



BMA

Health and human rights in the new world (dis)order

A report from the
British Medical Association



British Medical Association
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Contents

Health and human rights in the new world (dis)order– acknowledgments	3
Key recommendations	5
Foreword.....	7
Health and human rights in the new world (dis)order – a report from the British Medical Association – Introduction.....	12
Learning from the pandemic	12
Human rights – enduring challenges	13
Health professionals and human rights.....	15
Looking forward	17
A new report.....	17
The BMA and human rights.....	18
Chapter 1 – Human rights: the international frameworks and the right to health	21
Introduction: The development of human rights	22
Section 1 – International conventions and framework.....	22
Section 2 – Duty-bearers.....	24
Section 3 – Accountability and enforcement	25
Section 4 – The right to health.....	26
Section 5 – The BMA and human rights.....	29
Chapter 2 – Neoliberalism, inequality and health	32
Introduction.....	33
Section 1 – What is neoliberalism?	35
CASE STUDY: Clydebank, Scotland – neoliberalism, health and British manufacturing industry, a cautionary tale?	37
Section 2 – Neoliberalism and the human right to health: a clash of paradigms?	38
CASE STUDY: Neoliberalism and health services – health inequality and disability in Chile.....	39
Section 3 – Neoliberalism and the ‘responsibilisation’ of health – markets and morality	40
Section 4 – Globalisation, insecurity and wellbeing – neoliberalism and mental health.....	41
Section 5 – Conclusion and recommendations	43
Chapter 3 – Migration, ethnicity and health.....	44
Introduction.....	45
Section 1 – Nationalism and minorities: the bigger picture.....	46
CASE STUDY: The Roma in Europe – centuries of oppression continuing to this day.....	47
Section 2 – Detention centres and refugee camps	48
Section 3 – Migrant worker conditions.....	50
Section 4 – Health access for migrants and minorities	52
Section 5 – Seeking refuge, seeking asylum.....	53

CASE STUDY: Rohingya – still seeking safety	55
Section 6 – Threats to medical impartiality.....	56
Section 7 – Conclusion and recommendations.....	57
Chapter 4 – Climate change and environmental degradation	60
Introduction.....	61
Section 1 – Climate change and human rights.....	63
Section 2 – Pollution	64
Section 3 – Disease.....	65
Section 4 – Food and water	66
CASE STUDY: Zambia – droughts and famine.....	67
Section 5 – Mental health	68
Section 6 – Climate change as a threat multiplier.....	69
CASE STUDY: The Marshall Islands – on the front line of the climate disaster	70
Section 7 – Conclusion and Recommendations.....	71
Chapter 5 – The information age: new media and the assault on medical expertise	75
Introduction.....	76
Section 1 – Populism, medicine and information: a complex landscape.....	77
Section 2 – Information, disinformation and the rest	79
CASE STUDY: Disinformation and reproductive rights – how US religious groups target women worldwide with false information about the risks of abortion	79
Section 3 – A changing media landscape	80
CASE STUDY: Social media, disinformation and the Ebola outbreaks in West Africa	81
Section 4 – Balancing the management of online content and freedom of expression.....	83
Section 5 – Conclusion and recommendations.....	83
Chapter 6 – Conflict, human rights and health.....	86
Introduction.....	87
CASE STUDY: Syria – Ten years of conflict	88
Section 1 – The changing nature of modern conflict.....	90
CASE STUDY: Extreme asymmetry – Al-Qaeda, the US and the ‘war on terror’	91
Section 2 – Attacks on healthcare.....	92
Section 3 – Conflict and health.....	94
Section 4 – War, conflict, health and human rights	96
Section 5 – Conclusion and recommendations.....	97
Conclusion	99
Afterword.....	100
References	102

Health and human rights in the new world (dis)order – acknowledgments

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This report is published under the auspices of the BMA's Medical Ethics Committee (MEC) which considered drafts at various stages of its development. Work on this report spanned across three committee sessions; the following people were members of the MEC for one or more of these sessions.

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Key recommendations

Neoliberalism, inequality and health

- Policymakers should consider the impact of policy reforms on health-related human rights and make necessary adjustments. This should apply to both governments and corporations.

Migration, ethnicity and health

- States must reaffirm their commitments to due process for asylum seekers under international law and wealthier states should offer support to poorer states in accommodating refugees and providing for them.
- Innovative, community-based initiatives should be explored to ensure the right to health of all marginalised groups.
- Barriers to migrant healthcare access should be removed.
- Healthcare systems must ensure they are designed with the wellbeing of all groups in mind including ethnic minorities and migrants.
- Those kept in detention must have their health-based human rights respected and realised.

Climate change and environmental degradation

- Legislation recognising the rights of future generations and to a healthy environment must be developed.
- Individuals should be encouraged to take steps to reduce their carbon footprint
- Single-use plastics should be used as little as possible across the NHS.
- The energy sector and transport should be decarbonised as soon as possible.

The information age: new media and the assault on medical expertise

- National and international health bodies including the World Medical Association take an active role promoting policies of transparency, accountability, disclosure and redress in the digital health landscape via an international regulatory framework.
- National and international health and medical organisations, including the World Health Organization, the World Medical Association, and leading national medical bodies should commit to a coordinated programme of enhancing global digital health literacy.
- National medical associations or equivalent national bodies explore the possibility of developing or promoting campaigns to target specific sources of dangerous health misinformation.
- National medical associations or other expert health bodies identify positive social media thought-influencers and offer support for their campaigns, including with regard to trolling and malicious attacks online.

Conflict, human rights and health

- Violations of international law and human rights norms during conflict must be recorded and the systems and mechanisms for reporting these violations must be properly funded and supported.
- Health professionals and their organisations and institutions should strengthen their public support for IHL and international human rights law as a matter of urgency.
- National and international medical associations should cooperate in the calling out of war crimes wherever they occur.
- Health professionals and their organisations and institutions should call for a strengthening of the International Court of Justice and the International Criminal Court.
- National and international medical associations should seek to maintain a list of violations of the Geneva Conventions and international human rights law that relate directly to the provision of health and healthcare.

Foreword

As I write, there is war in Europe. Russia has launched an unprovoked invasion of Ukraine, threatening its sovereignty, independence and right to self-determination, and putting Russia's nuclear arsenal on special alert. The war is unjustifiable and is predicated on a false irredentist, revanchist narrative. War and armed conflict always imperil health and human rights, with immediate death and injury and devastating longer-term and often lifelong effects, affect not just combatants but also civilian populations, and have dire consequences for the wellbeing of future generations.¹ Refugees are fleeing, with already huge population displacements. Yet while this war seems particularly real and vivid to those who live within Europe, not least given the extensive media reporting, there are wars elsewhere in the world with equally devastating effects: in Syria, Yemen, Afghanistan, the Democratic Republic of the Congo, in Myanmar and elsewhere. And war and conflict have devastated lives within Europe repeatedly since 1945: in Hungary in 1956, in Czechoslovakia in 1968, and in the Balkans from 1991 to 2001. The genocidal killing in the Srebrenica massacre in the latter conflict is the worst single atrocity in Europe since the Holocaust.² Since the Second World War, there have been genocides in many places, including Guatemala, Bangladesh, Burundi, Uganda, Cambodia, East Timor, Iraq, Somalia, Bosnia-Herzegovina, Rwanda, Zaire, the Democratic Republic of the Congo, Darfur and Myanmar. Some of those tragic genocides are little known about internationally. Now a terrible genocide and other serious crimes against humanity are being perpetrated by the People's Republic of China, with medical participation, against the Uyghurs, Kazakhs and other Turkic Muslim populations.^{3,4}

Such atrocities – in the words of the Universal Declaration of Human Rights (UDHR) 'barbarous acts which have outraged the conscience of mankind'⁵ – are examples of how human rights, including health-related human rights, continue to be threatened and eradicated. But the human rights which need to be upheld, protected and defended range far more widely than the challenges which arise in conflict situations. The concept of and discourse about human rights are relatively recent: the belief that everyone, by virtue of their humanity, is entitled to certain human rights. The commitment to human rights was catalysed by the Second World War, a war which had seen the oppression and extermination of Jewish, Romani and Sinti peoples and of gay individuals and the disabled, although the commitment also grew from older concepts of rights, responsibilities, duties and justice. Following the formation of the United Nations, and the publication of the UN Charter in 1945,⁶ a Commission on Human Rights was established, charged with drafting what became the Universal Declaration of Human Rights.⁷

The preamble to the Universal Declaration states that 'recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice, and peace in the world'. In order to establish mechanisms for implementing and enforcing the Universal Declaration, the UN Commission on Human Rights drafted two treaties, the International Covenant on Civil and Political Rights⁸ and the International Covenant on Economic, Social and Cultural Rights,⁹ which detail the rights to be enjoyed by all people and prohibit discrimination. Those rights have been further defined and elaborated in numerous United Nations Conventions. The paramount objective of international and national human rights law is to protect individuals from man-made, avoidable suffering inflicted on them through deprivation, exploitation, oppression, persecution and other forms of maltreatment. Human rights are not just about defending individuals against state abuse, but also about promoting individuals' opportunity to thrive and develop through education, healthcare and a safe living environment. Human rights are essential for the protection of human dignity.

At the heart of these various human rights declarations, covenants and conventions is the principle that human rights are universal and inalienable, indivisible, interdependent and interrelated. They are universal because everyone is born with and possesses the same rights, regardless of where they live, their gender or race, or their religious, cultural or ethnic background. As Article 1 of the UDHR states, 'All human beings are born free and equal in dignity and rights.' They are inalienable because people's rights can never be

taken away. They are indivisible and interdependent because all rights – political, civil, social, cultural and economic – are equal in importance and none can be fully enjoyed without the others. Denial of one right invariably impedes the enjoyment of other rights. They apply to all equally, and all have the right to participate in decisions that affect their lives.¹⁰

The British Medical Association has decades of commitment to defending human rights, and particularly health-related human rights, as well as advocating for global health. *The Torture Report*,^{11,12} in the production of which John Dawson was instrumental, and *Medicine Betrayed*,¹³ written by Ann Sommerville and Jim Welsh, were both landmark publications of international significance, which clearly demonstrated not only the perpetration of abuses through doctors' betrayal of their ethical and professional principles, but how institutions and organisations had failed to speak out and condemn such practices, whether through inertia or tacit approval or as the result of political interference, and thereby facilitated the continuation of abuses, of medical involvement in torture, capital and corporal punishment, and the abuse of psychiatry for political purposes.¹⁴

A major project led by Ann Sommerville resulted in the publication of *The Medical Profession and Human Rights: Handbook for a changing agenda*,¹⁵ a comprehensive analysis of health-related human rights internationally, and of the complex interface between medical practitioners and human rights abuses, and the medical profession's role in protecting, supporting and advocating for human rights, but also in abusing those rights. The report's objectives included stimulating inter-professional cooperation, including between health organisations, lawyers and human rights organisations; developing protective mechanisms, including legal protections, for those witnessing human rights violations, and to support both victims and whistleblowers; facilitating the punishment of perpetrators; encouraging practical guidance to assist doctors, including medical ethics and human rights training; widening the debate, in particular in respect of recognition of health as a human right; and encouraging medical input into human rights, including through campaigning against health-related abuses of human rights, nationally and internationally, and against state decisions that have an adverse impact on health.

While the publication of *The Medical Profession and Human Rights* was seminal, the BMA was already working in the human rights field. For decades, the Association has engaged in lobbying and letter-writing campaigns, in response to evidence of human rights abuses involving doctors as either victims or collaborators, with letters to heads of state, governments, embassies, international organisations and national medical associations. The *BMA procedures for human rights interventions*¹⁶ were first published in *Medicine Betrayed* and are available on the BMA website. They stress the necessity of independent verification by human rights organisations such as Amnesty International, and state that the BMA primarily responds to cases in which doctors are involved and to cases involving important health issues.

One particular focus has been on violations of medical neutrality, which is fundamental to international humanitarian law¹⁷ and protected by UN Security Council Resolution 2286¹⁸ and the Colombo Declaration.¹⁹ In recent years, the BMA has taken action in respect of abuses of medical neutrality in Bahrain, Turkey, Gaza, Afghanistan, Nicaragua and Sudan. Doctors and other healthcare professionals must have the freedom to provide care and treatment without interference or reprisal, and must be able to speak out about health-related aspects of conflict and raise concerns. Additionally, the sick and wounded, healthcare and humanitarian personnel, their means of transport and equipment, and hospitals and other medical facilities must be protected from attacks and threats.

In addition to letter-writing, the BMA also periodically issues joint statements on human rights abuses with other UK medical and health organisations; recent examples have included statements on Myanmar, Afghanistan, and the Uyghurs, and a joint letter on the Nationality and Borders Bill. Another focus of the BMA's work, led by Julian Sheather, has been the ethics of delivering humanitarian aid in conflict situations.

The BMA also works with other organisations, including the World Medical Association (which has produced many declarations, statements and resolutions on human rights), the Commonwealth Medical Association, European medical bodies, national medical associations, Amnesty International, Physicians for Human Rights, the International Federation of Health and Human Rights Organisations, the Johannes Wier Foundation, the International Dual Loyalty Working Group,²⁰ Médecins Sans Frontières, and other voluntary sector organisations, including those caring for victims of torture and for women's reproductive rights. One example of such international cooperation was the BMA's involvement in the development of the Istanbul Protocol,²¹ which established international guidelines for the documentation of torture and its consequences.

The BMA also publishes reports and statements on health-related human rights in the UK. For example, work led by Ruth Campbell has resulted in publications on the youth justice system,²² immigration detention,²³ and solitary confinement.^{24,25}

The BMA believes that immigration detention should be a measure of last resort, only ever contemplated when an individual poses a threat to public order or safety, and that immigration detention should be phased out and abolished, and replaced with alternative, more humane means of monitoring. Detention exacerbates vulnerability and causes deterioration in physical and mental health and wellbeing.²⁶

In the youth justice system, the BMA has identified practices in the secure estate, including the use of restraint, force and segregation, which are detrimental to health and wellbeing; has stated that detained children and young people should never be subject to solitary confinement; and believes that more welfare-based alternatives to custodial detention need to be explored. Solitary confinement damages health and wellbeing, increases the risks of suicide and self-harm, damages mental health and impairs social, psychological and neurological development.

The writing of the current powerful report has been led by Julian Sheather and Dominic Norcliffe-Brown, with input from a Human Rights Steering Group of international experts and from the BMA's ethics team and Medical Ethics Committee. It is part of a continuing and comprehensive approach by the BMA for the advocacy and defence of health-related human rights. Each chapter of the report includes practical recommendations for action – including recommendations applicable to the medical profession collectively and individually. The report does not aim to cover the whole field of human rights relevant to the medical profession, in the way that *The Medical Profession and Human Rights* did. There are many areas covered in that handbook which remain of grave concern but are not addressed or only peripherally considered in the current report. Such areas include the continuing use of torture, capital and corporal punishment; healthcare in prisons and detention settings; organ harvesting;²⁷ the ongoing threats to women's reproductive rights;²⁸ and many other areas on which the BMA continues to express concerns about abuses and to defend and promote rights, including transgender rights. Rather, this report

i For example the Declarations of Tokyo and of Hamburg on the Use of Torture and Other Cruel, Inhuman or Degrading Treatment; the Declaration of Malta on Hunger Strikers; the Declaration of Edinburgh on Prison Conditions; the Declaration of Washington on Biological Weapons; the Declaration of Delhi on Health and Climate Change; the Declaration of Montevideo on Disaster Preparedness and Medical Response; the Declaration on the Protection of Health Care Workers in Situation of Violence; the Statement on Body Searches of Prisoners; the Statement on Medical Ethics in the Event of Disasters; the Statement on Weapons of Warfare and Their Relation to Life and Health; the Statement on Nuclear Weapons; the Statement on Medical Care for Refugees; the Statement on the Protection and Integrity of Medical Personnel in Armed Conflicts and Other Situations of Violence; the Statement on the Right to Rehabilitation of Victims of Torture; the Statement on Solitary Confinement; the Statement on Riot Control Agents; the Statement of Ethical Principles of Health Care in Times of Armed Conflict and Other Emergencies; the Statement on Armed Conflicts; the Resolution on Physician Participation in Capital Punishment; the Statement on Medical Age Assessment of Unaccompanied Minor Asylum Seekers; the Resolution on Political Abuse of Psychiatry; the Resolution on the Responsibility of Physicians in the Denunciation of Acts of Torture or Cruel, Inhuman or Degrading Treatment; the Resolution on Violence Against Women and Girls; the Resolution on the Prohibition of Chemical Weapons; the Resolution on Prohibition of Physician Participation in Capital Punishment; the Resolution on Climate Emergency; and the Resolution on Human Rights Violations against Uighur People in China.

focuses on a smaller number of concerns, some of them areas in which health-related human rights are now threatened even more seriously than was perhaps the case twenty years ago - the threats resulting from climate change, digital threats and disinformation, neoliberalism, populism and socioeconomic inequalities – as well as other areas which were covered in the handbook but which remain huge problems and are addressed in a contemporary context: the continuing threats from armed conflict,^{29,30} migration and racism. The report notes that a toxic combination of populism, economic insecurity, nationalism, nativism, political majoritarianism and disregard for the rights of minorities is attacking and undermining human rights standards, threatening the vulnerable, the foreign, the marginal, the displaced, the 'other'. Human rights, and the institutional checks and balances that constrain unfettered power in democracies, are being challenged by political demagogues.

What this report illustrates with exemplary clarity is that human rights are under threat throughout the world, including in the UK. Human rights are curtailed when the rights of particular groups, often vulnerable minorities, are attacked. Such 'othering' betrays the universality and inalienability, and the indivisibility, interdependence and interrelatedness, of human rights. Those rights apply to all, and apply to all equally.

While the most egregious oppression occurs elsewhere, in the United Kingdom, there are increasing attacks on human rights in the Westminster Parliament and by the UK Government. The right to protest would be threatened by the proposals in the Police, Crime, Sentencing and Courts Bill. The UK's humanitarian obligations under the Refugee Convention³¹ would be breached by the Nationality and Borders Bill,³² which rejects the international system for the protection of refugees, removes choice as to where asylum is claimed, fails to create safe, legal routes, penalises refugees, and proposes offshore detention while asylum claims are processed. The Judicial Review and Courts Bill weakens checks on power and damages access to justice. Additionally, there have been proposals to provide immunity from prosecution for the military from genocide, war crimes and torture. Meanwhile, actual immunity for covert human intelligence sources has been conferred via the Covert Human Intelligence Sources (Criminal Conduct) Act 2021. All these policy proposals and changes have a deleterious impact on the UK's influence, trustworthiness and moral authority.

Additionally, the UK Home Office's hostile environment policy has resulted in the Windrush scandal;³³ an NHS charging regime that is increasingly detrimental to health; worsening arrangements for immigration detention; inappropriate deportations (including to countries where the risks of torture and death are high, and including the deportation of victims of modern slavery and human trafficking); refusals of leave to remain; and inappropriate data-sharing with the Home Office and immigration authorities,³⁴ which deters people from seeking the healthcare they need, with inevitable adverse consequences for individual and public health. The same hostile environment policy now seems to be underpinning the UK's parlous and slow response to the Ukrainian refugee crisis.

The UK Government is also proposing to reform the Human Rights Act 1998 and replace it with a Bill of Rights.³⁵ The proposals are intended to restrict the circumstances in which claims can be made, thus undermining access to justice; limit the interpretative and enforcement scope of the courts in relation to human rights claims; shift the constitutional balance of power from the judiciary to the legislature; limit the freedoms of certain classes of persons to bring human rights claims; and reduce the accountability of Government and public bodies. The reforms are also specifically intended to ensure that certain rights – including the right to a family life – cannot be used to prevent the deportation of certain classes of persons, to stop the courts overturning deportation decisions unless they are clearly flawed, and to remove what the UK Government sees as 'impediments' to the management of migrants. It seems highly probable that the proposals will have adverse impacts on access to healthcare, health-seeking behaviour, and individual and public health, compounding the problems already caused by NHS charges and inappropriate data-sharing. The BMA has policy opposing any repeal of the Human Rights Act, and regards the Act as highly effective legislation, which sets out a

range of negative and positive duties on the state that provide legal protection and support for the fundamental rights and interests of all those within the UK's jurisdiction, including their health-related rights. The necessary protection and support must continue to be fully available to all groups, migrants, adults lacking capacity, people detained under mental health legislation and those with protected characteristics under equality legislation.

Given that human rights are universal, indivisible and inalienable, the BMA would be gravely concerned by any moves to introduce procedural changes that would have the effect of making some groups of people less able to seek the enforcement of their fundamental rights, including by discriminating against people on the basis of their status, or discriminating against them on the basis of past behaviours. The concept that some have greater rights than others, with the human rights of unpopular groups being limited by selective withdrawal, is iniquitous. That concern about the discriminatory application of rights is not just national but international; it applies in any situation where rights are being curtailed or abused or rights are differentially applied. It is not for the state to defend some rights rather than others, or to distinguish between those who deserve and do not deserve protection.

Health professionals should apply their awareness of human rights to their professional practice. Traditional concepts of medical ethics overlap and interact with human rights obligations; both emphasise the protection and promotion of human welfare in its broadest sense. Violations of human rights usually have adverse health implications for individuals, groups and for society. Many doctors see examples of serious inequity concerning access to appropriate health care or the right to live in a safe environment. Many doctors can influence how the least powerful individuals – children, the mentally ill, the demented and prisoners – are treated by society. Doctors can sometimes intervene to prevent harm and to protect individuals. All health professionals may have opportunities, including through their professional organisations, to influence the development of public policy in ways that promote human rights, enhance public health and address the social determinants of health. Indeed, individually, as doctors and medical students, we have a moral duty to speak out about abuses of ethics and human rights. Doing so is an intrinsic, essential and ineradicable part of our professional, ethical and societal responsibilities.

I am enormously proud of the work of the British Medical Association in ethics and human rights over more than three decades. This report, the production of which has been so ably led by Julian Sheather and Dominic Norcliffe-Brown, takes that work forward. I hope that the report and its powerful recommendations will prove to be of lasting influence within the UK and internationally, will help strengthen international cooperation among health and human rights organisations to identify violations and coordinate responses, and will contribute to ensuring the protection and promotion of informed global debate on health issues. In the words of the Universal Declaration of Human Rights, we need to reaffirm our 'faith in fundamental human rights, in the dignity and worth of the human person and in the equal rights of men and women'.³⁶



Dr John Chisholm CBE
Chair, BMA Medical Ethics Committee, 2014-21

Introduction

The 'Doctors' Letter from Eastern Ghouta, Syria – a fragment

From: Dr Imad Al-Kabbani, Director Health Damascus and Rural Damascus

To: Dr. Tedros Adhanom Ghebreyesus Director General World Health Organization

Dated: 15/12/2017

“Once, we were family doctors and paediatricians, specialists in chronic diseases such as diabetes and coronary heart disease. Since March 2011, when the people of Eastern Ghouta joined the peaceful uprising begun in Dara’a that the Syrian government met with violence, we have become experts in war trauma caused by barrel bombs, missile strikes, incendiary weapons, vacuum bombs, and chemical weapons. We have also had to master care for starvation-induced malnutrition and war-aggravated infectious diseases such as typhoid and TB. The chemical massacre using sarin nerve gas in August 2013, causing 1100 civilian deaths in one night, mostly children and women, was beyond our worst expectations, our medical training, and our clinical capacity, but that was only the worst case on a horrible continuum of deliberately induced civilian suffering.”

Relief of suffering is the moral heart of medicine. Inevitably this means that doctors and other health professionals find themselves engaged in some of the most challenging places – and times – in the world. Conflicts in Syria, Ukraine, Myanmar and across the globe have seen health professionals and their services under siege. This was clear when we started planning this report. But we could not have foreseen the onset of the most serious global public health emergency since the closing of the First World War. COVID-19 put every healthy system in the world under enormous stress – and the critical interdependence of health and human rights was forced into the spotlight.

Learning from the pandemic

During the writing of this report the world changed in a way few anticipated. COVID-19 triggered the most serious global public health crisis since the 1918 influenza pandemic. The COVID pandemic overstretched every health system in the world. It killed millions, decimated economies, challenged national and international governance, and exposed the depth of in-country and global health inequalities. Not since the Second World War have liberal democratic governments stepped so emphatically into the private and commercial lives of their citizens. Political leaders were forced to make agonising choices about the balance between individual liberties and infection control. Global lockdowns put hitherto unimaginable constraints on economic activity. Other than for essential goods, commercial zones and high streets were effectively closed.

And yet for all its unquestionable horrors, the pandemic also shook up our sense of what was possible. Orthodoxies that had hardened into the status of natural laws were unsettled. In the face of a global health emergency, neoliberal truisms about the inefficiency of states or their capture by special interests were brushed aside in favour of massive government intervention. After decades of seeing administrations positioning health as a question of private choices, we saw how rapidly governments could act to safeguard both individual and public health. The COVID pandemic also put the reality of global interconnectedness beyond doubt, along with the need for international collaboration to face humanity’s collective threats.

COVID and health rights

From a health rights perspective, COVID brought serious challenges along with opportunities for a global reset. Early in the pandemic, the absence of effective vaccines or treatment meant reliance on traditional public health methods: quarantine; social distancing; track, trace and isolate. Although highly effective at controlling transmission, they also involved serious infringements of privacy and liberty rights. Good public health

interventions also require accurate, real-time data. Mobile digital devices offered huge potential for identifying and managing outbreaks, but also opened the door to the potential for unprecedented levels of state surveillance.

Health professionals were on the front line of the response. Too many of them were harmed, even killed by the virus. Initial shortages of personal protective equipment both exposed a damaging lack of preparedness and provoked important questions about the limits of professional obligations to treat in the face of serious harms.

Equality of respect is fundamental to human rights – the rights of each of us matter equally. But the harms of the pandemic did not fall equally. COVID exposed the persistence of harsh and enduring health inequalities – between countries, between regions, within countries, and between ethnic, social and age groups. And COVID also clarified the costs of those inequalities and the urgency of the requirement to address them. Here too there is potential for positive change. Attention will soon turn to reducing the possibilities of further pandemics and it must involve addressing those global inequalities. Yes, we saw competition between nations for scarce medical supplies; yes, there was extensive vaccine nationalism, but we also glimpsed the potential – not fully realised – for urgent international collaboration.

This report was planned and partially written before the pandemic. We were motivated by alarmed reports that human rights in general, and health-related human rights in particular, were either retrenching globally or were under direct criticism and attack. Although from early 2020 global attention understandably focussed on COVID, the underlying situation regarding human rights remained – and remains – volatile.

Russia invades Ukraine

Just as this report was nearing completion, Russia unlawfully invaded Ukraine, an independent sovereign state. Failing to achieve its early military objectives, Russia had recourse to devastating wars of attrition against civilian targets. These are war crimes. To all intents and purposes the City of Mariupol, in south-eastern Ukraine, has been destroyed. A port city on the Sea of Azov – the tenth largest city in Ukraine and once home to over 400,000 civilians – Mariupol is now a smoking ruin, brutally reminiscent of Aleppo in Syria. Wars of attrition do not spare health facilities. From the earliest days of the invasion of Ukraine, reports emerged of hospitals bombed and shelled. As of the 23rd of March, the WHO reported 49 attacks on hospitals and nine on medical transports.³⁷ It is difficult to exaggerate the health implications. They are not confined to the devastating effects of modern munitions. Rough estimates suggest that for every person killed by direct fire, nine are killed indirectly.³⁸ The health impacts spread out through refugee routes and across generations.

Human rights – enduring challenges

During the last decade, an unprecedented set of factors has combined to challenge global commitments to human rights norms. Political populism, economic insecurity, nationalism and political majoritarianism are frequently said to be driving a piecemeal global retrenchment from human rights standards. While China under Xi Jinping and Putin's Russia are directly critical of human rights, 'democratic' leaders with autocratic tendencies – Viktor Orbán in Hungary, Jair Bolsonaro in Brazil, Narendra Modi in India, and Rodrigo Duterte in the Philippines – undermine with varying degrees of stealth. Under President Trump, the United States weakened its attachment to international institutions, withdrawing from both the United Nations Human Rights Council and the WHO (World Health Organization).

Taking a leaf from old and dangerous populist playbooks, invoking myths of nativism and ethnocentrism, some populist leaders seek to demonise the vulnerable, the foreign, the marginal and the displaced. Orbán has attacked LGBTQ+ rights. Bolsonaro has sought to undermine the rights and interests of Brazil's indigenous people. Duterte has disregarded

the rule of law. Human rights, along with the institutional checks and balances that constrain unfettered power in democracies – an independent judiciary, a free press – are targeted. Instead of minimal guarantees and entitlements, human rights are cast by these populists with authoritarian leanings as unnecessary constraints on the will of the majority – the will that political demagogues promise they alone can unfetter and realise.

The frailty of institutions

At the same time, it can be suggested that the rights-respecting framework of international and multilateral institutions – a precarious structure of global agreement and quasi-governance – seems to be weakening. We have seen how COVID became an excuse for then-President Donald Trump to withdraw the United States from the WHO. Notorious use of vetoes by China and Russia on the UN Security Council have blocked the ability of the Council to respond to rights violations in Syria. This is on the back of the systematic US use of the veto to block decisions detrimental to Israel. In recent years, China has opposed resolutions condemning human rights violations in Myanmar, Syria, Iran, the Philippines, Burundi, Venezuela, Nicaragua, Yemen, Eritrea and Belarus. In a minority of powerful states, international humanitarian law and human rights standards have been replaced by realpolitik and national self-interest.

Neoliberalism, global capital and social inequality

The period following the economic challenges of the 1970s saw a decisive global turn toward 'neoliberal' economic policy. Associated with 'the Washington Consensus' – free market policies promoted by a cluster of prominent financial institutions including the World Bank, the IMF (International Monetary Fund) and the US Treasury – this involved the pursuit of economic growth through market liberalisation and the curtailing of state intervention, with its associated turning away from the welfare safety nets and state-managed capitalism of the post-war decades. According to neoliberal theorists, states undermine the efficiency of the markets, create perverse incentives and are inevitably captured by vested interests.

Although the extraordinary levels of economic growth associated with neoliberalism bought significant health benefits, particularly where they lifted large numbers of people out of absolute poverty, they also triggered grave challenges for human rights. The concentration of enormous wealth in very few hands, the rise of kleptocratic capitalism in former Soviet countries, the extraordinary and disruptive global mobility of capital, and a belief that wealth is broadly distributed according to 'just desserts', have challenged the search for collective solutions to social problems affecting human health. States are critical addressees for human rights norms. Although some have argued that deregulation and the rolling back of the state are to an extent in sympathy with the more individualistic civil and political rights, the right to health requires some form of state intervention to offset extreme inequalities and market failure: experience suggests that left entirely to themselves, free markets simply leave too many people without access to even the minimum resources necessary to protect and promote their health and wellbeing.

Despite a welcome narrowing of inequalities between some countries, neoliberalism has nonetheless contributed to significant widening of inequality within countries, while the reduction in state-sponsored safety nets has led to widespread insecurity and unease. Social and economic precarity are increasingly the conditions of the global majority. What were once considered the ordinary elements of a decent life, whether real or aspirational, such as access to medical care, stable employment, reasonable housing, publicly-funded education – have become more elusive.

Our understanding of the impact of social gradients – of what professor of epidemiology and public health Sir Michael Marmot has identified as the social determinants of health – on wellbeing has deepened. At the same time, the effect of social inequalities, particularly within individual countries, on differential health outcomes has become clearer. Stagnating life expectancy in the UK and the US has been linked to the inequalities directly resulting from neoliberalism. Significant social inequalities have serious health and wellbeing implications that are of vital concern for health and human rights. The economic

costs alone of COVID suggest that international co-operation will be increasingly vital to manage emerging health threats. A highly mobile globalised economy creates more than economic opportunity. Health threats can be globalised almost as rapidly as capital.

The UK

The UK has also been affected by these global forces and trends. Economic instability, deepening inequalities of opportunity and wealth, and cultural disorientation driven by rapid globalisation, have provoked resentment of metropolitan and technocratic elites and the outward-looking institutions associated with them – a resentment easily flamed by populist-leaning politicians. Such politicians and their allies have caricatured human rights protections as ‘get-out-of-jail-free cards’ for terrorists and the preachers of hate – as favouring the very minorities that populists attack. Brexit had complex drivers but among them was an opportunistic attack on the post-war European social project with its deep foundations in the European Convention on Human Rights.

Health professionals and human rights

Medical impartiality

Global rights and norms in medicine have come under new pressure. Medical impartiality – the binding principle that the purpose of medicine is to care for the sick, irrespective of their status or affiliation – is again threatened. The ‘war against terror’ has dangerously blurred distinctions between urgent medical treatment and the provision of material support for terrorist organisations, opening up the possibility of the criminalisation of medical care. Turkey’s President Recep Tayyip Erdoğan passed laws effectively criminalising the provision of emergency healthcare in response to civil unrest. Turkish doctors have been arrested for providing treatment to alleged members of Kurdish armed groups, and the Turkish Medical Association has itself come under threat from the state – part of a war of attrition against Turkish civil society. Similar attacks on medical neutrality have been seen in Nicaragua and Bangladesh.

Inequality and human rights

Given its underlying commitment to the basic conditions of human flourishing – both ‘negative’ liberties and ‘positive’ entitlements – a human rights approach to health is alert to inequality and discrimination. Gender and ethnicity are long-standing concerns of health and human rights. Women and children remain too often marginalised and discriminated against. Practices, including female infanticide, child marriage, gender-based violence, enforced abortion and female genital mutilation are both enduring and urgent human rights concerns. Reproductive rights – along with access to gender-sensitive medical care – remain areas of critical concern. Racial discrimination, including the recent intensification of Buddhist persecution of the Rohingya minority in Myanmar, and the Chinese suppression of its Uyghur population, is widespread, with profound consequences for human health and wellbeing. In the US, which has the greatest per-capita health spend in the world, COVID has further highlighted existing social and ethnic inequalities in health. Although the Black Lives Matter movement has complex and multiple drivers, it reveals the depth of ethnic inequalities in the wealthiest country in the world. Similarly, parts of the UK ethnic minority population were hardest hit by COVID, as were ethnic minority health professionals.

Detention

Health and the provision of medical care in custodial settings have long been areas of human rights concern. Closed institutions, including prisons and immigration detention centres, render inmates vulnerable to abuse. Health professionals can struggle to maintain objectivity and impartiality in the face of isolation and institutional pressure. It can take courage to call out rights violations in the face of institutional resistance or even intimidation. We have seen all too often the insidious ease with which complicity with abusive practices arises. In some states, doctors are threatened with serious repercussions for themselves and their families if they try to resist, or speak out about, human rights abuses in detention settings.

Contemporary crises have brought new urgency. The mass displacement of peoples driven by conflict, persecution and desperate poverty have led to new forms of incarceration with terrible consequences for the health and human rights of the detained. Libyan detention centres – brutal semi-formal holding centres for migrants – are some of the most inhumane places in the world. Frequently run on a semi-commercial basis, rooted in extortion, trafficking and smuggling, the use of torture and rape is described by detainees as ‘routine’. Malnutrition and poor sanitation undermine health and the spread of infectious diseases, including tuberculosis, is impossible to control. The immigration detention centres on the US/Mexico border are a barbaric expression of a sustained campaign of ‘deterrence by cruelty’ and many children have been permanently separated from their families.

The UK’s ‘hostile environment’ for migrants, designed to address so-called ‘pull’ factors making the UK an attractive destination, has given rise to serious concerns about the health and human rights of asylum seekers arriving in the UK via informal routes. The drowning of 27 migrants in the English Channel in November 2021 marked a tragic nadir for the rights and interests of migrants seeking access to the UK. 2021 also saw the publication of the UK People’s Tribunal into allegations of Chinese crimes against humanity against Uyghur, Kazakh and other Turkic minorities. The Tribunal’s findings are deeply troubling, setting out evidence that shows, ‘beyond reasonable doubt’, the systematic use of medical skills, techniques and professionals in genocide and other crimes against humanity in Xinjiang.

Political failure

The Libyan detention camps are the outcome of wider political failure. They are the by-product of political deals struck by the EU to deter migrants and refugees from its borders. Despite some early important exceptions – principally Merkel’s Germany – Europe, beset by its own political challenges, is backpedalling on some of its commitments under the UN Refugee Convention. The 2016 EU-Turkey refugee deal hardened Europe’s borders, and has largely prevented onward movement of refugees from Greece’s eastern islands. Before it was destroyed by fire, Moria refugee camp on Lesbos, a former army barracks, was many times over capacity. Conditions in replacement camps are basic, migrant people are vulnerable to epidemics of infectious diseases, and MSF (Médecins Sans Frontières) has spoken about a mental health epidemic. Meanwhile, political logjam and rising numbers of stranded refugees have provoked local people to violence.

Medical neutrality under fire

The last decade has also seen an intensification of the deliberate targeting of health workers and facilities. In a sustained and flagrant violation of the Geneva Conventions, Bashar al-Assad has effectively unleashed total war in Syria, degrading and devastating civilian infrastructure. This has included deliberate targeting of health professionals and health facilities.

Figures jointly published by Physicians for Human Rights and the Yemeni human rights group Mwatana in March 2020 identified over 120 attacks on health facilities and medical workers in Yemen between 2015 and 2018. The collapse of the Yemeni health system has helped precipitate what the UN has labelled the worst humanitarian crisis in the world, with widespread malnutrition and outbreaks of cholera and diphtheria.

Emerging threats

In addition to renewed pressures in areas of established human rights concern, new issues are emerging. We are now seeing hard evidence of the destabilising impacts of climate change: the displacement of vulnerable people, shifting disease vectors, conflicts over food and water shortage. These issues will only become more urgent.

Health is increasingly being ‘securitised’: responses to both Ebola and COVID-19 contain examples of health challenges being reconfigured as security threats. Interventions cease to be concerned with realising the health rights of vulnerable populations and become means of containing threats to resource-rich settings.

Political populism takes aim at expertise. Unfettered by the checks and balances of traditional media outlets, conspiracy theories replicate virally on social media. Medical expertise is dismissed. Scientific evidence is neglected in favour of visceral appeals to popular fears and indignation – the swelling ranks of ‘anti-vaxxers’ and climate change deniers being among the most high-profile examples.

Looking forward

It is clear from the foregoing that there are widespread global challenges to health rights. Although the situation is serious, it is very far from hopeless – real grounds for optimism remain. As Kenneth Roth, executive director of Human Rights Watch, writes in its 2020 annual report, a bellwether of the state of human rights globally:

‘Despite the unfavourable winds, the past year shows that defending human rights remains a worthy imperative. When governments see political or economic advantage in violating rights, rights defenders still can raise the price of abuse and shift the cost-benefit calculus to convince governments that repression does not pay.’³⁹

In its 2021 report,⁴⁰ buoyed by President Biden’s reset, Human Rights Watch is more sanguine still, seeing the stirrings of a genuinely international human rights movement emerging in the space left by uncertainty about US commitments. As Kenneth Roth points out, new international coalitions have formed to promote human rights standards and the international structures supporting them. In an unprecedented move in 2018, the Organization of Islamic Co-operation, largely made up of Muslim-majority states, worked with the EU to develop the Independent Investigative Mechanism for Myanmar at the Human Rights Council in response to the brutal campaign against the Rohingya population of Rakhine State.

Many countries remain firmly committed to human rights norms and the institutions that support and articulate them. Despite its economic power, China is subject to sustained international criticisms for its abuses of the human rights of minority groups. Although compliance remains a challenge, human rights still offer a global language of social and political aspiration – meaningful claims to a minimum framework of liberties and entitlements necessary to a good life. Recent years have seen strong global movements coalescing in support of women and the lives of black people. In response to COVID, demands for global sharing of vaccines have been articulated in the language of fundamental rights.

A new report

It is clear from all we have said that we need to do more. As we have seen, along with established and enduring threats, new and unsettling challenges to global human rights – and to the most vulnerable people in the world – are emerging. It is essential that civil society organisations draw attention to the profound risks we are facing. We need to be clear about the nature of the threats, and imaginative about solutions.

The purposes of this report

A report of this nature, on an issue of this complexity and urgency, will inevitably have several, albeit closely linked purposes. In addition to drawing attention to these new and emerging threats – and seeking to hold duty-bearers accountable – the report seeks to:

- Reaffirm commitments to global human rights standards in health

At the risk of hubris, during this time of cultural, political, and intellectual criticism of the human rights movement, it is more than ever necessary to reinforce commitment to basic norms. Even without the human rights framing, access to the resources and underlying conditions required to lead a reasonably healthy life would remain a vital moral issue. Its articulation – and the steps made toward realisation – in the global health movement are critical successes that must be defended.

- Help strengthen international co-operation among health and human rights organisations to identify violations and coordinate responses

With international human rights bodies under attack, and powerful nations retrenching from human rights standards, it is more urgent than ever that those committed to human rights standards work together. In addition to seeking further to raise awareness of, and strengthen commitment to, human rights standards among global – and international – health bodies, the report seeks to develop further beneficial links between medical organisations and groups promoting human rights.

- Ensure the protection and promotion of informed global debate on health issues

Access to accurate and up-to-date scientific information is an essential component of the right to benefit from scientific progress and its application (art. 15 of the International Convention on Economic, Social and Cultural Rights). It is also a fundamental part of the right to health. Among the most menacing global developments of recent years has been a sustained attack, often via social media platforms, on medical expertise and the science that underpins it. This could have catastrophic implications for individual and public health globally. This report seeks to strengthen global pushback against medical disinformation.

- Further strengthen the medical voice in climate change awareness

The health implications of climate change and environmental degradation are established beyond reasonable doubt. It is vital that the global medical profession recognises the connection to human rights, lends its authoritative voice to this debate, identifying the likely major health implications and seeking ways to reduce and mitigate those health impacts.

The BMA and human rights

The BMA is a voluntary trade union and professional association representing the interests of doctors and medical students in the UK. Our policies are determined by our members at our ARM (annual representative meeting). Since the 1970s, successive ARM motions have demonstrated a long-standing interest in global health and human rights. Areas of particular concern have been doctors as both witnesses and perpetrators of human rights abuses, as well as the rights of marginalised and vulnerable people, both domestically and overseas, to an appropriate standard of health care.

An early focus of our human rights work was in response to the appearance of disturbing reports of medical involvement in torture in the 1980s. This resulted in the publication of *The Torture Report*⁴¹ and a mandate to support doctors anywhere in the world faced with evidence of torture. In the early '90s we published *Medicine Betrayed*,⁴² examining medical involvement in a range of human rights violations and judicially approved procedures such as execution.

The conflicts that erupted in Europe in the 1990s as Yugoslavia unravelled were another watershed. Doctors across Europe, including the UK, provided care for traumatised refugees, witnessing first-hand the impact of the atrocities. As in Rwanda, forensic doctors in the Balkans sought to identify the victims of ethnic cleansing interred in mass graves. These were and remain – the process of identifying continues – vital steps towards justice and reconciliation. They were also a warning. They brought home the brutal culmination of the gradual and systematic process of human rights violations and marginalisation – a process we are witnessing now in Myanmar and the Xinjiang province of China. The events in Rwanda and the Balkans were instrumental in the publication of *The Medical Profession and Human Rights*,⁴³ our landmark 2000 survey of the global health and human rights landscape.

More recently we have been involved in raising awareness of threats to the Geneva Conventions and the targeting of civilians, health professionals and their facilities during conflicts in the wider Middle East. We have worked with MSF, organising conferences and campaigns to seek the strengthening of international humanitarian law. We supported the United Nations' adoption of Security Council Resolution 2286 and have signed the

Colombo Declaration opposing the deliberate targeting of health facilities and health professionals. We have also joined with Amnesty International in supporting forensic doctors and health professionals to tackle torture and other forms of abusive behaviour in detention settings globally. Domestically, we have published reports on immigration detention⁴⁴ and the health of young people in the secure estate,⁴⁵ lobbying for change to ensure respect for fundamental health rights.

The 'right to health'

Much of our early concern with human rights was broadly linked to medical witnessing – or involvement in – violations of civil and political rights. These involve states', and other actors', obligations to refrain from encroaching on individuals' fundamental interests and liberties. As discussed above, medical involvement in violations of the right not to be subjected to torture or to cruel, inhuman or degrading treatment or punishment has been an enduring concern. Medically these are clearly not just human rights issues. They are matters of profound professional responsibility reflected in core international codes of medical ethics. The World Medical Association's Declaration of Tokyo, for example, states unequivocally that: *The physician shall not countenance, condone or participate in the practice of torture or other forms of cruel, inhuman or degrading procedures.*⁴⁶

Recent decades, however, have seen a flourishing of interest in economic, social and cultural rights, particularly, for our purpose, 'the right to the enjoyment of the highest attainable standard of physical and mental health', often shortened to 'the right to health'. This imposes a range of duties on states, both positive and negative, to provide a 'variety of facilities, goods, services and conditions'⁴⁷ necessary for the right's realisation. On the 'positive' side, duties include the provision of health services and public health protections, along with ensuring the 'underlying conditions of health' – such as clean and drinkable water, safe and adequate nutrition, and healthy working and environmental conditions. In addition, the right includes a number of freedoms – including freedoms from non-consensual medical treatment, forced sterilisation, torture and cruel, inhuman or degrading treatment or punishment.

Although still subject to widespread and systematic violation, the negative duties contained in the right to health, and the closely related ethical principles set out in international medical codes, receive broad public support across the political spectrum. Although the exercise of negative duties commits states to positive and costly actions – such as creating a functioning legal system to realise the right to a fair trial – many of the social, economic and cultural rights involve more widespread and systematic forms of redistribution. It is probably fair to say that rights that involve, broadly speaking, access to goods and services remain a source of political disagreement. By and large, those who favour market exchange as primary drivers of the distribution of goods are suspicious of large-scale, state-sponsored reallocation. These questions have become particularly critical – and acrimonious – during the decades of the Washington Consensus as resource-poor countries were encouraged to reduce welfare-related public spending in pursuit of economic growth.

As a medical association we believe that health is a foundational human good. Without a minimum level of health, we struggle to fulfil even the most basic of our goals and life plans. Poor health can catastrophically inhibit the ability to engage in the kinds of production and exchange required to access a range of goods and services, including those necessary for the maintenance of health, in a free market. Health is of such basic importance, and an issue of such important moral concern, that it is coherent to talk about it as a *right*. As justified moral norms,ⁱⁱ rights have particular strength and standing – they are not simply desirable high-priority goals, good to have if all is going well, dispensable when things are tough. Rights involve strong obligations on their addressees – usually

ii This view of rights as justified moral norms is taken from: Nickel JW (1987) *Making Sense of Human Rights*. Berkeley: University of California Press.

governments – to secure for rights-holders certain definable freedoms or benefits. While the expression of these obligations will always be to some degree dependent upon available resources, they can never be ignored: it is for governments to decide how best to realise their obligations given the resources available.

Although human rights are designed to have political effects, they are not in any straightforward sense party political. The drafters of the Universal Declaration of Human Rights, and its successors, were agnostic, for example, about states' underlying economic systems. But whatever their economic approach, where states have signed and ratified relevant treaties, they are required to fulfil, to the fullest extent possible, their rights-related obligations. Where states have not signed or ratified relevant treaties, as justified moral norms with universal application, human rights provide independent moral benchmarks against which states' failure to respect basic human interests can be criticised. This is the approach we take in this report.

Like human rights themselves, this report is unavoidably political – but it is not, politically, *parti pris*. If a state undertakes to pursue economic growth through prioritising free markets, human rights norms require it to be alert to the impacts on relevant human rights and to take appropriate action. Similarly, where a country takes a more collective approach, with government taking a far greater role in the distribution of economic goods, they must also be alert to relevant rights – historically, for example, more collectively-minded societies have been known to discount liberty rights.

In our view, whatever overall approach a country takes, health is such a fundamental human good that it is meaningful both to talk of it as a universal right, and to ensure that all governments are held accountable to their obligations to protect, respect and fulfil it. Whatever the underlying economic system, where a state has ratified relevant human rights treaties, it has accepted a set of standards against which its progress in realising those rights – and any violation of them – can be called to account.

The war in Ukraine

On the 24th of February 2022, just as this report was being finalised, Russia invaded Ukraine. In an act of unprovoked aggression, following years of deliberate destabilisation, the annexing of the Crimea and the effective occupation of the Donbas region of Eastern Ukraine, Russia sent its armed forces into a sovereign nation, in direct violation of international law. It is too early for this report to address the consequences of Russian aggression. In the first days of fighting, health facilities were struck. We do not know if they were targeted. Russia has the advantage of overwhelming military power. But if the Ukrainians defend their cities, military victory will only come at enormous human cost – as we have seen in Syria, Libya and the Yemen. Reports suggest that thermobaric weapons have already been used in Ukraine.⁴⁸ Their impact on built up areas is devastating. They can also vaporise human beings.

There will always be those who question whether law, or morality, has any part to play in warfare. As professor Michael Walzer writes in *Just and Unjust Wars*, his profound exploration of just war theory:

For as long as men and women have talked about war, they have talked about it in terms of right and wrong. And for almost as long, some among them have derided such talk, called it a charade, insisted that war lies beyond (or beneath) moral judgment... Inter arma silent leges: in times of war the law is silent.⁴⁹

As with so many of the conflicts disfiguring our world, the Russian war in Ukraine brings into sharp focus the importance of the fundamental moral norms protected by human rights – and the costs of their violation. Reflecting on these conflicts, and on the terrible cost in human life and suffering visited upon us by the COVID pandemic, this report is written out of a fundamental commitment to the importance of every human life, and the critical role of health in all our lives. It is also written in the belief that only a world in which our fundamental rights are realised holds out the possibility of our flourishing. And in the ineradicable hope, in Michael Walzer's words, that in the restraint of war lies the beginning of peace.

Chapter 1 – Human rights: the international frameworks and the right to health

Our hopes for a more just, safe, and peaceful world can only be achieved when there is universal respect for the inherent dignity and equal rights of all members of the human family.

Phumzile Mlambo-Ngcuka, UN Women executive director 2013-21

Introduction: The development of human rights

Despite their association with the aftermath of the Second World War, human rights frameworks have a long history. Within states, there is evidence of something resembling human rights in ancient Egypt, Persia and Greece (though these states often had limited concepts of who deserved such rights, with women and slaves often being excluded). Binding international agreements on human rights are a relatively recent phenomenon, having existed for approximately 150 years, and their effectiveness has been mixed. Despite several international human rights frameworks being in place, the lack of enforcement mechanisms has all too often enabled states, corporations and individuals to sidestep these agreements when politically expedient.

The centrepiece of international human rights law remains the Universal Declaration of Human Rights 1948, now ratified by over 150 countries. Laws of armed conflict, typically known as IHL (international humanitarian law), are some of the oldest international agreements on human rights, with the first Geneva Convention being agreed in 1864. Despite their relative infancy, international human rights agreements have developed significantly over the last 75 years, with specific regions developing their own human rights legislation. These include the African Charter on Human and Peoples' Rights,⁵⁰ implemented in 1986, the American Convention on Human Rights⁵¹ which entered into force in 1978 and the European Convention on Human Rights,⁵² which entered into force in 1953, and violations of which are adjudicated by the African Court on Human and Peoples' Rights, Inter-American Court of Human Rights and European Court of Human Rights respectively.

Nevertheless, despite the progress and development of international human rights agreements, the problem of enforcement remains. International human rights law and national legislation are often not fully aligned. Coupled with a recent rise in nationalism in many countries, this has led to some piecemeal retrenchment from the existing global governance institutions.

The difficulty of challenging states which violate human rights is notorious and while tools such as economic sanctions have been used against certain states in response to violations (as with China and Russia recently) this rarely deters future violations or leads to justice for those wronged. Due to the complex nature of global governance, there have been times when the international community has remained silent in the face of grave human rights violations. The use of arbitrary detention, torture, and restrictions of freedom of speech and assembly in countries such as Saudi Arabia are a prime example of this.

In this brief opening chapter, we introduce the main international frameworks of human rights and humanitarian law, and some of the challenges faced. The discussion then moves specifically to the right to health and the BMA's interest in human rights.

Section 1 – International conventions and framework

Of the international human rights instruments, the best-known remains the Universal Declaration of Human Rights 1948,⁵³ adopted overwhelmingly by the United Nations General Assembly at the time. This was the first pan-international attempt to create a framework of human rights, built out of the rubble of the Second World War. Though not legally binding, its adoption is nevertheless a signal of intent, and it has been adopted in, or has influenced, most national constitutions since its inception. It has been further elaborated on and incorporated into other international treaties as well as being a necessary document for membership of the UN.

There are 30 articles in the Universal Declaration. They include the right to asylum, the right to freedom from torture, the right to free speech and the right to education. It includes civil and political rights, such as the rights to life, liberty, free speech and privacy, along with economic, social and cultural rights, such as the rights to social security, education and, notably for our purposes, health.⁵⁴ This latter right has formed the basis of many of the BMA's interventions on human rights over the years.

The UN has since established nine binding treaties heavily influenced by the Universal Declaration. Every member country has ratified at least one of these treaties, with a significant majority having approved at least four.⁵⁵ The International Bill of Human Rights is formed of two of these treaties: the ICCPR (International Covenant on Civil and Political Rights) 1966 and the ICESCR (International Covenant on Economic, Social and Cultural Rights) 1966, along with the Universal Declaration.⁵⁶ These treaties have been signed and ratified by over 150 countries. There are notable exceptions, however. While the US has signed and ratified the ICCPR, it has not ratified the ICESCR. China, on the other hand, has ratified the latter but not the former. The reasons behind this are explored elsewhere in this report but can be understood as the US prioritising individual liberty in human rights whereas China focuses on more communitarian concepts.

Regarding international humanitarian law, the core international treaties are the four Geneva Conventions which define the basic rights of wartime prisoners and seek to protect those who are not involved in hostilities (such as civilians) or are no longer involved (such as the wounded or captured). Each Convention relates to the treatment of a different subgroup of those not (or no longer) engaging in combat. The Four Conventions are summarised by the International Committee of the Red Cross as follows:

1. The First Geneva Convention 'for the Amelioration of the Condition of the Wounded and Sick in Armed Forces in the Field' (first adopted in 1864, revised in 1906, 1929 and finally 1949)⁵⁷
2. The Second Geneva Convention 'for the Amelioration of the Condition of Wounded, Sick and Shipwrecked Members of Armed Forces at Sea' (first adopted in 1949, successor to the Hague Convention 1907)⁵⁸
3. The Third Geneva Convention 'relative to the Treatment of Prisoners of War' (first adopted in 1929, last revision in 1949)⁵⁹ and
4. The Fourth Geneva Convention 'relative to the Protection of Civilian Persons in Time of War' (first adopted in 1949, based on parts of the Hague Convention (II) of 1899 and Hague Convention (IV) 1907).⁶⁰

The 1949 conventions have been modified with three amendment protocols. These protocols have led to a convergence between the laws of the Hagueⁱⁱⁱ and the laws of Geneva and are entitled as follows:

1. Protocol I (1977) relating to the Protection of Victims of International Armed Conflicts
2. Protocol II (1977) relating to the Protection of Victims of Non-International Armed Conflicts
3. Protocol III (2005) relating to the Adoption of an Additional Distinctive Emblem.⁶¹

The Geneva Conventions have been highly successful, at least in terms of ratification, with 196 countries ratifying the Four Conventions. Many, though fewer, countries have ratified the first two Protocols: 174 countries have ratified Protocol I and 169 have ratified Protocol II (with the US refusing to ratify both). Protocol III, the most recent, has been ratified by only 78 countries, with most African states, South-East Asian states, and Russia declining to ratify it. This is critical from a health perspective, as Protocol III relates to symbols of medical (and religious) personnel during conflict (confirming the Red Crystal as an alternative to the Red Cross or Red Crescent due to the association of the latter symbols with religion).

Ratification of the Geneva Conventions is of course no guarantee that a state will respect them. In 2017, British troops and the British Ministry of Defence were found guilty of breaching the Conventions due to the treatment of detainees during the Iraq War amounting to torture.⁶²

iii Derived from the Hague Conventions of 1899 and 1907, the 'laws of the Hague' is a colloquial term regarding the body of laws relating to the rules of conduct of hostilities

Section 2 – Duty-bearers

A key element of human rights is establishing the 'duty-bearer'. It is in the duty-bearer that the obligation to fulfil the relevant human right is located. A duty-bearer is the person(s) or institution(s) with obligations and responsibilities concerning the realisation of a right, such as the right to health. The main duty-bearer is the state, particularly in international law, in which the state is one of the only actors that can participate. When a state has ratified a treaty that guarantees the right to health, it must respect, protect, promote and fulfil this right. Maintaining a productive relationship between the duty-bearer and the rights-holder (who is entitled to receive the right) is essential to the realisation of the right.

As a duty-bearer for human rights, the state's obligations can be summarised in three distinct ways. Firstly, respect for human rights. The state should acknowledge human rights and not hinder, directly or indirectly, the enjoyment of rights. Secondly, protection. The state should ensure that third parties do not interfere in others enjoying their human rights, such as through guaranteeing companies respect the rights of their employees, ensuring they do not work unreasonably long hours or work in dangerous circumstances. Thirdly, the state has a responsibility to fulfil human rights, which can be done through adopting suitable measures, whether financial, legislative or otherwise, to ensure the realisation of human rights.

The state is not the only institution with responsibilities regarding human rights. For example, the Inter-agency Network for Education in Emergencies has noted that international law states other actors also have responsibilities in upholding the right to education: multilateral intergovernmental agencies in providing technical and financial assistance; international financial institutions in their policies, credit agreements, structural adjustment programmes, and measures taken in response to the debt crisis; private businesses, which also have the responsibility to respect human rights and avoid infringing the rights of others; and even parents, who are expected to ensure their children receive compulsory education.⁶³ Hence, while the state is the primary duty-bearer for the provision of human rights, other bodies and individuals are not exempt, and they are expected at minimum to respect the human rights agreements that the country in question has ratified and not subvert them.

It can be difficult for duty-bearers fully to realise some of the more positive rights due to the arguably greater need for resources. As the Office of the UN High Commissioner for Human Rights states in its General Comment 14 on the right to health:

*'...for millions of people throughout the world, the full enjoyment of the right to health still remains a distant goal. Moreover, in many cases, especially for those living in poverty, this goal is becoming increasingly remote.'*⁶⁴

It is partly for this reason that human rights bodies, including the UNHCHR, talk about 'progressive realisation' of economic, social and cultural rights, which comes from the text of the 1966 international covenants. Progressive realisation requires states to take appropriate measures towards the full realisation of economic, social and cultural rights to the maximum of their available resources. It recognises that the realisation of these rights can be hampered by a lack of resources and can only be achieved over time. It also means that a state's compliance with a right is assessed in light of the resources available to it.⁶⁵

Section 3 – Accountability and enforcement

Options for enforcement are limited in scope, as there are few legal routes to penalise states guilty of human rights abuses, although there are numerous forms of soft pressure that can be applied.

The UN has called for strengthening the rule of law and accountability for human rights violations.⁶⁶ The Office of the UN Human Rights High Commissioner has been working with partners from 2018 to 2021 to ensure:

- Laws, policies, and practices increasingly address, prevent and reduce human rights violations in the context of law enforcement and justice systems
- Strengthened national mechanisms provide redress to victims and accountability for human rights violations, including for economic and social rights
- Justice systems investigate and prosecute gender-related crimes more effectively
- States take measures to ensure that their decision-making, policies, and actions are more transparent, and the public has access to information for accountability purposes
- UN efforts for the rule of law, justice, counter-terrorism and accountability put human rights at the core.⁶⁷

While on an individual level, people may be punished for violating human rights, issues arise surrounding violations by large corporations or countries. The critical question is: who should be punished and how? Coordinated economic sanctions, are often a route to apply pressure to countries that have violated human rights (the UK issued sanctions on 49 prominent individuals and organisations from countries including Russia, Saudi Arabia and Myanmar in July 2020)⁶⁸ but these are typically inconsistently applied – an inevitable result of the nature of geopolitics. ‘Public shaming’ can also be utilised, as such human rights abuses are often a cause for embarrassment for those involved.

The continuing rise and increasing influence of transnational corporations calls into question what responsibility they have regarding human rights. International human rights frameworks have historically centred on nation-states as the only players on the international geopolitical stage, but this is changing. There is an obligation on companies to respect human rights, but these frameworks were not devised with such corporations in mind, and oversight is limited. The exploitation of workers in systems that favour corporations can be found in both the developing and developed world. As part of their responsibility to respect human rights, corporations should carry out due diligence to ‘identify, prevent, mitigate and account for how they address their impacts on human rights’.⁶⁹ They must avoid causing or contributing to human rights harm through their activities and, if harm occurs, cease the activities and remedy the harm. Responsibility for adverse human rights impacts includes not just actions but also omissions.

The UN has developed guidance for countries when establishing or strengthening their national mechanism for reporting and follow-up with international human rights instruments.⁷⁰ The purpose of such a mechanism is ‘to coordinate and prepare reports to and engage with international and regional human rights mechanisms (including treaty bodies, the universal periodic review and special procedures), and to coordinate and track national follow-up and implementation of the treaty obligations and the recommendations emanating from these mechanisms’. Such mechanisms could be ad hoc, to produce a specific report; ministerial, which is a standing mechanism; interministerial, which is a standing mechanism across multiple government fields; or institutionally separate, which is established by the government but distinct from it.

The ICC (International Criminal Court), based in the Hague in the Netherlands, investigates specific crimes committed during war. It was established by the Rome Statute, which entered into force in 2002. The Rome Statute established the court’s functions, jurisdiction and structure.⁷¹ Four core international crimes are considered by the ICC. It ‘investigates and, where warranted, tries individuals charged with the gravest crimes of concern to the international community: genocide, war crimes, crimes against humanity and the crime of aggression’.⁷² The ICC is a key mechanism to address breaches of international humanitarian law and has jurisdiction over war crimes, crimes against

humanity and genocide. The ICC is unique in that it has competent jurisdictions over individuals in international law. It has had some success – in 2019, the warlord Bosco Ntaganda was imprisoned for 30 years for his crimes in the Democratic Republic of Congo which included murder, recruitment of child soldiers, and sexual slavery.⁷³

Nevertheless, the ICC is entirely dependent on member states to arrest and transfer those accused of crimes against humanity to the Hague. Many states are reluctant to do so, especially if the accused occupy prominent positions within their country. The ICC has no police force, nor military presence and relies on the co-operation of member states. Omar al-Bashir, the former President of Sudan is a prime example. Despite an arrest warrant being first issued in 2009, 19 countries ignored it, including 9 signatories of the Rome Statute. In South Africa, the Constitutional Court ruled that the state had an obligation to arrest al-Bashir and had failed in that obligation. This was ignored by South Africa's executive. There was a similar occurrence in Kenya. Omar al-Bashir was only removed from power and imprisoned following an internal coup in Sudan in 2019.⁷⁴ The dismissive attitude of the US towards the ICC under successive regimes has also undermined its standing,⁷⁵ despite frequent calls for the ICC to expand and strengthen its enforcement mechanisms.⁷⁶

Ultimately, there are still insufficient mechanisms at the international level to secure human rights and ensure they are enforced. Many state and non-state actors can conveniently ignore (and sometimes do) the requirements of international law. The Iraq war is a clear example. This damages the credibility of international human rights agreements. Steps need to be taken to further the enforcement mechanisms and capabilities that the international community has at hand.

Section 4 – The right to health

Health as a human rights objective

Given the fundamental importance of health to human wellbeing, and the challenge that ill health can present to the realisation of fundamental human goods, the BMA has long been interested in how the moral imperative to promote human health in the widest sense can be translated into the legal reality of specific, justiciable rights claims. We recognise that there are dangers in the tendency of rights to expand infinitely to incorporate all manner of human need,⁷⁷ and there are challenges in specifying the content of some health-related rights. Nevertheless, given that physical and mental health are basic human needs, and that without them our capacity to flourish can be severely limited, as a professional medical body, we support, as much on pragmatic as theoretical grounds, the translation of strongly felt professional and moral imperatives to promote human health into the practical language of health rights.

The 1945 UN Charter⁷⁸ called for the establishment of an international health body, which became the WHO. The WHO was charged with operationalising a human rights framework for the promotion of public health globally. The 1946 WHO Constitution declared with enormous ambition that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being', establishing obligations on all governments to realise for their citizens 'a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity'.⁷⁹ Two years later a rights-based approach to health was consolidated by the United Nations General Assembly in 1948 via the Universal Declaration of Human Rights. Article 25 (i) of the Declaration states:

'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.'

From early on, the ECOSOC (United Nations Economic and Social Council) recognised the importance of both medical care and the underlying conditions of health to the realisation of the right, incorporating a holistic view of health with deep roots in social medicine and public health insights into the determinants of human health and wellbeing.⁸⁰ Article 12 of the ICESCR 1966 declares:

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 to all medical service and medical attention in the event of sickness.'*

Despite the early ambition that drove the recognition of health as a focus for human rights, it struggled to gain traction. Partly this had to do with the Cold War and fundamental differences between the US and the Soviet Union as to the relative importance of political and social rights – broadly speaking between entitlements and freedoms, with the Soviet Union favouring economic and social rights and the US promoting civil and political rights. This is reflected in signatories to the ICCPR and the ICESCR, with states previously in the USSR's sphere of influence ratifying the latter (which the US has not ratified) while some have shown a reluctance to ratify the former.

Despite enduring ideological tensions, the 1978 International Conference on Primary Health Care, held in Alma-Ata in the Soviet Union, significantly strengthened global commitments to health as a fundamental right. Although the ensuing Declaration of Alma-Ata struggled against the prevailing economic headwinds, the arrival of the global AIDS pandemic effectively inaugurated the modern health and human rights movement.⁸¹ Early responses to the pandemic included stigmatisation, draconian public health measures and widespread discrimination. AIDS activists confronted these responses head-on, articulating their demands for access to compassionate non-discriminatory care in the language of fundamental rights and freedoms.

Alert to the challenges of specifying the content of the right to health, in August 2000 the UN Committee on Economic, Social and Cultural Rights issued General Comment 14, an authoritative statement on the nature of the freedoms and entitlements enshrined by the right.⁸² This made it clear that the right extends beyond access to preventive and remedial health services to incorporate the underlying conditions for human wellbeing.

Notable references to health, medicine, the provision of care, and medical professionals can be found throughout all Four Geneva Conventions, the UDHR, and the ICESCR. The ICCPR also refers to rights that are connected to health, such as the right to life and life with dignity. Furthermore, the ICCPR protects professional autonomy. The rights to freedom of expression and protection against discrimination, as well as the right of everyone to the enjoyment of just and favourable conditions of work, are all important to health also. This is particularly pertinent for healthcare workers, who look after people at their most vulnerable and provide the right to health.

The right to health, like other rights, does not exist in isolation. Amnesty International notes that both Article 27 of the UDHR and Article 15 of the ICESCR establish the right to enjoy the benefits of scientific progress and its applications, which is key for the right to health and the health products that health workers have at their disposal to carry out their duty.⁸³

Concerning the right to health, the capacity of the state, the resources available, the number of suitably trained healthcare staff and a host of other factors can affect the state's ability to provide healthcare for its citizens, despite its obligations as the primary duty-bearer. Research shows, for example, that despite Uganda ratifying the International Covenant on Economic, Social and Cultural Rights, it has struggled to provide food security to Ugandan children, resulting in hunger and malnutrition, as well as insufficient healthcare.⁸⁴ Uganda is, of course, far from alone in this and food security for children can be at risk in wealthier countries, including the UK.⁸⁵ This emphasises the obligations on resource-rich nations not only to ensure their own populations have access to fundamental goods but also, as set out in Article 2(1) of the ICESCR, to provide 'international assistance and co-operation, especially economic and technical',⁸⁶ to enable less affluent states progressively to realise their obligations in relation to economic, social and cultural rights. Furthermore, the right to health imposes immediate obligations such as the guarantee that the right will be exercised without discrimination of any kind and the obligation to take deliberate, concrete and targeted steps towards its full realisation.⁸⁷

Participation, transparency and accountability are also key principles underlying the right to health.⁸⁸ Health laws, policies and practices should be designed and implemented with the meaningful oversight and participation of civil society, especially by people most impacted by these measures, at the community, national and international levels. Similarly, transparency enhances the legitimacy of states' decisions regarding health and fosters ownership over these decisions and their implications across all members of society. Likewise, accountability should include access to effective judicial or other appropriate remedies for bodies such as national ombudspersons, human rights commissions, consumer forums, patients' rights associations or similar institutions to enable them to address such violations. All accountability mechanisms must be accessible, transparent and effective for all people.

As discussed later in this report in the chapter on neoliberalism, the role of the state can be further limited when healthcare is not in the government's purview but provided by private companies. As discussed above, while there is a legal expectation for corporations to respect human rights, and not infringe them, there is not the same expectation for them to enforce positive rights or to take steps to realise them.

The role of the private sector in health is perhaps most apparent in the US, which has not ratified the International Covenant on Economic, Social and Cultural Rights, and whose healthcare system is dependent on private healthcare insurers, leaving millions of American citizens uninsured and without access to healthcare, one of the core dimensions of the right to health. Concerns are also raised about the creeping role of private companies in the UK's NHS and its long-term implications for access to affordable health care.

Globally, this disparity persists between states, damaging access to healthcare. This is perhaps the most apparent in the current global inequality in access to COVID-19 vaccines, where pharmaceutical corporations have refused to share knowledge and technology with other companies to increase a much-needed global supply of vaccines. As of July 2021, 85% of existing vaccine doses have been administered in high- and upper-middle-income countries, while only 0.3% of doses have been administered in low-income countries, representing a violation of the right to health of millions around the globe. By January 2022, the situation had not much improved, with only 1% of doses administered in low-income countries⁸⁹ and just 4% of the population vaccinated,⁹⁰ compared with sizeable majorities of vaccination rates in most developed countries. Governments have indicated a reluctance to distribute these vaccinations to those with the direst need, despite the clear international public health benefit of a greater rate of global vaccinations, typically opting instead to provide booster jabs to those in their own country.

Though the principal duty-bearer is the state, international actors such as the United Nations and World Health Organization favour a rights-based approach to health, and greater coordination between countries, to help bridge the gap in development that affects health in and across countries.⁹¹ As the WHO notes, under a human rights-based

approach, the foundation of development efforts is a system of rights and corresponding state obligations established by international law. Civil, cultural, economic, political and social rights provide a guiding framework for development plans, policies and processes as well as appreciating the importance of capacity development.

The WHO recognises four key determinants that impact the duty-bearer of the right to health and General Comment 14 establishes that states must work towards ensuring that all health facilities, goods and services, including information, must be available (such as via the provision of sufficient functioning healthcare facilities), accessible (physically and financially), acceptable (taking into account medical ethics and cultural practices), and of good quality (safe and effective). Mutual aid through properly functioning international bodies can help improve all four of these aspects for resource-poor countries, empowering the state as a duty-bearer to guarantee the human rights of its population are met.

Section 5 – The BMA and human rights

The right to health and the rights and responsibilities of doctors and medical students are where the BMA's interests in human rights lie. We advocate on behalf of doctors internationally who have their human rights abused, we criticise states that do not respect the principle of medical neutrality by interfering in the provision of healthcare, and we call out medical professionals who have become complicit in human rights abuses. More information on our work on human rights, and our robust processes for intervening which were drawn up with Amnesty International and the International Committee of the Red Cross, can be found on our website.⁹²

Human rights, including health rights, are far from being universally realised. In the remainder of this report, we explore specific contemporary challenges to health-related human rights. This does not mean there are no reasons for optimism. The simple development of the frameworks outlined above is indicative of progress. They illustrate attempts by the international community to understand what constitutes a good life and work together to achieve it, which would have been unthinkable in our not-too-distant past. While still evolving, the ideas put forward in these international agreements represent a solid basis on which to achieve the health and wellbeing of people throughout the world. We have the structural foundations; we now need to build on them in practice.

The BMA and human rights

The BMA's commitment to human rights, including the right to health as well as the principles of medical neutrality and impartiality, remains unreserved, uncompromised and unapologetic. Regular resolutions at the BMA's Annual Representative Meeting⁹³ illustrate this, as well as conferences for specific groups of BMA members. Some examples of this are:

Annual Representative Meeting, 2002

That this Meeting utterly condemns the targeting of health personnel and health facilities in conflicts anywhere in the world and:

- (i) demands that patients have access to medical care without discrimination, and;*
- (ii) calls on all combatants to respect the principles of international humanitarian law and medical ethics.*

Annual Representative Meeting, 2003

That this Meeting insists that the principles of the Geneva Convention in respect of health and hospitals should always be upheld by all parties in any conflict in which our country is involved.

Annual Representative Meeting, 2004

That this Meeting views with dismay the illegal use of medical records during the incarceration of detainees in Guantanamo Bay and failure to report abuses of human rights by some doctors. We call on all national medical associations to condemn the role of doctors and the misuse of medical records in perpetuating torture.

Annual Representative Meeting, 2010

That this Meeting notes that doctors and healthcare professionals are often at the front line of defending the health-related human and humanitarian rights of others and:

- i) deplores that doctors are sometimes targeted by repressive governments solely for the impartial exercise of their professional duties;*
- ii) notes, in particular, that healthcare professionals can be targeted by repressive governments for defending the health and sexual and reproductive rights of women;*
- iii) deplores any intimidation of medical staff in the discharge of their duties;*
- iv) deplores any wilful restriction of access to healthcare to the patients of doctors who work in conflict zones or under oppressive regimes;*
- v) expresses solidarity and support for the doctors who work under intolerable conditions in conflict zones or under oppressive regimes;*
- vi) urges the BMA to work closely with human rights organisations in support of health care professionals at risk.*

Annual Representative Meeting, 2017

That this Meeting:

- i) believes that the Human Rights Act is fundamental to the primary role of doctors in advocating and caring for patients;*
- ii) urges the UK government not to repeal the Human Rights Act.*

GPs conference, 2004

That conference notes with concern the Department of Health's proposals to change the rules on eligibility of overseas visitors to NHS treatment and their proposed new system of administration. In particular conference opposes proposals to:

- (i) deny failed asylum seekers free primary medical services;*
- (ii) make practices responsible for the collection of any NHS charges;*
- (iii) remove the current discretion practices have to provide free NHS primary services to overseas visitors.*

Consultants conference, 2010

That this conference supports these words by Prime Minister Gordon Brown: 'I condemn the execution of Akmal Shaikh in the strongest terms and am appalled and disappointed that our persistent requests for clemency have not been granted. I am particularly concerned that no mental health assessment was undertaken.' It would like the BMA to work with human rights organisations and the British Government to impress on the Chinese authorities and the international community that patients with a serious mental disorder have every right to access to a psychiatrist, regardless of the offence for which they are held.

Junior doctors conference, 2014

That this conference expresses its concern that there are more slaves in Britain than ever before and human trafficking into the UK is becoming increasingly common. We therefore call upon the BMA to:

- i) highlight the concern amongst the medical profession of the health consequences of human trafficking, and raise awareness of this issue amongst doctors;*
- ii) publish guidance on the recognition and management of trafficked individuals when they come into contact with health services.*

Medical students conference, 2021

This conference, with respect to UK Government policy that prevents asylum seekers working, recognises the harm this policy has on the mental health of an already vulnerable group, believes that this policy incentivises unofficial work, perpetuating human slavery, disputes the claim that allowing asylum seekers to work on arrival will incentivise dangerous trips to the UK and deplores the wasted potential of skilled individuals that want to contribute to services that are in need, including but not limited to the NHS. Therefore, we call on the BMA to lobby the government to immediately amend the policy, allowing asylum seekers to apply to work on arrival.

Chapter 2 – Neoliberalism, inequality and health

I am certain, however, that nothing has done so much to destroy the juridical safeguards of individual freedom as the striving after this mirage of social justice.

FA Hayek *The Road to Serfdom*.

Ill fares the land, to hastening ills a prey,
Where wealth accumulates, and
men decay.

Oliver Goldsmith, *The Deserted Village*

Introduction

Human health is complex. Although sickness can be intensely private, even isolating, our wellbeing has multiple roots, over some of which we have limited control. Our genetics have a clear hand, as do health services – those designed to prevent us from getting sick and those that seek to help us when we sicken. Increasingly though the powerful contribution of our environments – the physical and social contexts within which we move throughout our lives – is acknowledged, particularly by Sir Michael Marmot and his team in their work on the social determinants of health.^{iv} The choices we make straightforwardly affect our health. But increasingly we can see the extent to which even those apparently free choices are determined by things to a greater or lesser extent out of our direct control. As Sir Michael writes:

*'The health of the population is not just a matter of how well the health service is funded and functions, important as that is: health is closely linked to the conditions in which people are born, grow, live, work and age and inequities in power, money and resources – the social determinants of health.'*⁹⁴

Life expectancy is a blunt but useful indicator of a country's health status. Our life expectancy straightforwardly matters to us. Globally, life expectancy has risen by twenty years since 1963 – from just over 52.5 years in 1963 to just over 72.5 in 2018.⁹⁵ There were of course complex drivers: global economic development, major advancements against killer infectious diseases, improvements in sanitation, along with the increasing technical sophistication of medicine. Conflicts and deadly pandemics notwithstanding, the expectation that this upward trajectory would continue had become a truism. It was therefore a surprise when, in 2014, troubling statistics emerged from the United States. For the first time in nearly a century, US life expectancy had gone into reverse.⁹⁶ The last time this happened was when the First World War had combined with a deadly flu pandemic. Such statistics were, as Nobel laureate and former chief economist to the World Bank Joseph Stiglitz put it, 'shocking'.⁹⁷ This had occurred in a country that in 2019 spent nearly \$4 trillion, almost 17% of its GDP, on healthcare.⁹⁸ Switzerland comes second in the global league of GDP spend on health care – just over 12%. Swiss life expectancy in 2017 was 83.6 years.⁹⁹ In the US it was 78.5.¹⁰⁰ In some ways more troubling is the nature of the illnesses driving the reverse: alcoholism, drug addiction, suicide – what have come to be called 'deaths of despair'.^v

In *Globalisation and its Discontents Revisited*, Stiglitz uses the United States to demonstrate the impact of that cluster of economic policies known as 'neoliberalism' on the 'advanced' world. The US data are, he says, 'sobering'.

*'For nearly a third of a century, the incomes of most Americans have been essentially stagnant. A middle-class life...has been moving increasingly out of reach for a large proportion of the country. The numbers in poverty have been increasing... The one group doing well has been the top – especially the top 1% and even more, the top .1%, the richest several hundred thousand Americans.'*¹⁰¹

iv See, for example, Wilkinson R, Marmot M (Eds) (2003) *Social Determinants of Health: The Solid Facts*. The World Health Organization.
<https://www.euro.who.int/en/publications/abstracts/social-determinants-of-health-the-solid-facts>. Accessed 25 Jan. 22.

v See Case A, Deaton A (2020). *Deaths of Despair and the Future of Capitalism*. Princeton: Princeton University Press.

And, as Stiglitz makes clear, these economic changes affect human health:

*'While moving up the ladder seems increasingly difficult, everyone knows someone who has fallen down: trying to avoid falling down the ladder has put increasing stress on individuals, and not surprisingly, has had health consequences. This stress, combined with increasing inequality, has had dramatic consequences: by 2015, the mortality rate (the probability of death) of American middle-age white males was increasing while elsewhere in the world it was decreasing. (This is to say nothing of life expectancies of, say, black Americans, which continue to lag far behind those of whites.)'*¹⁰²

Although the impacts of globalisation and liberalisation have been felt intensely in the US, other affluent countries that adopted neoliberal reforms have also seen serious health impacts. This is Sir Michael Marmot again:

*'From the beginning of the 20th century, England experienced continuous improvements in life expectancy but from 2011 these improvements slowed dramatically, almost grinding to a halt. For part of the decade 2010-2020 life expectancy actually fell in the most deprived communities outside London for women and in some regions for men. For men and women everywhere the time spent in poor health is increasing.'*¹⁰³

Health is clearly not the sole human good. But the fact that life expectancy is slowing – and even going into reverse – in some of the richest countries in the world, and before the outbreak of COVID, must surely give us pause to reflect.

In this chapter, we explore the complex relationship between health, health rights broadly understood, and neoliberal economic policy. It may be the case that some post-War economic changes – particularly the shift in manufacturing and heavy industry away from Europe and America – were unavoidable and brought benefits to recipient countries in terms of the generation and global distribution of wealth. But it is less certain that many of the policy decisions relating to public investment and welfare spending were equally constrained, particularly in high-income countries. Political choices were involved. What is clear is that human rights commitments prohibit utilitarian trade-offs between the interests of groups: a net health gain to one sector of society cannot be justified by a violation of the health rights of another. Where universal obligations apply, the interests of minorities cannot be sacrificed.

We discuss a complex set of phenomena related to neoliberalism, globalisation and global economic growth. These terms are not synonymous. Neoliberalism, as we discuss in more detail below, relates to a particular set of economic policies prioritising market solutions to major distributive challenges. It also contests the idea that there are some social goods, such as health or education, that are irreducibly public and that will always require some form of state intervention. Although generally favoured by neoliberals, particularly in its economic manifestations, globalisation – the tendency towards global interconnectedness and interdependency across a range of social, economic and political domains – is a distinct, if often associated factor. Human rights have been 'globalised' to a large extent, but their relationship with neoliberalism is far from straightforward. Similarly, although economic growth has been associated with neoliberal reforms, leading to health improvements in some areas, economic growth does not require either thoroughgoing neoliberalism or commitment to economic globalisation. Although export-led growth has been successful for some, particularly in South-East and East Asia, other countries have enjoyed economic growth without relying on these approaches. China's phenomenal economic growth has relied on some neoliberal reforms, but there is little doubt that the state remains central to most primary resource allocation questions.

Section 1 – What is neoliberalism?

Neoliberalism is a contested term, elusive of precise definition. It is used here to refer to that cluster of influential political and economic doctrines that have been globally dominant since the early 1980s and that favour free-market competition, private property rights, individual freedom and minimal government intervention. As such, neoliberalism directly challenges the idea that certain social goods are necessarily public and require state provision.

Broadly speaking, the birth of neoliberalism lay in the global economic challenges of the 1970s: the oil crisis and 'stagflation' – slow economic growth combined with high unemployment and high inflation rates. Partly in response, the 1980s saw the beginnings of a widespread global shift away from the post-war Keynesian economic consensus. This loose consensus, emerging from the Great Depression and the experiences of the Second World War, held that unregulated markets produced both extreme inequalities and radical economic instability, with ensuing social volatility. As a result, state regulation of markets, along with taxation to fund minimal public goods like welfare, healthcare and free basic schooling, was necessary to reduce inequalities and smooth out cycles of boom and shattering bust.

During the 1980s, this consensus was widely overthrown. Free market policies promoted by a cluster of prominent financial institutions including the World Bank, the IMF (International Monetary Fund) and the US Treasury became dominant. Neoliberal theorists argued that state intervention was inherently inefficient, liable to capture by vested interests, and to inhibit innovation. The state's economic role should be limited to controlling inflation through monetary policy. The ensuing neoliberal decades have seen the deregulation of markets, privatisation, globalisation, the search for market solutions to a wide range of distributive challenges, financial austerity and a reduction in state spending and intervention, along with the sustained undermining of collective approaches to social problems.

This is an area of strong political disagreement. Before going on to look at the challenges neoliberalism presents to health rights, it is important to acknowledge that increased globalisation and the liberalisation of markets have brought considerable economic growth, although its fruits have been, to put it mildly, unequally distributed: French economist Thomas Piketty has highlighted that 75% of US growth since 1980 has gone to the richest 10%.¹⁰⁴

Nevertheless, economic growth has brought concrete benefits, particularly to some of the emerging markets, with hundreds of millions moving out of poverty – nearly a billion people in China alone – and the growth of large middle classes in India and China.

Although distinct from neoliberalism and economic growth, globalisation itself has also been associated with successful cooperation in the pursuit of health and other critical public goods. As Stiglitz argues:

*'The UN has succeeded in reducing conflict and protecting children and refugees. Global diseases have been effectively attacked – including HIV, the avian flu and Ebola. Life expectancies have increased in many countries through the efforts of international organisations...these are remarkable achievements in a relatively short period and in which globalization has played a key role.'*¹⁰⁵

There is also good data suggesting strong correlations between economic growth – whether or not associated with neoliberal reforms – and improved health outcomes.¹⁰⁶ This is unsurprising: where governments have increased revenue, they have more resources to invest in health services and the underlying conditions for health. Where individuals have greater income, they have more to spend on nutritious food and general health, and their overall degree of agency is increased.¹⁰⁷ But for these outcomes to hold good, a great deal more than growth is required. To improve overall outcomes, governments must be willing both to tax wealth-producers and invest revenues in ways

that benefit health. Similarly, for individuals to spend the fruits of economic growth in ways that benefit their health, wealth must be sufficiently distributed, and people need to make beneficial choices. The rise of 'lifestyle' diseases such as obesity in developing countries suggests that increases in personal wealth are not always associated with health-promoting choices. Parts of Asia and Africa are now experiencing a double burden of both malnutrition and diet-linked obesity and other chronic diseases.¹⁰⁸ While growth is certainly associated with improved health indicators in several parts of the world, neoliberalism tends massively to accelerate inequalities, which, as Kate Pickett and Richard Wilkinson point out in their hugely influential book *The Spirit Level* themselves have serious health and wellbeing impacts.¹⁰⁹

One of the human rights challenges to states where they pursue neoliberal policies, particularly concerning the right to health, is precisely this issue of wealth distribution. Policies that seek to limit government spending, promote capital flows, and enable the market exchange of even the most essential goods, such as health services, are notorious for generating steep wealth inequalities, particularly within countries, with wealth frequently concentrated in small elites. In addition, neoliberal policies have again been associated with economic instability, culminating in the credit crunch and economic crisis of 2008, an increase in precarious employment with its associated physical and mental health challenges, along with a shift towards the private funding – and provision – of health care, the latter being particularly prominent in the early neoliberal decades.

Neoliberalism is also linked with 'ideological' shifts that favour individualism over collective solutions to social problems. In place of state intervention through welfare state policies and redistributive tax regimes, neoliberalism prioritises market solutions to social problems. As was clear during Margaret Thatcher's premiership in the UK, neoliberal regimes also seek to weaken trade unions and other forms of collective organisation. At the heart of the neoliberal world view lie both the marketplace, and the freely contracting individual motivated to maximise their economic interests via the market. The source of value lies in the individual and their freedoms, and the state is seen largely as having a range of negative duties – to refrain from restricting those freedoms. There are some sympathies between neoliberalism and – at least – some of the civil and political rights, with their focus on universalisation, personal freedom and the state's negative duties.^{vi} Challenges frequently arise, however, with rights that require a fairer distribution of primary economic goods. If market exchange is the primary method for the exchange of economic goods, neoliberalism, with its suspicion of state intervention, planned solutions, and civil society can struggle to realise many economic, social and cultural rights, including the right to health.

Neoliberalism has also been subject to sustained critique and 'pushback'. Many people familiar with the global health rights movement in recent decades will recall the devastating impact of the International Monetary Fund's Structural Adjustment Programmes and their imposition of health care user fees in indebted resource-poor countries. These led to serious violations of health rights with a resulting shift in consensus away from strict neoliberal approaches to health financing.¹¹⁰ The scale of government intervention in the global COVID response, and the intense cooperation between states and commercial companies suggest limits to the untrammelled success of neoliberal approaches in dealing with major global health challenges.

vi See, for example: Moyn S. 'A powerless companion: human rights in the age of neoliberalism.' <https://scholarship.law.duke.edu/cgi/viewcontent.cgi?article=4711&context=lcp>. Accessed 25 Jan. 22.

CASE STUDY: Clydebank, Scotland – neoliberalism, health and British manufacturing industry, a cautionary tale?

September 1976 was a critical moment in the fortunes of Clydebank, a small town on the outskirts of Glasgow in Scotland; a moment when the fortunes of this town aligned, prophetically, with the stirrings of a global shift in economic policy,¹¹¹ a shift that would have transformative effects on the economies of the world, and, through complex pathways, the underlying health of billions of people. Formerly a centre of heavy industry and manufacturing – Clyde shipbuilding was world-class, and the town was home to the largest Singer sewing machine factory in the world, employing 11,500 workers in its heyday – from the late 1960s it had entered a period of economic and social decline.^{vii} Skilled workers were either taking lower-skilled jobs or leaving the city, unemployment was rising, social networks weakening and labour unrest on the rise. Although the nationalisation of the Clyde shipyards in the early 1970s had brought hope of stability, if not quite revival, autumn of 1976 saw the British Labour Government under James Callaghan approach the IMF for a loan of £3.9bn to stabilise the value of sterling. It was, at the time, the largest loan the IMF had ever been approached for. In doing so the Labour Government agreed to the IMF's terms: they included heavy cuts in public expenditure and the budget deficit.¹¹² To some this was a belated acknowledgement of the necessity that governments accept the discipline of global capital markets. To others, it was the beginning of a wholesale ideological shift away from the post-War Keynesian pursuit of full employment and welfare and towards low inflation, reduced public spending and the liberalisation of global markets. Whatever one's political views, the decision, and the subsequent embrace of neoliberal economic policies, sealed the fate of Clydesdale as an industrial town.

In 2017 Lisa Garnham, a scholar at the University of West Scotland published an account of the public health effects of neoliberal policy on the people of Clydebank.¹¹³ Using a combination of photovoice^{viii} and oral history interviews she pieced together a reflective account, driven by first-person narratives, of the social and economic changes to Clydebank over the bulk of the twentieth century and their impact on the lives of its inhabitants. She divided her interviewees into three cohorts: a pre-war cohort born in the 1930s, a post-war cohort born around 1955 and a post-industrial cohort born around 1980. Garnham presents a fascinating, complex and unsettling picture as individual lifespans interact with waves of economic growth and decline, tracing their implications for individual wellbeing.

Although the generation born in the 1930s experienced early poverty and poor housing, with their associated health impacts, rearmament in the run-up to the Second World War provided full employment. As the pre-war cohort entered adulthood in the immediate post-war decade, so they began to reap the benefits not only of stable employment, but also of much improved public housing, strong social networks, a welfare safety net and, from 1948, the availability of free healthcare via the National Health Service. From the beginning of the 1960s, for complex reasons, including colonial legacies and intense foreign competition, British manufacturing decline intensified.¹¹⁴ Combined with the impact of neoliberal policies and the conditions imposed by the IMF loan, welfare and public infrastructure spending in Clydebank was decimated. Garnham's participants described it as a time of steadily rising unemployment and outward migration. With the loss of skilled engineering jobs, unskilled work – often the preserve of women – became economically critical to many families.

vii See Garnham LM. Public health implications of 4 decades of neoliberal economic policy: a qualitative case study from post-industrial west central Scotland. *Journal of Public Health* Vol. 39, No. 4, pp. 668–677 [doi:10.1093/pubmed/fox019](https://doi.org/10.1093/pubmed/fox019).

viii Photovoice is a qualitative research method for use in community-based participatory research. Participants are asked to explore and articulate their points of view or represent their communities by taking photographs that highlight the themes of the research.

As Clydebank's decline accelerated, these jobs also became precarious. Such precarity interacted disastrously with large-scale privatisation of public housing stock. The better-quality housing was sold off, while the least well-off were concentrated in the poorest housing stock, itself the victim of reduced public investment. Unable to buy or rent in private markets, Clydesdale's poorest were trapped in deteriorating housing estates that became centres of severe social deprivation. Health and social inequalities deepened and became entrenched. According to Garnham's participants, these changes fuelled a sense of powerlessness and hopelessness, with neoliberal policies being 'the underlying cause of growing alcohol and drug misuse problems among young adults during the 1980s.'¹¹⁵ For the 'post-industrial' cohort, particularly those who were unable to escape the most deprived areas, the effects were devastating. While the post-war participants grew up with memories of full employment and rewarding social networks, for those who came later there was little short of nothing. As Garnham writes, for those affected, 'these issues had significant impacts on their social connectedness, sense of worth, self-esteem and identity, as well as their exposure to stress and poverty.'

Garnham's research suggests that communities and population centres that do not benefit from neoliberal policies – those 'left behind' – can experience seriously destructive changes in the social determinants of health, with far-reaching inter-generational impacts on both individual health and the health of large communities. Exposure to global markets and a simultaneous rolling back of both welfare provisions and public investment in housing and social infrastructure leave those with the least agency, often the poorest, cruelly exposed.

Section 2 – Neoliberalism and the human right to health: a clash of paradigms?

As we have seen, under the major international human rights mechanisms, the state is the principal duty-bearer – it carries the primary burden of realising the human rights of those in its jurisdiction. These obligations are threefold: to respect, protect and fulfil the relevant rights. To respect rights the state must refrain from interfering in their enjoyment; to protect them the state must prevent others from interfering with their enjoyment; and to fulfil them the state must act to ensure the conditions for their realisation. Concerning the right to health, the CESR (Committee on Economic, Social and Cultural Rights) takes a maximal view of health, drawing on the WHO's definition of health as a 'state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity.'¹¹⁶ It moves beyond a narrow biological definition of health in favour of something more complex and holistic, with deep roots in concepts of human wellbeing and flourishing. As a result, the state's responsibilities extend beyond the provision of health services. As the CESCR's General Comment 14 states:

*'the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.'*¹¹⁷

To acknowledge this is not to ignore the responsibilities of states to provide, to the maximum of their available resources, access to timely, acceptable and affordable healthcare of appropriate quality. This is a central pillar of the right to health. But the critical importance of 'upstream' contributors to health and wellbeing, the impact of the social, cultural and environmental contexts in which people grow and live, are too powerful to ignore. Any government committed to realising the right to health therefore acknowledges an obligation to ensure that actions are taken progressively to improve those underlying conditions. This makes strong positive demands on the state, requiring it to engage wherever changes in the conditions of underlying health are amenable to influence.

As we have seen though, neoliberalism is suspicious of state-driven solutions. With deep roots in the work of the Viennese economist FA Hayek, it places individual 'negative' freedom – freedom largely from state interference – at the heart of its world view. As Hayek writes:

*'A society that does not recognize that each individual has values of his own which he is entitled to follow can have no respect for the dignity of the individual and cannot really know freedom.'*¹¹⁸

Between proponents of the right to health and those who seek to promote a neoliberal agenda, there is clearly a strong tension regarding the role of the state. For the CESCR, the state is the primary duty-bearer, and its right-to-health related responsibilities extend far beyond guaranteeing a properly functioning market in health services. In order properly to address the complex drivers of both ill health, and health inequalities, a human rights paradigm would involve the state in addressing issues such as clean water and sanitation; the control of environmental pollutants; the impact of the built environment and travel infrastructure on health; occupational health; the availability of healthy food; a reasonable standard of education, to mention only some of the dimensions of responsibility. Although the CESCR is clear that human rights do not require any particular political system to realise them, unlike many of the civil and political rights, the social, economic and cultural rights seem to require a level of state engagement at odds with neoliberal fundamentals. It is, in effect, this tension that structures the remainder of this chapter.

CASE STUDY: Neoliberalism and health services – health inequality and disability in Chile

At least until the political unrest in 2019,¹¹⁹ Chile was frequently touted as a success story for neoliberal social and economic reforms, a beacon of stability in a sub-continent plagued by corruption and political upheaval.¹²⁰ Its health systems, subject to partial market reforms by the Pinochet regime, had been widely studied and used as a model for World Bank driven reforms in other Latin American countries such as Colombia.¹²¹

In 1953, long before the 1973 coup d'état, Chile introduced a national health service, driven by then Senator Salvador Allende, a socialist and medical doctor, that provided health coverage for the poorest 70% of the population.¹²² In the early 1960s, President Eduardo Frei Montalva, a Christian Democrat, initiated widespread social reforms including large-scale investment in health infrastructure resulting in significant health improvements. Allende succeeded Montalva as President and sought to strengthen health services for the poor, to the fury of private medical practitioners, foreign investors, and powerful Chilean industrialists. In 1973 he was replaced and murdered by the military dictatorship of General Augusto Pinochet Ugarte.¹²³ Pinochet looked to increase the role of the private sector in healthcare and, while there have been some mitigations from Chilean centre-left governments since 2004, this structure has been left largely untouched.

The impacts of neoliberal and subsequent reforms on Chile's healthcare system, and the underlying conditions of health are complex, interesting and instructive. There is little doubt that health reform has been a priority for Chile at least since the time of Pinochet. Although reforms initially led to increased uptake of services by all sectors of society, with a consequent narrowing of health inequalities, post-2009 research suggests that inequalities are on the increase.¹²⁴ The poorest Chileans tend to rely on emergency visits, often waiting until health has deteriorated significantly.¹²⁵ Co-payments remain a significant barrier to accessing health care for this group, with out-of-pocket payments in Chile being high by OECD standards. An episode of serious illness can expose households to catastrophic health costs.¹²⁶ Although Chilean health spending as a percentage of GDP grew from 6.8 in 2010 to 9.0 in 2019, with a per capita health spend of US\$2182 in 2018, overall, it remains among the lowest of OECD countries.¹²⁷ Chile is among the most economically unequal countries in the world, with the highest share of GDP owned by billionaires globally.¹²⁸

Equality in the enjoyment of rights is fundamental to human rights. Partly because of historical disadvantages, this focus on equality has meant that people with disabilities are of particular human rights concern. Without appropriate adjustments to environments, people living with disabilities of whatever kind can be presented with serious barriers to the enjoyment of even the most basic rights and freedoms. The Convention on the Rights of Persons with Disabilities, ratified by Chile in 2008, has a deliberate social mission: adopting a broad definition of disability, it seeks to ensure that all persons with all types of disabilities can enjoy the full range of human rights and freedoms and lead a life in dignity. The Convention states:

*'States Parties recognise that persons with disabilities have the right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability ... [They should] provide persons with disabilities with the same range, quality and standard of free or affordable health care and programmes as provided to other persons.'*¹²⁹

Prior to signing the Convention, Chile had introduced a range of policies designed to improve the social inclusion of people with disabilities. Using a social model of disability, Chile had sought to promote active citizenship and community participation. But serious problems remain. In an important 2017 article in *Critical Public Health*, Rotarou and Sakellariou highlight significant and enduring inequalities in access to health services for disabled people.¹³⁰ Their findings show that Chileans with disabilities report greater challenges in accessing care than people without disabilities. These include problems getting to health facilities, obtaining appointments, being seen and, because of socio-economic challenges, paying for their treatment, including any medications. These challenges are particularly disturbing given that people with disabilities often have additional health needs not directly associated with their primary disability.

When reflecting on the likely origins of these inequalities of access, Rotarou and Sakellariou suggest that although their data cannot point to a direct causal connection:

*'we hypothesise that what Schrecker¹³¹ defined as the 'neoliberal epidemics' that is, the material effects of neoliberalism, is a major contributing factor. As people with disabilities are often excluded from the job market and they also have higher daily living costs (for instance, increased heating costs if they spend more time at home, or out-of-pocket payments for equipment or medication) they often cannot afford to pay for private coverage.'*¹³²

Section 3 – Neoliberalism and the 'responsibilisation' of health – markets and morality

As we have seen, neoliberalism does not restrict itself to a set of exclusively economic ideas about the efficiency of markets as distributors of goods. Its reach is far greater. For neoliberals the source of value lies in the choosing individual: the individual is before society. The (negative) rights of the individual to pursue their own goods in the marketplace ordinarily trump any restraint. Restraints, that is, must be justified. Consider then the role and meaning of health in such a paradigm. Health becomes one of many good things I may pursue in life. The value I place on health is expressed in the choices I make to promote it – or otherwise. If my health is (avoidably) imperfect, then this is an expression of the values I have and the choices I make. If I valued my health more, I would make alternative choices. As a rational, utility-maximising animal – *homo economicus* – my choices define me, and the health I have is the health I choose. It follows, therefore, that I am responsible for any – avoidable – ill health I suffer.

Neoliberals are not constitutionally blind to the fact that luck plays a part, even a large part, in health, that we are all exposed to genetic and other ill chances. For neoliberals though, the existence of even radical 'natural' inequalities does not necessarily give rise to

state obligations to redress them – although many neoliberal governments have accepted some role for the state in the provision of health care. Because these arise ‘naturally’, without any obvious agent bringing them about, they are not a proper focus of concern for political morality. For neoliberals, fairness has to do with the rules of the game of exchange, not its inputs or outcomes.

Among the most pressing of our contemporary global health challenges is the prevalence of chronic diseases, estimated by the WHO to account for around 71% of all deaths globally.¹³³ WHO member states have also committed to reducing premature mortality from four major chronic diseases – heart disease, lung disease, cancer and diabetes – by a third by 2030. Although causality in chronic diseases can be multifactorial, these major chronic diseases all have some link to ‘lifestyle’, to deliberate choices by individuals. In seeking to tackle these chronic health burdens, public health interventions therefore increasingly focus on changing individual behaviours to limit exposure to risks, such as smoking, drug and alcohol misuse, inactivity and nutritionally poor diets. To bring about change, questions about where responsibility for so-called ‘lifestyle’ choices inevitably arise.

To allocate responsibility is to link an agent to an event or situation, often through an act or omission on their behalf. *Causal* responsibility is where an agent makes a material contribution to the event or state of affairs; *moral* responsibility suggests that the agent’s contribution makes them worthy of praise or blame. Most accounts of moral responsibility draw on two conditions for responsibility: a *control* condition – the actor must have had some control over whether they perform the act; and an *epistemic* condition – that the actor was aware of the likely consequences of the act.¹³⁴ The work of Marmot and others has critically established the importance of factors that fulfil neither the control nor the epistemic conditions for responsibility in health outcomes. Speaking from the context of their research into access to healthcare by people with disabilities in Chile, Rotarou and Sakellariou suggest that ‘responsibilisation’ is problematic for various reasons:

‘First, the presence of disability (or chronicity) forms a structural disadvantage, which can lead to reduced economic and social capital, often resulting in further ill health. Second, the local environments where people live, work, fall ill, and seek health services, play a major role in experiences of health and illness and in the ways these are negotiated within people’s lives.’¹³⁵

Neoliberalism favours both minimal state intervention in health and a transfer of responsibility for health to the individual, with illness seen as the expression of private value choices. Such an approach significantly downplays the contribution of factors that lie outside the scope of private choice to sickness and health. This approach frequently underlies proposals to restrict certain kinds of treatment – or, in the UK context, to levy charges – where health conditions are deemed to arise from personal choices. Calls for people with alcohol-related health problems to be charged for A&E visits or for smokers or obese people to have restrictions put on access to certain interventions are certainly in step with neoliberal thinking.

Section 4 – Globalisation, insecurity and wellbeing – neoliberalism and mental health

According to the WHO, the global incidence of depression increased by 18.4% between 2005 and 2015.¹³⁶ WHO figures from 2017 suggest global sufferers exceeded 264 million.¹³⁷ A further WHO report suggests that by 2030, major depressive disorder will be the leading cause of disability in the world.¹³⁸ We are again in complex territory. Greater acceptance and understanding of depression with a corresponding willingness to report may have contributed to apparent increases in prevalence. Identification of depression relies largely on self-reported symptoms and may be subject to wide cultural variations. Distinctions between depression and ordinary human responses to challenging circumstances are not always clear. Nonetheless, as these and other WHO reports have made clear, in addition to the scale of the private suffering, depression is now a major global health phenomenon with significant social and economic implications. As mentioned earlier, suicide linked to depression is one of the factors contributing to the decline in US life expectancy.

In 2019 Ferrante and colleagues published an analysis of two Italian studies into relationships between precarious employment and depression amongst Italian men.¹³⁹ The study acknowledged that since the late eighties, precarious employment had increased in Europe following widespread changes to labour market laws. The changes were designed to increase the flexibility of the labour market through short-term, occasional and project-based contracts and the restructuring of apprenticeships – changes that led to a significant increase in precarious employment. Initial research from the early nineteen-nineties suggested that changes to the labour market might improve worker wellbeing.¹⁴⁰ Subsequent studies suggested however that these benefits tended to accrue to higher-skilled, better paid and more mobile workers.¹⁴¹

Associations between poor mental health and extreme economic precariousness are well established. In 2016 the European Psychiatric Association issued a consensus statement based on a review of 350 studies establishing strong links between economic crises and poor mental health.¹⁴² The evidence was particularly strong regarding depression, anxiety, sleep conditions, alcohol abuse and suicidal behaviour. Specific risk factors included debt, unemployment, lack of social connectedness, unstable housing and steep social inequalities. These associations were corroborated by Ferrante and colleagues. They found statistically significant links between precarious employment and poor mental health. Of particular importance for our purposes, these factors were driven to a great extent by neoliberal reforms to labour market laws.

The psychological impacts of neoliberal policies are not restricted to European countries subject to labour law reform. Sagar Sharma, former professor of psychology at Himachal Pradesh University, has outlined the psychological impacts of competitive globalisation on a middle-income country like India.¹⁴³ He argues that globalisation affects mental health via four core determinants: deepening poverty and inequality; migration; rapid and uncontrollable changes in social values; and what he calls 'identity diffusion.' For Sharma, the rapidity of social change triggered by globalisation and market-oriented reforms leads to the systematic weakening of traditional networks of social support. It drives large scale migration both from the country to the city and from country to country, further weakening social and familial bonds. Globalised communications and media outlets and the spread of smartphones and handheld devices daily expose huge numbers of people to the reality of these inequalities.

Sharma also argues that neoliberalism has undermined traditional socio-religious values, replacing them with radical individualism and materialism, to the detriment of psychological wellbeing. Globalisation disrupts what he calls 'heritage cultures' and severs the roots and 'hidden continuities' of traditional lifeworlds that, for Sharma, give people a sense of stability and social belonging. For Sharma:

*'Radical individualism, narcissism, consumer acquisitiveness and the erosion of collective (social) responsibility are eroding cultures, causing a disintegration of bonds, family breakdowns, social and domestic violence, dislocations and communities/societies in a state of social recession.'*¹⁴⁴

Associations between globalisation, neoliberalism and mental ill health are complex. Each issue is nuanced and multifactorial: their combination more so. Our mental health has many contributors, personal, familial, environmental and cultural. Despite this, there remain worrying signs of links between neoliberal policies, rapid globalisation, high mobility, economic precariousness, extreme inequalities, aggressive individualism, the disruption of traditional industries, communities and employment patterns with rising levels of mental ill health, particularly depression and anxiety.

Section 5 – Conclusion and recommendations

Neoliberalism has dominated economic policy globally since the beginning of the 1980s.¹⁴⁵ Overwhelmingly governments have turned to markets to address almost all major distributional challenges, including in health and health services in the broadest sense. Champions of neoliberalism point to the greater efficiency of markets, improved customer satisfaction, and the ability of globalised markets and capital flows to generate wealth. As the same decades have seen, unregulated, the same markets generate wide inequalities in the distribution of that wealth. According to a 2017 Oxfam survey the wealth of the world's eight richest people (\$426bn) was equal to the wealth of the poorest half of the world's population.¹⁴⁶

This chapter sets out some of the challenges neoliberalism presents to the realisation of health-related human rights. Although inequality in and of itself need not challenge human rights, as we saw in Chile and in Clydesdale, where markets are the sole, or even the leading allocator of human goods, absolute levels of poverty can undermine health and wellbeing.

Proponents of liberal markets frequently grant them the status of natural laws – that attempts to interfere with their inexorable logic are likely to be futile. Post-war experience makes clear, however, that without some form of state involvement, free markets, rather than being uniquely efficient and just, are liable to devastating shocks and lead to extreme concentrations of wealth and significant inequalities. Recent global experience with COVID also suggests that even neoliberal states are willing to countenance high levels of state involvement when stakes are sufficiently high.

Historically the United States has been seen as a cheerleader for globalisation and open markets, set within a framework very broadly regulated by a civil and political rights framework and underpinned by global institutions. But a sober look at the US health system – its costs, its inequalities, its burdens on individuals and organisations – and at the underlying health of its public, including the recent reversal in life-expectancy, must give pause for reflection on both the justice and efficiency of using markets by themselves to distribute 'goods' as fundamental as human health. If we are serious about the human right to health, if we seek to maximise all our flourishing, then we must ask of those who bear the duties to which human rights speak – obviously but not exclusively the state – to help bring about conditions for the universal realisation of health rights.

Like the drafters of the Universal Declaration of Human Rights, the BMA is agnostic about economic systems. We are not seeking here to make party political statements. Any choice of an economic system to address the allocation of fundamental resources will involve questions about their impact on basic rights. It is essential however that we remain alert to the impact of liberal markets on human health and seek to offset that impact when it violates or impedes those rights, as this is the system that predominates globally.

Recommendation

Policymakers should consider the impact of policy reforms on health-related human rights and make necessary adjustments. This should apply to both governments and corporations.

Chapter 3 – Migration, ethnicity and health

No one leaves home unless
home is the mouth of a shark

Warsan Shire, *Home*

Introduction

It is no secret that there has been a retrenchment in freedom of movement over the last decade for some of the world's most vulnerable groups. Displaced peoples' ability to move between countries, seek asylum and access healthcare has been severely curtailed. Complex forces are at work. Regime change, the Arab Spring and the resulting conflagrations, particularly in Syria and Libya, but also spreading out into the greater Middle East, have seen enormous dislocations of people fleeing for their lives. 'Economic migration', where those living in extreme poverty move to seek the basic materials for a reasonable life, has intensified. In response, countries have tightened their borders. Prime Minister Viktor Orbán, while simultaneously unleashing incendiary xenophobic rhetoric, has hardened the Hungarian border. In the US, nationalist politicians have demanded the building of a wall to prevent migration from Mexico and other Latin American countries. The European Union has sought to push the problem from its borders through deals with Turkey and North African regimes.

Simultaneously, ethno-nationalist sentiments are on the rise, with potentially disastrous impacts on rights to seek healthcare for those not part of dominant ethnic groups, a phenomenon we have seen in countries ranging from Turkey to Brazil. Media outlets have played a role in stoking these tensions and politicians from some of the countries with historically liberal approaches to migration have resorted to nativist rhetoric. The UK's hostile environment and Germany's reversal of its pro-refugee policies are attempts to manage domestic anxieties about migration that populists seek to exploit.

Migrants have particular difficulties protecting and promoting their health. Partly this is related to the direct health impacts of forced migration and their treatment within their countries of origin. But it is exacerbated by the uncertainty of their status in both transition and destination countries. Migrants have little political power and are often neglected by the state. Their displacement threatens traditional sources of wellbeing such as food and health services as noted by Felipe Morales, the UN Special Rapporteur on the human rights of migrants.¹⁴⁷ The UN High Commissioner for Refugees has highlighted the numerous threats irregular migrants face to their human rights, including access to education and security of person.¹⁴⁸ Racial differences regarding the provision of healthcare and health outcomes are notable also.

The BMA has a long-standing interest in these matters and has passed numerous resolutions affirming its support for migrants and their health-related human rights globally. We have raised these concerns with governments, including writing to the French Ambassador in 2016 about the plight of refugees in Calais,¹⁴⁹ and we continue to engage with the UK Home Office on the status and healthcare of those held in immigration detention centres, as well as having published a major report on the health-related human rights of those in such centres.¹⁵⁰

This chapter seeks to understand the impacts on the rights of migrants and ethnic minorities, specifically to secure access to health, arising from forced migration and intensifying nationalism. It is split into seven sections. The first considers pernicious forms of nationalism and how it impacts minorities generally. The second looks at health and human rights in detention centres and refugee camps. The third considers the health impact of the working condition of migrant workers. The fourth analyses health access for minorities and migrants. The fifth section explores those in transition who are currently seeking refuge or asylum. The sixth section illustrates how nationalist policymakers seek to undermine the principle of medical neutrality while the seventh proposes some solutions to the poor experiences many minorities and migrants have with realising their right to health.

Section 1 – Nationalism and minorities: the bigger picture

Minorities have always been a target of nationalist sentiments. Seen as the 'other' within society, minorities often face threats to their safety from the state as well as the public at large. For complex reasons, lower life expectancy, worse health outcomes, and increased incarceration rates are all commonplace for migrant communities and ethnic minority groups generally. A retrenchment towards nationalism across many states is likely to aggravate these issues.

Nationalism does not necessarily focus on ethnicity. Civic nationalism bases national identity on citizenship.¹⁵¹ An individual's ethnicity would not be relevant to membership of the nation-state, only their citizenship. Although this view of nationalism would still consider migrants to be an 'out group', routes to citizenship are not barred by definition. Although this distinction is important, in practical terms the pernicious effects of nationalism are all too often associated with discrimination rooted in ethnic identity. Hence, we rely here on a commonplace understanding: ethnic nationalism. For ethnic nationalists, national identity is determined by ethnicity as well as national self-identity. This understanding of nationalism does not preclude further distinction between domestic ethnic minorities and migrant communities, but both are subject to discrimination.

To give some examples of the persistence of ethnic discrimination, a recent study found that three out of four Australians have, to differing degrees, racial bias towards Aboriginal people, whose life expectancy is eight years lower than the national average.¹⁵² They also make up 27% of the country's prisoners despite being only 3% of the population.

Canada also has a troubling relationship with its First Nations, built up over years of oppression and abuse. Over 150,000 indigenous children were taken from their homes to residential schools where authorities attempted to forcibly assimilate them into Canadian society, during which both physical and mental abuses were committed. Despite the Canadian Prime Minister apologising for this practice in 2008, its effects continue to be felt today, with numerous survivors saying they were not taught basic literacy and numeracy skills in these schools.¹⁵³ The grim discovery of 751 unmarked graves in June 2021 at a former residential school, mere weeks after the remains of 215 children were found at a similar institution, is a stark reminder of the injustices committed in Canada.¹⁵⁴ Differential attainment rates and access to the Canadian healthcare system persist for First Nations communities and a 2020 Ipsos poll found that 60% of Canadians thought racism was a serious problem.¹⁵⁵

The US's cavalier attitude towards the rights of its indigenous communities is well-recognised; their historic disregard for the rights of Native Americans is perhaps best exemplified by the Trail of Tears in the 19th century when tens of thousands of indigenous people were forcibly displaced as part of a process of ethnic cleansing. Neglect of these communities continues to this day, with work on the controversial Dakota Access Pipeline, which goes through Native American territory, continuing. Though it was briefly paused by court order to allow for a full environmental review (after years of protest frequently met by aggressive responses from US security forces),¹⁵⁶ this decision was overturned and the pipeline continues to operate, with the Biden administration showing little indication they intend to shut it down.

There are signs that the situation is deteriorating for minority communities across the world. In India, Prime Minister Modi has fuelled Hindu nationalism and normalised anti-Muslim bigotry.¹⁵⁷ The Brazilian President Bolsonaro makes constant derogatory remarks about the country's indigenous population,¹⁵⁸ from whom he has continuously stripped rights, such as by planning to allow commercial exploitation of natural resources in indigenous territory.¹⁵⁹ Steps to improve healthcare provision to indigenous Brazilian peoples have stalled. While the strong anti-migrant 'America First' rhetoric of former US President Trump is indicative of an increased shift towards nationalism, the US has cultivated a belligerent anti-immigration stance for a long time, while the Black Lives Matter movement has drawn global attention to the treatment of US

minority communities. Health outcomes in the US reflect serious inequalities among African Americans and people of Latin-American origin. There has been no substantial improvement under president Biden; Trump's 'Remain in Mexico' immigration policy was relaunched by Biden despite the fact he had described the policy as 'inhumane'¹⁶⁰ while Vice President Harris told Guatemalans 'do not come' to the US.¹⁶¹

Unlike migrants, indigenous communities' connection to the land long precedes that of now dominant groups in areas such as Australasia and the Americas. The historical theft of this land, by invaders and colonisers, is not only a great injustice but a source of the continuing marginalisation and exploitation of such communities in states today.

The refugee crisis has highlighted Europe's approach to immigration, which has hardened with the highly publicised arrival of many asylum seekers from the Middle East and North Africa.

There were complex drivers behind the UK's decision to leave the European Union. While assessing the causes of Brexit is beyond the scope of this report, there has been an increase in reports of racism since the referendum. In 2019, 71% of people in the UK from ethnic minorities reported having faced some discrimination, up from 58% in January 2016.¹⁶² Nationalist sentiments were a significant part of the campaign to leave the European Union. Many prominent Brexit supporters emphasised 'reclaiming British sovereignty' from Brussels as well as 'taking back control of our borders'. One of the enduring images of the referendum is politician and former MEP Nigel Farage standing in front of a poster of non-white people, with the headline 'Breaking Point'.¹⁶³

Playing to such fears was not new in British politics – when the Home Office developed its Hostile Environment policy, then-home secretary Theresa May sanctioned vans driving around the UK telling migrants to 'go home'. A significant part of the Brexit campaign involved reclaiming 'Britishness', to the detriment of those deemed insufficiently 'British'.

CASE STUDY: The Roma in Europe – centuries of oppression continuing to this day

The Romani have been a constant focus of prejudice and discrimination across Europe. They have been enslaved for centuries, excluded from society, viciously attacked and abused, are the subject of numerous conspiracy theories, and were one of the main targets of the Holocaust, with half a million murdered.¹⁶⁴ Despite this long, dark and shameful history, discrimination towards Roma is still prevalent across Europe today. 91% of the Gypsy, Roma and Traveller community in the UK have experienced racial discrimination and it has been described as 'the last acceptable form of racism'.¹⁶⁵

There is ample evidence of the detrimental effects of societal ostracism on the living standards of the Roma. A 2016 EU survey found that 80% of Roma surveyed live below their country's at-risk-of-poverty threshold, one in three Roma lives in housing without tap water, every third Roma child lives in a household where someone went to bed hungry at least once in the previous month, and 50% of Roma between the ages of six and 24 do not attend school.¹⁶⁶ A study of the North and Southwestern regions of Czechia found that Roma women were 4.5 times more likely to have a baby born of low weight than non-Roma women and that they were 2.8 times as likely to have a pre-term birth.¹⁶⁷

Antiziganist (anti-Romani prejudice) attacks have been on the rise across Europe recently¹⁶⁸ and Roma have been the victims of forced evictions as well as still having separate schools for their children in certain countries. They were even encouraged to leave France by then President Nicolas Sarkozy for a payment of 300 euros in 2010.¹⁶⁹ There are abundant negative stereotypes of Roma still in use today and antiziganist rhetoric has become a hallmark of right-wing nationalist politicians across Europe. Hungary's Viktor Orbán has a long history of racist statements, and

the Roma community are just one target of his vitriol.¹⁷⁰ Matteo Salvini in Italy has called for the sterilisation of a Bosnian Roma woman accused of theft and far-right groups in Poland have been stirring up hatred towards the Roma population for many years now.

The COVID-19 pandemic further enhanced prejudice towards the Roma community. Countries with a large Roma population, such as Slovakia, Romania and Bulgaria, imposed draconian measures on their Roma citizens, much of which was based on a false and racist premise of Roma being a health and safety threat.¹⁷¹ In March 2020, the Bulgarian Government imposed roadblocks and police checkpoints on certain Romani neighbours despite there being no evidence of a positive case. A Bulgarian member of the European Parliament speculated that Romani communities could 'turn out to be the real nests of contagion'.¹⁷² There have also been reports of police abuse towards the Romani in countries such as Romania and stories of them being barred from entering certain cities. Furthermore, a Romanian national newspaper dangerously implied that Roma are immune from COVID-19,¹⁷³ which is not only entirely unfounded in evidence but also plays into harmful narratives and stereotypes regarding the Roma people.

Much of the treatment of the Romani is a violation of the International Convention on the Elimination of All Forms of Racial Discrimination (1965), most notably Articles 2 and 5, which obligate states to take forward proportionate and reasonable measures to eliminate racial discrimination and ensure government apparatuses are not engaging in racially discriminatory behaviour, as well as to ensure access to healthcare.

As one of the most marginalised communities in Europe's history, the fact that the stereotyping and discrimination of Roma has continued well into the 21st century is troubling. Old myths have been repackaged and rebranded for a modern audience, but the essence of vitriolic nationalism and 'othering' of minorities remains the same.

Nationalist tendencies and the 'othering' of minorities can lead to atrocities, sometimes with medical complicity. In December 2021, the Uyghur Tribunal found that the People's Republic of China and the Chinese Communist Party were guilty of genocide against the Uyghur people and other Turkic minorities in Xinjiang province, China.¹⁷⁴ The Tribunal identified that medicine was the main tool used to further the destruction of these minority populations through the restriction of births by forced sterilisation and compulsory abortion, segregation of the sexes within the detention centres but also through forcing Uyghur women to marry and procreate with Han men. Those in detention centres are being faced with mutilations and biological experiments – also a perversion of medicine. The BMA has spoken out strongly and repeatedly on the shameful medical involvement in these crimes and will continue to do so.¹⁷⁵

Section 2 – Detention centres and refugee camps

Detention centres for migrants have become an increasingly salient political issue in recent years, with images of abuse from Texas to Tripoli seared into the public conscience. These centres are not primarily for those who have committed crimes, but are intended to keep detainees in what the US calls 'civil detention', while their case is reviewed and a determination is made as to whether they can stay in the country in question.

Cultural and language barriers, a lack of outside support, indefinite detainment coupled with poor conditions create a hazardous environment ripe for human rights abuses and the degradation of health and wellbeing. With many detainees not speaking the local language, communication with authorities can be difficult. Detainees are not always fully aware of their rights. A lack of (or misdirected) funding means that adequate staff support from the authorities is not always in place, restricting opportunities and protections for the detained. Cramped living spaces, poor or limited food and unsatisfactory facilities create a world in which violence and abuse are a daily fact of life while physical and mental

health issues are widespread. Even a cursory consideration of these centres demonstrates consistent violations of the right to liberty and security, human dignity, the right to health and other human rights.

Perhaps the most notorious examples are the American facilities on the US-Mexican border. Reports of children sleeping on floors, dozens of migrants crammed into rooms as well as food and medical shortages are common.¹⁷⁶ Children separated from their families, almost certainly never to be reunited, and prevalent physical and sexual abuse¹⁷⁷ are rife in these detention centres, which are a key instrument in the US's deterrent policy. Physicians have also been arrested for protesting against the denial of medical treatment, including flu vaccinations, to those detained¹⁷⁸ and human rights groups across the world have called out the way these facilities are run. The enduring image of the US detention centres is of caged children in the richest country in the world.

The UK's detention centres are also controversial. The BBC's *Panorama* investigation uncovered mass abuses at the Brook House Immigration Removal Centre, with drug abuse, violence and self-harm common.¹⁷⁹ The BMA has long called for an overhaul of these detention centres, with our 2017 report *Locked Up, Locked Out*¹⁸⁰ highlighting serious issues of concern. Many FNOs (foreign national offenders) are detained beyond their sentence in IRCs (immigration removal centres) that make little distinction between hardened criminals and those who have simply overstayed their visas, leaving the latter highly vulnerable. The UK toughening its stance towards illegal migrants and asylum seekers must not entail the violation of fundamental human rights, which we are seeing in IRCs throughout the country.

There are concerns surrounding the proposed changes to human rights legislation in the UK and how it could damage the access of migrants and those in detention to healthcare. Furthermore, the Nationality and Borders Bill contains many retrograde clauses regarding asylum seekers' rights. It would also legalise offshoring asylum seekers, which means accommodating them away from the UK. Many view this policy as a violation of international law. It has been pioneered by Australia and has had disastrous effects, with it being described as 'ineffective' and 'cruel'.¹⁸¹

For a time, the epicentre of the refugee crisis in Europe was the makeshift detention centre on the Greek island of Lesbos known as Moria. The conditions on Lesbos were described as 'deplorable' by Amnesty International,¹⁸² with refugees kept in overcrowded surroundings, often with insufficient food and supplies. Over 20,000 people were being held on the island¹⁸³ with terrible sanitary conditions, limited electricity, and constant clashes with the police and locals. MSF (Médecins Sans Frontières) reported there was only one shower per 506 people and only two doctors for 14,000 people.¹⁸⁴ The BMA has previously worked with MSF to better understand the situation on Moria and the political failures driving it.¹⁸⁵ The Greek authorities took action to improve conditions (following international pressure), but COVID-19 stalled it, with the camp placed in quarantine. The tense situation resulted in fires across the detention centre in September 2020. Though the camp was destroyed, new facilities have been built across the Aegean islands. Hopes that lessons have been learned from Moria have quickly dissipated, with MSF describing the new institutions as 'prison-like'.¹⁸⁶

The evidence from across the world, including the UK, US and Greece, is clear. There are severe problems with detention centres and continual human rights abuses. These centres house highly vulnerable people with few advocates and little political power or personal agency with destructive effects on the health and wellbeing of detainees.

One of the main challenges for refugee camps is adequately providing for their inhabitants. Space is often at a premium, food and water scarce, violence common, and sanitation limited. Healthcare, despite the best efforts of organisations such as MSF and the UN, is often woefully inadequate.

The last decade has been a turbulent time for North Africa, with the Arab Spring creating political upheaval. Additionally, North Africa is the route through which many Sub-Saharan Africans travel to reach Europe. The result is an influx of refugees and migrants, many of whom are concentrated in refugee camps in Libya, at which abuses have become notorious. Following reports of torture and exploitation, as well as a desire to curb inward immigration, the EU has given more than £110m for improving conditions for migrants at Tripoli.¹⁸⁷

Things have not improved. Migrants at these facilities often find themselves in the middle of conflict in the war-torn country, with soldiers stealing their possessions or kidnapping them to ransom them back to their families. Within the camps reports of torture, assault, rape and murder are common. Food is scarce and disease rampant. Providing adequate health support for migrants in these settings is especially challenging in war zones with limited funds and resources. Conflict always breeds human rights concerns, as discussed elsewhere in this report. Nevertheless, the scale of the abuses of refugees in Libya should give us all cause for concern.

Furthermore, despite being one of the poorest regions in the world, Sub-Saharan Africa hosts more than 26% of the world's refugees.¹⁸⁸ Ongoing crises in Nigeria, Ethiopia, Somalia, South Sudan, the Central African Republic, Burundi and Yemen further exacerbate the problem. Many of these refugees face severe human rights violations at the hands of traffickers, militias and smugglers, including torture, random killings and forced labour.¹⁸⁹ Abuse of children is extensive as is sexual abuse, such as in disturbing reports of 'sex for food' arrangements in West African refugee camps.

Syrian refugees are concentrated largely in the Middle East. Since the outbreak of the Syrian civil war in 2011, more than 5.6 million Syrians have become refugees while another 6.2 million are internally displaced. 95% of those who have fled the country are in neighbouring Turkey, Iraq, Jordan and Lebanon.¹⁹⁰ However, reports of human rights abuses, such as those in Turkey, are common. In 2018, 74% of the refugees in Lebanon did not have legal status and local municipalities evicted thousands amidst increasing political calls for displaced Syrians to be returned to their country. Over 300,000 school-age Syrian children were not in education during the 2017-2018 school year in Lebanon, largely due to parents' inability to pay for transport, diversion of children into labour, school directors imposing arbitrary enrolment requirements, and language barriers preventing education without further support.¹⁹¹ Furthermore, stringent conditions have been imposed on accessing services for Syrian refugees, forcing many to live in squalid conditions.¹⁹² Accommodation for the refugees has been demolished and many are aggressively encouraged by Lebanese authorities to return to Syria, despite many refugees having been killed upon their return.

In Europe, the notorious Calais Jungle was a dire informal holding ground for many refugees. Infectious diseases, such as tuberculosis, scabies and malaria were rife, as was police violence, ethnic assault and sexual abuse. Psychological illnesses, including PTSD were widespread. Although now closed, the situation is still grave for many former inhabitants, some of whom have moved to informal settlements in the same region.¹⁹³ Others have gone elsewhere. For example, some live in unofficial camps in northern Paris. These sites are rat-infested, with prevalent diseases including scabies and respiratory conditions, though there is little to no healthcare available for those who live there.¹⁹⁴

Section 3 – Migrant worker conditions

Economic migration is widespread globally. Often from less developed countries where employment opportunities are limited, migrants travel both legally and illegally in search of employment. Depending on their status, and the country they arrive in, migrants can find themselves working and living in terrible conditions. Individuals may be forced to live in cramped, overcrowded accommodation as well as working in dangerous jobs without sufficient protection. With no citizenship, political power or access to means to enforce their human or domestic rights, migrant workers are ripe for exploitation, often with devastating impacts on a range of their human rights including their right to liberty and health. The Gulf states, such as Qatar, demonstrate how this exploitation

operates in practice, as do several other Asian countries, such as Indonesia. Difficulties for undocumented migrant workers are nonetheless global.¹⁹⁵

The abuse of migrant workers in Qatar is notorious including the large number who arrived for the FIFA World Cup 2022 preparations. They are forced to live in squalid, overpopulated areas, and required to work continuously without rest days, with Amnesty International reporting one case of a worker forced to work 148 days without a rest.¹⁹⁶ Despite Qatar insisting it has made huge progress on human rights, a UN report from 2020 noted that structural racism persists in the Gulf state and a 'de facto caste system based on national origin' exists in the country.¹⁹⁷ The report highlights racial profiling by police and denial of access to some public spaces as well as wages being unpaid and unsafe working conditions. Across six years, there have been 34 deaths of migrants working on the Qatari World Cup stadiums.¹⁹⁸ Exploitation of migrant workers can also be found in neighbouring Gulf states, including Saudi Arabia and the United Arab Emirates.¹⁹⁹

The COVID-19 pandemic has underlined the differential treatment of migrant workers, with many countries failing to provide adequate healthcare or protection to these communities, often with disastrous effects. Early in the pandemic, Singapore was heralded for its approach to the disease. Harvard University researchers described it as the 'gold standard' for case detection.²⁰⁰ Cases seemed low and under control, with early detection of COVID-19 key to their success. However, a complete failure to test, or even consider, Singapore's migrant worker community created a crisis. By the end of March 2020, hundreds of new cases were being discovered daily in the migrant worker community and the total number of cases reached 10,000 by 22 April 2020 with the overwhelming majority in the migrant worker community.²⁰¹ Social distancing is not possible in dormitories where up to 20 people share a single room. Singapore did get a grip on the virus in migrant worker communities, but this was by sealing them in bare dormitories for weeks with only their fellow workers for company. There have been numerous reports of self-harm and attempted suicide.²⁰²

Despite taking Herculean efforts with its citizens, Singapore failed to apply the same standard to its migrant workers, with the deficiencies of their living conditions exposed by the pandemic. The negligence of Singapore and the Gulf states breaches the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990), such as Article 16 which guarantees their security of person. While Singapore has not ratified this convention, it constitutes internationally mandated normative standards that should govern the state's approach.

The undocumented status of some workers in the US leaves them open to abuse by employers, who can hold the threat of deportation over their heads. While illegal workers typically, under US law, enjoy the same protections as domestic workers, and retaliatory actions against employees reporting prohibited workplace practices are illegal, the reality is different. It is scant consolation for migrants about to be deported that their former employer is going to face recriminations for having been reported to immigration enforcement agencies²⁰³ (if prosecutors decide to pursue charges against them) and often undocumented migrants accept their employer's abuses. Already facing language barriers, social prejudice and cultural differences, undocumented workers often work long hours without breaks for below the minimum wage, without safety equipment.²⁰⁴ Undocumented workers are overrepresented in lower-paid jobs such as childcare and agriculture. Their weak legal position limits their access to healthcare and allows employers to abuse their rights.

Section 4 – Health access for migrants and minorities

Migrants' rights, including access to healthcare, are often qualified. Access to state benefits is frequently limited and there can be differential expectations regarding employment status. Rights of access to healthcare and the underlying conditions of health can also be restricted, migrants often face more stringent requirements to receive healthcare and threats (real or perceived) of deportation can deter them from seeking it. Furthermore, migrants often report a poorer experience of healthcare compared to citizens.

The stigmatisation of migrants as disease-carriers endures globally. It undermines the status of migrants in host countries and feeds discrimination. For example, while the Republic of Korea removed mandatory testing for HIV for several categories of visas, including foreign teachers, in 2017, local authorities or employers can still force foreign workers to undergo testing either through coercion or without their knowledge.²⁰⁵ Not only does this contribute to a negative environment for migrants, but it also violates rights to confidentiality and informed consent. As a result, those who have HIV frequently have their right to live without discrimination compromised.

Migrants frequently face problems accessing healthcare. They can perceive (often correctly) the healthcare system as hostile, discouraging them from seeking treatment, they can face language barriers, as well as cultural obstacles, and face mistreatment by the healthcare system due to their migrant status. These barriers take many forms and can be dependent on the institutional structure of the healthcare system. Research undertaken by Pérez-Urdiales et al. found that Sub-Saharan African migrant women's experience of seeking healthcare in the Basque Country in Spain puts them at a disadvantage due to all three reasons: social status, poor communication and differential treatment.²⁰⁶

Migrants are often expected to pay more for their healthcare than the domestic population. In the UK, from 2015, migrants are expected to pay a health surcharge as part of visa applications, despite strong opposition from the BMA²⁰⁷ and other civil society organisations. In 2020, there was a public outcry about migrants working in the NHS having to pay the surcharge – especially perverse during a pandemic. While the UK Government withdrew the surcharge for healthcare workers, many NHS migrant workers were still paying it long into 2020.²⁰⁸

The hostile environment in the UK has certainly diminished the likelihood of migrants seeking healthcare. This has undermined the effectiveness of the COVID-19 response and is detrimental to both individual and public health. Despite offering a vaccine amnesty for all migrants, including those undocumented, many have not taken up the offer. After years of hostility towards migrants from the UK state, this is hardly surprising. Communication was also a problem – many GP practices did not know the vaccine could be offered to those who were not registered with a practice, a failure of government messaging.

Different communities frequently have differential health needs, often due to cultural and socioeconomic differences. International human rights standards require governments to take these differences into account when allocating health resources. This does not always happen. States often disregard the cultural preferences of minority groups, including indigenous communities, which affects both the healthcare they receive and the likelihood of them seeking treatment. This often has detrimental effects on their health outcomes. Furthermore, the provision of healthcare does not occur in a vacuum. Prejudices towards minority communities have an impact on their experience of the health system and subsequent health outcomes.

In the UK, different ethnic groups report different experiences of the NHS, with ethnically white and British people reporting more positive experiences than other groups. The GP Patient Survey 2020 found that 74% of patients of an Asian background had a good experience of their GP practice, compared to the national average of 82%.²⁰⁹ In 2019, 72.8% of Pakistani patients reported a positive experience with GP services compared to 88% of White Irish patients. There are also disparities in mental health care experiences, with a CQC survey finding that almost half of BME people (48%) had wanted to raise

concerns about mental health services (compared to 13% of non-BME people) while 84% of BME people had also wanted to raise concerns or make complaints about the standard of their care more generally (compared to 63% of non-BME people).²¹⁰ COVID-19 has also thrown into stark contrast the differing experiences of BME people in the UK, with a significantly higher portion of those dying from COVID being from BME backgrounds. Furthermore, some Muslim communities in Northern England have been encouraged not to seek treatment, with conspiracy theories circulating that non-white patients will be 'left to die'.²¹¹ These fabricated rumours play into fears in some South Asian communities that Islamophobia is rife in Britain, including in the health sector, which affects their willingness to seek treatment.

The UK is not alone. There is ample evidence across Western countries that minority experience of the healthcare system is different to that of ethnically white citizens. In October 2019, France's highest official for defending citizens' rights reported that it is 6.5 times harder for people with 'Muslim African names' to get psychiatry appointments²¹² while research from Hamed et al. in 2020 demonstrated the adverse effect of structural racism on healthcare in Germany, Portugal and Sweden, including reported pain by pregnant women of African origin not being taken seriously, leading to the unnecessary deaths of babies.²¹³ Structural racism in the US, highlighted again by the Black Lives Matter movement, pervades its health system. One critical indicator is higher maternal mortality rates among African American women compared to white women.²¹⁴

Globally there are significant health disparities between indigenous and non-indigenous populations for many preventable diseases, particularly among children.²¹⁵ These include infectious diseases such as malaria, HIV, COVID-19, and tuberculosis, as well as cardiovascular disease, diabetes and cancer. This is linked to failures of access, with indigenous communities in Brazil having limited opportunities to access modern healthcare. Progress in Brazil was made under the 'More Doctors' programme, set up in 2013, with hundreds of Cuban doctors servicing remote indigenous health facilities in the Amazon. Following President Bolsonaro's radical restructuring of the programme, the Cuban doctors withdrew, exposing once more the fragility of healthcare provision to indigenous communities in the region.²¹⁶

Many modern healthcare systems are insensitive to indigenous communities' conception of health. Far more than in 'western' medicine, First Nations in Canada frame health as environmental and communal as opposed to individualistic and mechanistic, with a greater focus on spirituality.²¹⁷

Health systems are not isolated from society and societal influences, including discrimination, will affect the provision of healthcare. These issues are not easy to resolve, and healthcare systems cannot address them alone. Nevertheless, while they exist, they will continue to drive differential health outcomes, undermining the rights of minority communities to healthcare.

Section 5 – Seeking refuge, seeking asylum

Borders are tightening. Seeking asylum has become more difficult, despite being a human right under Article 14 of the Universal Declaration of Human Rights (1948).²¹⁸ Entering countries, being recognised as an asylum seeker, and having your claim accepted, requires overcoming serious obstacles, often beyond the resources of many. Many refugees therefore find themselves stuck in perpetuity in refugee camps, often in horrendous conditions, or forced to undertake dangerous journeys that far too often end in death. Some Palestinian refugees have now lived in camps in Lebanon for over a generation.

In 2015, Germany opened its doors to one million refugees. While not as many as some Middle Eastern and North African states, it was both a powerful humanitarian gesture and an important symbol for Europe and the rest of the world. Unfortunately, this was a high point in the European response to the refugee crisis. Hungary, under right-wing populist Viktor Orbán, closed its borders, engaging in strong anti-migrant rhetoric, and many Southern European countries took a hard-line stance. Newspapers fuelled anti-immigration sentiments, reporting horror stories of migrants behaving poorly in their

host countries and describing the refugee crisis as an 'invasion'.²¹⁹ Far-right parties across Europe campaigned successfully using anti-migrant rhetoric. Countries began refusing to take more refugees, the EU implemented legislative and bureaucratic barriers to irregular migrants, and even Germany backpedalled from its internationalist approach.

The EU and Turkey reached an agreement regarding migrants and refugees attempting to enter Europe via Greece and its islands in 2016. Essentially, the deal stipulated that any migrant arriving irregularly (not through official channels, such as without permission or passage via boat) to Greek islands, including asylum-seekers, would be returned to Turkey. In return, EU member states would take one Syrian refugee from Turkey for every Syrian returned from the islands.²²⁰ This agreement was based on the faulty premise that Turkey is a safe place for asylum seekers. Turkey hosts over three million refugees with 69-80% living in poverty in 2019, depending on the region, according to the World Bank.²²¹ They also face threats to personal safety and inadequate facilities. The EU's deal with Turkey and hardening of policy in the Mediterranean effectively abandons the continent's duty to asylum seekers and refugees. Refoulement, the transfer of individuals to a place where they would be at real risk of serious human rights violations, is illegal under both international and EU law, enshrined under Article 3 of the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (1984).²²² Yet, by sending irregular migrants back to Turkey, Amnesty International argues the EU is potentially guilty of this, citing several cases where the right to challenge deportation on these grounds was not respected.²²³

Furthermore, Southern European states have taken aggressive measures to curb migrants seeking to cross the Mediterranean. Thousands have died attempting the dangerous crossing in unsafe boats provided by opportunistic smugglers. Concerningly, NGOs (non-governmental organisations) in the Mediterranean Sea seeking to rescue refugees stranded at sea have faced state repression. The ship *Luventa*, which rescued more than 14,000 migrants, was impounded in 2017 by the Italian government and its crew threatened with up to 20 years in prison, accused of helping illegal immigration.²²⁴ The ship is still impounded, and 10 crew members face criminal charges. Other countries are also encouraged to stop helping irregular migrants. In 2017, Italy, with the EU's blessing, spent tens of millions of euros funding a Libyan coastguard to intercept boats heading for Italy and return refugees and migrants to the war-ravaged country.²²⁵ The failure of Europe to abide by its obligations under international law forces migrants to hazard even more dangerous journeys, with no guarantee of support from states or NGOs, or remain in the squalid conditions of refugee camps.

Seeking asylum has also become progressively more difficult in the US. It was a key focus of former US President Trump's administration. From November 2018 those who entered the country between border checkpoints were banned from claiming asylum, in flagrant disregard for international law. Also, further restrictions were imposed on those who were eligible for asylum: from July 2019 threats against a family member no longer made an individual eligible, and neither were those fleeing domestic or gang violence.²²⁶

CASE STUDY: Rohingya – still seeking safety

In August 2017, the Myanmar military and local citizens began extensive and brutal attacks on the Rohingya Muslim population. Described by UN Secretary General Antonio Guterres as 'one of, if not the, most discriminated people in the world', the Rohingya are the largest Muslim minority in Myanmar but are denied citizenship by the Buddhist government and were excluded from the 2014 census.²²⁷ Tension was brewing in the years running up to 2017, and many Rohingyas had already made the perilous journey to escape communal violence. With thousands, including hundreds of children, killed when the security forces moved against the Rohingyas, hundreds of thousands fled the country, bringing reports of rape, torture and other atrocities. Now, according to MSF, nearly a million are situated in the Cox's Bazar area of Bangladesh, which holds the largest refugee settlement in the world.²²⁸

The UN Refugee Agency has noted that the response from the Bangladeshis has been generous, with local villages willing to take in the new arrivals, although the resources of the country are limited²²⁹ and in March 2019 the country said it would accept no more Rohingyas. The country has, recently, moved to further restrict access to the Rohingyas. Foreign Minister Abdul Momen said in April 2020, with hundreds of Rohingyas stranded on trawlers in the Bay of Bengal, 'I am opposed to allowing these Rohingya into the country because Bangladesh is always asked to take care of the responsibility of other countries... we have no room to shelter any foreign people or refugees'.²³⁰

Similarly, Malaysia and Thailand have refused to offer refuge to the Rohingya.²³¹ Two boats, with hundreds of Rohingya on board, were refused entry in June 2020, despite having been at sea for months without adequate food or water. On another boat, a hundred Rohingya died from malnutrition and other maladies after being refused access to ports for months. Such pushbacks have, tragically, become commonplace. A joint statement from the UNHCR, IOM and UNODC noted:

'There is no easy solution to the irregular maritime movements of refugees and migrants. Deterring movements of people by endangering life is not only ineffective; it violates basic human rights, the law of the sea and the principles of customary international law by which all States are equally bound. We call on States in the region to uphold the commitments of the 2016 Bali Declaration as well as ASEAN pledges to protect the most vulnerable and to leave no one behind. Not doing so may jeopardize thousands of lives of smuggled or trafficked persons, including the hundreds of Rohingya currently at sea'.²³²

International funding has been provided for the Cox's Bazar refugee camps, including from the EU, but this has failed to adequately provide for the hundreds of thousands of people there. The Myanmar Rohingya community are trapped. The 600,000 or so Rohingyas remaining in Myanmar are subject to continued government persecution. Confined to camps and villages, they have inadequate food, healthcare and education, while still being subject to state violence. The recent military coup in Myanmar will almost certainly result in further persecution of the Rohingya population. The 'lucky ones' who leave find themselves in overcrowded refugee camps with unsanitary conditions²³³ while others are left adrift, starving in boats, hoping for sanctuary.

It is always difficult for countries to provide adequate facilities for refugees and asylum seekers. This is especially true of poorer countries during a pandemic. Nevertheless, this does not weaken the international duty to respect the Rohingyas' human rights and abide by international law. Barriers have been put up to those seeking asylum from Myanmar and conditions in the overcrowded refugee camps are not suitable. There must be a better effort to secure the security, dignity and human rights of peoples who are fleeing atrocities.

Section 6 – Threats to medical impartiality

Health professionals are under a binding professional obligation to provide healthcare based on need, without discrimination on anything but clinical grounds. Medical impartiality is one of the cornerstones of modern medical and humanitarian practice. Regardless of gender, sex, race, religion, disability, sexual orientation or political belief, people are entitled to healthcare based on need.

Despite being a pillar of medical practice, medical impartiality is often under pressure. The political capture of migration and, in some instances, its framing in narratives relating to security and terrorism, have brought pressure to bear on the provision of impartial health and humanitarian aid to these populations.

There is a feeling, amongst those sceptical of refugees' claims, that many people attempt the journey to Western countries is to benefit from their welfare provisions.²³⁴ It is argued that reducing access to benefits will reduce the numbers attempting the journey. Healthcare should therefore be limited. By not supplying these benefits, they argue, only those who are 'genuine' asylum seekers and refugees would make the journey. The logic is questionable – those who undertake the dangerous journey across the Mediterranean Sea are hardly in an ideal situation. Such an approach is also clearly in contravention of the human right to health without discrimination. It can also threaten health professionals' fundamental obligation to provide treatment based on need. It has also been used to frustrate attempts to provide maritime assistance to those in danger at sea despite clear obligations under maritime and customary international law.

The hostile environment developed in the UK has also threatened the impartiality of healthcare staff. They have been asked to take on responsibilities beyond providing care, for example, until 2018 NHS England provided patients' details to the Government to allow them to trace those breaking immigration rules.²³⁵ The names and addresses of suspected illegal migrants were also expected to be passed on. Not only is this beyond the remit of a doctor, but it is also an attack on medical impartiality. An individual's immigration status should not affect how a medical professional treats them. The WMA (World Medical Association) has passed numerous resolutions reaffirming the right of all migrants to receive suitable healthcare regardless of their status, including the following, extracted from a resolution adopted in October 2016:

'The WMA reiterates the WMA Statement on Medical Care for Refugees originally adopted in Ottawa, Canada in 1998 which states:

- *Physicians have a duty to provide appropriate medical care regardless of the civil or political status of the patient, and governments should not deny patients the right to receive such care, nor should they interfere with physicians' obligation to administer treatment on the basis of clinical need alone.*
- *Physicians cannot be compelled to participate in any punitive or judicial action involving refugees, including asylum seekers, refused asylum seekers and undocumented migrants, or Internally Displaced Persons or to administer any non-medically justified diagnostic measure or treatment, such as sedatives to facilitate easy deportation from the country or relocation.'*²³⁶

Section 7 – Conclusion and recommendations

While the impact of rising nationalism on the health rights of minorities is clear, the search for concrete policy responses is far more challenging. The structural foundations of racism are deeply rooted and cannot be removed overnight. Furthermore, efforts to resolve the refugee crisis and secure the dignity and livelihoods of refugees require a coordinated international effort.

Despite the difficulties, there are clear steps that can be taken. Countries that have signed up to international human rights agreements must adhere to them. Governments that have ratified the Universal Declaration of Human Rights, should grant people access to asylum and repeal regressive measures they have taken in recent years, recommitting themselves to Article 14 (1) of the Universal Declaration of Human Rights which states:

'Everyone has the right to seek and to enjoy in other countries asylum from persecution'.

Numerous solutions have been proposed to ensure the right to health of peoples across the world, including the most marginalised. None has yet come to fruition with scale and expense often cited as a barrier. Indeed, many countries cannot (or do not) currently guarantee the health of their citizens, including the richest country in the world, the United States, which can make justifying health expenditure overseas difficult. One idea proposed by Friedman et al., in the light of the COVID pandemic, is a R2HCF (Right to Health Capacity Fund).²³⁷

The R2HCF would promote inclusive participation, equality, and accountability in advancing the right to health. The R2HCF recognises the right to health as a positive right which states and other actors need to take steps to realise, as discussed in the international frameworks section of this report. Civil society organisations would be the priority for the R2HCF, which would support their advocacy work as well as improve mechanisms for accountability and involvement. The goal would be making countries' health systems accountable to the public, with progress tracked on universal accessibility and sufficient healthcare workers and resources. R2HCF would be an independent non-profit organisation directly funding NGOs. Civil society and community leaders would take an active role, as would governments that are committed to the right to health. Regular assessments of healthcare could be carried out using indicators. Former UN Special Rapporteur on the Right to Health, Paul Hunt, did extensive work using a human-rights based approach to health indicators, despite the challenges.²³⁸ With the detail that these indicators would provide, resources can be focussed on specific issues in countries or regions. Instead of 'throwing money at the problem', an intricate understanding of the specific health concerns of different parts of the world, and how they interact, could be developed with the effectiveness of solutions monitored. Funding would come from governments, foundations and individuals with health initiatives. Key beneficiaries would include marginalised communities such as indigenous populations and vulnerable migrant communities. As opposed to a top-down approach to healthcare, the R2HCF is envisioned as being led by civil society with numerous stakeholders making it responsive to community needs and, as the proposers say, promoting 'a world where, whether during a health emergency or in ordinary times, no one is left behind'.

Within countries, barriers to migrants accessing healthcare should be scrapped. The UK's immigration health surcharge should be removed, as the BMA called for in 2019. There should be no expectation that healthcare professionals, will investigate or report an individual's immigration status. We have called for this on numerous occasions, with 2015 policy stating 'that NHS staff do not have any role in policing immigration' and further 2018 policy calling on the BMA 'to lobby the government to change the law so that doctors can treat patients regardless of immigration status without the threat of being prosecuted for fraud'.

Wealthier countries should ensure they provide financial support to states offering sanctuary to large numbers of migrants, as in Africa, the Middle East and Asia. It is not reasonable for nations of limited resources to bear the brunt of assisting those in dire need without other governments pulling their weight. The R2HCF is one mechanism through which support could be provided. The WHO can also help as can subsidising education in poorer countries, which improves health and life expectancy in developing countries.

Concerning racial inequities in health outcomes, healthcare systems must place new emphasis on ensuring high quality care for all, regardless of race or migration status. This entails building trust with these communities. This does not necessarily mean there should not be provisos on migrants accessing a country's healthcare system, but those who do access healthcare should not receive differential care based on their migration status. A focus on preventative care and addressing patients' social needs, as well as diversifying the medical workforce itself to more accurately reflect demographics, is a vital part of this.²³⁹ Bridging the gap between healthcare systems and minority communities will lead to greater understanding and trust. Indigenous populations should not see healthcare systems as alien institutions that they approach at their peril. Healthcare systems should be designed with these marginalised communities in mind. While there is sufficient evidence to start taking positive steps, there also needs to be more research into understanding health inequalities. The BMA successfully called for an inquiry into the disproportionate deaths of those from ethnic minority backgrounds in the UK from COVID-19;²⁴⁰ this must be built on to develop a more well-rounded understanding of ethnic health differences.

From here, more targeted policy solutions can be crafted. Harvard professor David Williams, who is committed to studying race and health, has called for a health observatory in the UK to look at the effects of racial discrimination on patients.²⁴¹ This would ensure continual interest and study of the problem, with steps taken to improve it, as opposed to fluctuations in the attention given. The International Convention on the Elimination of All Forms of Racial Discrimination includes under Article 4 'The right to public health, medical care, social security and social services'. Addressing racial inequities in healthcare is therefore incumbent on all states-parties, and change will not come without proactive action. A recognition of intersectionality, and how different characteristics can impact how an individual is perceived, is also useful.

The BMA has long campaigned for substantial reform to the UK's immigration detention system. We believe that the detention of people who have not been convicted of a crime should be a measure of last resort. Detention should be reserved for individuals who pose a threat to public order or safety. The BMA believes the use of detention should be phased out and replaced with more humane means of monitoring those facing removal. While this practice continues however, numerous improvements could be made. The Norwegian prison system provides a good framework on how people can be detained humanely. The BMA's report on immigration detention in the UK 'Locked Up, Locked Out'²⁴² made numerous recommendations with international applicability:

- address the health effects of indeterminate detention
- address aspects of the detention environment that affect the health and wellbeing of those detained such as sanitation and recreation facilities
- provide training and continued support in health and wellbeing issues for all those working with detained individuals
- recognise the importance of doctors acting with complete clinical independence. Medical care should not be politicised.

Beyond healthcare in detention centres, sufficient staffing and resources must be in place to secure the safety of detainees. Adequate food and other necessities should be provided. Families should not be separated, and children should not be kept from their parents or even placed in detention centres in the first place.

Though difficult to address, the problems discussed in this chapter are not insurmountable. Coordinated international action to protect the rights of minorities and vulnerable groups is vital, as is the swift condemnation of those who ignore or violate such rights. Through this, we can move towards a world where the health and human rights of all people are respected.

Recommendation

States must reaffirm their commitments to due process for asylum seekers under international law, and wealthier states should offer support to poorer states in accommodating refugees and providing for them.

Recommendation

Innovative, community-based initiatives should be explored to ensure the right to health of all marginalised groups.

Recommendation

Barriers to migrant healthcare access should be removed.

Recommendation

Healthcare systems must ensure they are designed with the wellbeing of all groups in mind, including ethnic minorities and migrants.

Recommendation

Those kept in detention must have their health-based human rights respected and realised.

Chapter 4 – Climate change and environmental degradation

When the well is dry, we know
the worth of water.

Benjamin Franklin, *Poor Richard's Almanac*

Preservation of our environment is not
a liberal or conservative challenge,
it's common sense.

Ronald Reagan

Introduction

Climate change is one of our greatest global threats. Its effects are being felt from the Arctic Circle²⁴³ to the Marshall Islands.²⁴⁴ It is eminently plausible that average global temperatures will have increased by four degrees Celsius by the end of the century, but long before that we will see huge disruption.²⁴⁵ Climate change disproportionately impacts those already at a greater disadvantage globally. This can be through changing weather patterns impacting farming, the heightening of health inequalities through pollution, as well as changing disease vectors, and the displacement of people. Indeed, some low-lying island countries will simply cease to exist. Much of this is already evident in countries as diverse as India, where pollution is prevalent,²⁴⁶ and New Zealand, with indigenous Māori communities being destabilised.²⁴⁷ Its effects are not limited to these communities though; the effects will be felt by everyone, throughout the world. In the UK, farmers are already being forced to adapt to the changing environment caused by climate change.²⁴⁸

Climate change is defined by NASA as 'a long-term change in the average weather patterns that have come to define Earth's local, regional and global climates. These changes have a broad range of observed effects that are synonymous with the term'.²⁴⁹ It is accepted amongst experts that, since the 20th century, climate change is driven by human activity. The most notable, and infamous, example of this is the 'greenhouse effect' where the burning of fossil fuels increases the gases in the Earth's atmosphere that trap heat, thus raising the Earth's average temperatures. All credible predictions state that, if left unchecked, climate change will cause catastrophic damage to all life on this planet. For many, it has already altered their lives in fundamental ways and, as this chapter will show, not for the better.

A related but distinct concept is environmental degradation. This involves anthropogenic disruption of local ecosystems and their biota. One of the most common causes of environmental degradation is pollution, largely driven by the same industrial processes as those behind climate change. Another is the destruction of natural habitats cleared for livestock, cash crops or human dwelling. The historical impact of environmental degradation is clearly not restricted to the natural world – its impact on human communities and human wellbeing has been severe and continues to be a major threat.²⁵⁰

The inevitable scarcity that climate change will bring is also likely to increase violence as competition for limited resources increases. If basic necessities, such as food, water and fuel, are only available at a premium, then it is reasonable to expect tensions between groups for these commodities to grow, as control of resources is often a primary cause of inter-group fighting. Thus, climate change contributes to the likelihood of further conflict in an already war-torn world.²⁵¹ This is to say nothing of the contribution of the military to climate change in and of itself, with the global military-industrial complex estimated to produce 6% of global emissions,²⁵² yet it is often excluded from negotiations on emission reduction, including COP26 (the 26th UN Climate Change Conference of the Parties).

The connection between climate change, human health and human rights is increasingly recognised. Climate change impacts the right to health, the right to food and water, and even the right to life, as noted in the report on a safe climate by the UN Special Rapporteur on Human Rights and the Environment.²⁵³ It also heightens the effect of other issues raised in this report – the problem of displacement from climate change or 'climate refugees' is increasing and, unabated, climate change will further exacerbate existing social inequalities. Historical legacies of atmospheric carbon largely stem from the industrialisation of now developed countries, and the US remains among the largest producers of greenhouse gases. The actions of those in developed countries continue to affect those already at a disadvantage globally, which has a profound effect on global justice. By increasing the inequalities that already burden society, there is a risk that those who are already heard very little will become voiceless. Meeting their human rights to health, food and water will become either unachievable or not a priority for those with the ability to make it so. The difference between the 'haves' and the 'have-nots' will never have been starker.

Climate change also threatens 'group rights'. Communities have a right to a healthy environment, profoundly linked to rights to enjoy their own culture and way of life. Climate change undermines this, making regions uninhabitable and devastating their human communities. This is particularly notable with those communities whose lives are intrinsically linked to their local environment, such as many indigenous groups around the world.²⁵⁴

A challenge for a rights-based approach to climate change and environmental degradation is the lack of a direct link between the wrongdoing of individuals and groups and the harm to others. Most of the impacts of pollution and fossil fuels are indirect and have an aggregate effect on communities. Greenhouse gases are dispersed widely from their areas of production. It is therefore difficult to identify causality and responsibility for climate change, making restitution or targeted action challenging.

Furthermore, the greatest impact of unfettered climate change will be felt by future generations; generations ranging from those who are just reaching adulthood to those who have not yet been born. While these cohorts bear no responsibility for the causes of climate change, they will bear the brunt of its effects and the damage it causes. This point has been made most famously, and passionately, by Swedish teenage activist Greta Thunberg in her speech to the UN.²⁵⁵

The perception of climate change has changed from an abstract future threat to a real and current danger. The climate protests that swept the world in 2019 are a heartening sign of potential change. However, this has not yet translated into serious commitments to carbon reduction by the world's major polluters.

Globally tackling the problem has not been helped by the prominent position climate change deniers have in countries across the world. Whether they deny climate change is happening, or deny it is man-made, they impede collaborative solutions to climate change. Climate change deniers – or sceptics – hold many great offices across the world, including the presidency of Brazil (and the immediate former President of the United States), while newly industrialising countries in the East have shown a reluctance to take any action that would impede their impressive economic growth. Countries and their governments, who now can substantially increase their wealth (and thus, it is hoped, the health and wellbeing of their citizens) are understandably hesitant to jeopardise this, often determining the short-term benefits are worth the dispersed long-term global threat. The negative externalities of pollution and waste, the result of industrialising, are often ignored by newly industrialised countries. They prefer instead to maximise the value of expending the world's natural resources, typically fossil fuels, due to their positive impact on their local economy, despite the negative global effect on our environment. The support of many large transnational corporations with clear vested interests has been crucial in maintaining this opposition to acting against climate change. An army of climate sceptics in the form of YouTubers, bloggers and others in more traditional media roles spreads sufficient disinformation to arrest the development of any public consensus on the issue, despite the consistency of scientific opinion on the matter.

The British Medical Association has long recognised the significant links between climate change, health and human rights. At the BMA's 2014 ARM (Annual Representative Meeting), the Association passed a resolution recognising the Lancet Commission's description of climate change as 'the greatest threat to human health of the 21st century',²⁵⁶ a position the Lancet maintains.²⁵⁷ The policy also called on the BMA to facilitate the widest possible alliance of healthcare bodies to ensure that the co-benefits to health and the economy of reducing greenhouse gases are more widely understood, and incorporated into health and economic policy. We called for healthcare bodies to transfer to electricity suppliers who are '100% renewable'. In 2019, the BMA declared a climate emergency.²⁵⁸ The BMA is a founding member of the UK Health Alliance on Climate Change,²⁵⁹ a coalition of health professionals advocating to protect the public's health in response to these health threats.

This chapter highlights the relationship between climate change, health and human rights. It is divided into seven sections. The first section examines how climate change impacts human rights in general, considering intergenerational justice, the right to life and other important damaging effects it will have. The following sections analyse how climate change influences the right to health specifically: the second section addresses pollution, the third section assesses climate change and disease vectors, the fourth section examines famine and drought and the fifth section explores the impact of climate change on mental health. The sixth section evaluates climate change's role as a threat multiplier, intensifying the impact of other negative influences on global human rights provisions. This includes how climate change increases the displacement of people, the likelihood of conflict and inequality, especially health inequality. The seventh section concludes the chapter by suggesting some potential steps forward to address these issues.

Section 1 – Climate change and human rights

On the face of it, anthropogenic climate change and human rights may seem like odd bedfellows. One is a description of environmental transformations resulting from human activity. The other is a normative set of principles intended to describe the minimum social and political conditions for a reasonable life. However, the significant impacts of climate change, from pollution to disease, are affecting people's health and human rights, disrupting the quantity and quality of living and agricultural space as well as the availability of resources. This creates pressure on living standards which threatens human rights.

Climate change impacts human rights in fundamental ways. There are implications for the Universal Declaration of Human Rights 1948, notably Article 25 (i), which states '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...' Famines and droughts will increase as the effects of climate change become more prominent, restricting people's access to food and an adequate standard of wellbeing, while new disease vectors and pollution will impact people's health. Furthermore, Article 3, which declares individuals' rights to life and security of person,²⁶⁰ is threatened by extreme weather events, which are linked to climate change, as well as other consequences of a changing environment.

Climate change gives rise to searching questions in intergenerational justice. While current (and previous) generations have wrought the most harm to our environment, future generations will be most harmed, even to the point of inheriting an uninhabitable planet.²⁶¹ Indeed, climate change is already having an impact on the children of the 21st century. With their bodies and minds still developing, children are more vulnerable to extreme weather patterns, increased heat, drought and famine, which can cause lasting physical and mental damage.

Intergenerational justice involves considerations of what current generations 'owe' future generations. The winning essay of the BMA President's 2020 essay competition explored this issue.²⁶² Concerning climate change there is a reasonable obligation to maintain the environment so that it continues to be hospitable to future generations (while meeting the needs of the current generation). One of the big challenges in intergenerational justice is the apparent priority given to the rights of the living. By contrast, what is owed to future generations feels much more abstract and is championed by far fewer and less influential voices. Which future generations count and how should their needs be weighted? Hence, the rights of current generations are prioritised at the expense of future generations. A well-known Native American proverb probably best sums up the sentiment: 'We do not inherit the Earth from our ancestors – we borrow it from our children'.

Intergenerational injustice is compounded because young people and future generations have no responsibility for climate change; they did not indulge in the overexploitation of planetary resources or pollute the earth and sea; they did not avoid the mounting evidence of climate change for decades or fail to take meaningful action. It is surely unfair for current and previous generations to enjoy the benefits of development while future generations shoulder the cost. Activist Greta Thunberg has become symbolic of the anger and frustration many young people feel with the inaction on climate change, and the

penalties they know they will have to pay, indicated by the global youth climate strikes that have taken place across the globe. In 1989, the UN adopted its UNCR (Convention on the Rights of the Child). This included agreements to 'combat disease and malnutrition... taking into consideration the dangers and risks of environmental pollution', to 'ensure... hygiene and environmental sanitation' and ensure 'the development of respect for the natural environment'.²⁶³ It is incumbent on those who have ratified the UNCR to take steps to arrest the pernicious effects of climate change, for the rights and safety of those who follow.

Section 2 – Pollution

Pollution, the introduction of harmful materials into the environment, can have major health implications. Human activity can pollute the air, land and water, through what we throw away as well as by-products of production. Pollution is not new. For centuries humans have unwittingly contaminated drinking water with raw sewage, spreading diseases such as typhoid and cholera, while the notorious London smog, the result of high-density air pollution following industrialisation, killed thousands of people with respiratory problems. Even in the 13th century, King Edward I threatened Londoners with strict penalties if they did not cease burning sea coal.²⁶⁴ Perhaps prophetically, the monarch's decree had little effect. In the 20th century, with mass industrialisation and globalisation, pollution reached heights not previously seen.

The negative health impacts of pollution are well known. Research indicates that in addition to relatively minor upper respiratory irritation, pollution leads to chronic respiratory and heart disease, lung cancer, acute respiratory infections in children and chronic bronchitis in adults, aggravating pre-existing heart and lung disease, or asthmatic attacks.²⁶⁵ Ultimately, it increases premature mortality and reduces life expectancy, undermining people's right to health and wellbeing. The WHO estimates that ambient air pollution accounts for roughly 4.2 million deaths each year.²⁶⁶ This is not just a contributing factor to the changing of our climate but is a current and immediate threat to the quality of human life.

India currently has 21 of the 30 most polluted cities in the world. It is estimated that 1.67 million deaths in India in 2019 can be attributed to air pollution, accounting for 17.8% of the total deaths in the country that year.²⁶⁷ China, which has previously held the unwanted accolade of topping the global league table for most polluted cities, has been making progress with concerted efforts to reduce particle pollution across dozens of Chinese cities. However, over a million deaths each year in China are still caused by air pollution.²⁶⁸ While the problem is more pronounced in certain countries, this is a global issue and the UK is affected also, with 9,400 deaths a year in London alone caused by air pollution²⁶⁹ and about 40,000 deaths throughout the UK.

Contaminated water is a serious and persistent problem. Many bodies of water are now tarnished with chemicals or microorganisms, which can stem from several sources: the pesticides and fertilisers used on farms, marine debris (especially plastic) as well as oil and chemical spills, or illegal dumping.²⁷⁰ The most notorious recent example is the 2010 BP Deepwater Horizon oil spill in the Gulf of Mexico, which left 11 dead and caused catastrophic damage to the local ecosystem. Contaminated water can result in the spread of numerous deadly diseases including diarrhoea, cholera, dysentery, typhoid, and polio. A study in the *Lancet* stated that water pollution was implicated in 1.8 million deaths worldwide in 2015.²⁷¹ More troubling is how the issue shows no signs of abating. Reports indicate every river, stream and lake in England is polluted, which presents challenges for the target of 100% healthy water by 2027.²⁷² Globally, it is expected that half of the world will be living in water-stressed areas by just 2025.²⁷³

Many of the countries with the worst access to clean water are in Africa, with 60.9% of Ethiopia lacking access to basic water services as well as 61.1% of Uganda and 80.7% of Eritrea; Papua New Guinea also has significant barriers to access to clean water: 63.4% do not have basic water services.²⁷⁴ Water facilities are limited in refugee camps globally, a reason why conditions such as dysentery and diarrhoea are rife. However, water is

contaminated in even the richest countries in the world, as the case of Flint, Michigan demonstrates. Regulatory failure resulted in lead from ageing pipes seeping into the town's water supply. The town's residents, including thousands of children, were exposed to water contaminated by lead. Lead exposure can damage children's brains and nervous systems, diminishing growth and development, and causing learning, behaviour, hearing, and speech problems.²⁷⁵

The full implications of Flint's water pollution are still debated, but what is clear is the potential for water contamination to manifest in any local area, especially given the high proportion of harmful substances used in production methods across the world. As discussed in the chapter on neoliberalism, environmental deregulation is often proposed in service of 'economic growth' and to 'reduce red tape in the market economy'. While this may be beneficial for the companies that pollute, the impact on local populations can be highly detrimental.

Section 3 – Disease

Climate change is exacerbating the occurrence of certain diseases. Dengue fever is on the rise. It can cause high temperatures, headaches, vomiting, rashes, and pain throughout the body. Capable of causing internal bleeding, organ damage or even death, dengue fever's increasing prevalence is a major public health concern and in large part a result of climate change.²⁷⁶ The disease is passed to humans via mosquitoes whose survival and reproduction are being improved by both changes to temperature, rainfall, and the frequency of natural disasters caused by climate change. This is not the only reason for the surge of the disease (rapid unplanned urbanisation in regions such as Latin America has contributed) but anthropogenic climate change is playing a significant role. Research in the *Lancet* has modelled the effect of climate change on dengue fever using expected change in humidity, predicting that five to six billion people (50-60% of the projected global population) will be at risk for dengue fever in 2085, as opposed to 3.5 billion in the absence of significant climatic changes.²⁷⁷

Dengue fever is not unique, there are increased risks of other diseases carried by mosquitoes, such as malaria and Rift Valley fever resulting from anthropogenic disruption of the El Niño cycle²⁷⁸ (the cycle of warm and cold sea surface temperature of the tropical central and eastern Pacific Ocean) which essentially creates a more hospitable environment for mosquitos. Scientists have also predicted that malaria-carrying mosquitoes will spread northwards in Europe when the Mediterranean becomes too hot and dry for them. This is just the tip of the iceberg, however. Different temperatures and weather patterns mean different degrees of suitability for different organisms and microorganisms. Climate change's influence on disease and disease vectors is expected to increase in the coming years, and not for the better. COVID-19 has demonstrated the monumental impact pandemics can have on our life and climate change will fuel this. Large populations and their continued growth drive soil degradation and biodiversity loss which can increase the chances of pandemics, as well as changes in temperature.²⁷⁹

Climate change's effect is not limited to insect vectors. The behaviour and range of larger disease vectors, such as rodents, are also affected by climate change, which can cause extensive harm to people. These include hantaviruses, carried by a range of rodents, which cause two major diseases for sufferers: haemorrhagic fever with renal syndrome in Asia and Europe, and hantavirus cardiopulmonary syndrome in the Americas.²⁸⁰ Climate change's early effects have already increased the prevalence of hantaviruses in parts of Europe. Elevated average temperatures in West-Central Europe have been associated with more frequent Puumala hantavirus outbreaks, through high seed production (mast year) and high bank vole densities.²⁸¹

There are also worrying links between climate change and Ebola. The 2016 outbreak in West Africa killed more than 11,000 people. Authoritative modelling suggests that over the next 50 years climate change could drive an increase in Ebola rates.²⁸² There is also potential for new parts of Africa to be exposed to the disease.

Hay fever and other allergies including conjunctivitis and asthma are aggravated by climate change.²⁸³ This is through increasing airborne pollen levels and an extended pollen season. Furthermore, flooding and severe storms can result in damp buildings. This increases the prevalence of mould which has also been known to worsen the effects of allergies.

Tuberculosis is one of the world's great killers, consistently in the top ten causes of death globally – 1.4 million people dying from it in 2019.²⁸⁴ Its virulence has long been linked to climate²⁸⁵ and it is likely that climate change will affect the incidence and distribution of tuberculosis in the future. Many of these conditions, such as tuberculosis and dengue fever, already impact the Global South significantly more than the North. Changing disease vectors are likely to exacerbate these inequalities, though the North will not be exempt.

Section 4 – Food and water

Human rights to food and water are inextricably linked to the right to health – people need food and water to remain healthy. However, climate change will continue to dramatically increase droughts and famines. Much previously safe-to-drink water will become contaminated and crop failure will threaten the world's food supplies.

Changing climates naturally affect agriculture and livestock. Continual fluctuations in weather patterns affect harvests. However, climate change threatens the irreversible depletion of swathes of once fertile land. Yale Climate Connections have summarised five ways in which climate change is damaging, and will continue to damage agriculture.²⁸⁶ First, more extreme weather, such as storms or resultant landslides, harms livestock and crops. Secondly, water scarcity (as well as the danger of drought in and of itself) diminishes the capability of farmers to provide adequate hydration. Thirdly, there are changes to the seasons. Fourthly, wildfire can decimate farms and cause widespread smoke damage. Finally, warmer weather and rising CO₂ levels adversely affect food supply, safety and quality. Rising temperatures can also increase exposure to some toxins and pathogens, such as Salmonella, while more carbon dioxide in the atmosphere can also decrease nutrients, such as protein, in certain crops.²⁸⁷

The results are predictable: an increase in famine, reduced food security, creating more malnutrition and ill-health. This will primarily, although not exclusively affect poorer areas of the world,²⁸⁸ many parts of which are already suffering from greater scarcity connected to climate change.

CASE STUDY: Zambia – droughts and famine

Zambia is a landlocked country in Southern Africa. Historically part of the British colonial empire, Zambia became independent in 1964. It is considered one of the more successful post-colonial countries in the region, recognised for its stability, having regular democratic elections and strong economic growth throughout most of the early 21st century, helped by its resource-rich environment.²⁸⁹ While there are contemporary concerns surrounding the increasing debt of the country (exacerbated by the coronavirus pandemic) and dubious circumstances surrounding the re-election of the President in 2016²⁹⁰ (who was then defeated in 2021),²⁹¹ it has not fallen into civil war or autocracy like several of its neighbours. There are, in other words, reasons for optimism for the country's long-term future.

The future of countries like Zambia will be sorely tested by climate change. In early 2020, the BBC reported that climate change has brought Zambia to the brink of famine.²⁹² Parts of the country had suffered a drought for over two years and more than two million people needed food aid. People were foraging for leaves and roots while going for days on end without food. Experts have blamed climate change. The rainy season, vital for the growing of crops, used to begin in October; it now starts in mid-December. Furthermore, the distribution of the rainfall has become erratic, leaving some areas of the country dry. The UN World Food Programme, which had not provided support to Zambia for 15 years, distributed 566 megatons in June 2020.²⁹³

The situation is highly likely to deteriorate. Temperatures in parts of Southern Africa are expected to rise by twice the global average.²⁹⁴ In Zambia, the prevalence of extreme weather, including flash floods, intense precipitation and droughts, is anticipated to increase (with annual average rainfall declining) while the temperature is predicted to rise by 1.2 to 3.4 degrees Celsius by 2060.²⁹⁵ With respect to agriculture, there will be a greater probability of waterlogging, more crop failures as well as pathogens and pests, while the availability and quality of water will decrease. This will cause greater food insecurity, malnutrition and famine. What Zambia experienced during the beginning of 2020 was terrible, but unless climate change is addressed it is only a taste of what is to come. Victoria Falls, one of the most astounding waterfalls in the world, is at risk of becoming dry.

This bleak assessment of Zambia's prospects is indicative of what is happening across the Global South. The bitter irony is that Zambians are not at fault for climate change. Responsibility largely lies in the Global North. The blindness, or even indifference, of the Global North to the indirect consequences of steps they have taken on others' health and human rights has contributed to the emerging crisis in poorer regions.

Climate change's impact on food production is already being felt. Up to 70% of Australia's wine regions are becoming less suitable for the growth of grapes and inhospitable environments mean that Australia could become a net-importer of wheat.²⁹⁶ Many of the staple crops of Central and Southern America will also see lower returns. A recent study predicted that Guatemala and Costa Rica will see reductions in their maize outputs by about 17% while Honduras will see a reduction of roughly 12%. Colombia, Peru, El Salvador and Nicaragua will experience a more modest, but still significant, decrease of about 8%.²⁹⁷ While wheat and sorghum losses are estimated to be similar to that for maize, sugarcane and barley deficits are expected to be significantly higher. Climate change will drastically damage the already precarious food security of the region, as well as its economy. The UK is not exempt – significant increases in the risk of flooding, exposure to high temperatures and heatwaves, shortages in water and threats to wildlife, which plays a natural role in the ecosystem including as pollinators, will diminish UK food production.²⁹⁸ Furthermore, the UK, like many Western countries, imports a notable portion of its fresh food from countries at high risk of climate change.²⁹⁹

As alluded to, climate change continues to affect our water supply, contributing to droughts across the world. In 2011, Texas experienced its driest 12 months ever while in 2012, 81% of the US was under abnormally dry conditions.³⁰⁰ Not only can this affect food production and agriculture, but it also limits the availability of drinking water, increases the likelihood of wildfires and can reduce transportation along waterways. The WHO reports that 700 million people are at risk of being displaced by the effects of droughts by 2030.³⁰¹

Paradoxically, the food production industry is one of the major drivers of climate change, responsible for one-quarter of the world's greenhouse gas emissions.³⁰² Livestock, fisheries, fertilisers and land use are major contributors. Much of the land being cleared in the Amazon rainforests is for livestock. Fertilisers and pesticides can have a lasting impact on the climate. These are typically used for the mass production of food for those in wealthier parts of the world, as poorer communities have historically often farmed more sustainably. The food industry is therefore both at great risk from climate change and one of the major causes of it. As part of the solution, more sustainable forms of farming and food production must be developed.

The impact of climate change on food and water presents serious risks to the rights to health and adequate standards of living. It further drives structural inequalities between poorer and richer regions in the world, with the former much more severely impacted by climate change. However, wealthier areas of the world will not avoid this. Strains on food production are expected to increase.

Section 5 – Mental health

Evidence of the impact of climate change on mental health is increasing. Our mental welfare is dependent on our environments, much like our physical health, and suffers if they are seriously harmed. Natural disasters can take a serious psychological toll due to both physical destruction and the collapse of social systems.

Research on climate change's impact on mental health is limited.³⁰³ However, studies suggest that rising temperatures, heat waves, floods, tornadoes, hurricanes, droughts, fires, loss of forest, and glaciers, along with the disappearance of rivers and desertification can directly and indirectly undermine mental health; acute events can create traumatic stress while exposure to prolonged events can cause delayed stress.³⁰⁴ A meta-analysis of studies on the relationship between disasters and mental health impacts found that between 7 and 40% of those affected showed some form of psychopathology³⁰⁵ while one year after wildfires in Australia, a study stated that 42% of the victims were at risk of harm to their mental health.³⁰⁶

One of the biggest mental health concepts to develop in relation to climate change is what is known as climate anxiety. Climate anxiety, also known as eco-anxiety, is described by the American Psychological Association as 'a chronic fear of environmental doom'.³⁰⁷ The slow and apparently unstoppable rise of the results of climate change worries people about their future and that of their children and later generations. Furthermore, we have broken our nutritive and co-dependent relationship with the planet, which can lead to psychological unease. This could be an additional source of stress. Evidence suggests that the impact of climate change on mental health is increasingly felt by young people; more than a thousand clinical psychologists have signed an open letter highlighting the impact of the unfolding climate crisis on young people's health and wellbeing, predicting 'acute trauma on a global scale in response to extreme weather events, forced migration and conflict'.³⁰⁸ Accounts from individuals are deeply troubling: a 20-year-old Australian, now living in London, reported crying throughout the day and waking up in panic in the night following the Australian wildfires while a young Kenyan climate activist has noted that a common fear among her peers is that they will die from climate change, not old age.³⁰⁹

Climate change also affects social cohesion and community continuity. Natural disasters can weaken community bonds while changing environments alter social relationships within and between communities, especially those with a particularly close relationship to the environment. For example, research on a small Inuit community in Rigolet,

Nunatsiavut, Labrador, Canada reported numerous negative impacts from altering patterns in weather, snow and ice stability and extent. Participants in the study reported greater family stress, increased drug and alcohol usage, an amplification of previous traumas and mental health stressors, as well as more suicidal thoughts.³¹⁰ Other research has indicated an increased likelihood of crime and other anti-social behaviours in societies resulting from climate change. The impact of climate change on mental health is not limited to the individual – the altering environment can drastically change group dynamics and diminish social wellbeing. This undermines group rights, including rights to a healthy environment, and the internal harmony of the community structure.

The mental health impact of climate change, like so many of its consequences, will be felt most in those societies who live in a more direct relationship with their natural environment, which means any disruption is felt more existentially.³¹¹ The communities in question are ordinarily among the least responsible for climate change. This applies to entire populations, such as the Inuit in Canada, which have consistently had worse mental health outcomes. The Inuit people are currently undergoing some of the most drastic and harmful changes to their local environment, further exacerbating national mental health inequalities. Climate change underlines existing health inequities including those relating to mental health. Those most at risk include indigenous peoples, children, seniors, women, people with low-socioeconomic status, immigrants, and people with pre-existing health conditions.³¹²

The impact of climate change on mental health is multifaceted. Beyond the acute effects of climate change which include depression, PTSD, anxiety, substance abuse and suicidal ideation, there is the overarching sense of hopelessness that many feel. Year on year, climate change looms larger in our lives, with bleaker studies and predictions appearing almost daily. In the meantime, despite all the rhetoric, little seems to change. Turning back the tide (literally and metaphorically) appears impossible to many, leading to a sense of futility. Positive and decisive action on climate change is necessary not just due to the physical consequences of it, but also for the sake of our mental health and wellbeing, particularly for young people and marginalised groups.

Section 6 – Climate change as a threat multiplier

Climate change will exacerbate many of the other threats to human rights raised in this report. This section looks at how climate change will interact with displacement and migration, conflict, and inequality.

Elsewhere in this report, the plight of refugees and migrants is covered in depth. The risks they face, their vulnerability to exploitation and the systematic abuse of their human rights are well established and recent refugee crises, such as those originating from conflicts in the Middle East, have exacerbated these issues. This will pale in comparison to the forced migration driven by unbridled climate change, with many experts predicting tens of millions of people will be forced to leave their homes within the next decade.³¹³ While some low-lying areas, such as the Maldives, are being submerged by rising sea levels, other parts of the world are becoming inhospitable to human life. Numerous peoples are doing their best to adapt but with failing crops, increasing droughts and dying livestock, many are forced to relocate, and the number of people displaced by climate change looks set to increase.³¹⁴

The terms 'climate refugee' (not recognised by international law or the UN³¹⁵) and 'climate migrant' have become increasingly common. It is expected, as the number of climate refugees increases, there will be more pressure on systems already failing to protect the basic rights of migrants and the role of climate change as a threat multiplier becomes clear.

CASE STUDY: The Marshall Islands – on the front line of the climate disaster

The Republic of the Marshall Islands is a collection of islands and atolls in the middle of the Pacific Ocean. They are low-lying, most are less than a mile wide with an average elevation of less than six feet. The geographical and topographical situation of the Marshall Islands puts them at extreme risk of climate change. Destructive tropical cyclones, damaged reefs and fisheries, along with worsening droughts and rising sea levels, have put the island nation in existential danger.³¹⁶ So-called 'king tides', the result of high swells combined with powerful wind currents, wreak havoc on the islands and are becoming ever more frequent and extreme.

The Marshall Islands could disappear if there is a rise in global temperatures above 1.5 degrees Celsius, which many now believe unavoidable. It has been predicted that several of the Marshall Islands will be submerged by 2035 while others will no longer have safe drinking water due to salt contamination.³¹⁷ Sea walls are being raised, but they will probably prove insufficient.³¹⁸ This is affecting the economy – wages are low, and the unemployment rate was 36% in 2016. Already, many of the citizens are migrating. It is estimated between 30 and 40% of the 60,000 Marshallese are in the United States.

In a limited sense, the Marshallese are fortunate, compared to those in some other areas where climate change threatens existentially, as they have a compact of free association with the US allowing them to move there relatively easily.³¹⁹ However, this will expire in 2023 and there is no guarantee it will be extended. More fundamental, though, is the impact on Marshallese culture. Culture and land are passed down from generation to generation. Migration, forced by climate change, is undermining these links. According to a 2016 report from the Guardian, there are real concerns that the heritage of the Marshall Islands will be lost, with a Marshallese student now living in the US stating that many young people who move there want to be American and learn English.³²⁰ While there are passionate attempts to maintain cultural traditions in the US, the President of the Marshall Islands has stated that, ultimately, the culture is attached to the land. She does not believe Marshallese culture will survive without the islands.³²¹ There are also concerns about the opportunities available for the Marshallese in the US, with the US-based Marshallese student noting:

'They come and they work in factories... they look at themselves ending up in factories... it's kinda sad'.³²²

The compact of free association is, in large part, compensation for the nuclear weapon testing the United States undertook on the Islands. They neglected to inform the residents as the northern islands were irradiated, causing cancer in those who came into contact.³²³ Many of those eventually evacuated were taken to the Southern island of Kili, a sparse isle, dependent on regular shipments of food. This isle is now under major threat from climate change, meaning another mass evacuation may be underway again soon, which is again not the fault of the islanders.

The Marshallese have been exploited. Their rights to the environment, health and wellbeing have been violated, subjecting them to an existential crisis physically and culturally. One local informed the Guardian 'We believe we have been given a bad deal. We make a minuscule contribution to the climate greenhouse effect but we are at the very frontline of the problems of climate change'. In the Pacific, the effects of climate change are causing irreparable damage. Forced migration will further increase (where to remains to be seen) and the local environment will continue to be damaged.

The Marshall Islands became self-governing in 1979 and gained their independence from the United States in 1986. Less than 40 years later, they are in danger of being lost to the sea.

In 2007, UN Secretary General Ban Ki-moon described the conflict in Sudan's Darfur region as the world's first climate change conflict: water scarcity from climate change was helping drive the conflict.³²⁴ Though climate change in and of itself does not cause armed conflict, increased scarcity can.³²⁵ This link is not new – a study of conflicts from 1500 to 1800 concluded that lower temperatures reduce agricultural output which, in turn, increases the likelihood of war.³²⁶ Climate change has also been linked to the recent Syrian civil war. Between 2006 and 2010, a drought in Syria transformed 60% of the land into desert and, by 2009, may have killed 80% of cattle. Many farmers migrated to Syrian cities and felt mistreated by the Government, sparking tensions that contributed to the conflict.³²⁷ While there were many complex drivers of the Syrian civil war, including religious divides and frustrations with an authoritarian regime, climate change should be recognised as a factor. Economic crises, long linked to conflict and political instability, such as in the cases of the French and Russian Revolutions, are likely to be increased by climate change. This is not to say that climate change will directly cause extreme political upheaval, only to recognise the numerous ways in which climate-driven disruptions in resource provision can lead to conflict. As the impacts of climate change grow, scarcity will increase, with inter- and intra-group tensions rising.

Conflict damages the environment directly, further increasing the effects of climate change, much like how it contributes to refugee crises and other humanitarian issues – they can be thought of as mutually aggravating.³²⁸

We know that there are massive global health disparities. Despite the widely ratified human right to health and wellbeing, billions of people do not receive suitable care, with pronounced regional differences alongside inequalities within communities. Climate change worsens these differentials.³²⁹ For example, in the UK, those on low incomes, who already have worse health outcomes, will suffer most from food shortages, as food gets more expensive, but also from weather extremes and flood damage, causing further health problems. People whose homes have been flooded will be exposed to injuries, infectious diseases, and mental health problems. Affluent individuals will locate to less flood-prone areas or invest in making their properties more flood-resilient, neither of which may be an option for the impoverished.³³⁰ Furthermore, geographical and socioeconomic factors mean that the burden of climate change will fall differently on men and women respectively in different countries and the health disparities between men and women will be particularly increased in low and middle income countries.³³¹ There is also evidence of it worsening racial health differences.³³²

As discussed throughout this chapter, many of the heaviest burdens of climate change will fall on the Global South. Not only are these countries generally poorer, but they are also less responsible for causing climate change. They pollute and emit far less on average than countries in, say, Europe or North America. Even in developed countries, the effects of climate change can be felt in regions occupied by marginalised populations. One case of this is the indigenous Māori community in New Zealand. Māori employment and business are heavily invested in climate-sensitive primary industries which are expected to experience significant adverse effects from global environmental and socioeconomic trends. This will increase unemployment in the Māori community and reduce an average income that is already lower than the national average, accentuating health disparities.³³³

Section 7 – Conclusion and Recommendations

While responding to climate change is essential, it will not be easy. An IPCC (Intergovernmental Panel on Climate Change) report from 2018 stated that global emissions have to be reduced by 45% from 2010 levels to 2030 and reach net-zero around 2050 to just limit global temperature rises to 1.5 degrees Celsius.³³⁴ A 2019 UN Environment Programme report indicated that global greenhouse gas emissions would have to fall by 7.6% annually to reach this temperature rise target.³³⁵ This would require substantial changes to the structure of the global economy and how we live. Signs suggest there is little chance of this target being reached. The 2021 IPCC report described climate change as widespread, rapid and intensifying, with some trends now being irreversible.³³⁶ The 2022 IPCC report was even graver. For the first time, it referenced the impact of

climate change on mental health and said many consequences of climate change are now unavoidable.³³⁷ The UN Secretary General, Antonio Guterres, reacting to the report, declared he had never read a scientific report like it before, describing it as an 'atlas of human suffering', and condemned global leaders by stating:

*'The facts are undeniable. This abdication of leadership is criminal. The world's biggest polluters are guilty of arson of our only home.'*³³⁸

There were high expectations for COP26 and, while progress was made, the agreements reached are ultimately insufficient to keep global temperature increases below 1.5 degrees Celsius above pre-industrial levels, which is necessary to avoid catastrophic damage to health.³³⁹

It is not too late, though. The 2022 IPCC report stated that the most devastating impacts of climate change can still be avoided, but it will require radical change. It is incumbent on us, individually and collectively, to push for this.

Actions addressing climate change often fall into one of several categories. Climate change prevention seeks to stop climate change before it happens; climate change mitigation aims to lessen the effects; adaptation is the process of adjusting to current or expected climate change and geoengineering is the deliberate large-scale intervention in the Earth's natural systems to counteract climate change. They all have a role to play.

Human rights can also play an important role in coordinating international efforts in tackling climate change. Many countries now incorporate the right to a healthy environment into their constitutions.³⁴⁰ For example, the 2009 Bolivian constitution recognises the rights of Mother Earth and calls on 'all Bolivians' to 'safeguard, defend and protect the natural, economic, and cultural patrimony of Bolivia'.³⁴¹ This made it the first national-level legislation in the world to bestow rights to the natural world. Numerous countries have followed suit. A key point made by current and former UN Special Rapporteurs on Human Rights and the Environment is that states have obligations based on existing human rights treaty commitments. In their 2018 report, they also argue that the UN should formally recognise the human right to a healthy environment.³⁴² Some governments are looking to implement this unilaterally, including the Scottish Government.³⁴³

There is now widespread agreement that human rights incorporate environmental rights and the healthy climate they protect. The UN has noted that governments have an obligation to take effective measures to mitigate climate change, enhance the adaptive capacity of vulnerable populations and prevent foreseeable loss of life. This includes preventing the potential violation of rights by third parties, especially businesses, as well as establishing, implementing and enforcing laws, policies and programmes to fulfil their citizens' rights.³⁴⁴ Encouragingly, in June 2021, worldwide legal experts formulated a definition of ecocide. If adopted by the ICC's members, it would become just the fifth offence the court prosecutes, alongside war crimes, crimes against humanity, genocide and the crime of aggression.³⁴⁵

Ideas gaining increased prominence include a universal framework on the environmental rights of children and/or future generations. A concrete legal framework for international intergenerational justice with urgent practical steps must be developed. Makuch et al (2019) have proposed such an outline for the rights of children. They note that current legal frameworks tend to be adult-centric and make five arguments:

1. Much of the multilateral legislation designed to address environmental issues ought to benefit the child as a distinct recipient, particularly if interpreted and applied purposefully with the child in mind, resulting in improved standards of health and well-being for the child and increased environmental protection and standards.
2. Children would benefit from higher environmental standards than those currently prescribed in international legal instruments, given that they are physiologically more vulnerable than adults to environmental pollution and other adverse environmental impacts.
3. More concerted action is needed to safeguard the health of children relative to substantive environmental measures (such as access to clean water).
4. Providing children with environmental rights is a prerequisite to attaining sustainable development in the future as adults.
5. There are currently no international standards (and very few national ones) on the environmental rights of the child per se.³⁴⁶

The winner of *The Economist's* 2019 Open Future Essay Competition makes a similar argument – stating a healthy climate should be made a legal right extending to future generations.³⁴⁷ Future generations are not typically considered identifiable individuals under the law. If recognised as such, it is easier to codify legal obligations towards them, helping enforce necessary global changes to tackle climate change and secure our future.

Action against climate change is not limited to governments. There are steps individuals can take. *There is No Planet B* contains numerous suggestions for reducing our carbon footprint, including limiting meat and dairy consumption, driving less and, if possible, switching to renewable energy sources such as solar panels.³⁴⁸ Furthermore, communities and groups can organise. For example, EcoSikh is a non-profit international Sikh organisation looking to tackle climate change through initiatives such as planting one million trees.³⁴⁹ Thought-leaders also play an important role; Pope Francis has often drawn attention to the dangers of climate change and in March 2021 called for common efforts in environmental education, stating:

*'It is particularly important that young people are trained in the safeguarding of creation and respect for others, to be able to engage in the promotion of new production and consumption habits, in order to generate a new model of economic growth that puts the environment and people at the centre.'*³⁵⁰

Movements such as One Health also look to recognise the interconnectivity of human, animal and ecosystem health.³⁵¹ It describes itself as 'a collaborative, multisectoral, and trans-disciplinary approach – working at local, regional, national, and global levels - to achieve optimal health and wellbeing outcomes recognizing the interconnections between people, animals, plants and their shared environment.'³⁵² Combining multiple health science professions, One Health tackles environmental contamination, habitat use conflicts, biodiversity loss, emerging infectious diseases, antimicrobial resistance and ecosystem function degradation.

It must be recognised that many mitigations against climate change, such as decarbonisation, may worsen health inequalities between the Global North and Global South. This must be acknowledged and addressed. Market mechanisms will push the burden onto those least responsible;³⁵³ creative solutions and government interventions are required along with suitable compensation.

In 2020, the BMA published two reports on making the health service more sustainable. The BMA's GPC (GPs committee) England published 'Sustainable and environmentally friendly general practice' which looked at improving sustainability within GP practices. The report is publicly available, and the recommendations include:

- the introduction of a nation-wide medication (including inhalers and devices) returns and recycling scheme that is easily available for the public to use
- supporting and resourcing GP practices to return to re-usable medical equipment safely to reduce the carbon impact of disposable equipment
- promoting and supporting more remote working for staff
- investing in infrastructure and premises to make the general practice estate carbon-neutral by no later than 1 January 2030.³⁵⁴

The second report focussed on sustainability in NHS trusts and health boards and suggested steps to make the NHS less carbon intensive. We recommended that trusts should implement ambitious targets to reduce single-use plastic waste and that trusts and health boards should publish consistent and detailed reporting on their carbon footprint.³⁵⁵

Beyond the NHS's role in fighting climate change, the BMA also set out global steps to achieve net-zero carbon emissions by 2050. These include:

- decarbonisation of the energy sector, involving the phasing out of coal by 2025 and a significant uptake in renewable energy sources
- decarbonisation of transport, including phasing out petrol and diesel cars as soon as possible with an accompanying uptake in electric vehicles
- a reduction in the number of journeys taken by motor vehicle, with improved public transport and the encouragement of active travel
- making new housing carbon-neutral and introducing funding to retrofit older housing
- support consumers in making choices that reduce their carbon footprint
- a large campaign supporting reforestation and rewilding for natural carbon capture, with funding to support research into different modes of carbon capture.³⁵⁶

The impacts of climate change on human rights are profound. While we know what is needed the political will does not exist. Through the improved implementation of existing human rights commitments and more ambitious and farsighted concepts of human rights, we can resolve issues of current and intergenerational justice and exert the pressure necessary to force the change that is required.

Recommendation

Legislation recognising the rights of future generations and to a healthy environment must be developed.

Recommendation

Individuals should be encouraged to take steps to reduce their carbon footprint.

Recommendation

Single-use plastics should be used as little as possible across the NHS.

Recommendation

The energy sector and transport should be decarbonised as soon as possible.

Chapter 5 – The information age: new media and the assault on medical expertise

If allowed to flourish these counterfeit truths will result in the collapse of public trust, and without trust democracy as we know it will simply decline into irrelevance.³⁵⁷

House of Lords Select Committee on Democracy and Digital Technologies

Introduction

As we have seen with COVID, to protect our health, we need access to reliable, up-to-date information. Whether we are making personal, health-promoting decisions, seeking advice from health professionals, or where governments, health departments or public health experts are seeking to protect the health of communities, access to the best available information is critical. From its infancy, medical science has been committed to pushing back the frontiers of knowledge to protect and promote human health and wellbeing. So essential is access to authoritative sources of opinion that it forms part of a cluster of health-related human rights, including, most obviously, rights to health and self-determination.

This chapter explores the complex and unsettling impact of new media on medical expertise globally. However, making sense of these developments is not possible without some understanding of their political context. During the last decade our global political discourse has changed significantly. The driving factors are widely acknowledged: the aftershocks of the 2008 crisis in global financial institutions; decades of increasing inequalities; a declining faith in the political classes through widespread accusations of 'sleaze'; a deepening frustration with technocratic government; and a corresponding shift to a politics of identity and emotionalism – to what journalist Matthew D'Ancona³⁵⁸ has called a politics of 'post-truth': what matters in this new political landscape is not so much the truth of a political utterance, but its emotional charge, how it makes the voter feel. Added to this are social media platforms with their power to target, influence and persuade.

In April 2020, during a White House briefing after the arrival of the COVID pandemic, speaking to a global audience, then US President Donald Trump suggested that an 'injection inside' the body with a disinfectant such as bleach could help combat the virus. Alternatively, he suggested that 'hitting' the body with a powerful dose of ultraviolet light, either inside or outside, might prove effective. Although loudly condemned by medical doctors – as well as the manufacturers of bleach – and later dismissed by Trump himself as an exercise in 'sarcasm', it felt emblematic. Here was perhaps the most powerful political leader in the world seeking to bend the institution and practice of medical science to clear political ends. Aided by his unprecedented use of Twitter and other forms of social media, such comments had an impact far beyond the reach of ordinary White House press releases. It did not seem to disconcert the President that calls to poison centres in the US following exposure to bleach and disinfectant subsequently spiked, or that ensuing research from the US Center for Disease Control found that 4% of responders had drunk or gargled bleach after his suggestions.³⁵⁹

Even before COVID, public health interventions, particularly vaccination and other responses to outbreaks of infectious disease, were the targets of conspiracy theorists and disinformation campaigns. It would be difficult for example to exaggerate the impact of falsified research by the discredited British gastroenterologist Andrew Wakefield into alleged links between the MMR vaccine and autism in children.³⁶⁰ Despite being in the (undeclared) employ of litigants seeking to sue the vaccine manufacturers, and having taken out prospective patents on single vaccines for measles, mumps and rubella, Wakefield nonetheless published a paper in *The Lancet* in 1998 that falsely declared a link between the MMR vaccine, bowel problems and 'regressive autism' in vaccinated children. As a result, vaccination rates in the UK dropped from 92 in 1996 to 84% in 2002. In 2003, vaccination rates in parts of London were as low as 62%, far below the levels required to prevent epidemics.³⁶¹ Although the paper was retracted by *The Lancet* and Wakefield was struck from the UK's medical register, he subsequently achieved celebrity status among anti-vaxxers in the US, even appearing at one of Trump's inaugural balls where he was quoted as contemplating the overthrow of the pro-vaccine US medical establishment.³⁶² Subsequent 2007 research found that almost a third of all vaccine-related content on YouTube was anti-vaxx.³⁶³

Because public health interventions sometimes entail liberty restrictions, they can be politically controversial. As we have seen in social media exchanges about COVID, the slow and incremental acquisition of scientific knowledge, with all its acknowledged

uncertainties, was undermined by rumours of political manipulation, of the use of vaccines to insert microchips for surveillance, along with the allegedly self-interested actions of politicians and global scientific and medical elites. Intuiting the emotional appeal of these conspiracies, certain populist politicians were quick to exploit them. Where people are afraid, populist politicians of a particular ilk have shown themselves adept at channelling their fears for short-term political advantage. The potential effect of these populist appeals on health-seeking behaviour can be extremely damaging. The Brazilian President Jair Bolsonaro's response to the pandemic is a particularly vivid case in point. Drawing on 'strong man' mythologies, he repeatedly dismissed COVID as 'a little flu', said that self-isolating was for the weak, and the virus should be faced 'like a man, not a boy.'³⁶⁴ These statements were made at a point where Brazil had over five million COVID cases and more than 147,000 deaths.

Nurse Monica Calazans was the first person in Brazil to be vaccinated against COVID, on 17 January 2021. Almost immediately she became the target of a social media onslaught. Despite having worked in Brazil's hospitals for 30 years, she was subject to racist slurs, was decried for being part of a cult, and for being a con-artist. This occurred despite Brazil seeing almost half a million deaths from COVID at the time. As Ms Calazans complained – all the hostility came from social media, where those posting the most destructive disinformation were shielded by anonymity.

Despite the pandemic raging out of control in Brazil, Bolsonaro's popularity hit a record 40% – although this may have had more to do with the emergency payments that some 87 million Brazilians started to receive.³⁶⁵ His popularity has since plummeted, with deaths in Brazil from COVID passing 622,000 in Jan 2022.³⁶⁶ Similarly, in Tanzania, the administration was in sustained denial regarding COVID, exalted the efficacy of prayer and was reluctant to accept vaccines, thereby putting a swathe of East African countries at risk of exponential spread.³⁶⁷

In this chapter we explore the potentially devastating impact of the combination of rising anti-expert political populism, the spread of disinformation and the extraordinary reach of new media on health-related rights. We offer a working definition of populism and identify the tendency for many right-wing populist governments to undermine authority in traditional institutions and practices, particularly, in the context of this report, trust in the medical sciences. We then look at the nature of the new media and information landscape and its potential to amplify populist challenges to health-related human rights. Following this, we describe the difficult balance that must be sought between managing the spread of damaging information through new media, and the requirement to respect rights to freedom of speech and expression. The chapter concludes by proposing a range of initiatives designed to rebuild trust in democratic and scientific institutions, including medicine and public health.

Section 1 – Populism, medicine and information: a complex landscape

Populism is a complex political phenomenon. Although the definition is contested, it is generally accepted that populism has two core features: a claim to speak on behalf of 'the people', often perceived as somehow ignored, overlooked or exploited; and a belief that their interests are being actively opposed and frustrated by elites of various kinds.³⁶⁸ Left-wing populism typically contrasts the people with financial elites: bankers, industrialists, or international capital; right-wing populism often takes on a pronounced 'nativist' colouring, opposing the people's interests to those of 'outsiders', whether migrants or minorities, with liberal political elites and institutions accused of offering them preferential treatment. The terms 'the people' and 'elite' are of course sufficiently ambiguous to lend themselves to a variety of political uses.

Science has been – and probably remains – our most authoritative source of expertise, certainly regarding the workings of the physical world. Since the European Enlightenment, the combination of reason and the scientific method has transformed our understanding of physical reality, providing hitherto undreamt-of benefits, including in the medical sciences. Once again, we are in complex terrain, but it is because of the authority of

the institutions of science that they are targets for some populists. The scientific and academic communities are an elite to whom they juxtapose their brand of populism. As a recent commentary by Robert Crease in *Nature* suggests,³⁶⁹ 'The authority of science is again under attack. In areas of national and global consequence – from climate to medicine – political leaders feel confident that they can reject scientific claims, substituting myths and cherry-picked facts.' As Crease points out, the strengths of the scientific method as a truth-seeking enterprise – its caution, its provisional conclusions, its openness to refutation and revision, not to mention its ability to challenge prevailing norms – leave it vulnerable to misrepresentation and, where it is cast in opposition to popular values, demonisation. The extreme specialisation of modern science – how many of us understand quantum computing? – inevitably makes its mysteries the preserve of the highly educated and skilled, opening the door for politicians to dismiss it as out of touch, elitist and irrelevant to ordinary people.

Following the elections of a range of populist administrations, the winter of 2019-20 saw the outbreak of COVID-19, precipitating the most serious global health crisis since the great influenza epidemic of 1918-20. The management of such an event is, to risk understatement, complex. Fear and uncertainty become widespread. Information is imperfect, particularly in the beginning. Understanding the virus, the natural history of the disease in human hosts, and which public health and clinical interventions are successful, takes time. The policy challenges are similarly complex. Balancing the requirement to control the spread of the disease with the social and economic impact of infection control measures is ethically and politically challenging. There are no easy answers, no obvious quick fixes. Trade-offs are required and all options involve serious harm.

In the face of these levels of complexity and uncertainty, it is possible to understand the appeal of conspiracy theories, despite their falsity and clear capacity to cause significant harm. Instead of chance and evolutionary dynamics, conspiracy theories give the pandemic a more human form and the illusion of human responsibility and accountability. For the conspiracy theorists, the responsibility lies not with chance and evolution, but with foreigners, or with elites, either individuals like Bill Gates, or faceless multinationals. One particularly enduring conspiracy has Bill Gates teaming up with international telecommunications companies and the medical profession to inject 5G-sensitive microchips along with vaccines.³⁷⁰ The virus ceases to be a 'natural', accidental occurrence and is weaponised – a tool for elites to sustain or intensify the suppression of ordinary people. Somebody somewhere is responsible. Fear and the ensuing anger find an outlet. Where conspiracies involve minorities or marginal groups, they can lead to scapegoating and violence.

It would be a mistake to dismiss the impact of these theories. Polling data published in *The Conversation*³⁷¹ suggest that more than 60% of UK correspondents believed 'to some extent' that the virus was man-made. 20% agreed that the virus was caused by 5G and a further 19% believed it to be a Jewish conspiracy to profit from global economic collapse. A recent article in *Scientific American* lists nine enduring COVID 'myths'.³⁷² Among those publicly supported by then US President Donald Trump, include that the virus was engineered in a Chinese laboratory; that it was no worse than seasonal flu; that hydroxychloroquine was an effective treatment; and that spikes in cases were the result of increased testing. It is probably reasonable to suggest that these views are also widespread beyond the UK and the US.

Given the extent to which conspiracy theories, and their close relations, 'post-truth', 'fake news', 'misinformation' and 'disinformation' – of which more later – attract believers, their impact on public health and health-seeking behaviour is significant. Although the motives behind those who disseminate – or simply repeat – frauds, conspiracies and counterfeits are undoubtedly complex, among the political motives, a concern for the health and wellbeing of those who come to believe them is unlikely to be front and centre. As the historian Timothy Snyder suggests:

*'To abandon facts is to abandon freedom. If nothing is true, then no-one can criticise power, because there is no basis on which to do so. If nothing is true, then all is spectacle. The biggest wallets pay for the most blinding lights.'*³⁷³

Section 2 – Information, disinformation and the rest

'Fake news', conspiracy theories, the wilful or accidental spreading of lies, errors and misrepresentation – these are hardly new phenomena. During the twentieth century, before the days of social media, political misinformation was generally known as propaganda: the selective use of communication to promote a political agenda, often with little concern for objective truth.

In recent years the impact of inaccurate information distributed via online platforms on political choices has intensified. The vulnerability of digital information to manipulation by malicious actors has led to an increased focus on this new information landscape. As a result, several useful distinctions have been introduced. *Misinformation* is ordinarily defined as false information where it is not clear whether there was a deliberate intent to deceive. Many people circulate rumours – 'like' or 'retweet' – without knowledge of their truth content and without any explicit intention to deceive. Disinformation, by contrast involves the deliberate and knowing intent to misinform. Both can clearly be harmful.³⁷⁴ A recent report by the Transatlantic High Level Working Group on Content Moderation Online and Freedom of Expression³⁷⁵ has identified what it calls the ABC of Disinformation: a powerful manipulative *Actor* hiding its identity and trying to manipulate public debate; deceptive *Behaviour*, such as the use of bots, to make others believe that the campaign is more spontaneous and viral than it is, and harmful *Content* designed to spread falsehoods.

CASE STUDY: Disinformation and reproductive rights – how US religious groups target women worldwide with false information about the risks of abortion

The fundamental importance of sexual and reproductive health to the wellbeing of women is irrefutable. It is underscored by a range of interlocking human rights, including the right to life, the right to be free from torture and inhuman and degrading treatment, the right to health and the prohibition of discrimination.^{ix} The Committee on Economic, Social and Cultural Rights and the Committee on the Elimination of Discrimination against Women have confirmed its centrality to the right to health. As a matter of service provision, the Special Rapporteur on the right to health has clarified that women are entitled to reproductive health care services that are: (a) available in adequate numbers; (b) accessible physically and economically; (c) accessible without discrimination; and (d) of good quality.

In early 2020, *openDemocracy*, an independent liberal-leaning news network, published the details of an investigative report³⁷⁶ into a global network of 'pregnancy crisis centres' linked to the Ohio-based organisation Heartbeat International. Undercover reporters posing as vulnerable women with unwanted pregnancies visited centres in 18 countries. The investigation revealed:

- women being told abortion increased risks of cancer and mental illness
- women being told they needed consent from a partner to access abortion
- staff encouraging women to delay abortion and emergency contraception
- training materials claiming that 'condoms do not do a good job at preventing pregnancy'
- claims that abortion increases women's risks of abusing their children
- suggestions that abortion can 'turn' a woman's partner gay
- Italian women being told that having a baby can cure serious illnesses including leukaemia

ix See, for example, The Office of the United Nations High Commissioner on Human Rights (OCHCR). *Sexual and Reproductive Health and Rights*. <https://www.ohchr.org/en/issues/women/wrgs/pages/healthrights.aspx>. Accessed 25 Jan. 22.

- a Spanish woman being given an article that claimed that after an abortion a woman is ‘144% more likely’ to physically abuse her children.

Data from the US suggest an alarmingly high rate of disinformation about abortion given out by pregnancy crisis centres, with one study concluding that ‘most crisis pregnancy centers listed in state resource directories for pregnant women provide misleading or false information regarding the risks of abortion.’³⁷⁷

Disinformation about abortion is not limited to its alleged health consequences. In the run-up to the 2020 US election, politically damaging disinformation regarding Vice President Kamala Harris’s views on late-term abortion was deliberately circulated via social media platforms among religious Latinos with a view to encouraging them to vote Republican.³⁷⁸

The impact of such deliberately targeted information on women’s ability to make informed health-seeking choices is difficult to exaggerate. Here again we see health information undermined and distorted for clear political ends.

Section 3 – A changing media landscape

Mobile technology has introduced extraordinary new powers of social and political engagement. Before digital technologies, political participation, and the ensuing media commentary, were largely the preserve of an elite minority – those who participated in the political process and the traditional media and academic outlets which commented on it. Even the so-called popular press was owned and edited by members of the elite, granting them enormous influence over popular opinion. Now, as a recent report by the United Kingdom House of Lords Select Committee on Democracy and Digital Technologies convincingly puts it, we all have ‘a printing press, a broadcast station and a place of assembly in our pockets.’³⁷⁹ From a rights perspective, this can bring powerful and important benefits. New media can provide access to a wide range of information and opinion. From a health rights perspective, new media can offer immediate access to accurate and up-to-date health data, can help monitor personal health, and link those with rare conditions through social support groups. They can also offer necessary challenges and engagement to entrenched and remote power. New media are far more participatory and ‘democratic’ than traditional media. They can give voice to the dispossessed and hold established power and abuse to account. From the Arab Spring to the Bersih 4.0 rallies demanding freedom of expression off and online in Malaysia,³⁸⁰ the power of social media platforms to communicate and cooperate for clear political goals is clear.

The efforts made by Turkey and China to muzzle social media demonstrate their political potency.³⁸¹ Repressive regimes can struggle to contain their liberalising power – and there is little doubt that monopolies on information and comment are politically dangerous. Any attempt to impose statutory or other restrictions on new media are likely to engage a variety of fundamental rights, including freedom of speech and, arguably, democratic participation. It is inconceivable that we could return to the pre-existing status quo. But as the Select Committee’s Report makes clear, new media bring serious challenges. Writing in the introduction to the Report, Lord Puttnam, Committee Chair, states:

‘In the digital world, our belief in what we see, hear and read is being distorted to the point at which we no longer know who or what to trust. The prospects for building a harmonious and sustainable society on that basis are, to all intents and purposes, non-existent... Misinformation can pervert common sense to the point at which it is easy to forget the fragile foundations upon which so many of our freedoms are built.’

From a health perspective, along with their considerable benefits, new media have shown themselves capable, in the wrong hands, of spreading damaging misinformation. As the COVID pandemic – and, before it, the outbreaks of Ebola in sub-Saharan Africa – demonstrated, the unregulated nature of new media, combined with their power, reach

and vulnerability to manipulation, can, in the wrong hands, present significant threats to trust in medical expertise, medical institutions and the legitimacy of public health interventions.

CASE STUDY: Social media, disinformation and the Ebola outbreaks in West Africa

In July 2019, the World Health Organization declared the outbreak of Ebola in the DRC (Democratic Republic of the Congo) a public health emergency of international concern.³⁸² The reasons why the outbreak developed are complex and include endemic conflict, fractious internal politics, and an extreme shortage of resources along with a sluggish international response. But among the drivers was the destructive impact of disinformation circulated via social media. Online disinformation both denied the existence of the disease and accused foreign health workers of starting the outbreak, accusations which rapidly led to the violent targeting of health professionals. As a result, despite the effectiveness of the vaccine, workers struggled to contain the outbreak. As David Fidler writes for the US thinktank the Council on Foreign Relations:

*'Disinformation threatens health because it undermines confidence in the underlying science, questions the motivations of health professionals, politicizes health activities, and creates problems for responses to disease challenges.'*³⁸³

A small study into information disseminated about Ebola on Twitter during the 2014 West African outbreak identified several potentially hazardous claims circulating, including that it could be cured by the ewudu plant, by blood transfusion or by drinking or washing in saltwater.³⁸⁴ There is little doubt that disinformation, including that distributed by social media, undermined attempts to respond to the outbreak and resulted in increased transmission and death. As Margaret Harris, WHO spokesperson and medical doctor involved in the 2019 Ebola response in the DRC, made clear:

*'Misinformation hampers efforts to stop transmission of infectious disease wherever it spreads — and it seems to spread even faster than the disease itself. It can even lead to dangerous behaviors that increase the likelihood of being infected or failing to get lifesaving treatment.'*³⁸⁵

Nor was the impact of disinformation restricted to West Africa. As an article in *Time Magazine* in early October 2014 stated:

*'Following the first diagnosis of an Ebola case in the United States on Sept. 30, mentions of the virus on Twitter leapt from about 100 per minute to more than 6,000.'*³⁸⁶

Despite a succession of subsequent negative tests on patients thought to be exposed in the US, Twitter was alight with rumours that the disease was running rampant. The Iowa Department of Public Health was forced to issue a statement dispelling suggestions that Iowans were infected. At the same time, endless posts stating that Ebola could be spread via air, water or food were proliferating. Researchers subsequently suggested that:

*'rumors such as the existence of "Ebola zombies", misperceptions about the disease transmission, or inaccurate information about experimental Ebola vaccines was common, potentially leading to fear, uncertainty, and confusion amongst the public.'*³⁸⁷

Following the rise of online platforms, traditional media have struggled to maintain a foothold. New media, able to exploit apparently limitless amounts of free, user-generated content, have shattered traditional media's business model. 'News' is now freely available to anyone with access to the internet, and the default expectation of new media users is that content is free. But this has consequences. As 'publishers', print and broadcast media have editorial responsibility for their content. Although at times lacking effectiveness, they are also subject to external oversight and regulation. Errors could in theory be corrected and spreaders of disinformation held to account. The political leanings of traditional commercial media were often explicit, with editorial commentary transparently promoting or defending certain social and political positions. Although traditional media were, and remain, liable to capture by vested interests, and frequently exercised considerable political power without much in the way of scrutiny or responsibility, to an extent their political biases were open and understood.

However, seeking to compete with the new platforms, some traditional outlets have copied their approach, turning to sensationalism and the use of 'clickbait' to attract viewers and advertising revenue. Without the funds to invest in serious investigative journalism, traditional outlets are increasingly republishing – 'churning' – content published elsewhere. Fact-checking is slow and costly so misinformation and disinformation can be rapidly circulated.

Another striking feature of the new landscape is its extraordinary fragmentation. Although the online platform market is an oligopoly – dominated by a few powerful companies – the platforms nonetheless enable – effectively host – a huge and ever-increasing number of micro-broadcasters. Where before people would ordinarily have turned to a small number of established media providers, many of whom would publish content from a range of perspectives, it is increasingly possible for people to occupy filter bubbles and echo chambers: not only to hear a single perspective but to believe it is the only perspective available.

We know that the internet is a major source of health-related information. Research by King's College London³⁸⁸ found that people who exclusively used social media to source information about COVID were more likely to believe conspiracy theories linked to the virus than those who also accessed established media. The research also identified a 'statistically significant' link between belief in conspiracy theories and breaking lockdown rules. Importantly, the CCDH (Center for Countering Digital Hate) has estimated that the biggest English language anti-vaccination social media accounts have a following in the region of 59.2 million, and that their following increased by nearly 20% during the pandemic.³⁸⁹ Given this formidable architecture of online disinformation, we must understand how the new media work.

First, despite the clear benefits new media platforms bring, and their avowed emphasis on digital liberty and empowerment, paradoxically there are only a small number of social media companies with serious global reach. This inevitably concentrates enormous political, social and economic power into a small number of hands. Between them, the four major global platforms – Facebook, YouTube, Google and Twitter – are used by upwards of six billion people a day.³⁹⁰ And yet, despite their small number, and their public commitments to promoting social benefits, research by the CCDH suggests that they have not acted upon three-quarters of anti-vaxx disinformation that has been reported to them.³⁹¹ The CCDH also suggest that revenue resulting from anti-vaxx use of social media has exceeded \$1bn.³⁹²

The sluggishness of the major social media platforms to respond to damaging health disinformation is likely linked to their business model. Unlike traditional media outlets, social media platforms do not take editorial or publishing responsibility for the material they distribute. They act as intermediaries between users and content generated elsewhere. Google does this by indexing material already on the internet, while Facebook, Twitter and YouTube rely on free user-produced content. Funded overwhelmingly by advertising, the platforms have powerful commercial motivation to ensure as much user

attention as possible. To do this they trawl users' personal data with powerful algorithms to recommend content the user is likely to find interesting based on past behaviour. As such, algorithmic ranking and recommendation can have a de facto editorial effect: choosing content for users, often with a confirmatory impact. Apparent bias can be exacerbated and openness to divergent perspectives restricted. Although there is nothing intrinsically sinister about this, or unique to social media platforms, the impact can be profound with harmful material. User content is not restricted to expressions of opinion. Deliberately misleading material masquerading as fact can be posted by any user almost without fear of interference or editorial correction of any kind. Leveraged by algorithms, the spread of misinformation of all kinds can be massively amplified.

Section 4 – Balancing the management of online content and freedom of expression

The information that pours through our digital networks is highly complex. Although recent analysis is beginning to understand this complexity and, concerning potential malicious actors, introduce some helpful classifications, identifying and filtering out specifically harmful content is difficult and fraught with the potential for unintended consequences. The speed of development of online communication has rapidly outpaced the regulatory structures designed to deal with malicious or damaging communications in a pre-internet era. Our ordinary legal approaches are ineffective in the face of algorithms, hands-off platforms, bots and fake accounts, not to mention the trans-national reach of online communications. The speed and complexity of these developments – along with the exploitation of the media by malicious governmental and non-governmental actors – has meant that an international consensus on how to manage harmful content has failed to materialise. Given the challenge that regulation presents, some governments have opted for crude, broad-brush approaches, such as restricting, filtering or even shutting down access to global platforms, with potentially disastrous effects on rights to freedom of expression.

The Anti-Fake News Act in Malaysia, for example, has criminalised the publication or circulation of 'fake news', which it describes as *any information 'wholly or partly false'* even where no harm ensues or was even intended. In a joint declaration on freedom of expression and 'fake news',³⁹³ the UN Special Rapporteur on Freedom of Opinion and Expression, along with regional freedom of expression experts, emphasised that 'the human right to impart information and ideas is not limited to "correct" statements and "protects information and ideas that may shock, offend and disturb"'. The Rapporteur argued that the Malaysian Act would lead to 'censorship and the suppression of critical thinking and dissenting voices.' The Act has already led to the imprisonment of a Danish citizen for inaccurately criticising the time police took to respond to the shooting of a Palestinian lecturer.³⁹⁴ Despite its potentially chilling effect on freedom of expression, similar legislation is being proposed for Singapore and the Philippines.³⁹⁵ Amnesty has also drawn attention to the use of comparable legal measures in Algeria, Morocco and Western Sahara,³⁹⁶ and equivalent proposals in Brazil.³⁹⁷ Such laws, as UK journalist Peter Pomarentsev writes, by creating 'new, vague, and often subjective types of speech to control', can play into the hands of authoritarian governments:

*'This is a solution that delights the Putins and Xis of this world, who are already conjuring up "fake news" and "disinformation" laws that allow them to arrest anyone they care to. In trying to save democracy from disinformation, we risk boosting authoritarians.'*³⁹⁸

Section 5 – Conclusion and recommendations

Anti-scientific political populism, combined with the leverage of global social media platforms and the difficulties regulating manipulative and harmful content online, are affecting trust in the institutions of medicine. The repercussions for individual and public health are concerning. Such developments can also lead to violations of a cluster of core health-related human rights. Although it is tempting to reach for statutory responses to disinformation, we have seen the risks that crude legislative approaches pose for rights to expression – rights that are critical to democratic participation and autonomy.

Acknowledging the tension between these human interests, in this section, we make some suggestions for policy change that are sensitive to both disinformation and rights to expression.

In the summer of 2020, the Annenberg Public Policy Centre at the University of Pennsylvania published the findings of a high-level transatlantic working group on freedom of expression and content moderation online.³⁹⁹ The working group found that although individual pieces of information could be false, and potentially harmful, the greater problem lay not so much with fragments of disinformation as with orchestrated but invisible campaigns driven by malicious actors. As Pomarentsev writes:

*'The problem with the cyber militias and troll farms is not so much individual pieces of content they post, but the way they distribute them en masse in a way that looks organic, as if it's real citizens exercising their freedom of speech, when in reality these are hidden, coordinated campaigns from a single source.'*⁴⁰⁰

As Pomarentsev argues, the ability of those who manipulate the information landscape to remain concealed behind technology undermines rights of access to information – specifically, information about who is warping the information landscape and for what purposes. By regulating in favour of transparency, rather than seeking to stifle the flow of information, rights to freedom of expression need not be curtailed. To this end the working group recommended the development of an international regulatory framework, rooted in trust, transparency and accountability and based upon:

- transparency rules for platforms
- an accountability regime holding platforms to their transparency obligations
- a disclosure structure to enable regulators, researchers and the public to judge performance
- independent redress mechanisms
- a framework that prioritises actors and behaviours before content.

National and international health bodies should support these policies within an international regulatory framework.

In 2018 the European Commission published the final report of a high-level working group on fake news and online disinformation.⁴⁰¹ In addition to proposals relating to transparency, it also recommended a suite of proposals designed to promote online and digital literacy among EU citizens. As the report argued:

*'...media and information literacy helps to ensure that the digital information ecosystem is trustworthy: a critical readership will give an incentive to media companies to continuously improve their products and services... media literacy is an important... response to disinformation because it can empower individual users... and mass empowerment of users will lead to greater social resilience against disinformation and perhaps other disorders of the information age.'*⁴⁰²

National and international health bodies should commit to a coordinated programme of enhancing global digital health literacy.

During the COVID-19 outbreak in the UK, Professor of Primary Care Patricia 'Trish' Greenhalgh took to Twitter to promote the best available medical evidence about the pandemic, including promoting the results of surveys of research on the efficacy of wearing facemasks to prevent transmission of the virus. With over 100,000 followers, Professor Greenhalgh, at some personal cost in terms of online vitriol, became a significant source of reliable expertise on the pandemic. Given the proliferation of online disinformation, it is vital that reputable bodies consider how best to coordinate and promote online responses, employing both institutional online accounts and those of significant thought-leaders such as Professor Greenhalgh. This should extend to offering support for thought-leaders in managing online trolling and hate speech.

During the summer of 2020, the WHO partnered with the UK Government to promote its 'Stop the Spread' campaign.⁴⁰³ The global campaign raises awareness of the risks of disinformation regarding the pandemic, encouraging people to check information with trusted sources. National medical associations or equivalent national bodies should explore the possibility of developing or promoting campaigns to target specific sources of dangerous health misinformation. They should also identify positive social media thought-influencers and support their campaigns.

Recommendation

National and international health bodies including the World Medical Association take an active role promoting policies of transparency, accountability, disclosure and redress in the digital health landscape via an international regulatory framework.

Recommendation

National and international health and medical organisations, including the World Health Organization, the World Medical Association, and leading national medical bodies should commit to a coordinated programme of enhancing global digital health literacy.

Recommendation

National medical associations or equivalent national bodies explore the possibility of developing or promoting campaigns to target specific sources of dangerous health misinformation.

Recommendation

National medical associations or other expert health bodies identify positive social media thought-influencers and offer support for their campaigns, including with regard to trolling and malicious attacks online.

Chapter 6 – Conflict, human rights and health

Testimonial – Forced violation of medical ethics in Syria

In November 2011, Dr. Zaki (not his real name), a military anaesthetist, was sent to Aleppo Military Hospital. The hospital usually received injured Syrian army combatants, but from the start of 2012, it began taking civilian patients injured by pro-government forces during the peaceful demonstrations in Idleb and Aleppo. Notably there was no conflict at the time in either city. These civilian patients were interrogated and tortured, either directly through electric shocks or beatings with rubber hoses, or indirectly, by leaving gunshot wounds or open fractures untreated. A few days prior to the visit to the hospital by the UN-Arab League Special Envoy, who insisted on visiting all patients, Dr. Zaki was ordered by his superiors to find a way to keep the patients silent. The subtext of the order, issued by three generals, one in charge of the hospital plus the head of military intelligence, and the head of the military secret police in Aleppo, was clear: 'we know exactly who your family are and your wife's family, and they will be arrested unless you comply'. Under duress, Dr. Zaki used a combination of anaesthetic agents to sedate over 60 patients, so their wounds and shackles could be covered up, and they would not be able to describe the torture and conditions of their confinement to the Special Envoy. Shortly after this, Dr. Zaki defected and fled to Turkey, along with his family and his wife's family.

Introduction

Conflict^x is central to this report. It would be hard to exaggerate its impact on individual and public health, as well as its complex relationship with the issues we discuss. Conflict is both causal, directly contributing to the human rights challenges we consider, but can also be an effect of those challenges. We know that conflict drives the displacement of people, but it can also be driven by that displacement. As we have seen in Lebanon, Lesbos and other settings, the appearance of large numbers of displaced people can itself trigger conflict.⁴⁰⁴ Conflict almost always involves the violation of fundamental human rights norms, including those directly related to health. And yet violations of human rights, particularly where severe and sustained, can themselves trigger conflict.⁴⁰⁵ Following conflict, it can be difficult to achieve lasting stability unless there have been acknowledgements of past human rights violations, acceptance of responsibility by the perpetrators, and some form of reparations or rehabilitation offered to victims or their representatives. One of the ongoing tragedies in Bosnia-Herzegovina is the inability of at least some former combatants to seriously consider such a reconciliation.⁴⁰⁶

Although there is disagreement about long-term trends, conflicts – however we seek to define the term – have significantly increased since 2010.⁴⁰⁷ According to the World Bank, in 2020 an additional 23 million people were pushed into extreme poverty because of fragility, conflict or violence.⁴⁰⁸ Currently, nearly 80 million people are displaced through conflict or violence, with close to 70% of those remaining within state borders as internally displaced people. Conflict also drives at least 80% of all humanitarian need.⁴⁰⁹

As discussed in the chapter on climate change, there are increasingly troubling links between climate change and conflict. Desertification, increased salinity and the rising sea levels associated with climate change can force migration, and where competition for scarce resources becomes intense, conflict can result – the enduring civil war in Sudan, a focus of long-term humanitarian engagement, is associated with sustained drought linked to climate change. Parts of the country may well be uninhabitable within decades.⁴¹⁰ Conflict over basic goods is particularly likely in already resource-poor settings. Conflict-driven displacement has also been associated with rising nationalism and xenophobia, particularly where politicians portray migrants as a threat to national cohesion and identity. Although there is no necessary link between nationalism and violence, historically, ethnically driven nationalism has been notoriously prone to violence, and can be particularly hazardous for minority ethnic or religious groups. There is little evidence that the extremes of in-country inequalities characteristic of neoliberalism give rise directly to conflict, but where they are overlaid on tribal, ethnic or religious differences, serious conflict can ensue.^{xi} Sexual and reproductive health is notoriously vulnerable to conflict. The nature of conflict is also rapidly evolving and the digitalisation of conflict through cyber-warfare, disinformation campaigns and remote warfare brings its own challenges.

In this chapter we look at the impact of conflict on health-related human rights. Given that the modern human rights movement emerged out of the Second World War, and the abuses of totalitarian states party to the conflagration, it is unsurprising that conflict is an area of particular human rights concern. The desire to limit the human cost of war – to create some legal and normative limits to its harms – is front and centre for IHL (international humanitarian law), to which the human rights movement is strongly allied.

x Although there is no internationally agreed definition of violent conflict, in this report we draw broadly on the concept of fragility, conflict and violence as used by the World Bank and the OECD. See, for example: The Organisation for Economic Cooperation and Development (2018). *States of Fragility 2018: Highlights*. https://www.oecd.org/dac/conflict-fragility-resilience/docs/OECD%20Highlights%20documents_web.pdf. Accessed 20 Jan. 22. See also: <https://www.worldbank.org/en/topic/fragilityconflictviolence/overview>. Accessed 20 Jan. 22. For a more specific and internationally recognised definition of various conflict types, see the Uppsala Conflict Data Program. <https://ucdp.uu.se/>. Accessed 20 Jan. 22.

xi See, for example: Nygard HM. Inequality and conflict: some good news. World Bank. 2018. <https://blogs.worldbank.org/dev4peace/inequality-and-conflict-some-good-news#:~:text=Countries%20in%20which%20there%20is,higher%20risk%20of%20armed%20conflict>. Accessed 20 Jan. 22.

For several decades the British Medical Association has been deeply concerned about the impact of conflict on health in its broadest sense.^{xii} Partly this is straightforwardly to do with seeking to limit the impact of modern weaponry. This has included the publication of reports on the medical effects of nuclear war (1983),⁴¹¹ and on worrying developments in potential genetic weapons (biotechnology, weapons and humanity 2004),⁴¹² as well as motions from its Annual Representative Meeting seeking to restrict the use of a range of particularly hazardous munitions including depleted uranium and white phosphorus. The BMA has also been a global leader in defending medical neutrality, that cluster of rights and obligations supporting the conviction that doctors must practise – and be permitted to practise – medicine without interference, and without regard to morally irrelevant factors such as nationality, class, ethnicity, religion, belief or other feature of identity not directly linked to clinical need. These issues remain of concern both to the BMA and to the international medical community. The deliberate targeting of health facilities, which was a pronounced feature of the ethnic conflict that followed the fragmentation of Yugoslavia,⁴¹³ has continued to disfigure recent conflicts, particularly in the wider Middle East. The BMA has repeatedly engaged both nationally and internationally on this issue, including support for the passing of UN Security Council Resolution 2286⁴¹⁴ condemning the targeting of medical facilities during conflict. More recently, the BMA has developed an interest in the human right to health.⁴¹⁵ As discussed in Chapter one, part of the Convention on Economic, Social and Cultural rights, the right to health has to do with ensuring all human beings have access to that minimum level of basic goods, services and freedoms necessary to lead a healthy life, commensurate with a state's available resources. Given the impact of contemporary conflict on human populations, consideration must also be given to how health-related human rights, including the right to health, can provide a minimum set of standards for the protection and promotion of the health of civilian populations during conflict. In this chapter we set out some of the major features of contemporary conflict, its impact on human health and the challenges faced by both international humanitarian law and international human rights in responding to these changes. We conclude with some suggestions for further action.

CASE STUDY: Syria – ten years of conflict

The conflict in Syria, which started in March 2011, is among the most destructive of recent decades. It illuminates both the changing nature of modern conflict, the consequences for individual and public health, and the difficulties for those seeking to moderate the effects of warfare via IHL (international humanitarian law) and human rights norms. The conflict was triggered by pro-democracy demonstrations that started in Tunisia, then spread throughout the Middle East, a phenomenon soon to be dubbed 'the Arab Spring' – a rolling wave of protest precipitating social unrest and regime change across the region. After pro-democracy demonstrations in the southern Syrian city Deraa, Government troops responded with deadly fire, triggering nationwide protests.⁴¹⁶ Brutally suppressed by Bashar al-Assad's forces, the protests became violent and the country descended into civil war. Hundreds of rebel groups emerged and foreign powers started to intervene, providing Government and rebel troops with material support. As the country disintegrated, extremist Jihadist organisations, including al-Qaeda and the Islamic State joined the conflict. Syrian Kurds, although not directly party to the conflict, are nonetheless seeking self-government and regional independence, introducing further complexity.

Today, President Assad's regime, supported by Iran and militarily assisted by Russia, controls much of the country. Islamic rebels remain in the northwest, while Kurdish and US forces remain in control in the northeast. Diplomatic efforts to resolve the crisis have been ineffective. As a report by the United Nations Human Rights Council in March 2021 put it:

xii See, for example: British Medical Association (2001). *The Medical Profession and Human Rights: Handbook for a Changing Agenda*. London: Zed Books. See, in particular chapter 10, neutrality, and chapter 11, doctors and weapons.

*'Although the March 2020 ceasefire still largely holds, the Syrian Arab Republic remains a tinderbox, with five foreign militaries active therein. Without concerted, immediate action to further a permanent ceasefire and a good faith Syrian-led peace process, the conflict may yet descend to new levels of inhumanity.'*⁴¹⁷

The human cost of the Syrian conflict has been extreme. More than 500,000 people have been killed, and half the country's pre-war population has been displaced, mostly into surrounding countries, with serious disruption, suffering and a cascade of ongoing health effects, both for displaced Syrians and for host countries.⁴¹⁸ Geir Pedersen, the UN's Special Envoy to Syria, spoke of the 'slow tsunami' of humanitarian suffering breaking across the country.⁴¹⁹ According to *The Lancet* 70% of health professionals have left the country, and more than half of the health infrastructure has been damaged or destroyed, much of it by deliberate targeting. Life expectancy has declined by 20 years and the provision of even basic health services presents serious challenges. Close to 60% of Syrians – 12.4 million people – have insecure access to food, largely as a result of economic disruption, COVID and rising food prices; the cost of basic goods has more than doubled.

In addition to the shortage of health professionals, those who remain are forced to use old equipment, often fashioning it themselves. Funding for health care in parts of the country not controlled by the government is dependent on the UN – in the northwest of the country there are only two cardiovascular surgeons for a population of 4 million.

It would be difficult to exaggerate the scale of human rights abuses in Syria. Successive reports by Human Rights Watch and others detail a level of brutality and deliberate violation of international humanitarian law and human rights that are difficult to comprehend. The most serious violations include:

- The Syrian Government's widespread use of chemical weapons.⁴²⁰ In April 2017, a nerve agent, Sarin, was dropped over Khan Sheikhoun in the north western governate of Idlib, killing 83 people, including 28 children and 23 women, and injuring another 293, including 103 children.⁴²¹
- The Syrian-Russian military alliance has systematically attacked population centres using internationally banned incendiary weapons, cluster bombs and explosives with wide area effects, including improvised 'barrel bombs'. These weapons have been directed at schools, hospitals and private homes.
- Physicians for Human Rights (PHR) has corroborated 599 attacks on 350 medical facilities and the killing of 930 medical personnel between March 2011 and March 2021. Of these, 540 have allegedly been committed by Syrian government and allied Russian forces, 34 by non-state armed groups and four by international coalition forces. 20 were committed by unknown forces. Medical personnel have also been arrested, imprisoned, tortured, and executed, and have disappeared. From April 2019 to February 2020, PHR verified 40 attacks on health facilities in northern Hama, Idlib, and western Aleppo.⁴²² Barrel bombs, banned under UN Resolution 2139, are suspected to have been used on at least 83 attacks on medical facilities.⁴²³ According to PHR, 57% of health workers were killed by shelling and bombing and 21% by shooting. At least 167 health professionals have been executed or tortured to death by government forces since the start of the conflict.
- Tens of thousands have been detained or have disappeared since the start of the war, overwhelmingly by government forces, with many thousands dying in Syrian government custody from torture and brutal conditions.

As with other conflicts, the war in Syria presents a serious challenge to international humanitarian and human rights law. Firstly and straightforwardly there is the scale of the war crimes and the associated human suffering. Overwhelmingly the victims – and all too often the targets – are civilians. It is a return to the ‘total war’ of the early twentieth century with domestic populations systematically exposed to modern munitions. As we have seen, the health consequences are complex, multiple and sustained. The nature of the conflict, with its constantly shifting militias, asymmetry of forces and the involvement of external states pushing their geopolitical agendas – including Russia’s willingness to deploy its formidable arsenal in support of Assad’s regime – presents serious practical and definitional challenges for international humanitarian law. The involvement of powerful external nations also makes peace-building initiatives challenging. Added to this is the reluctance of UN-affiliated countries to bring perpetrators of war crimes to account, the Assad regime’s commitment to prevailing irrespective of the human cost and the extent to which it is willing to cast aside norms of conduct.

Section 1 – The changing nature of modern conflict

There is broad consensus that the nature of modern conflict is changing.⁴²⁴ As the Syrian civil war makes clear, contemporary conflicts are increasingly protracted and complex. Drivers of conflict – and exacerbating factors – are also increasingly diverse and include socio-cultural, economic and political factors, with a blurring of traditional distinctions between state and non-state actors, local, national and regional boundaries, and between military and criminal factions. Added to this is an increase in urban warfare, which is particularly dangerous for civilians and destructive of the built environment, alongside proliferating arms sales to combatants.⁴²⁵ As Dr Carayannis, Director of the Social Science Research Centre’s Understanding Violent Conflict (UVC) program and director of the Conflict Prevention and Peace Forum (CPPF) writes:

‘Increasingly, conflict environments feature not only state armies but non-state armed groups, criminal gangs, drug-traffickers and terrorists. These actors employ new communications and weapons technologies, and frequently operate across national borders and regions, even though local allegiances are a critical dynamic of violence. This greater complexity in the production of violence has hampered efforts to respond to violent conflict around the world. There is a growing recognition that the international community’s conflict response toolbox, including expensive international interventions, is inadequate in the face of new empirical realities.’⁴²⁶

There is also increasing debate among researchers and policy analysts about the importance of distinguishing between conflict, very broadly understood as politically driven, and violence more generally. Certain states in Latin and Central America for example, suffer widespread and at times extreme levels of violence, often involving criminal gangs, but they would not be classed as intrastate conflicts. Similarly, in some parts of the Democratic Republic of the Congo, many armed militias are not fighting wars in any accepted sense, rather they are involved in extortion or rent-seeking, which can nonetheless involve extreme levels of violence. As we discuss later, it can be challenging to address such sustained violence via traditional humanitarian law frameworks. It can also make conflict resolution more complex still as these groups frequently have an economic interest in instability.⁴²⁷ In these circumstances, an approach grounded in human rights, with their emphasis on state obligations to protect and promote human health, can be more fruitful.

CASE STUDY: Extreme asymmetry – Al-Qaeda, the US and the ‘war on terror’

In the 18 months following the September 2001 terrorist attacks on the World Trade Center in New York, the US fought two brief but technologically overwhelming wars. The first was in Afghanistan against the Taliban and al-Qaeda militia; the second was against Saddam Hussein in Iraq. Both seemed successful. At very little cost to the US and allied life, Saddam Hussein’s regime fell in months, the Taliban were overthrown, and al-Qaeda dispersed. At the time these apparent military successes seemed to speak of the absolute global hegemony of American military and economic power, supported by the technological sophistication of its military-industrial complex – invincible against both conventional and ‘asymmetric’ forces. Nearly 20 years later, with the US embroiled in the longest military campaign in its history, the US withdrew from Afghanistan, with the Taliban quickly reasserting control of the country.

The repercussions of those two US engagements remain significant. Within two years, the US and its allies were trapped in increasingly violent wars of attrition against unconventional opponents – conflicts that came to be dubbed ‘forever’ wars by then Presidential hopeful Joe Biden, somewhat paradoxically given Biden’s historic support for a vast array of US conflicts.

Rather than emerging into democracy, Iraq disintegrated. The subsequent power vacuum was exploited by a range of extremist groups, including al-Qaeda and ISIS (the Islamic State in Iraq and Syria) which had recourse to extreme violence. In addition to the US being bogged down in apparently unending conflict in the Middle East, as we have seen, the repercussions of the conflicts reached far beyond the boundaries of Iraq and Afghanistan. Huge numbers of people have been displaced, sending ripples out into the greater Middle East and beyond, with serious political consequences across the Arab world and into Europe.

In addition to both the immediate and long-term impacts of these conflicts on health, the US response to 9/11 has seriously undermined respect for international human rights norms. The US has incarcerated hundreds of thousands of people, both at home and in Afghanistan and Iraq. It has been directly involved in the detentions of suspects in countries with questionable respect for human rights. Suspects have been detained without trial, with no ability to challenge their detention. Red Cross visits, a requirement under international law, have also been prohibited. Of the approximately 780 people detained at Guantánamo Bay, 40 currently remain.⁴²⁸ Suspects detained by the US have been subject to torture or mistreatment, either by the military, CIA, contractors or allies. In addition, in the US, Muslims and people of Arab and South Asian origin have been subject to racial profiling, discrimination and hate crime. Domestically, the terrorist threat has also resulted in a significant expansion of the Government’s surveillance of its citizens.⁴²⁹ Once seen as the centre of a global movement toward democracy and respect for fundamental human rights and liberties, the undermining of the reputation of the US during the long ‘war on terror’, combined with its retrenchment from global institutions and human rights norms under former President Trump, has serious ramifications for the institutions of international law, and their underlying norms.

Medicine and allied professions have also been drawn into this morally troubling picture. The CIA’s Detention and Interrogation Program permitted the use of so-called ‘enhanced interrogation’ techniques to which some of the inmates detained in Guantanamo Bay were subject. They included waterboarding, which simulates asphyxiation; sleep deprivation; solitary confinement; stress positioning; rectal feeding and rectal examination; sustained nudity; and severe physical threats. The United Nations Committee on Torture regards these interventions as torture. Commenting on the medical records relating to nine Guantanamo detainees subject to these techniques, Vince Iacopino from US Physicians for Human Rights states:

*'The medical affidavits in each of the nine cases indicate that the specific allegations of torture and ill treatment are highly consistent with physical and psychological evidence documented in the medical records and evaluations by non-governmental medical experts. However, the medical personnel who treated the detainees at GTMO failed to inquire and/or document causes of the physical injuries and psychological symptoms they observed. Psychological symptoms were commonly attributed to "personality disorders" and "routine stressors of confinement." Temporary psychotic symptoms and hallucinations did not prompt consideration of abusive treatment. Psychological assessments conducted by non-governmental medical experts revealed diagnostic criteria for current major depression and/or PTSD in all nine cases.'*⁴³⁰

In addition, there has been a troubling global trend, linked to security and counter-terrorism, to impose legal restrictions on the provision of humanitarian aid and to prosecute those providing health services to alleged terrorists. Following a period of social unrest in Turkey, for example, the Government introduced laws outlawing the independent provision of health care to those injured during anti-Government protests.⁴³¹ Physicians in Nicaragua have been dismissed and, in some cases, criminalised for providing medical care to persons involved in anti-government protests.⁴³² In the UK, a number of civil society groups have raised concerns about the impact on trust in the provision of healthcare arising from obligations on healthcare organisations to identify individuals who may be at risk of radicalisation.⁴³³

Section 2 – Attacks on healthcare

Attacks on healthcare during armed conflict are not new – both IHL and relevant human rights standards were in part developed to ensure the protection of health personnel, their services, and the sick and wounded under their care during times of conflict.⁴³⁴ As we have seen with Syria, however, such attacks have been a particular feature of recent conflicts in the Greater Middle East. Furthermore, in a recent report⁴³⁵ the medical-humanitarian agency MSF described attacks on its health facilities in the Democratic Republic of the Congo, the Central African Republic, Mali, Ethiopia and South Sudan. Recently, the Tatmadaw in Myanmar has also taken steps against healthcare professionals opposed to their rule.⁴³⁶ Attacks on healthcare take many forms, including bombing, shelling and other direct forms of physical assault, as well as various kinds of threat, interference or intimidation.⁴³⁷ Health facilities, healthcare workers, medical transport and supply have all been targeted. In addition, both conflict and political unrest have seen health professionals threatened, assaulted, arrested and jailed for seeking to provide healthcare. These attacks are not restricted to the military. Health facilities, staff and patients are all too often victims of various non-state armed groups.

In addition to being serious violations of IHL and fundamental international norms, attacks on health care degrade civilian infrastructure, further undermine individual and public health, and inhibit the ability of a society or community to recover from armed conflict. The long-term impact of significant mortality among health workers on the ongoing provision of healthcare, particularly in resource poor countries, is significant.

Early in the morning of Saturday 3 October 2015 a US AC-130 gunship opened fire on the main hospital building of MSF's trauma facility in Kunduz, Afghanistan. In one of the worst violations of medical neutrality in recent years, 42 people were killed in the airstrike: 24 patients, 14 staff and 4 caretakers. Many of the patients were asleep or being operated on. They burned in their beds. Medical staff were decapitated or shot from the air when they fled the burning building. The onslaught lasted an hour. Throughout the attack MSF teams desperately called military authorities to stop. MSF had given GPS coordinates of the trauma hospital to the US Department of Defense, Afghan Ministry of Interior and Defense, and US Army in Kabul the previous week. The 92-bed hospital was the only facility treating major trauma injuries in north-eastern Afghanistan. Before its destruction, it

had undertaken more than 15,000 surgical interventions and treated more than 68,000 emergency patients. The US accepted responsibility, saying that the attack was a 'mistake'. Despite repeated calls from MSF, no independent inquiry into the attack has ever been undertaken.

Partly in response to this deadly US airstrike, and the ongoing attacks on health facilities in Syria and Yemen, in 2016 the United Nations Security Council issued Resolution 2286,⁴³⁸ strongly condemning attacks on health staff and facilities during armed conflict. Despite its strong words, it did little if anything to prevent continued attacks, with Assad's regime showing little concern for international norms and conventions. UN member nations, including members of the Security Council, have also shown little appetite for holding violators of IHL to account, enabling perpetrators to continue with impunity.

Despite these challenges, there is much that the international community can do. It is vital, for example, that attacks on health care are documented – both with a long-term view to holding perpetrators to account, but also to better understand and limit the impacts of such attacks. As Haar et al suggest in a recent article:

*'Better understandings of attacks on healthcare can contribute to preventing attacks, mitigating their effects, bearing witness to the costs, and prosecuting the violations of IHL and international human rights law (IHRL) that they represent. Documentation of attacks can contribute to preventing attacks by identifying vulnerabilities, shaming perpetrators, and developing security strategies. Knowledge of the scope, scale and impact of attacks on health can help humanitarian actors target resources and programs towards those have been attacked and support recovery processes. The voices of survivors are powerful in condemning violence and deepening understanding of the social, psychological, physical and economic repercussions of attacks. Bearing witness and securing accountability for perpetrators and by exposing these attacks and their human toll is an important part of ensuring justice has been served.'*⁴³⁹

In the long run there can be no substitute for seeking means to strengthen international commitment to IHL, to the Rome Statute⁴⁴⁰ and to the work of the International Criminal Court as it seeks to overturn the impunity with which international humanitarian standards are violated.

Section 3 – Conflict and health

Insecurity and Insight report⁴⁴¹ on attacks on health services in Ukraine 24 February to 13 March 2022

'The morning of 24 February 22 saw coordinated ground, air and sea-launched missile strikes, artillery fire and airstrikes against Ukrainian military and civil Command, Control, Communications, and Intelligence (C3I) facilities beginning at 0430 (local time).

Since then, civilian infrastructure has been affected in all towns under attack. Curfews imposed on cities under attack affect access to health care and make it very difficult for health workers to move between home and work.

While exemptions are in place for persons seeking urgent medical care and workers in critical infrastructure, moving between home and work and accessing health facilities remain very dangerous and often impossible. Public transport is unavailable during curfew hours.'

As of the 13th of March, Insecurity and Insight have confirmed the following health care related attacks:

- Total incidents: 47
- Incidents where health facilities were damaged or destroyed: 29
- Health workers injured: 24
- Health workers killed: 8

As the Syrian conflict makes clear, it is not easy to overestimate the health impacts of conflict. The figures are daunting. The 20th century saw an estimated 191 million conflict-related deaths.⁴⁴² Although overall mortality from conflict plummeted in the first decades of the 21st century, according to the World Bank,⁴⁴³ two billion people are currently living in areas affected by fragility, conflict or violence, with serious long-term consequences for personal and public health. The scale of physical injury from direct trauma is frequently dependent upon the nature of the conflict, and the munitions used. Direct mortality and morbidity were particularly high in Rwanda and the conflicts in the former Yugoslavia, both of which were characterised by inter-ethnic violence, with indiscriminate shelling of civilian areas particularly prevalent in the latter. Some munitions, including chemical, nuclear and biological weapons along with landmines, can continue to cause harm long after the conflict has subsided. Many victims of conflict will have ongoing health needs, placing enduring burdens on already fragile health systems and economies post-conflict.

In addition to the direct health effects of the conflict itself – physical trauma or the psychological trauma of witnessing violence – there are many indirect health effects, both physical and psychological. Although methodologically challenging to quantify with precision,⁴⁴⁴ indirect harms are defined as those that would not have arisen but for the conflict, minus the direct harms.⁴⁴⁵ Although the figures are agreed to be approximate, it is estimated that indirect harms outweigh direct harms ninefold,⁴⁴⁶ although there will likely be significant variation depending upon the nature of the conflict.

The health impacts of conflict will be to an extent dependent upon underlying population health, including levels of nutrition, access to health services and the ongoing resilience of public health systems.⁴⁴⁷ Having said this, degradation of infrastructure, supply lines and traditional social functioning can rapidly trigger deadly outbreaks of infectious disease – 80% of deaths during the ongoing conflict in Darfur have been linked to infectious diseases.⁴⁴⁸ The physical and psychological impacts of conflict-driven displacement can seriously undermine wellbeing. Displaced people are far less likely to live in areas with appropriately functioning public health systems and services, as our chapter on migration and ethnicity demonstrates.

Conflict and its associated displacement can lead to a 'cascade' of health burdens. As Ozaras and colleagues demonstrate, the conflict in Syria not only decimated Syrian health care systems and undermined the health of its population, but infectious diseases outbreaks were sustained along the routes through which displaced people travelled and spread into the countries of refuge.⁴⁴⁹ Reported infectious diseases included re-emergent tuberculosis, cutaneous leishmaniasis, polio and measles. Increased rates of tuberculosis were reported among Syrian refugees in Lebanon and Jordan. Ongoing regional outbreaks of measles were exacerbated by the conflict. Conditions had become so challenging in Syria that it reported its first outbreak of polio in 15 years.⁴⁵⁰ Cutaneous leishmaniasis was also reported in Turkey, Jordan and Lebanon. In addition, Turkey, Lebanon, Jordan and Egypt have all reported serious overburdening of their health services as they seek to support large refugee populations.

Women and children are particularly at-risk during conflict. Bendavid and colleagues, writing in *The Lancet*, estimated that in 2017, somewhere in the region of 36 million children and 16 million women were displaced and between 2000 and 2017, the number of non-displaced women and children living within 50km of armed conflict increased from 185 million women and 250 million children to 265 million women and 368 million children.⁴⁵¹ The authors also estimate that between 1995 and 2015 more than 10 million children under the age of five died directly or indirectly as a result of conflict. The mortality rate of reproductive age women living close to high-intensity conflict is three times that of women in more peaceful settings.

Conflict, along with displacement, exposes women to increased rates of sexual violence, harassment and exploitation. Informed estimates suggest that a fifth of displaced women are subject to sexual violence, although this may well be an underestimate, with fears of stigmatisation and poor support services linked to under-reporting. Gender-based violence can also be used as a tactic of war. The impact of sexual and gender-based violence on physical and mental health is significant. In addition to the direct injuries associated with rape, it is associated with an increase in sexually transmitted diseases, including HIV, along with reproductive health problems and significant social and psychological sequelae. Figures suggest that maternal mortality increases by 11% on average, and up to 28% in more intense conflicts.⁴⁵² The disruption of antenatal, maternity and sexual health services, along with changes in sexual behaviour can all undermine reproductive and sexual health outcomes during and long after conflict.⁴⁵³ Children and some adults such as the elderly, those with underlying morbidities and pregnant and breastfeeding women can be particularly at risk.⁴⁵⁴

The mental health impacts of conflict, though too often overlooked, are serious, widespread and enduring. Charlson and colleagues, again writing in *The Lancet*, have used systematic reviews to update WHO statistics on the prevalence of mental disorders among conflict-affected populations between 2000 and 2017. They estimate that as many as one in five of those affected by conflicts has either depression, anxiety, post-traumatic stress disorder, bipolar disorder, or schizophrenia.⁴⁵⁵ Focussing on the Syrian conflict, which involved sustained assaults on civilian populations and infrastructure, including the deliberate targeting of health facilities and professionals, Hassan and colleagues⁴⁵⁶ identified a number of groups with particular vulnerabilities to poor mental health. These included children exposed to violence or exploitation, male and female survivors of sexual or gender-based violence, and those who are lesbian, gay, bisexual, transgender or intersex.

For complex reasons, including stress, harmful coping mechanisms and lack of access to ordinary health-supporting services and amenities, conflict is also associated with significant increases in NCDs (non-communicable diseases). Risk factors for NCDs such as smoking, inactivity, poor or irregular diet and alcohol consumption were identified as having increased during the conflicts in Syria⁴⁵⁷ and Bosnia.⁴⁵⁸

Section 4 – War, conflict, health and human rights

The tension between the chaos of war and the requirement for moral or law-guided action is as old as recorded history and can be traced back at least as far as the Melian dialogue in Thucydides' *History of the Peloponnesian War*. As the philosopher and social scientist Michael Walzer puts it in *Just and Unjust Wars*:

*'For as long as men and women have talked about war, they have talked about it in terms of right and wrong. And for almost as long, some among them have derided such talk, called it a charade, insisted that war lies beyond (or beneath) moral judgment.'*⁴⁵⁹

Although the tension between the chaos of armed conflict and the moral requirement to exercise proportionality and restraint is enduring, the development of both International Humanitarian Law – initiated with the original Geneva Convention of 1864 – and international human rights norms and institutions has sought to introduce global standards to constrain the human cost of armed conflict. From a health perspective, international humanitarian law, in particular, has provided a framework for the protection of medical personnel and facilities, along with the wounded and sick, in both international and non-international armed conflict.⁴⁶⁰ As Footer and Rubenstein argue, however, all too often attacks on medical personnel and facilities fall outside the aegis of IHL because hostilities have failed to reach the threshold of a declarable non-international conflict.⁴⁶¹ Critically as well, at least since the First World War, civilians have increasingly been drawn into modern conflicts. It has been estimated that one in seven casualties during the First World War were civilian. In the Second World War two-thirds of deaths were civilian.⁴⁶² Among some more recent conflicts the civilian death toll has been as much as 90%.⁴⁶³ As mentioned above, even without the direct targeting of health professionals and facilities, conflict can have a range of indirect effects on individual and population health which, for good reasons, does not fall under the purview of IHL. Although the BMA's initial interest in health and human rights was focussed on the protection of health facilities and staff, and securing medical neutrality, the scale of indirect harms arising from modern conflict has demanded a widening of focus to include acknowledgement of the vital contribution of human rights law, particularly, although by no means exclusively, the human right to the highest attainable standard of physical and mental health as set out in Article 12 of the Convention on Economic, Social and Cultural Rights.⁴⁶⁴ In this section, drawing on Footer and Rubenstein, we set out a brief account of the applicability of both IHL and human rights to the protection of health and health services during conflict.

IHL and human rights law derive from both international treaties and customary international law. Treaties are binding agreements between states on the conduct of war and the protection of people during conflicts. Key principles from IHL include distinctions between civilian and military targets, proportionality and precaution in the use of force. Human rights by contrast focus on rights and duties between states and their citizens. Both derive their normative force from obligations to preserve life and dignity. Where IHL focuses on conflict, human rights have wider and more general applicability:

*'Civil and political rights are the foundation of protection against violence, discrimination, and denial of rights of citizenship and due process committed or tolerated by the state. The rights to life, to liberty, to security of person, and not to be subjected to torture or cruel, inhuman, or degrading treatment or punishment are of special relevance to attacks on health services and are enshrined in major international and regional human rights treaties, as well as in a number of subject-specific treaties.'*⁴⁶⁵

The applicability of human rights law to armed conflict is now established.⁴⁶⁶ Concerning civil and political rights, medical personnel along with the wounded and sick are protected under Article 6 of the ICCPR,⁴⁶⁷ which prohibits states from subjecting anyone under their jurisdiction or control to arbitrary deprivation of life. Article 7 prohibits torture and cruel, inhuman and degrading treatment. Denial of medical care can also amount to such treatment. Similarly, the arrest of health professionals for providing care in accordance with medical ethics and professional duties can amount to a violation of the right to be free from arbitrary arrest and detention.

As Footer and Rubenstein point out though, the protections offered to health and healthcare during conflicts by the right to the highest attainable standard of health are powerful but too often neglected. In addition to the ICESCR,⁴⁶⁸ the right is supported by a range of other human rights instruments. The Universal Declaration of Human Rights states⁴⁶⁹ that 'Everyone has the right to a standard of living adequate for the health and well-being of himself and his family, including food, clothing, housing and medical care'. Subsequently, all key international and regional human rights treaties adopted now contain provisions designed to protect and promote the right to health. It is vital to note that even in wartime, states have an obligation to maintain, as far as possible in the circumstances, continuity of health services along with the broader requirements of the right to health.^{xiii}

Section 5 – Conclusion and recommendations

The last decade or so has been more than ordinarily challenging for those committed to international human rights norms, both in health and more broadly. The precariousness of the international institutions supporting the global human rights framework has been made clear. The last decade has also seen a serious increase in conflicts, particularly in those internal to states. These conflicts have been characterised by high levels of violence, and a willingness among combatants to step outside the constraints of international law and directly target civilians, health professionals and health services, with the outcomes discussed in this chapter.

It would be difficult to exaggerate the challenge of trying to protect and promote the health of people caught up in war or other armed conflict. A full account of the multiple strategies that could and should be deployed is clearly beyond the scope of this chapter. Although international humanitarian law retains a vital role in the protection of health professionals, civilians and the sick or wounded, human rights standards have a powerful and important complementary role. Human rights can bring powerful legal and normative standards to bear in situations that may not amount to an armed conflict under IHL but that nonetheless present serious risks to health professionals, health facilities and the citizens they would ordinarily support. As with IHL though, the challenge is in supporting the transnational institutions, treaties and geopolitical alliances that can realise these protections. Despite these challenges, there is much that can and must be done.

National and international must clearly and vocally indicate their support for IHL and health-related human rights. Violations of international law during conflicts must be studiously recorded and called out. The institutions charged with implementing such laws should also be strengthened.

xiii See, for example: <https://casebook.icrc.org/case-study/report-special-rapporteur-right-everyone-enjoyment-highest-attainable-standard-physical>. Accessed 20 Jan 22.

Recommendation

Violations of international law and human rights norms during conflict must be recorded and the systems and mechanisms for reporting these violations must be properly funded and supported.

Recommendation

Health professionals and their organisations and institutions should strengthen their public support for IHL and international human rights law as a matter of urgency.

Recommendation

National and international medical associations should cooperate in the calling out of war crimes wherever they occur.

Recommendation

Health professionals and their organisations and institutions should call for a strengthening of the International Court of Justice and the International Criminal Court.

Recommendation

National and international medical associations should seek to maintain a list of violations of the Geneva Conventions and international human rights law that relate directly to the provision of health and healthcare.

Conclusion

This report has traversed the globe, detailing some of the most serious contemporary and developing threats to health-related human rights. More than 70 countries have been referenced, across every continent, and first-hand experiences from medical professionals have been drawn on as well as detailed case studies and extensive analysis of academic literature.

None of the issues raised exist in isolation. 'Fake news' spread online is stifling action against climate change, some of which has been demonstrably proven to originate with billionaires⁴⁷⁰ who have done so well out of the neoliberal consensus. Conflict causes displacement which fuels anti-migrant sentiments which can provide a catalyst for opportunistic and intolerant populist politicians to succeed.

We recognise with some frustration that numerous strands of human rights concerns have not been raised in this report. Torture; prisons; forensic medicine; capital punishment; corporal punishment; organ harvesting; research and experimentation; chemical, biological and nuclear weapons; abuse and neglect in institutions are just some of the issues that could have been explored more deeply in this report. We leave these for future work.

Furthermore, many historically marginalised groups continue to face major obstacles to full realisation of their human rights. Though we have drawn attention to women's reproductive rights in countries such as the US, and infant mortality rates, there is nevertheless evidence that violence against women is worsening, and this has been linked to the COVID-19 pandemic.⁴⁷¹ It is still illegal in over 70 countries to be homosexual with 11 imposing the death penalty.⁴⁷² In the US, Florida has passed legislation that bans discussion of LGBTQ+ issues in schools, with one (eventually withdrawn) amendment requiring schools to 'out' LGBTQ+ children to their parents.⁴⁷³ Discrimination against disabled people and certain religious groups remains prevalent across the world.

This only serves to underline the extent of health-related human rights concerns that plague the modern world. Indeed, as we finalise this report, the Russia-Ukraine war is reaching the degree of conflict that has not been seen in Europe since the bloody Balkans conflicts of the 1990s. In this report, we have sought to assess key emerging threats to health-related human rights, though there are many more areas that deserve continuing attention and coordinated international efforts to address.

Despite the scale of contemporary challenges, the situation is far from hopeless. We have provided a range of suggestions on how to address these problems and how human rights frameworks, including the right to health, can drive change. The interconnectivity of these issues reveals the complexity involved in tackling them, but it also shows how ambitious plans, that bring disparate groups working on different issues together, can help build a safer and more just world for all.

Afterword

When this report was conceived in early 2020, few imagined the impact COVID-19 would have on our lives. The pandemic has had a disastrous impact. Millions have died, economies have been stalled, with countless job losses and destroyed livelihoods. Lockdowns, while necessary to help arrest the spread of the virus, also brought unavoidable harms. Being isolated and housebound undermined the mental health of many while those at risk of domestic violence faced greater risks to their safety. The pandemic has also highlighted stark global and national health inequalities. At home, the BMA consistently called attention to the disproportionate deaths of those from ethnic minority backgrounds from COVID-19 in the UK.

Yet, despite the harm the pandemic wrought, from a human rights perspective, grounds for hope remain. Under pressure from the gravest public health crisis since the First World War, we all drastically changed how we live. We stopped shaking hands, we wore facemasks indoors, many of us worked and continue to work remotely when it was previously inconceivable, and we all took on burdens for the common good. We continue to isolate when at risk of infection to protect others and we have developed effective vaccines in hitherto unimaginably short order.

The pandemic has proved that we can change our habits immeasurably and live in ways we would have never dreamed of. More importantly, we did this not just for ourselves, but for society at large, and, if we can do this in response to the pandemic, we can do it to address major human rights issues.

Doctors have a major role to play in strengthening human rights. We see people at their most vulnerable, when they are in pain, and look to provide both relief and reassurance. Indeed, health can be seen as the foundation of all human rights, for what good is, say, the right to liberty if you are immobilised by debilitating pain? A minimum standard of wellbeing, which doctors can contribute to establishing, can help ensure a more cohesive society, where basic needs are met. Human rights can provide the framework for individual, public and global health.

This report has excellently summarised the key threats to human rights today. It has traversed the world, from Brazil to Britain, Australia to Afghanistan, China to Chile, and the US to Uganda. This shows that human rights are not a regional problem, they are a global issue, and all countries in the world can and must do more. As this report was being completed, Russia invaded Ukraine. Evidence is emerging of attacks on health facilities throughout the country. Wars of attrition have devastating impacts on human health – both for individuals and populations. The fundamental requirement to respect international law could not be clearer.

Some of the ideas and recommendations in this report may sound ambitious, but as the pandemic has demonstrated, in the face of grievous threats, changes once thought impossible are eminently achievable. It requires governments to take their rights commitments seriously, international cooperation and teamwork, and the force of will of individuals and organisations to take things forward. Through this, global health inequalities can be challenged, institutional racism consigned to history, our economic systems adapted to work for all of us, and climate change, surely the greatest threat we face today, can be tackled.

As this report has highlighted, including the passionate foreword from our former medical ethics committee chair, Dr John Chisholm CBE, the BMA has proudly stood up for human rights for decades. We have achieved much in this field, often working with international colleagues and through the BMA's membership of the World Medical Association. We have not been afraid to speak out on big issues. The WMA adopted a BMA resolution condemning the treatment of the Uyghur population of Xinjiang in China, despite strong opposition from the Chinese Medical Association (CMA) and, following the findings of the Uyghur Tribunal in December 2021, we are now demanding that either the CMA acknowledge and condemn the genocide or be expelled from the WMA.

Going forward, the BMA will continue to play its part to help fully realise the human right to health of all peoples and I hope you will join us.

A handwritten signature in black ink, appearing to read 'Chaand Nagpaul', with a large circular flourish on the left side.

Dr Chaand Nagpaul CBE
Chair, BMA Council, 2017-22

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