

# Health as a Human Right: A Position Paper From the American College of Physicians

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The relationship of health to rights or human rights is complex. Although many find no right of any kind to health or health care, and others view health care as a right or human right, the American College of Physicians (ACP) instead sees *health* as a *human right*. The College, in the ACP Ethics Manual, has long noted the interrelated nature of health and human rights. Health as a human right also has implications for the social and structural determinants of health, including health care. Any rights framework is imperfect, and rights, human rights, and ethical obligations are not synonymous. Individual physicians and the profession have ethical obligations to patients, and these obligations can go beyond matters of rights. Society, too, has responsibilities—the equitable and universal access to appropriate health care is an ethical obligation of a just society. By recognizing health as a human right based in the intrinsic dignity and equality of all patients and supporting the patient-physician relationship and health systems that promote equitable access to appropriate health care, the

United States can move closer to respecting, protecting, and fulfilling for all the opportunity for health.

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The American College of Physicians (ACP) has long had policy on the ethical responsibility of physicians to care for all (1), the obligation of society to provide equitable and universal access to appropriate health care (1), and the continuing need for health reform in the United States to increase access to care (1, 2). This paper examines the intersection of human rights, ethical obligations, and health reform in recognizing health as a human right—matters of great concern for ACP, its members, our patients, and society.

Individuals, communities, and countries have different views on whether health or health care—or neither—is a right or human right. ACP views *health* as a *human right*. Central to human rights theory and law are United Nations documents, including Article 25 of the Universal Declaration of Human Rights, which states, “Everyone has the right to a standard of living adequate for . . . health and well-being . . . including . . . medical care” (3); the International Covenant on Civil and Political Rights (4); and the International Covenant on Economic, Social and Cultural Rights (5). The United States has ratified the International Covenant on Civil and Political Rights but not the International Covenant on Economic, Social and Cultural Rights. This reflects, in large part, concerns about the nature of the rights at issue and the worldview and legal systems of different countries. The International Covenant on Civil and Political Rights is about negative rights, which

is in keeping with the U.S. rights tradition of freedom of individuals from interference—for example, of speech, liberty, and privacy. The International Covenant on Economic, Social and Cultural Rights is about positive rights—that is, economic and social rights, such as a right to work. It directs governments and others to recognize a right “to the enjoyment of the highest attainable standard of physical and mental health” (5).

In 2000, General Comment 14 by the United Nations Committee on Economic, Social and Cultural Rights added clarification. It says that health “is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity” (6). Although a rights framework is imperfect, this is the formulation of health as a human right with which ACP agrees. But the College also recognizes the importance and necessity of other approaches to health and justice discussed in this paper. Is conceiving of health as a human right aspirational or something that can be implemented? ACP maintains that the answer is not either/or, but instead, yes and yes.

## See also:

Editorial comment

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## METHODS

This paper was developed for the ACP Ethics, Professionalism and Human Rights Committee (EPHRC). Committee members abide by the ACP's conflict-of-interest policy and procedures, and appointment to and procedures of the EPHRC are governed by the ACP bylaws. After an environmental assessment to determine the scope of issues and literature reviews, the EPHRC evaluated and discussed drafts of the paper. The paper was reviewed by the ACP Board of Governors, Board of Regents, Council of Early Career Physicians, Council of Resident/Fellow Members, Council of Student Members, and other committees and experts, and it was revised to incorporate comments from these groups and individuals. The ACP Board of Regents approved the paper on 24 April 2023.

## POSITIONS

### Position 1

*ACP views health as a human right based in the intrinsic dignity and equality of all patients.*

The concept of the human right to health as “the highest attainable standard of health” (6) is an ideal, but one we must strive for. It has never been meant to be a guarantee of health (6). Critiques of health as a human right as utopian or lacking in substance seem to neglect progress made over several decades in clarifying and specifying what this means in the real world. Although it remains subject to philosophical disagreement (7, 8), the contemporary understanding of health as a human right supported here includes several key features.

Health as a human right is a moral or ethical claim—that is, separate from its legal status in international or domestic law. Although many countries have ratified the International Covenant on Economic, Social and Cultural Rights, and some include health-related rights in their constitutions (such as Brazil and South Africa), health as a human right is the subject of complex international law. As a matter of morality or ethics, however, health as a human right does not depend on legal systems (just as the physician's duties of honesty and transparency with patients, for example, do not depend only on patient self-determination laws) (9). In fact, the moral and ethical conception is agnostic as to whether legal mechanisms are necessary or sufficient to ensure the opportunity for health.

The moral or ethical view calls attention to a fundamental interest everyone has in health—one that is so important that it generates correlative obligations on others (10). This interest is rooted in our equal status and dignity as fellow humans—not because of who someone is—and the recognition that the opportunity to pursue health is a capability that all individuals desire (11) and that is necessary for exercising or enjoying other rights (12). Also, even widely accepted human rights, such as those against torture or false imprisonment or of due process, can require actions on the part of society (for example, public defenders and fair jury trials) (12).

In fact, both human rights and bioethics are deeply rooted in human dignity as a first principle. Pellegrino reminds us that “intrinsic human dignity is expressive of

the inherent worth present in all humans simply by virtue of their being human” (13). Intrinsic dignity is not conferred, or taken away, by circumstances or by others. Patients are autonomous, he explains, because they have intrinsic dignity, not the other way around. And it is fundamentally a hallmark of the goals of medicine to focus on the good of the patient as a person, with preserving dignity and preventing indignity as “obligations built into the ends of medicine” (13). The ACP Ethics Manual states, “The physician must respect the dignity of all persons and respect their uniqueness” and notes that the physician must have an “unwavering commitment to human dignity” (1) in the care of, and advocacy for, all patients.

The obligations generated in viewing health as a human right must be assigned to someone or something (14). For instance, in international law, the primary addressee is the state or national government, which is responsible for creating a policy, legal, and institutional environment conducive to achieving health. In ethics, a distinction exists between the primary and secondary bearers of obligations (15). In human rights, secondary duty bearers can include the broader international community, which plays a role in supporting human rights in failed states, in states with nonfunctioning governments, or for individuals who are “stateless” (that is, who lack citizenship in any nation).

### Position 2

*Recognizing and implementing health as a human right requires ethical and evidence-based medical care but also the optimization of social and structural determinants of health.*

As the ACP Ethics Manual notes, “Health and human rights are interrelated” (1). The late physician Jonathan Mann was among leaders advocating the recognition of the health effects of human rights violations and how promoting human rights could promote health (16). However, a human rights violation, such as torture, is not wrong only because of its health effects.

Ethical and evidence-based medical care can support health as a human right. Availability, acceptability, accessibility (including affordability), and quality as key elements of medical care are noted by the United Nations Committee on Economic, Social and Cultural Rights in General Comment 14 (6). But viewing health as a human right does not mean, for example, that every patient in need of an organ for transplantation can require it from someone else, or that any medication patients ask for should be prescribed. It also does not require the provision of all medical care without limits; instead, the idea is to protect individuals from significant and remediable threats to the opportunity for health.

Health is about more than health services. From its earliest conceptions, health as a human right has had implications for the social and structural determinants of health, such as essential food, access to clean water and air, and education. The social determinants of health are widely recognized as a key determinant of health equity (17). The idea of the “highest attainable standard of health”

provides a benchmark for comparison in defining and measuring health equity (18).

In some cases, acting directly on health disparities and social determinants of health (that is, the broader, nonmedical conditions in which people live, eat, work, and play, including in a changing climate [19]) may be more effective at promoting positive health outcomes and directly addressing root causes of ill health (20). Social determinants of health are believed to be responsible for about 60% of health outcomes in the United States (21). This broader approach to health recognizes these connections and encourages physicians and health care institutions to develop partnerships across sectors and with others (such as community-based organizations) to promote health and welfare. The point is to emphasize issues of shared concern and synergies to solve real-world problems, not to medicalize social issues, which could have unintended consequences (21).

### Position 3

*Understanding health as a human right can inform the ethical design, implementation, and evaluation of health care delivery.*

In recent years, there has been attention to operationalizing the idea of a “human rights-based approach” to health system design (22, 23). Viewing health as a human right does not directly imply a particular health system design, but its ethical norms can be translated into practical actions and accountability measures to assess health system performance at the national and local levels. Here, the well-being of individuals and communities is central. Health systems concerned with health as a human right will commit to substantive and procedural ethical principles in the implementation and evaluation of health care delivery.

A human rights-based approach to health has several points of emphasis, many of which are shared with other substantive principles of justice. One is a focus on especially urgent health needs, particularly for vulnerable, excluded, and marginalized groups. This requires a commitment to disaggregating data on access, quality, and cost along appropriate variables, such as age, race, ethnicity, self-identified gender, and education. Data disaggregation focuses on making visible issues of equity and fairness. Of particular concern are areas of overlapping systematic disadvantage—that is, when individuals experience multiple, compounding forms of social disadvantage, perhaps due to structural or systemic issues (24). Health care institutions should not only collect data as part of performance evaluation and quality improvement but also be transparent about those data. Transparency supports accountability and informed decision making.

Along with substantive principles are procedural principles that shape decision making (“participation”). In 1978, the Declaration of Alma-Ata emphasized primary care and the importance of full participation of individuals and communities in health care decision making. Contemporary examples of this, when done meaningfully and with authenticity, include patient, family, and community engagement in health care design through patient and family advisory councils and other means.

This approach also includes procedural safeguards regarding participation and engagement as well as safeguards against discrimination, a primary duty that ACP emphasizes in the articulation of the obligation of physicians to not discriminate against a class or category of patients (1).

Physicians and health professionals play a key part in but are not primarily responsible for achieving all of health; it is a responsibility shared with patients, health care institutions, government agencies, and others. Of note, health as a human right acknowledges the reality of progressive realization; in the real world, not all aspects of health can be achieved immediately, but progress toward that goal is essential (6, 25).

### Position 4

*Health as a human right aligns with—but does not fully encompass—the ethical obligations of physicians, the medical profession, and a just society.*

Health as a human right entails an ethical obligation of society to provide access to health care, according to its resources and means, to its members. It stresses the urgency and importance of health as part of human flourishing, empowering patients to make choices in pursuing health. There is a general consensus around the importance of health in policymaking and among theories of justice, but rights-based approaches have limits (26). For instance, some theories of social justice, such as the capabilities approach, emphasize the opportunities and conditions for human flourishing (11) and therefore extend beyond human rights.

Although human rights emphasize justice with special attention to vulnerable or marginalized individuals and communities, physician ethical obligations of non-maleficence, beneficence, respect for autonomy, and justice do so as well. Like the physician’s commitment to put the patient’s interests first, human rights also emphasize the individual. This is understandable, given that the modern human rights movement was born out of a response to state-sanctioned violence against the individual for the sake of the collective. Appropriate emphasis is also placed on the obligation to respect, protect, and fulfill the opportunity for health. At the collective level, the profession has long advocated for patients and social justice (for example, for universal access to health care as a matter of a just society). “Physicians must fulfill the profession’s collective responsibility to advocate for the health, human rights, and well-being of the public” (1).

It would be a mistake to think that all physician obligations and commitments in a patient-physician relationship or in society reduce to a matter of rights. The proper moral foundation is one of relational caring for patients who may be vulnerable due to illness, of competent and artful medical practice (the science and art of medicine), and of the professed commitment to put the patient first. Such virtues as honesty, humility, moral integrity, and compassion are integral to this relationship. The lived experience of patients and physicians supports this. Physicians who carefully listen, cautiously diagnose, and are steadfast in holding their patients’ hands through illness or near life’s end do so not as a matter of rights but as a matter of compassionate care. The medical profession, as a special moral

community that professes duties to patients, physicians, and society (1, 27), is more than a set of human rights, obligation bearers, or duty holders. ACP reiterates these truths.

Physicians should each do their fair share to “work toward ensuring access to health care for all persons; act to eliminate discrimination in health care; and help correct deficiencies in the availability, accessibility, and quality of health services” (1). Society has responsibilities as well. Equitable and universal access to appropriate health care is an ethical obligation of a just society. But a just society also recognizes health-related obligations are not answered only by reference to the concept of health as a human right, that other concepts of fairness, just priority setting, virtues of caring, and other ethical values are still needed. There still will be necessary resource allocation decisions (for example, regarding organ allocation, resources in a pandemic, or even day-to-day prioritization decisions within hospitals and health systems about how best to provide care) that require more comprehensive approaches to social justice.

## CONCLUSION

A just society will recognize the special role of medical ethics and virtues like compassion, humility, and integrity, among others that are essential to the delivery of health care—traits that are independent of rights. The Ethics Manual states, “The principle of distributive justice requires that we seek to equitably distribute the life-enhancing opportunities afforded by health care. How to accomplish this distribution is the focus of intense debate” (1). With ever-changing circumstances and technologies, debate will continue. But recognizing health as a human right—emphasizing the opportunity for health—and supporting the patient-physician relationship and systems that promote equitable access to appropriate health care for all help ground and reinvigorate the discussion.

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## References

1. Sulmasy LS, Bledsoe TA; ACP Ethics, Professionalism and Human Rights Committee. American College of Physicians Ethics Manual: Seventh Edition. *Ann Intern Med.* 2019;170:S1-S32. [PMID: 30641552] doi:10.7326/M18-2160
2. Crowley R, Daniel H, Cooney TG, et al; Health and Public Policy Committee of the American College of Physicians. Envisioning a better U.S. health care system for all: coverage and cost of care. *Ann Intern Med.* 2020;172:S7-S32. [PMID: 31958805] doi:10.7326/M19-2415
3. United Nations. Universal Declaration of Human Rights. Accessed at [www.un.org/en/about-us/universal-declaration-of-human-rights](http://www.un.org/en/about-us/universal-declaration-of-human-rights) on 5 September 2023.
4. United Nations. International Covenant on Civil and Political Rights. United Nations General Assembly; 1966.
5. United Nations. International Covenant on Economic, Social and Cultural Rights. United Nations General Assembly; 1966.
6. Office of the High Commissioner for Human Rights. CESCR General Comment no. 14: the right to the highest attainable standard of health (art. 12). Committee on Economic, Social and Cultural Rights; 2000.
7. Brudney D. Is health care a human right? *Theor Med Bioeth.* 2016;37:249-257. [PMID: 27522224] doi:10.1007/s11017-016-9376-6
8. Rumbold BE. Review article: the moral right to health: a survey of available conceptions. *Crit Rev Int Soc Political Philos.* 2017;20:508-528.
9. Sen A. Why and how is health a human right? *Lancet.* 2008;372:2010. [PMID: 19097279] doi:10.1016/S0140-6736(08)61784-5
10. Tasioulas J, Vayena E. Just global health: integrating human rights and common goods. In: Brooks T, ed. *The Oxford Handbook of Global Justice.* Oxford Univ Pr; 2020;139-162.
11. Nussbaum MC. *Creating Capabilities: The Human Development Approach.* Harvard Univ Pr; 2011.
12. Shue H. *Basic Rights: Subsistence, Affluence, and U.S. Foreign Policy.* Princeton Univ Pr; 1980.
13. Pellegrino ED. The lived experience of human dignity. In: *Human Dignity and Bioethics: Essays Commissioned by the President's Council on Bioethics.* President's Council on Bioethics; 2008:513-539.
14. Sen A. Elements of a theory of human rights. *Philos Public Aff.* 2004;32:315-356.
15. Liao SM. Health (care) and human rights: a fundamental conditions approach. *Theor Med Bioeth.* 2016;37:259-274. [PMID: 27476575] doi:10.1007/s11017-016-9373-9
16. Mann JM, Gruskin S, Grodin MA, et al, eds. *Health and Human Rights: A Reader.* Routledge; 1999.
17. Daniel H, Bornstein SS, Kane GC, et al; Health and Public Policy Committee of the American College of Physicians. Addressing social determinants to improve patient care and promote health equity: an American College of Physicians position paper. *Ann Intern Med.* 2018;168:577-578. [PMID: 29677265] doi:10.7326/M17-2441
18. Braveman P. Social conditions, health equity, and human rights. *Health Hum Rights.* 2010;12:31-48. [21178188]
19. Crowley R, Mathew S, Hilden D; Health and Public Policy Committee of the American College of Physicians. Environmental health: a position paper from the American College of Physicians. *Ann Intern Med.* 2022;175:1591-1593. [PMID: 36279541] doi:10.7326/M22-1864
20. Reidy DA. A right to health care? Participatory politics, progressive policy, and the price of loose language. *Theor Med Bioeth.* 2016;37:323-342. [PMID: 27456664] doi:10.1007/s11017-016-9370-z
21. DeSalvo KB, Gracia JN. Health is more than health care. *Ann Intern Med.* 2020;172:S66-S67. [PMID: 31958809] doi:10.7326/M19-3895
22. London L. What is a human-rights based approach to health and does it matter? *Health Hum Rights.* 2008;10:65-80. [20845830]
23. Hunt P, Backman G. Health systems and the right to the highest attainable standard of health. *Health Hum Rights.* 2008;10:81-92. [20845831]
24. Powers M, Faden R. *Social Justice: The Moral Foundations of Public Health and Health Policy.* Oxford Univ Pr; 2006.

25. Rumbold B, Baker R, Ferraz O, et al. Universal health coverage, priority setting, and the human right to health. *Lancet*. 2017;390:712-714. [PMID: 28456508] doi:10.1016/S0140-6736(17)30931-5
26. Nussbaum M. Capabilities and human rights. *Fordham Law Rev*. 1997;66:273-300.
27. Pellegrino ED. The medical profession as a moral community. *Bull N Y Acad Med*. 1990;66:221-232. [2364217]