Chapter 22

Taking a Human Rights Approach to Healthcare Commercialization

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CONTENTS

22.1 Introduction

Commercialization or privatization of public healthcare services is increasingly taking place in many countries across the world. In this chapter, the implications of healthcare commercialization are addressed from a human rights perspective.

In principle, human rights law is neutral on the issue of healthcare commercialization. In other words, provided that the human rights standards are guaranteed they may be satisfied through whatever mix of public and private sector services is appropriate in the national context.

Public health experts, however, warn that healthcare commercialization amounts to an increase in health disparities, in particular in poor nations. They suggest that ethical principles, including equity, should be embedded in privatization processes so as to guarantee the availability, accessibility, acceptability, and quality of healthcare services to all groups of society.

This suggests that a closer look needs to be taken at the existing human rights laws. It appears that despite their above-mentioned neutrality, they can offer an interesting framework for assessing the consequences of healthcare commercialization.

In this contribution, a human rights impact assessment is designed which enables governments and civil society organizations to assess the implications of governmental plans to introduce healthcare commercialization. At the core of this analysis lies the right to the highest attainable standard of health (right to health), but other important human rights are the right to participation, the right to information, the right to an effective remedy, and the right to privacy.

This contribution contains two parts: first, an overview of commercialization of healthcare, which draws heavily on the work of public health experts (Sections 22.2–22.5) [1], and secondly, an analysis of the possible human rights consequences of healthcare commercialization resulting in an outline of the human rights impact assessment (Sections 22.6–22.9).

22.2 Commercialization of Healthcare Services: Definition

First, the distinction between commercialization and the narrower term "privatization" needs to be addressed. According to Graham, privatization can be defined as

the sale or transfer of state-owned goods into private hands. As such, it does not necessarily embrace commercial behavior by publicly owned bodies, nor liberalization, the shift to market-led provision from state-led or state-constrained systems, nor deregulation, i.e., relaxing the rules under which a certain sector conducts its activities [2]. As a result, the use of the term "privatization" can result in an unnecessary confusion of the debate and to situations where certain trends remain unidentified. An example concerns the United Kingdom, where the British government is currently in the process of contracting out public healthcare services to private healthcare providers. As part of its plans it has invited multinational companies to manage certain NHS (National Health Service) services. The question arises, does this contracting out to private healthcare providers constitute privatization? In June 2006, the British health secretary, Patricia Hewitt, insisted that there was "'no question whatsoever' of privatising a whole tier of the NHS." An opponent, on the other hand, claimed that "it is hard to see it as anything other than privatisation by stealth" [3].

The aim of the current analysis is to cover all developments that imply a move away from direct government responsibility over the provision of healthcare services. To avoid uncertainty over whether there is actually privatization, this article will follow the lead of Mackintosh and Koivusalo and use the wider term "commercialization," instead [4].

22.3 Causes of Healthcare Commercialization

Healthcare commercialization is a global trend that affects both poor and rich nations. The main rationale for healthcare commercialization is to curb public spending. Because of the rising cost of healthcare services, public health systems are increasingly coming under pressure [5].

In developed nations, the underlying causes of the rising costs are the general inefficiency of the publicly ran services, improvements of medical techniques, an ageing population, and rising expectations of the quality of care [6]. To promote their approach, Western governments often stress that with their commercialization policies they seek to enhance the consumer's range of choice [7].

In the developing world, the lack of financial resources seem to be caused by general poverty on the part of the government and inefficiency of the publicly ran health system. In addition, there is an increasing pressure from international financial institutions to reduce the cost of public health expenditure, resulting in a gap that is filled up by private healthcare providers, including nongovernmental organizations (NGOs) and foreign multinationals [8]. A side effect of these developments is an increase of out-of-pocket expenditure for healthcare services, which Mackintosh and Koivusalo call the "most regressive form of health finance" [9].

22.4 Trends in Healthcare Commercialization

Healthcare commercialization may take various shapes, including privatization of the health insurance branch, the contracting out of healthcare services to private healthcare providers, and the penetration of national health markets by multinationals [10]. An example of each is given below.

An example of the privatization of the health insurance branch concerns the reorganization of the Dutch healthcare system, where a private health insurance with social conditions has come into existence [11]. By way of a first step, all health insurance companies were gradually turned into private entities. Secondly, a new insurance system for curative healthcare came into force in 2006, implying that all residents of the Netherlands are now obliged to take out a health insurance from one of the private health insurance companies. In turn, these companies are under an obligation to accept every resident in their area of activity and to provide a basic health insurance package that has been designed by the government [12]. This new and innovative approach has created a certain tension with European competition law, which seeks to create a European insurance market by lifting trade barriers and as such does not allow governments to impose too many restrictions on health insurance companies [13].

Commercialization of healthcare services can also affect healthcare provision. In the United Kingdom, for example, health services previously provided by the NHS are gradually being contracted out to private healthcare providers. As explained by Pollock, the NHS has abandoned to the private sector almost all long-stay inpatient care, all routine optical care, and most dental care. In addition, multinational corporations are being invited to take over the running of failing NHS hospitals and to provide routine surgery in private treatment Centers [14].

Similar but more dramatic are the developments in Lebanon. Here the civil war has weakened the institutional and financial capacity of the government, which has created a vacuum that was filled up by nongovernmental groups and the private sector. As such, governmental healthcare provision became reduced to secondary and tertiary care for civil servants, and care for the most disadvantaged. Primary care largely fell into the hands of a large amount of national and international NGOs, which are often poorly coordinated and often function on a reactive rather than on a proactive basis. The private sector became the most important secondary and tertiary care provider, which emphasizes curative over primary and preventive care with a focus on hospitals and centers for high technology services [15]. A side effect of these developments in Lebanon has been a huge increase in out-of-pocket spending of healthcare services. Statistics demonstrate that in 1999 more than half the population in Lebanon remained uninsured [16].

Another trend that occurs mostly in developing nations concerns the continuing multinational expansion of cross-border investment in the provision of health services. This development has been triggered by changes in the government health sector, sometimes under pressure of the World Bank, the International Monetary

Fund (IMF), and the World Trade Organization (WTO), which may trigger privatization of public health services [17]. As explained by Jasso-Aguilar et al., U.S.-based multinationals corporations have expanded worldwide, especially in Latin America. A declining rate of profits in U.S. markets triggered these corporations to seek access to public social security funds in countries like Mexico and Brazil [18].

22.5 The Vision of Health Professionals and of Public Health Experts

The British Medical Association (BMA) has expressed its concern about the British health reform, which foresees in an increasing role of the private sector. It has stated that

> The British Medical Association is dismayed by the incoherence of current government policies and the damage they have caused to the NHS and the delivery of patient care. (. . .) There should be no further involvement of the commercial private sector in providing NHS care. The BMA will campaign to restore an integrated publicly provided health service in England. [19]

AQ1

Mackintosh and Koivusalo have done extensive primary research examining the impact of healthcare commercialization. Their conclusion is that it can have a negative impact on health outcomes and on the accessibility of healthcare services for poor and disadvantaged people, in particular in poorer countries. For example, their research demonstrates that better care at birth is associated with more of gross domestic product (GDP) spent by government or social insurance funds on healthcare, but not with more private spending. Furthermore, they indicate that higher primary care commercialization is associated with greater exclusion of children from treatment when ill [20]. Their overall conclusion is that health systems are part of the public policy sphere and that policies toward commercialization within health systems should and can be within national and local democratic control [21].

This assumption poses an interesting challenge to the human rights dimension. As already mentioned, human rights law is neither for nor against privatization, indeed, it provides an interesting framework for assessing whether healthcare commercialization will negatively affect people's access to health services and health information and their privacy.

AQ2

22.6 Human Rights Law

Human rights, as defined in international law, are claims or entitlements of individuals versus their governments. They represent fundamental values of

humanity and seek to protect the human dignity of individuals. As such they are closely connected to equity, the ethical principle that is used in a public health framework.

Human rights are set forth in international treaties that are subsequently ratified by governments, the so-called state parties. The entitlements that fall upon the state may imply a duty to refrain from acting on the part of the state (e.g., not to torture), but they may also oblige the state to take a certain action (e.g., to enact legislation or to provide a certain service) [22].

Because it is states that have ratified the human rights treaties, they are the primary duty holders under international human rights law. However, increasingly the argument is being made that other actors may have responsibilities under human rights law, such as international organizations, multinationals, and individuals like war criminals. In this contribution, however, the emphasis will be on the responsibilities of governments [23].

Human rights are generally thought of as standards that victims of violations can use to seek remedy for past harms. In addition, however, international human rights can function as a guide for governments and other national and international public bodies to assess in advance the consequences of draft legislation and planned policies. It is this second function of human rights law that we will examine in this chapter.

22.7 Human Rights and Healthcare Commercialization

As mentioned, human rights law does not interfere with a government's choice of whether health and other public services are publicly or privately provided. Yet, commercialization of healthcare services can have serious human rights consequences. Commercialization of public health services implies a move away from government control over the provision of healthcare services. This is problematic, because private healthcare providers do not necessarily have an interest in improving the health of the population as a whole, nor of marginalized population groups. In terms of human rights, all this can imply as a loss of legal accountability of governments for conduct that comprises human rights [24].

Governments, as the primary duty-bearers under human rights law, have a responsibility to ensure that healthcare services, also if they are privately provided, are available, accessibly, acceptable, and of good quality [25]. They have to enact legislation that ensures that private healthcare providers provide healthcare services that meet quality and accessibility standards. They have to make sure that mechanisms are in place for patients to seek legal redress if they have received inadequate or untimely care.

A doubt that may arise in the mind of the reader is that governments themselves are not necessarily dedicated to realizing human rights, so why ask them to address human rights violations of private healthcare providers? Here, it should be born in

mind that governments have primary responsibility under human rights law and so they are the first actors that should be addressed. Whether healthcare providers, pharmaceutical companies, and other actors involved in the health sector have human rights responsibilities is a separate matter that should never undermine the primary responsibility of governments [26].

22.8 A Human Rights Impact Assessment of Healthcare Commercialization

A human rights impact assessment is a tool which enables states and international and national organizations to assess the possible human rights implications of a certain policy, program, project, trend, or development. There is an increasing call on governments to do human rights impact assessments before the introduction of, for example, privatization of public services, new business plans, and trade agreements [27]. For example, the special rapporteur on the right to health, Paul Hunt, has suggested that human rights impact assessments of trade-related policies be undertaken. According to Hunt, such impact assessments should be taken both at an international and a national level [28]. In addition, with regard to healthcare privatization, he remarked that "[health care privatization] should be preceded by an independent, objective and publicly available assessment of the impact on the respective right" [29].

In an extensive study on human rights impact assessments, Hunt and McNaughton address the possibility of integrating human rights in more general impact assessments. For this purpose, they suggest seven general principles which reflect a rights-based approach to performing impact assessments and they mention six steps for integrating a right to health more specifically into existing impact assessments [30].

At the core of our human rights impact analysis for healthcare commercialization lies the right to the highest attainable standard of health and its conceptual framework.

The right to the highest attainable standard of health, often abbreviated as the right to health, is an economic and social right, which is set forth in several rights treaties at the United Nations (UN), as well as at the regional level [31]. Although many states have embedded a right to health in their constitution, the most widely recognized international provision is Article 12 of the UN International Covenant on Economic, Social and Cultural Rights (ICESCR). The content and implications of Article 12 ICESCR are explained in an explanatory document, a so-called General Comment, which was adopted by the UN Committee on Economic, Social and Cultural Rights, the treaty-monitoring body of the ICESCR [32]. As the General Comment explains, the right to health is not a right to be healthy, but rather a right to a number of freedoms and entitlements, extending not only to timely and appropriate healthcare, but also to the underlying determinants of health, such as safe and potable water and healthy occupational and environmental conditions [33].

In addition, several other human rights are of particular importance when assessing the impact of healthcare commercialization: the rights to participation, to information, to an effective remedy, and to privacy.

The assessment presented below is by no means meant to be exhaustive and it is recognized that other human rights can also be of crucial importance when assessing the implications of healthcare commercialization. It is also to be noted that human rights may reflect overlapping values. For example, while there is a separate right to information, a right to health embraces a right to health-related information. In addition, where a denial of access to healthcare services results in the death of a patient, a right to life may be at stake in addition to the right to health [34].

22.8.1 Participation in the Decision-Making Process

As demonstrated above, healthcare commercialization is a process that can have serious consequences for the way the public can access healthcare services. It is therefore important that the public has a say in the process of adopting the policies and the rules that lead to commercialization.

This notion is reflected by the international human rights framework. The General Comment on the right to health, which will be discussed more elaborately below, stipulates as an important element of the right to participation of the population in all health-related decision-making at the community [35]. The right to participation is further set forth as a separate human right in Article 25 of the UN International Covenant on Civil and Political Rights (ICCPR) and attached General Comment. Paragraph (a) of Article 25 ICCPR relates to the conduct of public affairs. According to the General Comment, this covers all aspects of public administration, and the formulation and implementation of policy at international, regional, and local levels. Governments should establish laws that foresee in the allocation of powers and the means by which individuals can exercise their right to participation in the conduct of public affairs [36]. AQ3

In the Netherlands, for example, the public was not directly consulted before the introduction of healthcare privatization. However, a great number of public bodies were consulted, including patients' associations and trade unions [37]. As such, the public had at least an indirect say in the reorganization of the Dutch healthcare system.

22.8.2 AAAQ: Availability, Accessibility, Acceptability, and Quality

According to the Right to Health General Comment, governments are to guarantee the availability, accessibility, acceptability, and quality of health services, the so-called AAAQ. Availability means that sufficient health services must be provided. Accessibility implies nondiscrimination, physical accessibility, economic accessibility

(affordability), and access to information. Acceptability means that health facilities must respect medical ethics and be culturally appropriate. Quality, finally, requires that health services are scientifically and medically appropriate and sound [38]. If we apply these principles in the context of healthcare privatization, the following comes to the fore.

First, in terms of "availability," it is important to assess how healthcare commercialization will affect the sufficient availability of healthcare services. It is in fact possible that healthcare commercialization exerts pressure on healthcare providers to work more efficiently. As such, healthcare commercialization may enhance the availability of healthcare services.

In terms of "accessibility," the following overlapping principles need to be addressed:

1. *Nondiscrimination*. According to the General Comment, nondiscrimination implies that health facilities, goods, and services must be accessible to all, especially the most vulnerable or marginalized sections of the population [39]. Commercialization trends in healthcare can result in discrimination of customers or patients because private health insurance companies and private healthcare providers do not necessarily have an interest in providing equal access to healthcare services. For example, they may be inclined to refuse patients with chronic diseases, because these patients require more expensive treatment and care.
2. *Physical Accessibility*. Physical accessibility requires that health facilities be within safe reach for all sections of the population, especially vulnerable or marginalized groups [40]. Here, it should be noted that private insurance companies and private healthcare providers do not necessarily have an interest in ensuring that healthcare services are within safe physical reach of the population. People living in remote, rural areas are particularly vulnerable in this respect [41].
3. *Affordability*. Affordability implies that health facilities, goods, and services are affordable for all, including socially disadvantaged groups [42]. In many countries, healthcare commercialization trends have led to an increase in out-of-pocket expenditure, which in turn can have dramatic consequences for the affordability of healthcare services. For example, Volkmann reports that in Vietnam, the introduction of a private/public healthcare mix has led to a huge increase in out-of-pocket expenditure. He points out that as a result, many Vietnamese are turning to cheaper healthcare providers, such as traditional healers and drug vendors [43]. Furthermore, under the new Dutch system, insurance companies can ban persons who refuse or are unable to pay their insurance premiums. Several critics have expressed the concern that as a result, many people will remain uninsured [44].
4. *Information Accessibility*. Information accessibility implies the right to seek, to receive, and to impart information and ideas concerning health issues [45].

As mentioned above, healthcare commercialization is sometimes defended by the claim that it will enhance consumer's range of choice [46]. However, the question arises to what extent the consumer is actually able to make an adequate choice between the various health insurance companies and the healthcare providers. With insurance policies being often quite complex, it is not always easy to make a well-informed choice [47]. Furthermore, patients may lack information about the quality of the range of available healthcare services and about the best available option to them.

In terms of "acceptability," as mentioned, it implies that health facilities, goods, and services are respectful of medical ethics and culturally appropriate (respectful of the culture of individuals, minorities, peoples, and communities). They should also be sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned [48]. The role of private health insurance companies is of particular concern. Private health insurance companies may not necessarily contract those healthcare services that are most suitable for their customers. This may hamper the acceptability of the healthcare services [49].

In terms of "quality," it is important to assess that healthcare commercialization does not undermine the quality of the healthcare services. An example concerns systems where public health services are contracted out to private healthcare providers. Once privatized, it is more difficult for governments to supervise the quality of these privately provided healthcare services. An element of this concerns safeguarding the quality of medical personnel. In the United Kingdom, for example, there is concern whether profit-making companies running treatment centers will provide training that is up to the same standards as the NHS [50].

22.8.3 Minimum Core Obligations

Furthermore, the General Comment on the right to health stipulates that states parties have a so-called core obligation or minimum obligation to ensure the satisfaction of minimum essential levels of healthcare. In this respect, the General Comment makes reference to the Programme of Action of the International Conference on Population and Development and to the Primary Health Care Strategy of the World Health Organization (WHO) [51]. Mention should also be made of the Millennium Development Goals (MDGs), a set of eight time-bound targets by which progress can be measured, agreed upon by countries around the world in 2000 [52]. According to Alston, the MDGs can to some extent "be taken as reflecting the minimum content of certain economic and social rights." He argues that states which fail to achieve their MDGs "cannot easily seek to excuse themselves by relying upon a lack of available resources or arguments based on progressive realisation" [53].

Altogether, although there is no obligation for governments to provide essential health services publicly, the core content doctrine underlines that there is an extra

strong obligation to ensure that these services are available under all circumstances, whether publicly or privately provided.

22.8.4 Obligation to Protect

Furthermore, the General Comment on the right to health explains that human rights impose three levels of obligations on states parties: the obligations to respect, to protect, and to fulfill. The obligation to respect requires states to refrain from interfering directly or indirectly with the enjoyment of the right to health, the obligation to protect requires states to take measures that prevent third parties from interfering with Article 12 guarantees. The obligation to fulfill, finally, requires states to adopt appropriate measures toward the full realization of the right to health [54]. As de Feyter and Gómez Isa point out, when a state privatizes a certain service, there is in fact a shift from the state's obligation to fulfill to the state's obligation to protect [55]. The state is no longer the provider of the service, but now needs to supervise that third parties provide the services adequately. According to the present author, this can imply three things:

1. The adoption of legislation to regulate the private health sector. An example concerns the Dutch Health Insurance Act which regulates the behavior of private insurance companies by prohibiting them from refusing customers and from differentiating based on health status, age, or other factors related to the insured [56]. It also obliges the insurance companies to provide one basic health insurance package to everyone [57]. With regard to China, where private healthcare providers play an increasing role, Sun points out that regulations identifying the respective roles and responsibilities of social and commercial health insurers would support the commercial health insurance market. Sun explains that according to informants, the Chinese government should play an active role in regulating the health insurance market [58].
2. The adoption of monitoring mechanisms aimed at regulating the behavior of private insurance companies and private healthcare providers. Adequate regulation of the health sector implies that there is supervision not only over the financial behavior of the actors in the health sector, but also over the quality, the geographic accessibility, and the affordability of health services provision [59].
3. The creation of possibilities for individuals to complain about failure or malpractice by the (private) actors in the healthcare sector (see Section 22.8.5).

22.8.5 Accountability

As mentioned above, an important aspect of the obligation to protect the right to health is the obligation to ensure that individuals have means of redress when the private healthcare provider/insurer has not treated them adequately.

The right to an effective remedy is also set forth in several human rights treaties that contain civil and political human rights. The right to a remedy is also contained in the UN ICCPR, but this particular provision relates to the rights in the ICCPR and not necessarily to the right to health. In addition, the right to a remedy is contained in the Universal Declaration on Human Rights (UDHR) [60]. Article 8 UDHR stipulates that everyone has the "right to an effective remedy by the competent national tribunals for acts violating the fundamental rights granted him by the constitution or by law." As such, when people are denied access to adequate health services, they should have access to legal recourse. The term "competent" refers to courts that serve a certain area of the law, for example a court specialized in medical law.

22.8.6 Protection of Privacy

Healthcare commercialization may put the protection of medical data under threat. Private health insurers do not necessarily have an interest in safeguarding the privacy of their customers. For example, private health insurers may seek to use medical data to address or to select the more "profitable" patients or to reject those patients who are likely to consume more medical services.

The General Comment on the right to health stresses that accessibility of health information should not impair the right to have personal health data treated with confidentiality [61]. More generally, the right to privacy, family, home, and correspondence is protected by Article 17 of the UN ICCPR and it has been elaborated further by the Human Rights Committee's General Comment and also by its case law under the Optional Protocol [62]. Under this General Comment, governments have a responsibility to regulate by law the gathering and holding of personal information on computers, data banks, and other devices, whether public authorities or private individuals or bodies [63]. As a result, if a private health insurer or healthcare provider acquires access or responsibility over medical data, legislation has to be in place to regulate the gathering and holding of this information. Among other things, individuals have the right to know and if so what personal data is stored, and they should be able to ascertain which entities have control over their files [64].

22.9 Conclusions

As demonstrated above, commercialization of healthcare services can have serious human rights consequences. Governments or civil society organizations are recommended to undertake a human rights impact assessment to identify the possible human rights consequences of healthcare commercialization bills and planned policies. As explained more elaborately above, this has the following elements:

- Assessing whether the public has been consulted about the proposed change, for example by means of a public enquiry.
- Assessing the effects of the proposed commercialization on the availability, accessibility, acceptability, and quality of the healthcare services. Legislation has to be in place to ensure that private healthcare providers meet national quality standards, as well as legislation that prohibits public and private insurance companies and healthcare providers to discriminate between patients on the basis of their health status. Another requirement may be legislation that prohibits insurance companies and healthcare providers to discriminate between patients on the basis of their financial capacity.
- Identifying whether adequate regulatory mechanisms are in place that will oversee the (partly) independent health sector. Such mechanisms should not only oversee issues like the financial performance of the actors in the healthcare sector, but also the adequacy of the healthcare services.
- Identifying whether patients will have adequate means of redress when their rights have been ignored by both the public and the private healthcare sector. To this end impartial complaint mechanisms have to be in place that can take binding decisions.
- Identifying whether legislation is in place that ensures that medical data from patients are treated confidentially by both public and private healthcare providers.

In some instances, it will boil down to identifying existing mechanisms that offer the above-mentioned protection, like the Dutch legislation that prohibits insurance companies from discriminating between persons. In other situations, it may be a matter of identifying which elements need to be added to existing mechanisms, for example when supervisory mechanisms are in place that however do not yet oversee the availability, accessibility, acceptability, and quality of the services. AQ4

At an international level, several measures can be taken to assess and to monitor the negative effects of healthcare commercialization. International institutions including the WHO have an important role to play by collecting and disseminating information on national experiences and expertise on how best to deal with this development. Furthermore, given the increasing trend to provide healthcare services, transnationally, it is important to think of ways to better oversee compliance with human rights and other standards by transnational healthcare providers, for example by means of an International Health Authority. Finally, the UN Committee on Economic, Social and Cultural Rights can urge governments to undertake a human rights impact assessment when introducing healthcare commercialization into their system. It can then monitor these assessments within the framework of its state reporting procedure. To assist governments in this task, it can adopt a General Comment that discusses how to tackle the possible negative human rights consequences of commercialization of public services including health, water, and social security.

Notes

1. *Inter alia*, Mackintosh, M. and Koivusalo, M., *Commercialization of Health Care: Global and Local Dynamics and Policy Responses*, Palgrave Macmillan, Hampshire/New York, 2005; Pollock, A.M., NHS plc, *The Privatisation of Our Health Care*, Verso, London/New York, 2005.
2. Graham, C., Human rights and the privatisation of public utilities and essential services, in *Privatisation and Human Rights*, De Feyter, K. and Gomez Isa, F. (Eds), Intersentia, Antwerp/Oxford, 2005, pp. 33–56, at p. 35.
3. *The Guardian*, June 30, 2006, at http://www.guardian.co.uk.
4. See Mackintosh, M. and Koivusalo, M., Health systems and commercialization: In search of good sense, in *Commercialization of Health Care*, see note 1, pp. 3–21, at pp. 3–4.
5. For an interesting illustration of this tension see the decision of the Canadian Supreme Court, *Chaoulli v. Quebec* (2005) 1 S.C.R. 791, in which it ruled that the prohibition to obtain private health insurance is not constitutional where the public system seems to fail to deliver reasonable services (available at http://www.lexum.unmontreal.ca). See also Kraus, C., In blow to Canada's health system, Quebec law is voided, *New York Times*, June 10, 2005.
6. Weale, A., Ethical issues in social insurance for health, in *Health Care: Ethics and Insurance*, Sorell, T. (Ed.), Routledge, London/New York, 1998, p. 138.
7. See Toebes, B., The right to health and the privatization of National Health Systems: A case study of the Netherlands, *Health and Human Rights*, 9: 110, 2006. For the United Kingdom, see Pollock, *The Privatisation of Our Health Care*, see note 1, p. 234.
8. For analysis see Mackintosh and Koivusalo, *Commercialization of Health Care*, see note 1, Chapter 2.
9. Mackintosh and Koivusalo, *Commercialization of Health Care*, see note 1, p. 8.
10. For a definition see Mackintosh and Koivusalo, Health systems and commercialization, see note 4.
11. See the Web site of the Dutch Ministry of Health, Welfare and Sport, at http://www.minvws.nl/en/themes/health-insurance-system. Dutch Health Insurance Act (*Zorgverzekeringswe*), Tweede Kamer, 2004–2005, A 30 124. Available at the Web site of the Dutch Ministry of Health, Welfare and Sport at http://www.minvws.nl. For a more elaborate evaluation of this Act see Toebes, *Health and Human Rights*, see note 7. For an evaluation of a number of developed nations see European Observatory on Health Care Systems, *Health Care Systems in Eight Countries: Trends and Challenges*, London School of Economics, London, United Kingdom, April 2002.
12. Before 2006, two thirds of the population fell under the Social Health Insurance Act (*Ziekenfondswet*).
13. See Toebes, *Health and Human Rights*, see note 7, 112–113.
14. See Pollock, *The Privatisation of Our Health Care*, see note 1, pp. 36–41.
15. Sen, K. and Mehio-Sibai, A., The dynamics of commercial health care in Lebanon, in *Commercialization of Health Care*, see note 1, pp. 66–83, at p. 68.
16. Sen, K. and Mehio-Sibai, see note 15, pp. 66–83, at p. 78. See also Sen, K. and Mehio-Sibai, A., Transnational capital and confessional politics: The paradox of the health care system in Lebanon, *International Journal of Health Services*, 34: 540, 2004.

17. See Lethbridge, J., Strategies of mutinational health care companies in Europe and Asia, in *Commercialization of Health Care*, see note 1; Jasso-Aguilar, R. et al., Mutlinational corporations and health care in the United States and Latin America: Strategies, actions and effects, in *Commercialization of Health Care*, see note 1, Chapter 2. AQ5
18. Jasso-Aguilar et al., Strategies, actions and effects, see note 17, p. 38.
19. British Medical Association, *NHS Reforms in England*, available at http://www.bma.org.uk/ap.nsf/Content/NHSreformsinEngland.
20. Mackintosh and Koivusalo, *Commercialization of Health Care*, see note 2, pp. 15–16.
21. Mackintosh and Koivusalo, *Commercialization of Health Care*, see note 2, p. 20.
22. The current human rights doctrine makes a distinction between (negative) state obligations to respect and (positive) state obligations to protect and to fulfill. See Section 22.8.4.
23. As to the human rights responsibilities of multinationals in the health industry see *inter alia* Toebes, *Health and Human Rights*, 2006, see note 7, 108. More generally see for example, Jägers, N., *Corporate Human Rights Obligations: In Search of Accountability*, Intersentia, Antwerp/Oxford/New York, 2002.
24. Bloche, M.G., Is privatisation of health care a human rights problem?, in *Privatisation and Human Rights*, see note 2, p. 221.
25. For a definition of these principles see Section 22.8.2.
26. As to the human rights responsibilities of multinationals in the health industry, see note 23.
27. For an elaborate analysis of a human rights impact assessment for the right to health see Hunt, P. and MacNaughton, G., *Impact Assessments, Poverty and Human Rights: A Case Study Using The Right to the Highest Attainable Standard of Health*, Submitted to UNESCO, available at http://www2.essex.ac.uk/human_rights_centre/rth/docs/Impact%20Assessments%2031%20May%2006.doc. AQ6
28. Commission on Human Rights, Report of the Special Rapporteur, Paul Hunt, *Mission to the World Trade Organization*, UN Doc. E/CN.4/2004/49/Add.1, 1 March 2004, paragraphs 54–56.
29. Hunt, P., The International Human Rights Treaty Obligations of States Parties in the Context of Service Provision, in *Day of General Discussion: The Private Sector as Service Provider and Its Role in Implementing Child Rights*, UN Doc. CRC/C/121, 31st session, September 20, 2002, 4–5.
30. Hunt and MacNaughton, *Impact Assessments, Poverty and Human Rights*, see note 27, pp. 32–35.
31. The first instrument to lay down a right to health was the Constitution of the World Health Organization (adopted 1946). Furthermore, the right to health can be found in Article 25 of the Universal Declaration of Human Rights (UDHR, 1948), Article 12 of the International Covenant on Civil and Political Rights (ICESCR, 1966), Article 12 of the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW, 1979) and Article 24 of the Convention of the Rights of the Child (CRC, 1989), and in several other UN conventions. With the regional level, reference is made to regional intergovernmental organizations that address human rights, including the Council of Europe (CoE), the Organization of American States (OAS), and the Organization of African Unity (OAU). For example, Article 11 of the European Social Charter (ESC, 1965) stipulates a right to protection of health.

32. UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment 14 on the Highest Attainable Standard of Health, UN Doc. E/C.12/2000/4, August 11, 2000. See also Potts, H., *A Right to Public Participation in Public Health Strategy Management*, available at http://www.engagingcommunities2005.org/abstracts. AQ7
33. CESCR, General Comment 14, see note 32, paragraphs 8 and 11.
34. For example, Council of Europe's European Court of Human Rights (ECHR) has addressed the question whether the right to life in Article 2 ECHR implies a right to treatment. In *Cyprus v. Turkey* (May 10, 2001, at http://cmiskp.echr.coe.int) it argued that "an issue may arise under Article 2 of the Convention where it is shown that States parties put an individual's life at risk through the denial of health care which they have undertaken to make available to the population generally." For more cases see Samanta, A. and Samanta, J., The Human Rights Act 1998—why should it matter for medical practice?, *Journal of the Royal Society of Medicine*, 98: 404–410, 2005. For a striking example from medical practice see Boy's death sparks riots over China health AQ8 costs, *The Guardian*, November 13, 2006, available at http://www.guardian.co.uk, the case concerned a hospital in southwest China where a young boy had died, reportedly because his guardians could not afford to pay treatment fees of more than £40.
35. CESCR, General Comment 14, see note 32, paragraph 1.
36. UN Human Rights Committee (HRC), General Comment 25: The Right to Participate in Public Affairs, Voting Rights and the Right of Equal Access to Public Service (Article 25), UN Doc. CCPR/C/21/Rev.1/Add.7, July 12, 1996, paragraph 5, available at http://www.unhchr.ch.
37. See the explanatory document to the Draft Health Insurance Act, *Tweede Kamer*, 2003–2004, 29763, No. 3, available at http://www,overheid.nl.
38. CESCR, General Comment 14, see note 32, paragraph 12.
39. CESCR, General Comment 14, see note 32, paragraph 12.
40. CESCR, General Comment 14, see note 32, paragraph 12.
41. See also Pollock, *The Privatisation of Our Health Care*, see note 1, p. 230, who observes that in the United Kingdom "Physical access is already being curtailed by the closure of local hospitals and the movement of services to out-of-town locations, involving higher transport costs."
42. CESCR, General Comment 14, see note 32, paragraph 12.
43. Volkmann, S.C., Children's rights and the MDGs: The right to health within Vietnam's transition towards a market economy, *Health and Human Rights*, 9: 56–79, 2006, at p. 64.
44. See Toebes, *Health and Human Rights*, see note 7, 114.
45. CESCR, General Comment 14, see note 32, paragraph 12.
46. Regarding the UK system see Pollock, *The Privatisation of Our Health Care*, see note 1, p. 234. With regard to the Netherlands, see Toebes, *Health and Human Rights*, see note 7, 110.
47. See Toebes, *Health and Human Rights*, see note 7, 115.
48. CESCR, General Comment 14, see note 32, paragraph 12.
49. See Toebes, *Health and Human Rights*, see note 7, 116.
50. See for example Toebes, *Health and Human Rights*, see note 7, 116. See also Some private hospitals are falling short of minimum standards, *The Guardian*, December 20, AQ9 2006, at http://www.guardian.co.uk.

51. CESCR, General Comment 14, see note 32, paragraph 43–44.
52. Millennium Development Goals, see http://www.un.org/millenniumgoals/.
53. See Alston, P., *A Human Rights Perspective on the Millennium Development Goals*, paragraph 164, available at http://www.ohchr.org/english/issues/millenium-development/docs/alston.doc.
54. CESCR, General Comment 14, see note 32, paragraphs 33–36.
55. Feyter and Gómez Isa, *Privatisation and Human Rights*, see note 2, p. 3.
56. Dutch Health Insurance Act, see note 11, Article 3. This is the so-called *acceptatieplicht*, the obligation to accept all customers.
57. Health Insurance Act, see note 11, Article 10.
58. Sun, Q., The interactions between social and commercial health insurance after China's entry into the World Trade Organization, in *Commercialization of Health Care*, see note 1, pp. 94–95.
59. For the United Kingdom see Pollock, *The Privatisation of Our Health Care*, see note 1, p. 227. For the Dutch system see Toebes, *Health and Human Rights*, see note 7, 119.
60. Although as a Declaration this document is in principle not legally binding, increasingly it is argued that this document has obtained the status of customary international law.
61. CESCR, General Comment 14, see note 32, paragraph 12.
62. UN Human Rights Committee (HRC), General Comment 16: The Right to Respect of Privacy, Family Home and Correspondence, and Protection of Honour and Reputation (Article 17), 32nd session, April 8, 1988. AQ10
63. HRC, General Comment 16, see note 62, paragraph 10.
64. HRC, General Comment 16, see note 62, paragraph 10.

AUTHOR QUERIES

[AQ1] We have set the paragraph "The British . . . England" as a display extract. Is this OK?
[AQ2] Please check if the changes made in the sentence "While as . . . their privacy" is OK.
[AQ3] Please check if the change made in the sentence "The General Comment . . . community" is OK.
[AQ4] Please check if the change made in the sentence "In some instances . . . insurance companies" is OK.
[AQ5] Please provide the chapter number of "Lethbridge, Strategies of Mutinational Health Care Companies in Europe and Asia" in Note 17.
[AQ6] Please provide the complete information in Note 27, if appropriate.
[AQ7] Please provide the complete information of "Potts, A Right to Public Participation in Public Health Strategy Management" in Note 32.
[AQ8] Please provide the author name for "Boy's death sparks riots over China health costs" in Note 34, if appropriate.
[AQ9] Please provide the author name for "Some private hospitals are falling short of minimum standards" in Note 50, if appropriate.
[AQ10] Please check if the date "April 8, 1988" is correct in Note 62.
[AQ11] Recto running head is edited from chapter title. Please check.