themselves against illness.<sup>21</sup> COVID-19 has exacerbated long-standing situations of exclusion, deprivation, and discrimination against the most disadvantaged segments of the population. In numerous countries, the national health system does not guarantee access to healthcare and health services in a non-discriminatory manner, owing to different factors ranging from individuals' ability to pay out of pocket for healthcare, to the absence of health infrastructures and facilities in the areas where those people live, to a

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- 15 Cf. CDC, 'Introduction to COVID-19 Racial and Ethnic Health Disparities', December 2020. Available at: <http://bit.ly/3VEzxZl>; Lopez, Harts, Katz, 'Racial and Ethnic Health Disparities Related to COVID-19', *JAMA*, 2021, 23:719-720; Tai, Shah, Doubeni, Sia, Wieland, 'The Disproportionate Impact of COVID-19 on Racial and Ethnic Minorities in the United States', *Clinical Infectious Diseases*, 2021, 72, 2021:703-706; Adelle Simons, Andre Chappel et. al., 'Health Disparities by Race and Ethnicity During the COVID-19 Pandemic: Current Evidence and Policy Approaches, ASPE Issue Brief, 16 March 2021.
- 16 Cf. Mrigesh Bhatia, 'COVID-19 and BAME Group in the United Kingdom', *The International Journal of Community and Social Development*, 2, 2020, 271-274; Public Health England, 'Beyond the data: Understanding the impact of COVID-19 on BAME groups', 2020; Kausik Chaudhuri, Anindita Chakrabarti, et. al., 'The interaction of ethnicity and deprivation on COVID-19 mortality risk: a retrospective ecological study', *Scientific Reports* Jun 2021. Available at: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8172854/>.
- 17 Cf. World Economic Forum, 'How coronavirus is affecting indigenous people in the Amazon', 29 April 2020. Available at: <http://bit.ly/3ExoSKx>; PAHO, 'The Impact of COVID-19 on the Indigenous Peoples of the Region of the Americas Perspectives and Opportunities, 30 October 2020; Lucas Ferrante, Philip M. Fearnside, 'Protecting Indigenous peoples from COVID-19', *Science*, 17 April 2020, 368(6488):251-252.
- 18 UN ECLAC, 'People of African descent and COVID-19: unveiling structural inequalities in Latin America', COVID-19 Reports, January 2021.
- 19 FRA, 'Coronavirus pandemic in the EU: Impact on Roma and Travellers, 1 March-30 June 2020; Overview of the impact of Coronavirus measures on the marginalised Roma communities in the EU, 2020. Available at: <http://bit.ly/3ijTTSn>.
- 20 NIPH, 'Systematic Review: Incidence and severe outcomes from COVID-19 among immigrant and minority ethnic groups and among groups of different socio-economic status, Report 2021.
- 21 Charles Agyemang, Anke Richters, Shahab Jolani, et. al., 'Ethnic minority status as social determinant for COVID-19 infection, hospitalisation, severity, ICU admission and deaths in the early phase of the pandemic: a meta-analysis', *BMJ Global Health*, 6 Nov 2021, 11:1-14; Andres Felipe Valencia Rendon, Isabela Mendes Volschan et. al., 'Marginalization, Vulnerability and Economic Dynamics in COVID-19', *International Journal of Cardiovascular Sciences*, 2021, 34(3):319-323.

more general problem of social exclusion. Moreover, the COVID-19 pandemic has some peculiarities. In the current phase, the adoption of a series of preventive measures is proving to be of fundamental importance in preventing the spread of the disease and in protecting the health of each individual. Both environmental and individual measures – hygiene, sanitization of places, frequent use of soap and disinfectants, face masks – and the ability to maintain a safe physical distance from others have proven essential for protection against the virus. The adoption of these measures can, however, be nearly impossible where the poorest and most vulnerable segments of the national population live. In many such settings, residents are more exposed to becoming infected or dying from COVID-19 due to poor access to running and clean water, washing facilities, soap and disinfectant; scarcity of sanitation and waste disposal systems; the high concentration of people in overcrowded areas and slums; multigenerational households; and/or living far away from hospitals and health centres. The ability to meet health care costs together with the increased exposure to the risk of infection and, last but not least, higher rates of comorbid chronic conditions – a situation that very frequently characterizes members of ethnic and racial minorities – is making a difference in the current pandemic, increasing the incidence of infection among minorities and indigenous peoples.<sup>22</sup> Again, this situation has arisen in developed countries, such as Canada,<sup>23</sup> as well as in developing ones.

A similar point can be made with regard to the additional adverse effects produced by the spread of the pandemic. In various countries, the pandemic has provided a useful opportunity for governments to adopt intentionally discriminatory measures. Since the beginning of the pandemic, various NGOs and human rights defenders have warned about an increase in different forms of discrimination against minorities, particularly ethnic and religious minorities. All measures taken by states to limit the spread of the virus and the number of fatalities – the closure of non-essential businesses, schools and borders, as well as other restrictions on movement aimed at enforcing social distancing such as curfews and lockdowns – should indeed be legally grounded. However, since the outbreak of the pandemic, the adoption of unjustified, more restrictive measures towards some specific groups has been repeatedly denounced. For example, the alarm was raised about the conditions of African immigrants and Uighurs in China,<sup>24</sup> of Roma in various

22 Efrat Shadmi, Yingyao Chen, Inês Dourado et. al. 'Health equity and COVID-19: global perspectives', *International Journal for Equity in Health* 2020, 19:1-16; Claire Bamba, 'Pandemic inequalities: emerging infectious diseases and health equity', *International Journal for Equity in Health*, 2022, 21:1-4.

23 Emily Thompson, Rojemiahd Edjoc, Nicole Atchessi, et. al., 'COVID-19: A case for the collection of race data in Canada and abroad', *Canada Communicable Disease Report* 2021;47(7/8):300-304.

24 HRW, China: COVID-19 Discrimination Against Africans, 5 May 2020. Available at: <http://bit.ly/3XnYusf>; Michel Caster, 'COVID diplomacy' fuelled by Uygur oppression. Available at: <https://minorityrights.org/programmes/library/trends2021/china/>.

European countries,<sup>25</sup> and of Rohingya and other ethnic and religious minorities in Myanmar.<sup>26</sup> Furthermore, since the outbreak of the epidemic, an increase in scapegoating, labelling, stigmatization, and racist speech against minorities or those who are regarded as belonging to lower castes has been reported. This was the case with the Shi'a minority in Pakistan,<sup>27</sup> the Muslim minority in India and Sri Lanka<sup>28</sup> and the Roma communities in several European countries.<sup>29</sup> They have been scapegoated and blamed for spreading the virus, both by the general population and by public officials.

This situation raises serious concerns about the possibility of effectively protecting vulnerable groups from the pandemic and ensuring that they enjoy the right of access to healthcare and necessary health treatments. Most importantly, it is clearly in contrast with the provisions of international law on human rights and, more specifically, with general provisions that prohibit discrimination.

#### 4. The right to health and the prohibition of discrimination in international human rights law

In the debate on the prohibition of discrimination in the general system of the international law on human rights, a central point is represented by the nature and scope of the principle of non-discrimination. This principle can be indeed considered as a sort of foundational norm that inspires the entire system of international human rights law and is, as such, incorporated in the most relevant international instruments adopted both at universal and regional levels. These instruments – led by the United Nations Covenants on civil and political rights

25 ERRC, Roma Rights in the Time of COVID, 9 September 2020, <http://www.errc.org/reports-submissions/roma-rights-in-the-time-of-covid>; Amnesty International, 'Europe: Policing the Pandemic. Human Rights Violations in the Enforcement of COVID-19 Measures in Europe', 24 June 2020. Available at: <https://www.amnesty.org/en/documents/euro1/2511/2020/en/>.

26 Marlene Spoerri, Yasmin Ullah, N. Chloé Nwangwu, 'The Rohingya and COVID-19. Towards an Inclusive and Sustainable Response', Independent Diplomat, Policy Report, July 2020. Available at: <http://bit.ly/3UE7fNB>.

27 Jaffer Abbas Mirza, 'COVID-19 Fans Religious Discrimination in Pakistan', The Diplomat, 28 April 2020; Ruchir Joshi, Esha Joshi, 'COVID-19: A Catalyst for Minority Exploitation in Pakistan', Journal of International Affairs, 8 July 2020; Did 'Shia virus' blame affect attitudes towards Pakistan's Shia Hazara, Institute of Development Studies, 12 March 2021. Available at: <http://bit.ly/3iy8HU8>; British Home Office, 'Country Policy and Information Note. Pakistan: Shia Muslims', July 2021. Available at: <http://bit.ly/3P3VUVT>.

28 Amjad Nazeer, 'India Muslim minority experiences increased targeting and violence during COVID-19', Institute of Development Studies, 4 June 2020. Available at: <http://bit.ly/3VBrpJ3>; Kanika K. Ahuja, Debanjan Banerjee, 'The "Labeled" Side of COVID-19 in India: Psychosocial Perspectives on Islamophobia During the Pandemic', Frontiers in Psychiatry, 22 January 2021. Available at: <http://bit.ly/3VYuYck>; Nehaluddin Ahmad, 'Protecting the Rights of Minorities Under International Law and Implications of COVID-19: An Overview of the Indian Context', Laws, 23 March 2021. Available at: <https://www.mdpi.com/2075-471X/10/1/17>; France 24, 'Sri Lanka sticks to cremation of Muslim COVID-19 victims despite uproar', 8 Jan 2021. Available at: <http://bit.ly/3ULqpkI>; Mohamed Imtiyaz Abdul Razak, Amjad Mohamed Saleem, 'COVID-19: The Crossroads for Sinhala-Muslim Relations in Sri Lanka', Journal of Asian and African Studies, 14 June 2021, 57(3):529-542.

29 Council of Europe (CDADD), 'COVID-19: an analysis of the anti-discrimination, diversity and inclusion dimensions in Council of Europe member States', November 2020. Available at: <http://bit.ly/3FbbvOz>.



and on economic, social and cultural rights, as well as the European Convention and the American Convention on human rights – contain a general provision that obligates states to recognize all the rights enshrined in the international instrument without discrimination of any kind, such as by race, colour, sex, language, religion, political or other opinion, or national or social origin.

This fundamental and general rule concerns discrimination in legislation and policies as well as their implementation, but although the adoption of specific measures and policies is a general problem in any implementation of rules guaranteeing human rights, this problem can take on a different dimension with regard to economic and social rights, including the right to health.

For a long time, the international debate on the two categories of human rights has focused on the different natures of the categories and, accordingly, of the state's obligations. The fundamental assumption has been that whereas civil and political rights require the state to refrain from interfering with individual freedoms, the realization of economic, social and cultural rights requires the state to make investments and adopt targeted economic plans aimed at ensuring the effective protection and realisation of these rights. Although such a debate seems outdated and the division between different categories of rights has been abandoned, the idea that the realization of economic, social and cultural rights cannot be achieved in a short period of time and that states are responsible for the “progressive realization” of these rights has not been completely overcome.

The Committee on Economic, Social and Cultural Rights (CESCR), in its General Comment number 3 on the nature of the state's obligations under the Covenant,<sup>30</sup> has offered several valuable insights in this respect. The first one is that the obligations undertaken by state parties to the Covenant are both obligations of result and obligations of conduct; the second is that, although it is understood that the realization of some rights enshrined in the Covenant may be conditioned by resource constraints and poor investments, some obligations are of immediate effect. Among these obligations, two are of particular importance here: the obligation to “take steps,” i.e., all the appropriate measures to guarantee the realization of the relevant rights, and the obligation not to discriminate.

Clearly, this reasoning is applicable to the problem of recognition of the right to health as a right of an economic and social nature enshrined in Article 12 of the Covenant. This provision is designed to achieve a fundamental aim already provided for in WHO's statute, that is “the enjoyment of the highest attainable standard of physical and mental health.” When we analyse the content and scope

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<sup>30</sup> CESCR, General Comment n. 3: The Nature of States Parties Obligations (Art. 2, Para.1, of the Covenant), E/1991/23.

of the right to health, some elements deserve to be highlighted, as reflected in General Comment number 14 on the content and scope of Article 12, adopted in 2000 by the CESCR.<sup>31</sup> The CESCR has made clear, first, that Article 12 imposes specific obligations upon the states in terms of availability and access to healthcare facilities, goods and services, and second that the right to health must be ensured without discrimination of any kind, such as by race, sex or religion.

The state's obligations are positive in nature, and the state is called upon to ensure the progressive realization of this right. Such progressive realization implies that an obligation to adopt the necessary measures to ensure this right, taking into account each state's own level of development and available resources. Clearly, this means that the most appropriate measures to implement the right to health will vary significantly across countries. In deciding on the adoption of the necessary or the most appropriate measures, and therefore in how its national health system must be organized, each state has a considerable margin of discretion. But over and above the unavoidable differences and the discretion of each state in implementing the right to health, some basic obligations are common to all states.

The first such obligation pertains to the progressive nature of the right to health, which cannot be interpreted as an alibi for a state that does not wish to fulfil its obligation. Article 12 obliges each state party to take the necessary steps to the maximum of its available resources; it thereby follows that a state which is unwilling to use the maximum of its available resources for the realization of the right to health is violating its obligations under Article 12. The second fundamental obligation pertains to the basic principle of non-discrimination: Article 12, which imposes the obligation to recognize the right to health without any distinction or discrimination, also indicates that states must ensure this right for the most vulnerable and marginalized segments of the population.<sup>32</sup> In this respect, the CESCR has pointed out, "States are under the obligation to respect the right to health by, *inter alia*, refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum-seekers and illegal immigrants, to preventive, curative and palliative health services."<sup>33</sup> Analogously, the misallocation of public resources which results in the denial of the right to health for individuals or groups – particularly those who are vulnerable or marginalized – and the failure to take measures to reduce the inequitable dis-

31 CESCR, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12), *E/C.12/2000/4*.

32 A similar approach to the issue of the recognition of the right to health under equal conditions characterizes the provisions of the UN Convention against Racial Discrimination. Article 5 of this convention declares that states have the obligation to guarantee without distinction the right of everyone to the equality before the law in the enjoyment of a series of fundamental rights including the right to health.

33 CESCR, General Comment No. 14, *cit.*, at para 34.

tribution of health facilities, goods and services represent clear violations of the obligations to fulfil the right to health.

The principle of non-discrimination also inspires the system of the International Health Regulations, which is the system of international rules laid down by the WHO in 2005. These regulations provide for member states' obligations in case of an outbreak of a pandemic and more specifically of a "public health emergency of international concern" (PHEIC). Over and above the duty to report the outbreak of epidemics that could spread across a state's national border and the obligation to cooperate with other states in handling such events, states are also obligated to adopt specific measures aimed at curtailing an epidemic and to protect and safeguard the health of the population. These health measures may include quarantine, screening of and/or restrictions on persons from affected areas, medical treatment, vaccination and prophylaxis. These provisions impose a series of obligations that seem clearly interrelated with those envisaged by Article 12 of the Covenant. In its general comment, the CESCR explains that this rule imposes upon states some "core obligations," among which the Committee has included the obligations to provide immunization against major infectious diseases occurring in the community; to take measures to prevent, treat and control epidemic and endemic diseases; and to provide education and access to information concerning the main health problems in the community. As pointed out above, the system of International Health Regulations is grounded on the basic principle of non-discrimination; Article 42 provides that "health measures taken pursuant to those regulations shall be initiated and completed without delay and applied in a transparent and non-discriminatory manner." It follows that the adoption of measures aimed at curtailing a public health emergency in a discriminatory manner – that is to say, in a manner which does not ensure equal access to the necessary preventive or curative services – is clearly in contrast with the provisions of both Article 12 of the Covenant on economic, social and cultural rights and Article 42 of the International Health Regulations.

Finally, when dealing with the issue of the right to health in international human rights law, we should note that the reduction of health inequalities and the fulfilment of the principle of non-discrimination in health matters constitute one of the pillars of Universal Health Coverage (UHC). The latter has been defined by WHO and the United Nations as a strategy to be implemented by all states as part of strengthening national health systems so that all people have access to promotive, preventive, curative, and rehabilitative health services of quality, when and where they need them, without financial hardship.<sup>34</sup> UHC – which, given its importance,

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34 UNGA Res. 63/33, 26 November 2008; 67/81, 12 December 2012; 74/20, 11 December 2019.

has been included in the SDGs – is strongly focused on the goal of breaking the link between illness and poverty and making access to health and healthcare affordable and available for all. Clearly, the achievement of this goal requires a progressive reorientation and strengthening of national health systems, but it mostly requires that a commitment to leaving no one behind in terms of health protection must become the founding principle of any national health system.

## 5. Conclusions

As noted at the beginning of this article, the COVID-19 pandemic has proved to be a very important test and an important lesson should be learnt from it. We have often heard – particularly when dealing with the problem of vaccinations – that until every country is safe, no country will be safe; however, the same principle also applies to the internal situation of each country, and indeed, until every person is safe, there is a real risk that the epidemic will remain out of control. COVID-19 should represent a watershed moment for health inequalities. It is demonstrating that the appropriate allocation of resources to create conditions for healthy lives is an essential prerequisite for the state to be able to react adequately to emergencies of the magnitude of COVID-19. The problem is not merely one of increased earmarking of resources necessary for strengthening and improving the efficiency of the health system; rather, it is a matter of ensuring access to healthcare and health facilities for all segments of the national population on equal terms. Ensuring access to healthcare and treatment becomes particularly important in times of emergency, when there is a real risk that, due to limited resources and exceptional pressure on health systems, national authorities will give priority to certain groups, thereby discriminating in access to care or reinforcing existing discrimination. The ongoing pandemic is demonstrating that inequalities and discrimination in health not only create favourable conditions for the spread of diseases, especially infectious diseases, but can also put the health of the entire population at risk.

As a last point, with specific regard to the problem of other forms of discrimination generated by the pandemic, we should recognize that an efficient health system capable of providing assistance for all is also a useful and effective instrument for preventing other adverse effects that a pandemic could provoke. If the national health system functions in such a way as to guarantee access to treatment and care without distinction, it will be more difficult for even a health emergency to become a pretext for fuelling other pre-existing forms of discrimination against minorities and other vulnerable groups or a further tool to exacerbate inter-ethnic and inter-religious conflicts.