University of Essex

HUMAN RIGHTS CENTRE

THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

HEALTH SYSTEMS
AND THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

PAUL HUNT & GUNILLA BACKMAN

PREFACE

This briefing looks at health systems from the perspective of the right to the highest attainable standard of health.[1] It outlines how this fundamental human right underpins and reinforces an effective, integrated, accessible health system — and why this is important. In other words, the briefing signals a right-to-health approach to health systems strengthening.

Today, there is growing recognition that a strong health system is an essential element of a healthy and equitable society. In any society, an effective health system is a core social institution, no less than a fair justice system or democratic political system. However, according to a recent publication of the World Health Organization, health systems in many countries are failing and collapsing. In these circumstances, it is critically important to find ways of strengthening health systems.

In the last decade or so, the right to the highest attainable standard of health has ceased to be merely a slogan and has become an operational tool that can help health policy makers and practitioners achieve their professional objectives. In that case, what can the right to the highest attainable standard of health contribute to health system strengthening? What are the key right-to-health features of a health system? These are some of the questions that this briefing explores.

The briefing begins by identifying some of the historical landmarks in the development of health systems, such as the Declaration of Alma-Ata on primary health care (1978). Taking into account health good practices, as well as the right to the highest attainable standard of health, the study then outlines, in general terms, a right-to-health approach to strengthening health systems. It also signals six elements — or "building blocks" — that together constitute a functioning health system and argues that the right-to-health approach should be applied, consistently and systematically, across these six "building blocks". By way of illustration, the briefing takes the general right-to-health approach to strengthening health systems and begins to apply it to two of the health system "building blocks".

The last section draws an analogy between a fair court system and an equitable health system. There is no doubt that the right to a fair trial has helped to strengthen court systems. In a similar fashion, the right to the highest attainable standard of health can help to strengthen health systems.

In 2006, the UN Human Rights Council asked Paul Hunt, then UN Special Rapporteur on the right to the highest attainable standard of health, to prepare a report on health systems. He and colleagues consulted with a wide range of individuals and organisations in developed and developing countries. This briefing draws from those consultations, as well as the UN report on health systems submitted by the Special Rapporteur to the UN Human Rights Council in January 2008.[2]

The relationship between health systems and the right to the highest attainable standard of health is a large and complex topic. This briefing is offered as an accessible introduction for the non-specialist. By no means is it comprehensive. Much more work needs to be done to consistently and systematically apply the general right-to-health approach to the six "building blocks" of a health system. This approach needs further examination, as well as testing in the field. It is hoped that this introductory briefing will help to generate the serious attention of health policy makers, practitioners and researchers at the local, national and international levels.

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Photograph © 2008
Gunilla Backman.
District Hospital Juan José
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Guatemala.

SECTION I: INTRODUCTION

The last six decades of international and domestic policy and practice have confirmed that health is not only a human rights issue but also a fundamental building block of sustainable development, poverty reduction and economic prosperity. Recently, there has also been growing recognition that a strong health system is an essential element of a healthy and equitable society. In any society, an effective health system is a core institution, no less than a fair justice system or democratic political system.[3]

Yet according to a recent publication of the World Health Organisation (WHO), health systems in many countries are failing and collapsing. "In too many countries" health systems "are on the point of collapse, or are accessible only to particular groups in the population".[4] Too often health systems "are inequitable, regressive and unsafe". "Health outcomes are unacceptably low across much of the developing world, and the persistence of deep inequities in health status is a problem from which no country in the world is exempt. At the centre of this human crisis is a failure of health systems."[5]

WHO also confirms that sustainable development depends on effective health systems: "It will be impossible to achieve national and international goals — including the Millennium Development Goals — without greater and more effective investment in health systems and services."[6]

At the heart of the right to the highest attainable standard of health lies an effective and integrated health system, encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all. Without such a health system, the right to the highest attainable standard of health can never be realised.

Thus, it is only through building and strengthening health systems that it will be possible to secure sustainable development, poverty reduction, economic prosperity, improved health for individuals and populations, as well as the right to the highest attainable standard of health.

At the Heart of the Right to the Highest Attainable Standard of Health

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Photograph © 2007 Arturo Sanabria, courtesy of Photoshare. A t-shirt in East Timor promotes usage of Long Lasting Treated Bed Nets.

SECTION I:
HEALTH SYSTEMS AND THE RIGHT TO THE HIGHEST ATTAINABLE STANDARD OF HEALTH

A. HEALTH SYSTEMS: SOME HISTORICAL LANDMARKS

Health systems of some sort have existed as long as people have tried to protect their health and treat diseases, but organised health systems are barely 100 years old, even in industrialised countries. [7] They are political and social institutions, and usually include the State, private and voluntary sectors. Many health systems have gone through several, sometimes parallel and competing, generations of development and reform, shaped by national and international values and goals. One of the first attempts to unify thinking about health within a single policy framework was embodied in the Declaration of Alma-Ata on primary health care, agreed by Ministers of Health from throughout the world and adopted in 1978 at the International Conference on Primary Health Care. This seminal Declaration does not seek to address health systems in their entirety; [8] instead, it focuses on some vital components of an effective health system and still remains very relevant to health systems strengthening.

The Declaration begins by affirming that the attainment of the highest possible level of health is a fundamental human right. Several principal themes recur throughout the Declaration, all of which are relevant to health systems in both developed and developing countries: [9]

Alma-Ata Declaration themes

Several principle themes recur throughout the Alma-Ata Declaration, all of which are reflective of the right to the highest attainable standard of health and relevant to health systems in both developed and developing countries:

a. The importance of equity

b. The need for community participation

c. The need for a multisectoral approach to health problems

d. The need for effective planning

e. The importance of integrated referral systems

f. An emphasis on health-promotional activities

g. The critical role of suitably trained human resources

h. The importance of international cooperation

In addition to these themes, the Declaration highlights a number of essential health interventions:

a. Education concerning prevailing health problems

b. Promotion of food supply and proper nutrition

c. Adequate supply of safe water and basic sanitation

d. Maternal and child health care, including family planning

e. Immunisation against major infectious diseases

f. Prevention and control of locally endemic diseases

g. Appropriate treatment of common diseases and injuries

h. Provision of essential drugs

Photograph © 2006 Felix Masi/Voiceless Children, courtesy of Photoshare. A young girl at Mudoba village in Funyula, Kenya, quenches her thirst at a newly drilled water bore hole, installed as part of a Voiceless Children project.

One of the most striking characteristics of the Declaration is that it encompasses the interrelated domains of medicine, public health and human rights. For example, it includes medical care, such as access to essential drugs, and public health, such as community participation and access to safe water, all of which are major preoccupations of the right to the highest attainable standard of health. The Declaration is situated on the common ground between medicine, public health and human rights. This convergence is reinforced by the Committee on Economic, Social and Cultural Rights' general comment No. 14 (2000) on the right to the highest attainable standard of health, [10] according to which "the Declaration of Alma-Ata provides compelling guidance on the core obligations arising from" the right to the highest attainable standard of health.

Since its adoption, some of the elements of the Declaration have developed. The Ottawa Charter for Health Promotion (1986), for example, laid the foundations of modern health promotion. Looking beyond a curative-oriented health sector, the Charter emphasises the vital role of multisectoral prevention and promotion in relation to many health problems.

For the most part, however, the central messages of the Declaration of Alma-Ata were obscured in the 1980s and 1990s. For a variety of reasons, there was a shift towards vertical (or selective) biomedical interventions. Driven by neo-liberal economics, structural adjustment programmes led to reduced health budgets and the introduction of user fees. As WHO recently observed: "The results were predictable. The poor were deterred from receiving treatment and the user fees yielded limited income. Moreover, maintaining a network of under-resourced hospitals and clinics, while human and financial resources were increasingly pulled into vertical programmes, increased pressures on health systems sometimes to the point of collapse." [11]

This quotation is astonishing – and shaming. International and national policies were introduced that – predictably – brought health systems "to the point of collapse". [11]

Since 1978, a number of other issues — such as gender, the environment, disability, mental health, traditional health systems, the role of the private sector, and accountability — have been increasingly recognised as important. When revisiting the Declaration, they need to be taken into account.

The Alma–Ata Declaration of 1978

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As the health crisis deepened, efficiency became the watchword and health sector reform "focused above all on doing more for less". [12] It was only around the turn of the century that the international community started to confront the reality that running health systems on US$ 10 per capita, or less, is simply not a viable proposition.

In the last few years, there has been a significant increase in the amount of international funding available to health. Some States have also increased their domestic health funding. Much of the increase in investment by external partners, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, as well as the GAVI Alliance (GAVI), has focused on specific diseases and conditions. However, these initiatives exposed (some would say aggravated) the degraded state of many health systems. There has been a dawning realisation that these specific initiatives cannot thrive without effective, strengthened health systems. Recent years have also seen a growing appreciation of the seriousness of the health workforce crisis, including the skills drain from low-income to high-income countries, a perverse subsidy from the poor to the rich. [13]

In 2005, recognising that inadequate health systems were impeding progress towards improved Immunisation coverage, GAVI decided to support health system strengthening with an initial commitment of US$ 500 million for 2006-2010. [14] Launched in 2007, the International Health Partnership

Photograph © WHO/Oliver Asselin. A vaccination site in Yade Bohu, north of Kara, a child receives his vaccination. Togo has a population of 5.4 million, out of which 1.3 million people in the Kara region were targeted in the campaign.

— a global compact for achieving the health Millennium Development Goals — aims to build health systems in some of the poorest countries in the world. It is hoped that the Partnership will go beyond making better use of existing aid and also generate additional resources.

As increased resources are invested in health systems, it is important to clarify the relationship between health systems and the right to the highest attainable standard of health. In this way, the right to the highest attainable standard of health, informed by health good practices, can help to make a practical, constructive contribution to health system strengthening.

Additionally, States have a legal duty to comply with their binding international and national human rights obligations. Identifying the features of a health system that arise from the right to the highest attainable standard of health can help States ensure that their policies and practices are in conformity with their legally binding human rights duties.

B.   HOW DO YOU DEFINE A HEALTH SYSTEM?

There are countless competing definitions of health systems. In an important publication brought out by WHO in 1991, Tarimo defines a health system as "the complex of interrelated elements that contribute to health in homes, educational institutions, workplaces, public places and communities, as well as in the physical and psychological environment and the health and related sectors". [15] In 2007, WHO adopted a narrower definition: "A health system consists of all organisations, people and actions whose primary intent is to promote, restore or maintain health." [16] The literature reveals many other definitions, each with carefully nuanced differences.

For present purposes, there is no need to favour one definition over another because all the features and measures identified in this report should be part of any health system, however defined.

C.   IN GENERAL TERMS A RIGHT-TO-HEALTH APPROACH TO STRENGTHENING HEALTH SYSTEMS

International human rights law signals the content and contours of the right to the highest attainable standard of health. In the last decade or so, States, international organisations, international and national human rights mechanisms, courts, civil society organisations, academics and many others have begun to explore what this human right means and how it can be put into practice. Health workers are making the most decisive contribution to this process.

Drawing on this deepening experience, and informed by health good practices, this section briefly outlines the general approach of the right to the highest attainable standard of health towards the strengthening of health systems.

The general approach of the right to the highest attainable standard of health towards the strengthening of health systems:

1 At the centre: the well being of individuals, communities and population	7 Medical care and the underlying determinants of health	12 Vertical versus integrated interventions
2 Not only outcomes, but also processes	8 Progressive realisation and resource constraints	13 Coordination
3 Transparency	9 Duties of immediate effect: core obligations	14 Health as a global public good: the importance of international cooperation
4 Participation	10 Quality	15 Prioritisation and striking balances
5 Equity, equality and non-discrimination	11 A continuum of prevention and care with effective referrals	16 Monitoring and accountability
6 Respect for cultural differences		17 Legal obligation

1. AT THE CENTRE: THE WELL BEING OF INDIVIDUALS, COMMUNITIES AND POPULATIONS

A health system gives rise to numerous technical issues. Of course, experts have an indispensable role to play in addressing these technical matters. But there is a risk that health systems will become impersonal, "top-down" and dominated by experts. Additionally, as a recent WHO publication observes, "health systems and services are mainly focused on disease rather than on the person as a whole, whose body and mind are linked and who needs to be treated with dignity and respect." [17]

The publication concludes, "health care and health systems must embrace a more holistic, people-centred approach". [18] This is also the approach required by the right to the highest attainable standard of health. Because it places the well-being of individuals, communities and populations at the centre of a health system, the right to health can help to ensure that a health system is neither technocratic nor removed from those it is meant to serve.
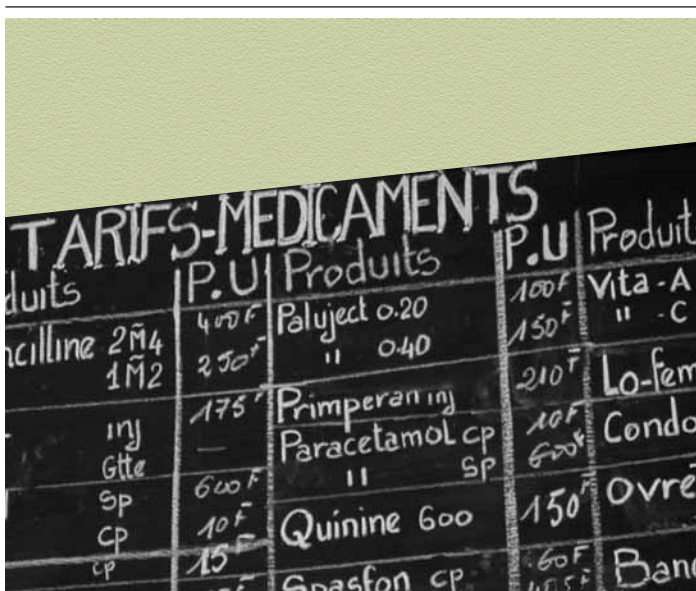
2. NOT ONLY OUTCOMES, BUT ALSO PROCESSES

The right to the highest attainable standard of health is concerned with both processes and outcomes. It is not only interested in what a health system does (e.g. providing access to essential medicines and safe drinking water), but also how it does it (e.g. transparently, in a participatory manner, and without discrimination).

3. TRANSPARENCY

Access to health information is an essential feature of an effective health system, as well as the right to the highest attainable standard of health. Health information enables individuals and communities to promote their own health, participate effectively, claim quality services, monitor progressive realisation, expose corruption, hold those responsible to account, and so on. The requirement of transparency applies to all those working in health-related sectors, including States, international organisations, public private partnerships, business enterprises and civil society organisations.

Photograph © 2003 Amelie Sow/CCP, courtesy of Photoshare. The price list for medicine and medical supplies is displayed on a chalkboard at a health post in the rural community of Gassane in the Louga region of Senegal.

4. PARTICIPATION

All individuals and communities are entitled to active and informed participation on issues relating to their health. In the context of health systems, this includes participation in identifying overall strategy, policymaking, implementation and accountability. The importance of community participation is one of the principal themes recurring throughout the Declaration of Alma-Ata. Crucially, States have a human rights responsibility to establish institutional arrangements for the active and informed participation of all relevant stakeholders, including disadvantaged communities. [19]

5. EQUITY, EQUALITY AND NON-DISCRIMINATION

Equality and non-discrimination are among the most fundamental elements of international human rights, including the right to the highest attainable standard of health. A State has a legal obligation to ensure that a health system is accessible to all without discrimination, including those living in poverty, minorities, indigenous peoples, women, children, slum and rural dwellers, people with disabilities, and other disadvantaged individuals and communities. Also, the health system must be responsive to the particular health needs of women, children, adolescents, the elderly, and so on. The twin human rights principles of equality and non discrimination mean that outreach (and other) programmes must be in place to ensure that disadvantaged individuals and communities enjoy, in practice, the same access as those who are more advantaged.

Equality and non-discrimination are akin to the critical health concept of equity. There is no universally accepted definition of equity, but one sound definition is "equal access to health care according to need". [20] All three concepts have a social justice component. In some respects, equality and non-discrimination, being reinforced by law, are more powerful than equity. For example, if a State fails to take effective steps to tackle race discrimination in a health system, it can be held to account and required to take remedial measures. Also, if a health system is accessible to the wealthy but inaccessible to those living in poverty, the State can be held to account and required to take remedial action.

6. RESPECT FOR CULTURAL DIFFERENCE

A health system must be respectful of cultural difference. Health workers, for example, should be sensitive to issues of ethnicity and culture. Also, a health system is required to take into account traditional preventive care, healing practices and medicines. Strategies should be in place to encourage and facilitate indigenous people, for example, to study medicine and public health. Moreover, training in some traditional medical practices should also be encouraged. [21]

Of course, cultural respect is right as a matter of principle. But, additionally, it makes sense as a matter of practice. As Thoraya Ahmed Obaid, Executive Director of UNFPA, observes: "cultural sensitivity... leads to higher levels of programme acceptance and ownership by the community, and programme sustainability". [22]

Respect for Culture

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Source: Culture Matters – Working with communities and faith-based organisations: Case studies from country programmes, UNFPA, 2004, p. v.

7. MEDICAL CARE AND THE UNDERLYING DETERMINANTS OF HEALTH

The health of individuals, communities and populations requires more than medical care. For this reason, international human rights law casts the right to the highest attainable standard of physical and mental health as an inclusive right extending to not only timely and appropriate medical care but also the underlying determinants of health, such as access to safe water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, access to health-related education and information, including on sexual and reproductive health, and freedom from discrimination. [23]

The social determinants of health, such as gender, poverty and social exclusion, are major preoccupations of the right to the highest attainable standard of health. In his work, for example, the Special Rapporteur has consistently looked at medical care and the underlying determinants of health, including the impact of poverty and discrimination on health. In short, the right to the highest attainable standard of health encompasses the traditional domains of both medical care and public health. This is the perspective that the right to the highest attainable standard of health brings to the strengthening of health systems.

Photograph © 2007 Diego Merino, courtesy of Photoshare. In Quetzaltenango, Guatemala, a group of indigenous midwives demonstrate how they check a pregnant woman for complications in her pregnancy, in order to determine whether the child can be born in the community or should be taken to a hospital. Although a large majority of births in rural indigenous communities are attended by midwives, they are rarely respected and recognised as critical health care providers by the public health system.

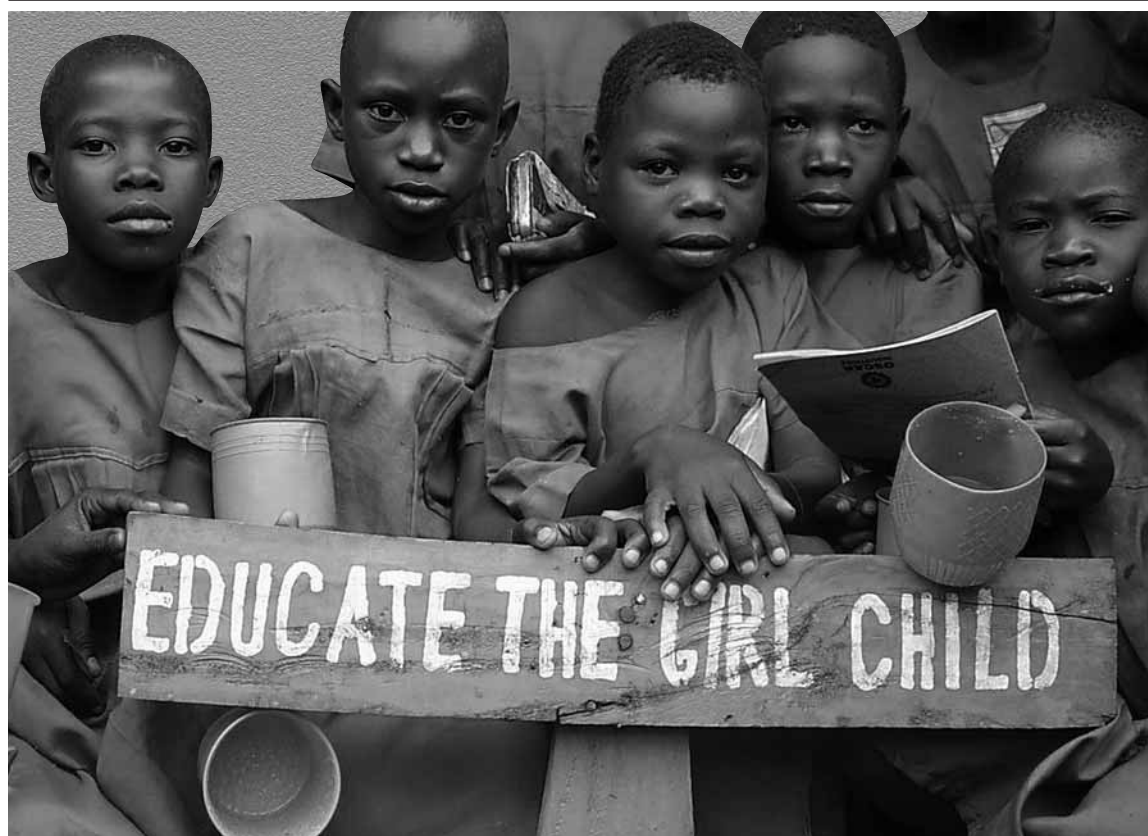# 8. PROGRESSIVE REALISATION AND RESOURCE CONSTRAINTS

The right to the highest attainable standard of health is subject to progressive realisation and resource availability. In other words, it does not make the absurd demand that a comprehensive, integrated health system be constructed overnight. Rather, for the most part, human rights require that States take effective measures to progressively work towards the construction of an effective health system that ensures access to all. The disciplines of medicine and public health take a similar position; the Declaration of Alma-Ata, for example, is directed to "progressive improvement". [24] Also, the right to health is realistic: it demands more of high income than low-income States, in other words, implementation of the right to health is subject to resource availability. However, there is "a minimum level of expenditure below which the system simply cannot work well." [25]

These two concepts — progressive realisation and resource availability — have numerous implications for health systems. For example, because progressive realisation does not occur spontaneously, a State must have a comprehensive, national plan, encompassing both the public and private sectors, for the development of its health system. The crucial importance of planning is recognised in the health literature, the Declaration of Alma-Ata and Committee on Economic, Social and Cultural Rights general comment No. 14 (2000) on the right to the highest attainable standard of health. Another implication of progressive realisation is that an effective health system must include appropriate indicators and benchmarks; otherwise, there is no way of knowing whether or not the State is improving its health system and progressively realising the right to the highest attainable standard of health. Moreover, the indicators must be disaggregated on suitable grounds, such as sex, socio-economic status and age, so that the State knows whether or not its outreach programmes for disadvantaged individuals and communities are working. Indicators and benchmarks are already commonplace features of many health systems, but they rarely have all the elements that are important from a human rights perspective, such as disaggregation on appropriate grounds. [26] A third implication arising from progressive realisation is that at least the present level of enjoyment of the right to the highest attainable standard of health must be maintained. This is some-times known as the principle of non-retrogression. [27]

Although rebuttable in certain limited circumstances, there is a strong presumption that measures lowering the present enjoyment of the right to health are impermissible.

Finally, progressive realisation does not mean that a State is free to choose whatever measures it wishes to take so long as they reflect some degree of progress. A State has a duty to adopt those measures that are most effective, while taking into account resource availability and other human rights considerations.

Photograph © 2006 Karen Smith/MSH, Courtesy of Photoshare. Young girls at Nwambwa school in Bugiri, Uganda, promote education for girls.

9. DUTIES OF IMMEDIATE EFFECT: CORE OBLIGATIONS

Although subject to progressive realisation and resource availability, the right to the highest attainable standard of health gives rise to some core obligations of immediate effect. A State has "a core obligation to ensure the satisfaction of, at the very least, minimum essential levels" of the right to the highest attainable standard of health. [28] What, more precisely, are these core obligations? Some are discussed later. Briefly, they include an obligation to:

a. Prepare a comprehensive, national plan for the development of the health system;

b. Ensure access to health-related services and facilities on a non-discriminatory basis, especially for disadvantaged individuals, communities and populations; this means, for example, that a State has a core obligation to establish effective outreach programmes for those living in poverty;

c. Ensure the equitable distribution of health-related services and facilities, e.g. a fair balance between rural and urban areas;

d. Establish effective, transparent, accessible and independent mechanisms of accountability in relation to duties arising from the right to the highest attainable standard of health.

Also, a State has a core obligation to ensure a minimum essential package of health-related services and facilities, including essential food to ensure freedom from hunger, basic sanitation and adequate water, essential medicines, immunisation against the community's major infectious diseases, and sexual and reproductive health services including information, family planning, prenatal and post-natal services, and emergency obstetric care. Some States have already identified a minimum essential package for those within their jurisdiction. Some international organisations have also tried to identify a minimum essential package of health services. This is a difficult exercise, not least because health challenges vary widely from one State to another, which means that in practice, the minimum essential package may vary between countries. In some countries, the challenge is under nutrition, elsewhere it is obesity.

Much more work has to be done to help States identify the minimum essential package of health related services and facilities required by the right to the highest attainable standard of health. However, that vital task is not the purpose of this publication. This study is not attempting to provide a list of essential services and facilities that are needed for a well-functioning health system. Rather, it is seeking to identify a number of additional, and frequently neglected, features arising from the right to the highest attainable standard of health, and informed by health good practices, that are required of all health systems. These include, for example, access on the basis of equality and non-discrimination, an up-to-date health plan, effective accountability for the public and private health sector, and so on.

10. QUALITY

Health services and facilities must be of good quality. For example, a health system must be able to ensure access to good quality essential medicines. If medicines are rejected in the North because they are beyond their expiry date and unsafe, they must not be recycled to the South. Because medicines may be counterfeit or tampered with, a State must establish a regulatory system to check medicine safety and quality. The requirement of good quality also extends to the manner in which patients and others are treated. Health workers must treat patients and others politely and with respect.

11. A CONTINUUM OF PREVENTION AND CARE WITH EFFECTIVE REFERRALS

A health system should have an appropriate mix of primary (community-based), secondary (district-based) and tertiary (specialised) facilities and services, providing a continuum of prevention and care. The system also needs an effective process when a health worker assesses that a client may benefit from additional services and the client is referred from one facility to another. Referrals are also needed, in both directions, between an alternative health system (e.g. traditional practitioners) and "mainstream" health system. The absence of an effective referral system is inconsistent with the right to the highest attainable standard of health.

Photograph © 2007 **Ivan Chernichckin, courtesy of WHO.** Novotroits'kiy City Tuberculosis Dispensary. Khersons'ka Oblast.

12. VERTICAL OR INTEGRATED?

There is a long-standing debate about the merits of vertical (or selective) health interventions, which focus on one or more diseases or health conditions, and a comprehensive, integrated approach. By drawing off resources, vertical interventions can jeopardise progress towards the long-term goal of an effective health system. They have other potential disadvantages, such as duplication and fragmentation. However, in some circumstances, such as during a public health emergency, there may be a place for a vertical intervention. When these circumstances arise, the intervention must be carefully designed, so far as possible, to strengthen and not undermine a comprehensive, integrated health system.

13. COORDINATION

A health system, as well as the right to the highest attainable standard of health, depends on effective coordination across a range of public and private actors (including non governmental organisations) at the national and international levels. The scope of the coordination will depend on how the health system is defined. But however it is defined, coordination is crucial. For example, a health system and the right to the highest attainable standard of health demand effective coordination between various sectors and departments, such as health, environment, water, sanitation, education, food, shelter, finance and transport. They also demand coordination within sectors and departments, such as the Ministry of Health. The need for coordination extends to policymaking and the actual delivery of services.

Health-related coordination in many States is very patchy and weak. Alone, the Cabinet is an insufficient coordination mechanism for health-related issues. Other coordination mechanisms are essential.

14. HEALTH AS A GLOBAL PUBLIC GOOD: THE IMPORTANCE OF INTERNATIONAL COOPERATION [29]

Public goods are goods that benefit society as a whole. The concept of "national public goods", such as the maintenance of law and order, is well established. In an increasingly interdependent world, much more attention is being paid to "global public goods". They address issues in which the international community has a common interest. In the health context, global public goods include the control of infectious diseases, the dissemination of health research, and international regulatory initiatives, such as the WHO Framework Convention on Tobacco Control. Although it remains very imprecise, the concept of "global public goods" confirms that a health system has both national and international dimensions. The international dimension of a health system is also reflected in States' human rights responsibilities of international assistance and cooperation. These responsibilities can be traced through the Charter of the United Nations, the Universal Declaration of
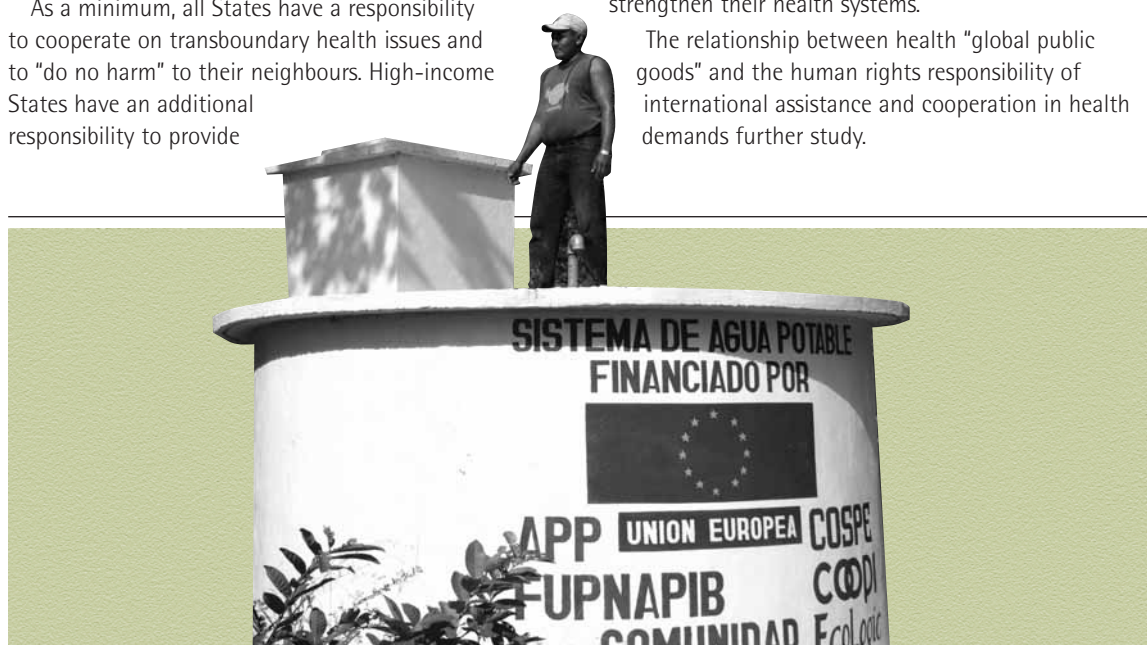
Human Rights, and several more recent international human rights declarations and binding treaties. [30] They are also reflected in the outcome documents of several world conferences, such as the Millennium Declaration, as well as numerous other initiatives, including the Paris Declaration on Aid Effectiveness (2005).

As a minimum, all States have a responsibility to cooperate on transboundary health issues and to "do no harm" to their neighbours. High-income States have an additional responsibility to provide

appropriate international assistance and cooperation in health for low-income countries. They should especially assist low-income countries with the fulfilment of their core obligations arising from the right to the highest attainable standard of health. Equally, low-income States have a responsibility to seek appropriate international assistance and cooperation to help them strengthen their health systems.

The relationship between health "global public goods" and the human rights responsibility of international assistance and cooperation in health demands further study.

Photograph © 2005 Todd Shapera, courtesy of Photoshare. The EcoLogic Development Corporation and the Pico Bonito Foundation established a community water tank for indigenous Tulepan villagers living in Honduras' Pico Bonito National Park area.

15. PRIORITISATION AND STRIKING BALANCES

Few human rights are absolute. Frequently, balances have to be struck between competing human rights. Freedom of information, for example, has to be balanced with the right to privacy. Moreover, there are often legitimate but competing claims arising from the same human right, especially in relation to those numerous rights that are subject to resource availability. In the context of health systems, finite budgets give rise to tough policy choices. Should the Government build a new teaching hospital, establish more primary health-care clinics, strengthen community care for people with disabilities, improve sanitation in the capital's slum, improve access to antiretrovirals, or subsidise an effective but expensive cancer drug? [31] Human rights do not

provide neat answers to such questions, any more than do ethics or economics. But human rights require that the questions be decided by way of a fair, transparent, participatory process, taking into account explicit criteria, such as the well-being of those living in poverty, and not just the claims of powerful interest groups.

Because of the complexity, sensitivity and importance of many health policy issues, it is vitally important that effective, accessible and independent mechanisms of accountability are in place to ensure that reasonable balances are struck by way of fair processes that take into account all relevant considerations, including the interests of disadvantaged individuals, communities and populations.

16. MONITORING AND ACCOUNTABILITY

Rights imply duties, and duties demand accountability. Accountability is one of the most important features of human rights — and also one of the least understood. Although human rights demand accountability this does not mean that every health worker or specialised agency becomes a human rights enforcer. Accountability includes the monitoring of conduct, performance and

outcomes. In the context of a health system, there must be accessible, transparent and effective mechanisms of accountability to understand how those with responsibilities towards the health system have discharged their duties. Because of its crucial importance, accountability is explained further in a later section.
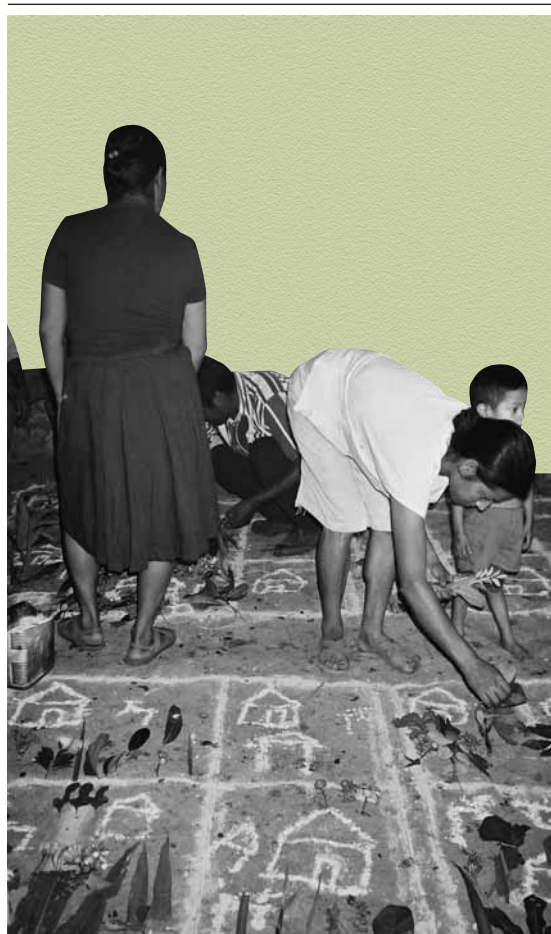
17. LEGAL OBLIGATION

The right to the highest attainable standard of health gives rise to legally binding obligations. A State is legally obliged to ensure that its health system includes a number of the features and measures signalled in the preceding paragraphs. The health system must have, for example, a comprehensive, national plan; outreach programmes for the disadvantaged; an essential package of health-related services and facilities; effective referral systems; arrangements to ensure the participation of those affected by health decision-making; respect for cultural difference; and so on. Of course, these requirements also correspond to health good practices. One of the distinctive contributions of the right to the highest attainable standard of health is that it reinforces such health good practices with legal obligation and accountability.

A State's legal obligations include:

- Comprehensive national health plan

- Ensure access to health-related services and facilities on non-discriminatory basis, especially for disadvantaged individuals, communities and populations

- Equitable distribution of health-related services and facilities

- A minimum essential package of health related services and facilities

- Effective referral systems

- Arrangements to ensure the participation of those affected by health-decision making

- Respect for cultural differences

- Accessible, transparent and effective mechanisms of accountability

D.   THE "BUILDING BLOCKS" OF A HEALTH SYSTEM

Photograph © 2007
Bonnie Gillespie,
courtesy of Photoshare.
A health worker at a rural
health clinic in Tanzania
examines a specimen for
presence of malaria.

Informed by health good practices, the preceding section outlines the general approach of the right to the highest attainable standard of health towards the strengthening of health systems. This general approach has to be consistently and systematically applied across the numerous elements that together constitute a functioning health system.

What are these functional elements? The health literature on this issue is very extensive. For its part, WHO identifies "six essential building blocks" which together make up a health system: [32]

a. Health services. "Good health services are those which deliver effective, safe, quality personal and non-personal health interventions to those who need them, when and where needed, with minimum waste of resources." Non-personal health interventions include, for example, safe water and adequate sanitation.

b. Health workforce. "A well-performing health workforce is one which works in ways that are responsive, fair and efficient to achieve the best health outcomes possible, given available resources and circumstances, i.e. there are sufficient numbers and mix of staff, fairly distributed; they are competent, responsive and productive".

c. Health information system. "A well-functioning health information system is one that ensures the production, analysis, dissemination and use of reliable and timely information on health determinants, health systems performance and health status".

d. Medical products, vaccines and technologies. "A well-functioning health system ensures equitable access to essential medical products, vaccines and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use".

e. Health financing. "A good health financing system raises adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them".

f. Leadership, governance, stewardship. This "involves ensuring strategic policy frameworks exist and are combined with effective oversight coalition-building, the provision of appropriate regulations and incentives, attention to system-design, and accountability".

WHO's "building blocks" of a health system

a. Health services

b. Health workforce

c. Health information system

d. Medical Products, vaccines and technologies

e. Health financing

f. Leadership, governance, stewardship

Source: Everybody's Business: Strengthening Health Systems to Improve Health Outcomes, WHO, 2007, p. 3 (available at http://who.int/healthsystems/strategy/everybodys_business.pdf).

Although some of these formulations may be subject to debate, for the purposes of this report these "building blocks" are a useful way of looking at a health system. Of course, each "building block" has generated a huge literature over many years.

For present purposes, three short points demand emphasis:

1. These are not only "building blocks" for a health system; they are also "building blocks" for the right to the highest attainable standard of health. Like a

health system, the right to health requires health services, health workers, health information, medical products, financing and stewardship.

2. In practice, the "building blocks" might not have all the features required by the right to the highest attainable standard of health. For example, a country might have a health information system, one of the WHO "building blocks". But the information system might not include appropriately disaggregated data, which is one of the requirements of the right to health. In short, an essential "building block" might be in place, but without all the features required by international human rights law.

3. The crucial challenge is to apply — or integrate — the right to the highest attainable standard of health, as well as other human rights, across the six "building blocks". The general approach outlined in the preceding section has to be consistently and systematically applied to health services, health workers, health information, medical products, financing and stewardship — all the elements that together constitute a functioning health system.

The systematic application of the right to health to the six "building blocks" is likely to have a variety of results. In some cases, the right to health will reinforce existing features of the "building blocks" that routinely receive the attention they deserve. In other cases, the application of the right will identify existing features of the "building blocks" that tend to be overlooked in practice and that require much more attention, such as the disaggregation of data on appropriate grounds. It is also possible that the application of the right may identify features that, although important, are not usually regarded as forming any part of the six "building blocks". [33]

E. APPLYING THE GENERAL APPROACH: SOME SPECIFIC MEASURES FOR HEALTH SYSTEMS STRENGTHENING

The present section begins to apply the right to the highest attainable standard of health to two "building blocks" of WHO: (i) a health workforce and (ii) leadership, governance and stewardship. Although a very brief application, it gives a sense of the practical implications of the general approach of the right to health general right to health approach to health systems strengthening.

1. HEALTH WORKFORCE

While human resources in health have attracted increasing attention in recent years, the human rights dimensions of the issue rarely receive significant consideration. If the general right to health approach already outlined was applied to health workers, the following points would be among those that need detailed examination. [34]

A State should have an up-to-date development plan for human resources in preventive, curative and rehabilitative health; it should encompass physical and mental health.

When planning, the State should consider providing a role for mid-level providers, such as assistant medical officers and surgical technicians, as well as public health workers. Described as a key strategy to uphold the fundamental human right to health, midlevel providers are already an essential part of the health systems in some countries, such as Mozambique. [35]

Recruitment of health workers must include outreach programmes to disadvantaged individuals, communities and populations, such as indigenous peoples.

Effective measures are required towards achieving a gender balance among health workers in all fields.

The State should ensure that the number of domestically trained health workers is commensurate with the health needs of the population, subject

Photograph © 2007 Gopal Bhattacharjee, courtesy of Photoshare. A doctor examines a child during a free dental checkup camp at an educational fair beside EM bypass, Kolkata, India. Indian children often suffer physical deficiencies due to malnutrition, including dental problems like cavities and root canals. This health camp also helps to promote awareness of child health issues.

Photograph © 2006 Ben Barber, courtesy of Photoshare. In Kabul, Afghanistan, three young women medical students stand outside the main building of the Kabul University medical school, which is training its first class of women doctors since the Taliban were ousted.

to progressive realisation and resource availability. In this context, appropriate balances must be struck between, for example, the number of health workers at the community or primary level and specialists at the tertiary level.

The number of health workers should be collected, centralised and made publicly available. The data should be broken down by category, e.g. nurse, public health professional and so on. The various categories should be disaggregated, as a minimum, by gender.

Health workers' training must include human rights, including respect for cultural diversity, as well as the importance of treating patients and others with courtesy. [36]

After qualifying, all health workers must have opportunities, without discrimination, for further professional training.

Health workers must receive domestically competitive salaries, as well as other reasonable terms and conditions of employment. Their human rights must be respected, for example, freedoms of association, assembly and expression. They must be provided with the opportunity of active and informed participation in health policymaking. The safety of health workers, who are disproportionately exposed to health hazards, is a major human rights issue.

There should be incentives to encourage the appointment, and retention, of health workers in underserved areas. [37]

The skills drain raises numerous human rights issues, including in relation to the right to the highest attainable standard of health in countries of origin. Where relevant, both sending and receiving States must have policies in place to address the skills drain. [38]

2. LEADERSHIP, GOVERNANCE, STEWARDSHIP

This is "arguably the most complex but critical building block of any health system". [39] It encompasses many elements, including planning and accountability.

(a) Planning

This is one of the weakest features of the development and strengthening of health systems. With a few honourable exceptions, the record of health planning is poor, while the history of health planning is surprisingly short. Many States do not have comprehensive, up-to-date health plans. Where they exist, plans "often fail to be implemented and remain grand designs on paper. Elsewhere plans may be implemented but fail to respond to the real needs of the population." [40]

However, from the perspective of the right to the highest attainable standard of health, effective planning is absolutely critical. Progressive realisation and resource availability — two inescapable components of the international right to health — cannot be addressed without planning.

Recognising the critical role of effective planning, the Committee on Economic, Social and Cultural Rights designated the preparation of a health "strategy and plan of action" a core obligation arising from the right to the highest attainable standard of health. The Committee also encouraged high-income States to provide international assistance "to enable developing countries to fulfil their core... obligations", including the preparation of a health plan. [41] According to the Declaration of Alma-Ata: "All governments should formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a comprehensive national health system and in coordination with other sectors." [42]

Health planning is complex and many of its elements are important from the perspective of the right to the highest attainable standard of health, including the following.

The entire planning process must be as participatory and transparent as possible.

It is very important that the health needs of disadvantaged individuals, communities and populations are given due attention. Also, effective measures must be taken to ensure their active and informed participation throughout the planning process. Both the process and plan must be sensitive to cultural difference.

Prior to the drafting of the plan, there must be a health situational analysis informed by suitably disaggregated data. The analysis should identify, for example, the characteristics of the population (e.g. birth, death and fertility rates), their health needs (e.g. incidence and prevalence by disease), and the public and private health-related services presently available (e.g. the capacity of different facilities).

The right to the highest attainable standard of health encompasses an obligation on the State to generate health research and development that addresses, for example, the health needs of disadvantaged individuals, communities and populations. Health research and development includes classical medical research into drugs, vaccines and diagnostics, as well as operational or implementation research into the social, economic, cultural, political and policy issues that determine access to medical care and the effectiveness of public health interventions. Implementation research, which has an important role to play with a view to dismantling societal obstacles to health interventions and technologies, should be taken into account when drafting the national health plan.

The plan must include certain features such as clear objectives and how they are to be achieved, time frames, indicators and benchmarks to measure achievement, effective coordination mechanisms, reporting proce-dures, a detailed budget that is attached to the plan, financing arrangements (national and international), evaluation arrangements, and one or more accountabili-ty devices. In order to complete the plan, there will have to be a process for prioritising competing health needs.

Before their finalisation, key elements of the draft plan must be subject to an impact assessment to ensure that they are likely to be consistent with the State's national and international legal obligations, including those relating to the right to the highest attainable standard of health. For example, if the draft plan proposes the introduction of user fees for health services, it is vital that an impact assessment is undertaken to anticipate the likely impact of user fees on access to health services for those living in poverty. If the assessment confirms that user fees are likely to hinder access, the draft plan must be revised before adoption; otherwise, it is likely to be inconsistent with the State's obligations arising from the right to the highest attainable standard of health. [43]

Of course, planning is only the means to an end: an effective, integrated health system that is accessible to all. The main task is implementation. Evaluation, monitoring and accountability can help to ensure that all those responsible for implementation discharge their duties as planned, and that any unintended consequences are swiftly identified and addressed.

(b) Monitoring and accountability
As already discussed, monitoring and accountability have a crucial role to play in relation to human rights and health systems. Accountability provides individuals and communities with an opportunity to understand how those with responsibilities have discharged their duties. Equally, it provides those with responsibilities the opportunity to explain what they have done and why. Where mistakes have been made, accountability requires redress. But accountability is not a matter of blame and punishment. It is a process that helps to identify what works, so it can be repeated, and what does not, so it can be revised. It is a way of checking that reasonable balances are fairly struck. [44]

In the context of health systems, there are many different types of accountability mechanisms, including health commissioners, democratically elected local health councils, public hearings, patients' committees, impact assessments, judicial proceedings, and so on. An institution as complex and important as a health system requires a range of effective, transparent, accessible, independent accountability mechanisms. The media and civil society organisations have a crucial role to play.

Accountability in respect of health systems is often extremely weak. Sometimes the same body provides health services, regulates and holds to account. In some cases, accountability is little more than a device to check that health funds were spent as they should have been. Of course, that is important. But human rights accountability is much broader. It is also concerned with ensuring that health systems are improving, and the right to the highest attainable standard of health is being progressively realised, for all, including disad-vantaged individuals, communities and populations.

In some States, the private health sector, while playing a very important role, is largely unregulated. Crucially, the requirement of human rights accountabili-ty extends to both the public and private health sectors. Additionally, it is not confined to national bodies; it also extends to international actors working on health-related issues.

Accountability mechanisms are urgently needed for all those — public, private, national and international — working on health-related issues. The design of appropriate, independent accountability mechanisms demands creativity and imagination. Often associated with accountability, lawyers must be willing to understand the distinctive characteristics and challenges of health systems, and learn from the rich experience of medicine and public health.

The issue of accountability gives rise to two related points:

First, the right to the highest attainable standard of health should be recognised in national law. This is very important because such recognition gives rise to legal accountability for those with responsibilities for health systems. As is well known, the right is recognised in the Constitution of WHO, as well as the Declaration of Alma-Ata. It is also recognised in numerous binding international human rights treaties, including the Convention on the Rights of the Child, which has been

ratified by every State in the world, except for two (the United States of America and Somalia). The right to the highest attainable standard of health is also protected by numerous national constitutions. It should be recognised in the national law of all States.

Second, although important, legal recognition of the right to the highest attainable standard of health is usually confined to a very general formulation that does not set out in any detail what is required of those with responsibilities for health. For this reason, a State must not only recognise the right to health in national law but also ensure that there are more detailed provisions clarifying what society expects by way of health-related services and facilities. For example, there will have to be

provisions relating to water quality and quantity, blood safety, essential medicines, the quality of medical care, and numerous other issues encompassed by the right to the highest attainable standard of health. Such clarification may be provided by laws, regulations, protocols, guidelines, codes of conduct and so on. WHO has published important standards on a range of health issues. Obviously, clarification is important for providers, so they know what is expected of them. It is also important for those for whom the service or facility is intended, so they know what they can legitimately expect. Once the standards are reasonably clear, it is easier (and fairer) to hold accountable those with responsibilities for their achievement.

CONCLUSION

In summary, there is a legal obligation arising from the right to the highest attainable standard of health to ensure that there is an up-to-date development plan for human resources in health; programmes to recruit from disadvantaged populations; an adequate number of domestically trained health workers (subject to progressive realisation and resource availability); domestically competitive salaries for health workers; incentives to work in underserved areas; and so on. In the context of health planning, there is a legal obligation to ensure that the process is participatory and transparent;

addresses the health needs of disadvantaged individuals, communities and populations; and includes a situational analysis. Before finalisation, key elements of the draft plan must be subject to an impact assessment and the final plan must include certain crucial features.

These (and other) features are not just a matter of health good practice, sound management, justice, equity or humanitarianism. They are a matter of international legal obligation. Whether or not the obligations are properly discharged should be subject to review by an appropriate accountability mechanism.

F.   THE RIGHT TO HEALTH HELPS TO ESTABLISH A HEALTH SYSTEM IN THE SAME WAY AS THE RIGHT TO A FAIR TRIAL HELPS TO ESTABLISH A COURT SYSTEM

How does it help to recognise that the right to the highest attainable standard of health underpins and reinforces the features and measures required to establish an effective, integrated, accessible health system? One way of answering this question is by using the analogy of a court system and the right to a fair trial.

Just as every State must have a health system, it must also have an effective court system. The key features of an effective court system include independent, impartial judges. A case must come to trial without undue delay. All parties to a case must be given an opportunity to give their version of events, call witnesses and make a legal argument. In serious cases, an impecunious defendant must be provided with legal aid. In some cases, an interpreter must be provided. The judge must give reasons for his or her decision. There must be an appeal process in case the judge makes a mistake. Usually, the hearing should be in public.

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The human right to a fair trial requires a court system to have all these features. Significantly, many of these features have major budgetary implications.

States have designed a range of mechanisms and measures to ensure that these features of a court system are available in law and fact. For example, judicial independence must be protected by a carefully constructed process of judicial appointment and dismissal and by judges enjoying reasonable terms and conditions of employment.

Of course, a State could construct an effective court system without any express reference to the right to a fair trial. Indeed, policymakers in the Ministry of Justice could construct an effective court system without even thinking about human rights. And if they do, so be it. What is important is that there is an effective court system, with the key human rights features, dispensing justice without fear or favour.

But the record shows that many court systems do not possess all the key human rights features and do not dispense justice. In practice, some right-to-a-fair-trial features are overlooked or compromised. In this context, human rights play a number of important roles, including the following two.

First, the right to a fair trial provides guidance to policymakers in the Ministry of Justice. Human rights law reminds them what are the key features of a court system that must always be respected. Also, if officials in the Ministry of Justice are under political pressure to introduce unfair trials, they can explain that the State has minimum, legally binding, human rights obligations that cannot be compromised. In this way, human rights discourage backsliding.

Sometimes human rights can stop the Government from introducing misconceived reforms to the justice system.

Human rights have a second function. Anticipating that policymakers and others sometimes make mistakes, human rights require an effective mechanism to scrutinise important decisions. As already discussed, they require that those responsible be held to account — at the national and international levels — so that if there is an error, it can be identified and corrected. On countless occasions, human rights have been used to challenge policymakers and others about unjust court systems. Crucially, human rights have been used to expose unfair systems of justice — and they have led to welcome reforms.

Of course, sometimes human rights law fails and an unfair court system is uncorrected and unreformed. Sometimes policymakers reject the guidance provided by human rights, and accountability mechanisms prove too weak to provide redress. Human rights are only tools — and flawed tools to boot — and do not always work. But sometimes they do. Indeed, human rights have worked on many occasions and helped to establish court systems that are fairer and more just than they would otherwise have been.

By analogy, these arguments also apply to a health system.

From the perspective of the right to the highest attainable standard of health, as well as health good practices, an effective health system must include a number of features and measures, some of which are signalled in this briefing. There must be, for example, an up-to-date health plan; outreach programmes for

disadvantaged groups; publicly available data that is appropriately disaggregated; an essential package of health-related services and facilities; an up to-date,

national essential medicines list; meaningful regulation and effective accountability of the public and private health sector; and so on.

The right to health can be of practical assistance in building a health system

The right to the highest attainable standard of health can play a similar role in relation to the health system as the right to a fair trial plays in relation to a court system. The right to health can provide guidance to health policymakers, reminding them what features of a health system must always be respected. If there is national or international pressure to introduce reforms that will hinder access to health services for children, those living in poverty or other disadvantaged individuals or populations, officials can explain that the State

has minimum, legally binding human rights obligations that cannot be compromised in this way.

Recent history is littered with misguided reforms that have brought many health systems "to the point of collapse". While the right to health is not a panacea, it can help to stop the introduction of such ill-conceived health reforms. Just as the right to a fair trial has been used to strengthen systems of justice, so the right to health can be used to strengthen health systems.

Of course, it is possible to build a health system that has these features without any express reference to human rights, even without taking human rights into account. But the record shows that very many health systems do not, in fact, have these (and other) features that are required by the right to the highest attainable standard of health, and suggested by health good practices.

In this context, the right to the highest attainable standard of health can play a similar role in relation to the health system as the right to a fair trial plays in relation to a court system. The right to health can provide guidance to health policymakers, reminding them what features of a health system must always be respected. If there is national or international pressure to introduce reforms that will hinder access to health services for children, those living in poverty or other disadvantaged individuals or populations, officials can explain that the State has minimum, legally binding

human rights obligations that cannot be compromised in this way.

Also, because health policymakers and others sometimes make mistakes, the right to the highest attainable standard of health requires an effective mechanism to review important health related decisions. Under the right to health, those with responsibilities should be held to account so that misjudgements can be identified and corrected. Accountability can be used to expose problems and identify reforms that will enhance health systems for all.

Recent history is littered with misguided reforms that have brought many health systems "to the point of collapse".[45] While the right to health is not a panacea, it can help to stop the introduction of such ill-conceived health reforms. Just as the right to a fair trial has been used to strengthen systems of justice, so the right to health can be used to strengthen health systems.

SECTION III: CONCLUSION

Today, there are numerous health movements and approaches, including health equity, primary health care, health promotion, social determinants, health security, continuum of care, biomedical, macroeconomics, and so on. All are very important. It is misconceived, however, to regard human rights as yet another approach with the same status as the others. Like ethics, the right to the highest attainable standard of health is not optional

– and, like ethics, it recurs throughout all other approaches. The right to health is the only perspective that is both underpinned by universally recognised moral values and reinforced by legal obligations. Properly understood, the right to the highest attainable standard of health has a profound contribution to make toward building healthy societies and equitable health systems.

ENDNOTES

1 The full formulation of the right is "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health". In this briefing, "the right to health" and "the right to the highest attainable standard of health" are used as shorthand.

2. A/HRC/7/11, 31 January 2008. (Available at: *www2.essex. ac.uk/human_rights_centre/rth/docs/A-HRC-7-11.doc*). All the reports and work written by the UN Special Rapporteur on the right to the highest attainable standard of health are available at: *www2.essex.ac.uk/human_rights_ centre/rth/index.shtm.*

3 L. Freedman, "Achieving the MDGs: Health systems as core social institutions", Development 2005, vol. 48, No. 1, pp. 19-24. (Available at: *www.palgrave journals.com/ development/ journal/v48/n1/pdf/1100107a.pdf*).

4 *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes,* WHO, 2007, p. 1. (Available at: *who.int/healthsystems/strategy/everybodys_business.pdf).*

5 Ibid.

6 Ibid., p. v.

7 This section draws extensively on *Everybody's Business* (note 4 above), p. 9.

8 For a broader approach see *The World Health Report* 2000 - Health Systems: Improving Performance, WHO, 2000.

9 This passage draws extensively on A. Green, *An Introduction to Health Planning for Developing Health Systems*, Oxford University Press, 2007, pp. 63-64.

10 Art. 12 in the International Covenant on Economic, Social and Cultural Rights and General Comment No 14, paragraph 43.

11 *Everybody's Business* (note 4 above), p. 9.

12 Ibid.

13 For the Special Rapporteur's report on the skills drain, see A/60/348, paragraphs 18-89.

14 See *www.gavialliance.org/resources/HSS_Background.pdf*

15 E. Tarimo, *Towards a Healthy District. Organizing and Managing District Health Systems Based on Primary Health Care,* WHO, 1991, p.4.

16 *Everybody's Business* (note 4 above), p.2.

17 *People at the Centre of Health Care: Harmonizing Mind and Body, Peoples and Systems,* WHO, 2007, p.v.

18 Ibid., p.vii.

19 These issues have been explored in several of the Special Rapporteur's reports, including on *Uganda* (E/CN.4/2006/48/Add.2) and *Mental Disability* (E/CN.4/2005/51). Also see H. Potts, *Human Rights in Public Health: Rhetoric, Reality and Reconciliation*, PhD thesis, Monash University, Melbourne, Australia, 2006.

20 *An Introduction to Health Planning* (note 9 above), p. 64.

21 For the Special Rapporteur's reflections on indigenous peoples and the right to the highest attainable standard of health see, for example, A/59/422 and E/CN.4/2005/51/Add.3.

22 *Culture Matters - Working with communities and faith-based organisations: Case studies from country programmes,* UNFPA, 2004, p. v.

23 See, for example, article 24 of the Convention on the Rights of the Child. Health care includes dental care.

24 Declaration of Alma-Ata: Paragraph VII (6). (Available at: *www.who.int/hpr/NPH/docs/declaration_almaata.pdf*).

25 D. Evans et al., "Comparative efficiency of national health systems: cross national econometric analysis", BMJ 2001, p.209. (Available at: *http://bmj.com/cgi/content/full/323/7308/307*).

26 For a human rights-based approach to health indicators, see the Special Rapporteur's report E/CN.4/2006/48

27 Committee on Economic, Social and Cultural Rights general comment No. 14 (2000), paragraph 32.

28 Ibid., paragraphs 43-45.

29 This section draws extensively on *Health is Global: Proposals for a UK Government-Wide Strategy*, Department of Health, 2007, especially p. 46.

30 See S. Skogly, *Beyond National Borders: States' Human Rights Obligations in International Cooperation*, Antwerp/Oxford, Intersentia, 2006.

31 A report of the Special Rapporteur submitted to the United Nations General Assembly begins to address these challenging issues (A/62/214).

32 *Everybody's Business* (note 4 above), p. 3.

33 Such as ex ante impact assessments.

34 "Health workers" include all those developing, managing, delivering, monitoring and evaluating preventive, curative and rehabilitative health in the private and public health sectors, including traditional healers.

35 See *Health Systems Strengthening for Equity (HSSE): The Power and Potential of Mid-Level Providers*. (Available at: *www.midlevelproviders.org*)

36 This issue is explored in the Special Rapporteur's report on health workers and human rights education, A/60/348.

37 Uganda report E/CN.4/2006/48/Add.2.

38 In an earlier report, the Special Rapporteur examined the skills drain through the right-to-health lens, A/60/348.

39 *Everybody's Business* (note 4 above), p. 23.

40 *An Introduction to Health Planning* (note 9 above), p. 18.

41 Committee on Economic, Social and Cultural Rights general comment No. 14 (2000), paragraphs 43-45.

42 Declaration of Alma-Ata: Paragraph VIII (Available at: *www.who.int/hpr/NPH/docs/declaration_almaata.pdf*).

43 See G. MacNaughton and P. Hunt. The full report is available from the website of Essex University, Human Rights Centre, Right to Health Unit (Available at: *www2.essex.ac.uk/human_rights_centre/rth/projects.shtm*)

44 H. Potts "Accountability and the Right to the Highest Attainable Standard of Health" Human Rights Centre 2008. (Available at: *www2.essex.ac.uk/human_rights_centre/rth/projects.shtm*).

45 *Everybody's Business* (note 4 above), p. 1.