Enforcing the Right to Health: The Philippines and Covid-19 from a Human Rights Perspective

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Introduction

Respect for, protection, and fulfillment of human rights anchor the modern international legal system that emerged in the latter half of the 20th century. More than their persuasive political and normative content, human rights contain obligations mainly legally binding upon States in their relations with those governed. They create legal relationships between duty-bearers of human rights obligations and rights-holders. The present system of international human rights law emerged out of the wreckage of global conflict and destruction, with sovereign States coming together in recognition of the need to respect human dignity. Generally embodied within the international human rights treaty regime, human rights as legal concepts embrace the primary duties of States to nurture the totality of the human condition.

While civil and political rights are the main set of rights that come to mind in any discussion of legally enforceable rights, economic, social, and cultural rights (ESCR) are no less important or enforceable. These two main groups of rights are complementary and deeply entangled in terms of their normative aims and practical enforcement. With a global pandemic posing challenges to the elasticity of traditional legal concepts, there is a pressing need to examine how human rights can withstand the seeming need for increased State control. The right to health especially surfaces as a crucial species of rights in the context of the contemporary crisis brought about by the COVID-19 pandemic.

This brief essay first surveys the foundations of the right to health in international law. It then looks at how this right has been shaped and enforced in the domestic legal sphere. Finally, it will examine the prospects of enforcing the right to health within the context of the COVID-19 public health emergency in the Philippines.

I. The Right to Health

A. *In International Law*

Pre-dating the International Covenant on Economic, Social, and Cultural Rights (ICESCR) was the Constitution of the World Health Organization (WHO), which established the specialized United Nations body on July 22, 1946. The instrument contained a definition of health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity."[2] The preambular portion of the text further states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being", without any discrimination.[3] The main feature of the WHO definition is that of necessarily expanding the 'negative' definition of health (absence of disease or infirmity) into a more 'positive' one that embraces a complete state.[4] This formulation of the definition of health would be significant in that

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2 Constitution of the World Health Organization, 22 July 1946, *available at* https://treaties.un.org/doc/Treaties/1948/04/19480407%2010-51%20PM/Ch_IX_01p.pdf

3 *Id.*

4 Stephen P. Marks. *The Emergence and Scope of the Human Right to Health* in Advancing the Human Right to Health (José M. Zuniga, Stephen P. Marks and Lawrence O. Gostin, eds., 2013).

it included its social dimension, thus implicating the responsiveness of health systems of States-parties.

The definition embodied in the Constitution of the WHO appeared to be "nebulous" and of "little operational value,"[5] making it difficult to place it in a practical plane. The International Bill of Rights, whose constitutive instruments came later than the Constitution of the WHO, provides references to the right to health in a more concrete manner.

Article 25 (1) of the Universal Declaration of Human Rights (UDHR) provides for the following:

> (1) Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control.

The primary feature of the UDHR's reference to the right to health is that it contains an enumeration rather than a definition unto itself. While Article 25 (1) of the UDHR appears to be fleshed out in more detail than the Constitution of the WHO, it does not fully couch on its own an enforceable right to health. This is where the ICESCR's subsequent definition of the right to health becomes significant: it treats the right to health as a right that contains a regime of principles binding upon States-parties as duty-bearers. Specifically, Article 12 of the ICESCR provides for the following:

> *Article 12*
>
> 1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
>
> 2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
>
> (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
>
> (b) The improvement of all aspects of environmental and industrial hygiene;
>
> (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
>
> (d) The creation of conditions which would assure all medical service and medical attention in the event of sickness.

Traditionally, the ICESCR contained rights that were dubbed as *second-generation* rights which were "understood to be implemented only in the long term or progressively."[6] This historical misnomer—which in itself has produced misconceptions about the enforceability and bindingness of the ICESCR regime—stems from a problematic reading of the language of Article 2 (1) of the Covenant, which states:

> Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

In general contrast with the International Covenant on Civil and Political Rights

5 *Id.*

6 Frans Viljoen. *International Human Rights Law: A Short History.* 12 Journ. of Hum. Med. 4, 5 (2012).

(ICCPR), which couches obligations negatively, the ICESCR contains a positive language. The split between civil and political rights on the one hand and ESCR on the other can be ascribed to the historical tensions between geopolitical superpowers during the Cold War.[7] The 'generations' argument of traditional human rights scholarship is textually negated by the Vienna Declaration and Programme of Action of 1993, stating that "The international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis."[8]

Hence, 'taking steps' ought to be read as a binding legal obligation in itself. As a legal duty, it is unqualified and immediate. For developing countries, the duty is to "achieve progressively the full realization of rights," while in more developed countries, there is an implied duty to prevent retrogression to less-fulfilled states. The *respect, protect,* and *fulfill* framework in international human rights necessarily applies to ESCR, as it does with civil and political rights.[9] In complying with this tripartite obligation, conformity of States must be measured against the progressive realization standard set forth by the ICESCR.

Specific to the right to health, the United Nations Committee on Economic, Social, and Cultural Rights (CESCR) details the manner in which States must comply with the tripartite obligations in the context of Article 12. In *respecting* the right to health, State must refrain from "denying or limiting equal access for all persons"; in *protecting* the right to health, States must primarily "adopt legislation or to take other measures ensuring equal access to health care and health-related services"; and finally, in *fulfilling* the right to health, States ought to "give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation, and to adopt a national health policy with a detailed plan for realizing the right to health."[10] It should be pointed out that the CESCR considers the right to health primarily as having access to "facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health"[11] and not merely an abstract state of being healthy.

The ICESCR itself does not contain a parallel derogation clause in times of public emergencies as that in Article 4 of the ICCPR; rather, it contains a general limitations clause that may be invoked by States-parties. Limitations, as opposed to derogations, may be imposed by States even at times of normalcy, conditioned on their being provided for by law, compatibility with the nature of the rights in the Covenant, and the promotion of general welfare. General Comment No. 14 alludes to epidemics and emergencies—that a right to treatment exists in these urgent situations.[12] The same CESCR document observes that public health matters are sometimes used by States as a pretext for limiting the exercise of other fundamental rights. The CESCR notes that States have the burden of justifying these measures, and such must be in compliance with international human rights standards.[13]

The COVID-19 pandemic exposed the underlying weaknesses of the present global health system in that it highlighted inequality in access to resources between individuals on one level and

7 Lawrence O. Gostin, Matiangai V. S. Sirleaf, and Eric A. Friedman. *Global Health Law: Legal Foundations for Social Justice in Public Health* in Foundations of Global Health & Human Rights (Lawrence O. Gostin and Benjamin Mason Meier, eds. 2020).

8 World Conference on Human Rights, *Vienna Declaration and Programme of Action*, 25 June 1993, *available at* https://www.ohchr.org/en/professionalinterest/pages/vienna.aspx.

9 Judith V. Welling. *International Indicators and Economic, Social, and Cultural Rights.* 30 Human Rights Quarterly 933, 952 (2008).

10 United Nations Committee on Economic, Social and Cultural Rights, *General Comment No. 14*, E/C.12/2000/4 (August 11, 2000), ¶ 32-37, *available at* https://www.refworld.org/pdfid/4538838d0.pdf.

11 *Id.*, at ¶ 9.

12 *Id.*, at ¶ 28.

13 *Id.*, at ¶ 16.

between States on another. As a global event that disrupted the functioning of legal and social institutions, the pandemic created a "system shock" that could shape the future of human rights discourse in general and conceptions of the right to health specifically.[14] The illiberal response of States at the beginning of the pandemic through restrictive lockdowns and quarantines has brought to the fore discussions on the place of human rights in public emergencies. Putting human rights on the sidelines, however, has resulted in "impoverishing vulnerable communities, keeping children from school, preventing individuals from purchasing basic necessities, closing off necessary support services, increasing gender-based violence, and widening health inequities across populations."[15] If the right to health means access to a certain quality of life, then the inequities resulting from restrictive State response to the pandemic—even as unintended consequences—seriously interfere with its full enjoyment.

B. *In Domestic Law*

International human rights principles embodied in treaties and those which have crystallized into custom are part of the law of the land by virtue of the doctrine of transformation and doctrine of incorporation, respectively. The Supreme Court of the Philippines confirmed through case law that it considered the UDHR as part of customary international law and Filipinos as "proper subjects of the rules of international law."[16] Specific to the ICESCR, the Supreme Court had the opportunity to apply the treaty in cases involving the right to work[17] and the right to education.[18] From the foregoing, it is reasonable to state then that universal human rights principles embedded in the ICESCR are fully integrated into domestic law.

With respect to the right to health, no less than the 1987 Constitution pronounced its status as a State policy[19] and placed it under the umbrella of social justice and human rights.[20] The Court explicitly states in jurisprudence that the right to health is among the self-executing provisions of the Constitution.[21] Thus in the same case, the Court has impliedly affirmed the justiciability of the right to health before the courts. Various laws emanating from Congress also contain references to the right to health as a guiding statutory principle.[22]

While generally appearing to be uncontroversial in terms of its acceptability as a universal principle, domestic courts should still be able to determine the scope of the right to health should an actual case arise. CESCR General Comment No. 9 provides guidance on the application of the Covenant in domestic law. The ICESCR "does not stipulate the specific means by which it is to be implemented in the national legal order," but any domestic policy must abide by and be consistent with the "full discharge of its obligations by the State party."[23] Redress for any violations must be first settled in domestic courts, which themselves should be competent to grant remedies.

The right to health primarily implicates the efficacy of health systems of States and the access of individuals to resources, services, goods, and treatment. In the Philippines, however,

14 Lisa Forman. *The Evolution of the Right to Health in the Shadow of COVID-19*. 22 Health and Human Rights Journ. 375, 376 (2020).

15 Dainius Pūras, et al. *The right to health must guide responses to COVID-19*. 395 The Lancet 1888, 1889 (2020).

16 *Republic v. Sandiganbayan*, G.R. No. 104768, July 21, 2003.

17 *Central Bank Employees Association, Inc. v. Bangko Sentral ng Pilipinas and the Executive Secretary*, G.R. No. 148208, December 15, 2004.

18 *Pimentel v. Legal Education Board*, G.R. No. 230642, September 10, 2019.

19 *See* 1987 Const., Art. II, Sec. 2.

20 *See* 1987 Const., Art. XIII, Sec. 11.

21 *Imbong v. Ochoa*, G.R. No. 204819, April 8, 2014.

22 *See* for instance, Republic Act No. 11223; Republic Act No. 7277; Republic Act No. 11166; Republic Act No. 10354.

23 United Nations Committee on Economic, Social and Cultural Rights, *General Comment No. 9*, E/C.12/1998/24 (December 03, 1998), ¶ 9, *available at* https://www.refworld.org/docid/47a7079d6.html.

allocation of such public goods remains to be a challenge. The 2021 national budget, for instance, came under fire as the Department of Health (DOH) faced reduced funding even in the context of the ongoing COVID-19 public health crisis.[24] Such questions of policy are not new in the Philippines—not enough resource allocation to the health sector has produced decades-long problems for the country. These problems involve the issues of the cost of and access to medication, addressing the spread of communicable diseases, and investment in the training and retention of healthcare workers.[25]

As there is no narrow interpretation of the right to health in Philippine law, the concept remains nebulous and flexible enough to accommodate the necessary recalibration required in addressing an unprecedented health crisis. Being self-executing in nature, it is arguable that the right to health as embodied in the constitutional design of the Philippines is already a legal source of obligations in and of itself on the part of the State. However, it must be highlighted that its enforcement should still be in line with other fundamental rights found in the charter.

II. The Right to Health and the COVID-19 Crisis in the Philippines

At the close of 2020, the Philippines has recorded more than 470,000 cases of COVID-19 infections.[26] In terms of regard for human rights, the Philippine government's pandemic response has met criticisms from international human rights observers, including the United Nations Office of the High Commissioner for Human Rights (OHCHR). High Commissioner Michelle Bachelet characterized the Philippine response as "highly militarized", leading to thousands of arrests of quarantine violators.[27] The government itself has attempted to justify its wartime-like response and the appointment of retired military officials in key posts of the pandemic task force by reinforcing the need for discipline and organization.[28]

Through Republic Act No. 11469, or the *Bayanihan to Heal as One Act*, Congress declared a state of national emergency over the entire country. For purposes of addressing the pandemic, the *Bayanihan to Heal as One Act* is *lex superior* as a matter of construction or interpretation.[29] This highlights the status of the law as an extraordinary response to an unprecedented health emergency. As part and parcel of the legal response to the pandemic, however, the *Bayanihan to Heal as One Act* reflects a bigger problem: that there is an uncoordinated, shotgun, and iron-fisted approach on the part of the State. Textually speaking, absent in the *Bayanihan to Heal as One Act* is an explicit reference to the right to health, thus confirming the shortfall in a rights-based approach in the Philippine government response. And while the *Bayanihan to Heal as One Act* has already statutorily expired, the emergency-like mode of governance across the Philippines still persists.

The glaring absence of a rights-based approach to the pandemic does not come as a

24 CNN Philippines Staff. *"'Order of priorities' questioned as DBM slashes 2021 budget of DOH"*, CNN Philippines, *available at* https://www.cnn.ph/news/2020/9/18/DOH-2021-budget-cut-.html.

25 *See* Aurora A. Parong. *The Right to Health in the Philippines: Under the Weather.* (2006), https://www.philrights.org/wp-content/uploads/2010/10/The-Right-to-Health-in-the-Philippines.pdf.

26 Rappler.com, *"PH ends 2020 with 474,064 COVID-19 cases"*, *available at* https://www.rappler.com/nation/covid-19-updates-philippines-december-2020.

27 UN News, *"'Toxic lockdown culture' of repressive coronavirus measures hits most vulnerable"*, *available at* https://news.un.org/en/story/2020/04/1062632?fbclid=IwAR3XlWVpwLY9c5ZWZRjSuo5s6IHKiHpG32W-brlSScOrXdKvowRFu0K1YZ0.

28 Salvador S. Panelo. *On the raison d'etre on the President's appointment of ex-military men to lead the implementation of the national Policy against Covid-19.* (March 27, 2020), https://pcoo.gov.ph/OPS-content/on-the-raison-d-etre-on-the-presidents-appointment-of-ex-military-men-to-lead-the-implementation-of-the-national-policy-against-covid-19/.

29 Raphael Lorenzo A. Pangalangan and Anton Miguel A. Sison. *The Philippines*. A Human Rights and Rule of Law Assessment of Legislative and Regulatory Responses to the COVID-19 Pandemic Across 27 Jurisdictions, 1, 440 (2020).

surprise, as leadership on the highest levels of government forwarded a divisive narrative on human rights in the last few years. Similar to how the president framed a dichotomy between human rights and human lives in a past State of the Nation Address, the national government once again propped up the narrative that a choice must be made between human rights and public safety.[30] While the pandemic carves out a situation of national emergency allowing for the exercise of certain powers, it does not permit a situation where all human rights are suspended, more so without qualification. This much is clear in the regime of civil and political rights, especially with the right to life.[31] If taken together with the CESCR's interpretation that the right to health is dependent on the realization of other rights, including the right to life,[32] it can be reasonably inferred that its derogation cannot be permitted under international law. What will result from a denial of access to critical life-saving health services and—for all intents and purposes—is a violation of the right to health and, by extension, the right to life.

The COVID-19 regulations imposed by the national government have been "erratic and irregular," causing confusion to the general public and threatening to unsettle the rule of law at large.[33] Illustrative of the lack of a programmatic trajectory is the way in which the leadership of some local government units (LGUs) has diverged from the national government's approach.[34] The constantly shifting quarantine classifications across different local jurisdictions also contributed to the lack of consistent application of laws and regulations.[35] The "lack of consensus on the basic question of what rules people are even supposed to follow" effectively makes the implementation of the law arbitrary.[36] Without a concrete framework that moors the national government, the Philippines' pandemic response will continue to fall short of meeting fundamental State obligations.

Respecting human rights in general and enforcing the right to health, in particular, should be a core principle in any state's pandemic response. It also presents an alternative to militaristic and securitized approaches to public welfare and safety. Reasonable limitations on certain rights can be imposed by the State, as long as they comply with international obligations and are done with a view to promoting public health. The right to health includes entitlements to preventive, curative, and palliative healthcare.[37] Several aspects of the pandemic response where the Philippine government fell short can be addressed using this approach.

As a legal starting point, Republic Act No. 11132 provides a framework for the notification and monitoring of notifiable diseases such as COVID-19. Prevention can be done through proportional and reasonable limitations to the freedom of movement that would be sufficient to contain the spread of the disease. Any such regulation, however, must take into account mobility needed to work and have access to basic necessities. For instance, a total ban on public transport, which has been done at the beginning of the lockdown, disproportionately affects low-income workers reliant on mass transit.

30 Anton Miguel A. Sison. *Protecting Rights While Protecting Lives: Permissible Derogations of Human Rights in the COVID-19 Pandemic Philippine State of Emergency*. 93 (Special Online Feature) Phil. L.J. 155, 158 (2020).

31 *See* ICCPR, art. 4.

32 UN CESCR, *supra* note 10, at ¶ 3.

33 Paolo S. Tamase. *A Framework for Analyzing the Legality of COVID-19 Emergency Measures.* 93 (Special Online Feature), Phil. L.J., 198, 200 (2020).

34 Athena Charanne R. Presto. *"Mayors are keeping the Philippines afloat as Duterte's COVID-19 response flails"*, New Mandala (July 08, 2020), https://www.newmandala.org/mayors-are-keeping-the-phillippines-afloat-as-dutertes-covid-19-response-flails/.

35 Pia Ranada. "*Urong-sulong? 9 confusing rule changes, contradictions by Duterte's coronavirus task force",* Rappler.com *available at* https://www.rappler.com/newsbreak/iq/confusing-rule-changes-contradictions-duterte-coronavirus-task-force.

36 Tamase, *supra* note 33.

37 UN CESCR, *supra* note 10, at ¶ 34.

The framework of prevention may also include measures for surveillance, provided that such is only to the extent necessary and must be proportional to the aim of containing the pandemic. The World Health Organization's recommended guidelines on surveillance contemplate "rapid detection, isolation, testing, and management of cases."[38] Lockdowns without parallel mass testing are disproportionate limitations on a fundamental right without serving a public purpose. Pure lockdowns that do not demonstrate a link between means and ends are unnecessarily invasive.

On the matter of curative and palliative healthcare, giving ample resources to healthcare facilities and healthcare workers should be paramount. The national government has been heavily criticized by the public for placing security forces at the forefront of its pandemic response.[39] Meanwhile, medical frontliners have communicated their dissatisfaction with the government in responding with the urgency of procuring personal protective equipment that could have prevented the deaths of doctors.[40] Controversy also erupted in gaining access to quality vaccines against COVID-19 when the national government confirmed the early inoculation of members of the president's security group, effectively flouting the regulatory framework in place.[41]

The CESCR characterizes the "failure to take measures to reduce the inequitable distribution of health facilities, goods and services" as a violation of the right to health and should be the proper subject of available remedies.[42] The present pandemic response allows those well-off to be insulated from its effects. At the same time, it obliterates the safety nets of those with little access to healthcare, to begin with. This manifestly goes against the principle that human rights are supposed to be universal, inalienable, and indivisible. The legal guarantee to enjoy the highest attainable standard of health must apply to everyone at all times.

Conclusion

A phrase that gained popularity at the beginning of the pandemic, *"solusyong medikal, hindi militar"* (medical solutions, not military ones), encapsulates the need for the national government to shift its focus on enforcing the right to health instead of acute heavy-handed responses. At a time when resources have to be allocated to reach those with the most vulnerabilities, the State must always incorporate in its policies the fulfillment of its international and domestic obligations.

COVID-19 unraveled the weaknesses of the health systems all over the world. It also tested the integrity of certain legal values and institutions. Understandably, public emergencies place legal systems under extraordinary pressure. However, emergencies should not come at the price of undermining the normative values anchoring fundamental notions of human rights and the rule of law. These are foundational principles we should not be allowed to compromise, lest the legacy of the government's COVID-19 response be marked by nothing but human rights failures.

38 World Health Organization. *Public health surveillance for COVID-19: Interim Guidelines.* (August 07, 2020), https://www.who.int/publications/i/item/who-2019-nCoV-surveillanceguidance-2020.8.

39 Pangalangan and Sison, *supra* note 29, at 448.

40 CNN Philippine Staff. *"Medical group cites protective equipment lack for death of 17 doctors"*, CNN Philippines, *available at* https://cnnphilippines.com/news/2020/3/31/17-frontline-COVID-19-doctors-dead-due-to-lack-of-PPE-.html.

41 CNN Philippines Staff. *"AFP: PSG members got vaccinated first to 'protect' Duterte from COVID-19"*, *"*, CNN Philippines, *available at* https://cnnphilippines.com/news/2020/12/28/PSG-military-first-COVID-vaccination-protect-Duterte.html.

42 UN CESCR, *supra* note 10, at ¶ 52.

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