UN Committee on the Rights of the Child

Day of Discussion on

THE PRIVATE SECTOR AS SERVICE PROVIDER AND ITS ROLE IN IMPLEMENTING CHILD RIGHTS

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The international human rights treaty obligations of States parties in the context of service provision

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1. I am conscious that there are a large number of experts in this room who are very much more knowledgeable than I am about the Convention on the Rights of the Child (CRC). Accordingly, I would like to approach this important and challenging topic - the international human rights obligations of states in the context of service provision - by setting out, as succinctly as possible, how the UN Committee on Economic, Social and Cultural Rights has begun to tackle this issue. I will also briefly signal some of the differences between the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Child Convention which may require the Child Committee to take a somewhat different approach to CESCR.

2. May I emphasise that I am not suggesting that the Child Committee adopts CESCR's approach. Nor am I suggesting that CESCR has all the answers to this or any other issue. As I see it, this is work in progress for all of us. No doubt CESCR and all the other UN treaty-bodies can benefit from today's deliberations. Nonetheless, in case it might be of some assistance or interest, I will outline what I understand to be CESCR's approach. Please note another important qualification - what follows is my understanding of, and reflections upon, CESCR's position. This is a personal, not a CESCR, presentation.

'No single road'

3. The first point is that international human rights law is neither for, nor against, the privatisation of service provision. In 1990, CESCR put it like this. The Covenant, it said:

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> neither requires nor precludes any particular form of government or economic system being used as the vehicle for the [realisation of ICESCR], provided only that [the vehicle] is democratic and that all human rights are thereby respected. Thus, in terms of political and economic systems the Covenant is neutral and its principles cannot accurately be described as being predicated exclusively upon the need for, or the desirability of a socialist or a capitalist system, or a mixed, centrally planned, or laisser-faire economy, or upon any other particular approach. In this regard, the Committee reaffirms that the rights recognized in the Covenant are susceptible of realization within the context of a wide variety of economic and political systems, provided only that the interdependence and indivisibility of the two sets of human rights, as affirmed inter alia in the preamble to the Covenant, is recognized and reflected in the system in question. The Committee also notes the relevance in this regard of other human rights and in particular the right to development. (GC 3, para 8)

4. The same point is made in the *Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights*, an influential instrument adopted by a group of distinguished international lawyers in 1986:

> The achievement of economic, social and cultural rights may be realized in a variety of political settings. There is no single road to their full realization. Successes and failures have been registered in both market and non-market economies, in both centralized and decentralized political structures. (para 6)

Thus, international human rights law is interested in the *destination* - the full realisation of all human rights - and is less interested in the *road* by which that destination is reached, provided that the road chosen:

> (i) is consistent with democratic principles;
> (ii) is respectful of the interdependence and indivisibility of all human rights; and
> (iii) that it does, in reality, lead towards the destination.

5. Today, we reflect on the legal obligations of state parties in the context of service provision. CESCR's fullest examination of states' obligations is found in its General Comment 14 which was adopted in 2000.[2] General Comment 14, on the right to health, sets out more fully than any other document CESCR's understanding of the nature and scope of states' obligations under the Covenant. Of course, health services are among those services that are subject to private sector involvement - so I propose to examine states' obligations in relation to the right to health. The same or similar points apply to the rights to food, education and so on. But I hope that a specific focus on one right, the right to health, will shed light on generic issues around states' obligations in the context of service provision.

6. It is well-known that international human rights law imprecisely defines most international social rights, such as the rights to housing, food and health. Further, broadly speaking, these rights do not have a deep legal tradition to draw upon as a way of 'fleshing-out' what they mean. In my view, it is the responsibility of the international human rights community to remedy this situation and to gradually and carefully elaborate

[2] UN doc. E/C.12/2000/4, *General Comment 14 on the right to the highest attainable standard of health,* 11 August 2000.

the contours and content of those international social rights that are enshrined in the International Bill of Rights and other major international human rights instruments, such as the Convention on the Rights of the Child. But, in the absence of a deep legal tradition in these rights, this is a very difficult task. This difficulty is compounded by the fact that the elaboration of international social rights depends upon the elaboration of some new concepts, concepts like 'core obligations' and 'human rights indicators' and 'human rights benchmarks'. So, the challenge is not just to build this new edifice - the right to food or the right to health - in addition we have to make the conceptual bricks with which these rights can be constructed. And this is what you see happening in General Comment 14. So I will now try to signal CESCR's understanding of states'obligations in relation to the right to health - obligations which bear directly upon private sector service provision.

Normative content

7. Before being able to identify states' obligation, it has to be clear what the norms are in relation to which the obligations arise. The right to health norm is found in article 12 of ICESCR and, more fully, in article 24 of CRC. Still, these provisions remain quite imprecise. So, General Comment 14 devotes some paragraphs to exploring the normative content of the right to health.

8. First, consistent with the text of the Covenant - and also consistent with the text of CRC - CESCR takes the view that the right to health extends beyond the right to health care and includes "the underlying determinants of health, such as access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health." (General Comment 14, para 11) In the context of our topic today, this expansive interpretation of the right to health is significant. For example, it means that the privatisation of water services is a human rights issue falling within the Covenant.

8(a). Second, General Comment 14 tries to give depth to this definition by saying that the right to health consists of four elements. In any jurisdiction, the right to health in all its forms must be *available*, *accessible*, *acceptable* and of *good quality*. Here are some of the new concepts that I mentioned earlier. CESCR began to use this conceptual framework in 1991 in General Comment 4 on the right to housing. The framework has been refined by others, including the Special Rapporteur on the right to education. As we will see, the framework is very relevant to our topic today.

9. Briefly, public health and health care facilities, goods and services have to be *available* within a jurisdiction. But availability is not enough. The facilities might be available in a jurisdiction, but inaccessible to women, or minorities or the poor. So the facilities must be both available in a jurisdiction and also *accessible* to all, in law and fact, without discrimination. Accessibility itself has different dimensions - time does not permit me to go through them all - I will mention just one of them here. The health facilities, goods and services must be *economically accessible* ie. affordable. As the General Comment puts it, "whether privately or publicly provided", health facilities, goods and services shall be "affordable for all, including socially disadvantaged groups".

10. But even if health facilities, goods and services are both available and accessible - they could be culturally inappropriate and of low quality. Thus, in addition to being available and accessible, health facilities must also be *acceptable* and of *good quality*.

11. Here then is the normative content of the right to health: public health and health care facilities, goods and services which, within a particular jurisdiction, are available, accessible, acceptable and of sufficient quality. The General Comment adds that, of course, the precise application of these four elements will depend upon the stage of economic development of the state in question.

12. How does this apply to privatised health services? Under the Covenant, the state is expected to ensure that public health and health care facilities, goods and services - whether publicly or privately delivered - are available, accessible, acceptable and of sufficient quality. Further, what is expected of a developed state is more demanding than what is expected of a developing state.

Legal obligations: respect, protect, fulfil

13. Having outlined the normative content of the right to health, General Comment 14 turns to the obligations that arise in relation to this normative content. The right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations to *respect*, *protect* and *fulfil*. The obligation to *respect* requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. The obligation to *protect* requires States to take measures that prevent third parties from interfering with the right to health. Finally, the obligation to *fulfil* requires States to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realization of the right to health. (para 33)

14. For present purposes, perhaps the most significant levels of obligation are the obligations to protect and to fulfil. The General Comment itself provides the following examples of the duty to protect. It says that the State has a duty:

> to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; to control the marketing of medical equipment and medicines by third parties; and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct. (para 35)

Clearly, while a state may privatise health or other services, it cannot privatise its international human rights obligations. Under international human rights law, the state is the primary duty-bearer.[3] Where private bodies provide services, states' international human rights obligations remain.[4] Thus, states must take reasonable measures to ensure that the privatised services are consistent with international human rights - for example, that the services are non-discriminatory (duty to protect). Also, states must ensure that if the privatised services are not within the reach of all, for example the rural poor, then the state must provide other arrangements for the delivery of equivalent services to those individuals and groups (duty to fulfil).

Core obligations

[3] With notable exceptions, such as those under international criminal law. See UN doc. A/CONF.183/9, *Rome Statute of the International Criminal Court (as corrected by the procés-verbaux of 10 November 1998 and 12 July 1999*), Article 5(1).

[4] *Costello-Roberts v UK,* ECHR judgement of 25 March 1993, paragraph 27.

15. In several of its General Comments, CESCR has taken the position that states have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care. General Comment 14 outlines the core obligations in relation to the right to health. In the context of privatisation, core obligations play an important role. First, they indicate the bare minimum that privatisation must deliver. Second, they include some elements that only a state can deliver. For example, according to General Comment 14, a state has a core obligation:

> To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups. (para 43(f))

So, while the private sector may have role to play in the delivery of the right to health, the state has a core obligation to formulate the overarching national public health strategy and plan of action.

Violations

16. As General Comment 14 puts it, when the normative content of the right to health is applied to the obligations of states, "a dynamic process is set in motion which facilitates identification of violations of the right to health." (para 46) Thus, the denial of access to health facilities, goods and services to particular individuals or groups as a result of de jure or de facto discrimination, is a violation of the state's *obligation to respect* (para 50). The failure to adequately regulate the activities of individuals, groups or corporations so as to prevent them from violating the right to health of others, is a breach of the state's *obligation to protect* (para 51). And the failure to take measures to reduce the inequitable distribution of health facilities, goods and services, may be a violation of the state's *obligation to fulfil* (para 52).

17. The *Maastricht Guidelines on Violations of Economic, Social and Cultural Rights*, adopted in 1997 by a group of international legal experts, came to the same view:

> States are responsible for violations of economic, social and cultural rights that result from their failure to exercise due diligence in controlling the behaviour of ... non-State actors. (para 18)

Implementation at the national level: framework laws, monitoring, accountability, remedies

18. First and foremost, implementation of the right to health is going to take place at the national level. Accordingly, General Comment 14 devotes a number of paragraphs to this issue, including para 56:

> States should consider adopting a framework law to operationalize their right to health national strategy. The framework law should establish national mechanisms for monitoring the implementation of national health strategies and plans of action. It should include provisions on the targets to be achieved and the time-frame for their achievement; the means by which right to health

> benchmarks could be achieved; the intended collaboration with civil society, including health experts, the private sector and international organizations; institutional responsibility for the implementation of the right to health national strategy and plan of action; and possible recourse procedures.

There then follows some important paragraphs on right to health indicators and benchmarks, remedies and accountability.

19. May I emphasise the importance that CESCR attaches to accountability. As the Committee put it in its Statement on poverty:

> rights and obligations demand accountability: unless supported by a system of accountability, they can become no more than windowdressing.[5]

While the Committee leaves some discretion to duty-holders to identify the most appropriate mechanisms of accountability, such mechanisms must be "accessible, transparent and effective." However, accountability is only possible if there is adequate monitoring - and adequate monitoring depends upon indicators and benchmarks. In short, a state must identify appropriate right to health indicators and benchmarks, which permit effective monitoring, accountability and remedial action to be taken.

20. All of this bears upon service delivery by private actors. CESCR anticipates that such delivery will only take place in the context of the state's overarching participatory public health strategy and plan of action; a framework law; the identification of key right to health indicators and national benchmarks; adequate monitoring arrangements; accessible, transparent and effective accountability mechanisms; and, where appropriate, judicial or other remedies.

21. There is a related issue here. Before the adoption of any national policy, including privatisation, or international agreement which may bear upon the right to health, there should be an independent, objective and publicly available assessment of its impact on the right to health, especially the right to health of the poor. Further, if the assessment suggests that the proposed policy or agreement will have a negative impact on the right to health of the poor and others, effective countervailing measures must be adopted, consistent with the international human rights obligations of all parties.

22. Thus, if the private sector is invited to deliver health or other services, national and international human rights law should be explicitly considered and respected at all stages. Human rights should help to shape the process by which the policy is formulated; the content or substance of the policy; and the policy's monitoring and accountability arrangements. Any policy must be consistent with the State's international human rights obligations.

Distinctive features of the Convention on the Rights of the Child

23. In the preceding paragraphs, I have looked, in broad terms, at the approach of CESCR to the legal obligations of states, particularly in the context of private sector provision of health services. I hope there might be some ideas here that will be of interest to the Committee on the Rights of the Child. Of course, however, there are considerations, distinctive to the Convention on the Rights of the Child, that the Child

[5] UN doc. E/C.12/2001/10, para 14.

Committee would have to fold into CESCR's approach outlined above, such as the Convention's central principles of the best interests of the child and the development and survival of the child. The Convention's other two central principles - non-discrimination and participation - confirm and reinforce features found within ICESCR. There are other relevant textual differences between the Covenant and Convention which no doubt this Committee will take into account, such as article 3 of the Convention which refers to a state's obligation to regulate certain public and private institutions. I have the impression the textual differences between the Covenant and Convention will probably not take this Committee down a different track to the one taken by CESCR. On the contrary, it seems to me that CESCR's broad approach resonates with the provisions of the Convention on the Rights of the Child.

Conclusion: the responsibilities of private service providers

24. My focus has been the obligations of states in the context of private sector provision of services. But what about the obligations of private service providers? According to General Comment 14:

> While only States are parties to the Covenant and thus ultimately accountable for compliance with it, all members of society - individuals, including health professionals, families, local communities, intergovernmental and non-governmental organizations, civil society organizations, as well as the private business sector - have responsibilities regarding the realization of the right to health. State parties should therefore provide an environment which facilitates the discharge of these responsibilities (para 42).

25. Several recent inter-governmental initiatives have established sets of international guidelines or principles on responsibility for human rights of private sector actors, including service providers. Of particular relevance is the current initiative by the UN Sub-Commission on the Promotion and Protection of Human Rights to draft human rights principles for transnational corporations and other business enterprises. This states that "within their respective spheres of activity and influence, transnational corporations and other business enterprises have the obligation to respect, ensure respect for, prevent abuses of, and promote human rights recognized in international as well as national law."[6]

26. However these draft principles, when adopted, like other relevant initiatives including the OECD guidelines for multinational enterprises[7] and the ILO tripartite declaration of principles concerning multinational enterprises and social policy,[8] will not be binding on businesses (or on States) under international law.[9] Neither do they digress from the paradigm of ultimate State responsibility. Indeed, the draft human rights principles for transnational corporations points out that "States have the primary responsibility to respect, ensure respect for, prevent abuses of, and promote human rights recognised in international as well as national law."[10]

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[6] UN doc. E/CN.4/Sub.2/2002/WG.2/WP.1, *Human Rights Principles and Responsibilities for Transnational Corporations and Other Business Enterprises,* 29 May 2002, paragraph 1.

[7] Revised in June 2000.

[8] Adopted by the Governing Body of the ILO, November 1977.

[9] See *Beyond volunteerism: Human rights and the developing international legal obligations of companies,* International Council on Human Rights Policy, February 2002, p. 69.

[10] UN doc. E/CN.4/Sub.2/2002/WG.2/WP.1, paragraph 1.

27. In addition to these inter-governmental efforts, there are examples of private actors who have developing their own codes of conduct, which address responsibility of human rights. These private actors include multinational corporations and not-for-profit organisations. Regardless of whether the private actors adhere to such codes of conduct, States cannot absolve themselves of responsibility under international law for the enjoyment of rights in accordance with the treaties they have ratified.

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