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**PROMOTION AND PROTECTION OF ALL HUMAN RIGHTS, CIVIL,
POLITICAL, ECONOMIC, SOCIAL AND CULTURAL RIGHTS**

**Report of the Special Rapporteur on the right of everyone to the enjoyment of
the highest attainable standard of physical and mental health, Paul Hunt**

Summary

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, responsive to national and local priorities, and accessible to all.

The Human Rights Council, in its decision 2/108, requested the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health to identify and explore the key features of an effective, integrated and accessible health system from the perspective of the right to health, bearing in mind the level of development of countries. This report is a response to that request.

There is a 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.

The report briefly identifies 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 report identifies a general approach to strengthening health systems (chap. II, sect. C). This general approach should be applied, consistently and systematically, across the numerous elements - or “building blocks” - that together constitute a functioning health system. By way of illustration, the report takes the general approach outlined in the report and begins to apply it to two of the health system “building blocks” (chap. II, sect. E).

Section F signals how the right to a fair trial has helped to strengthen court systems and argues that, in a similar way, the right to the highest attainable standard of health can help to strengthen health systems.

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I. INTRODUCTION

1. The Human Rights Council, in its resolution 6/29, extended the mandate of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (“right to the highest attainable standard of health” or “right to health”) set out in the Commission on Human Rights resolutions 2002/31 and 2004/27. The present report is submitted in accordance with that resolution.
2. The Special Rapporteur submitted an interim report to the General Assembly (A/62/214) at its sixty-second session in October 2007, in which three issues were considered. The first is how to prioritize health interventions, given that budgets are finite. Second, the report outlines a right-to-health impact assessment methodology. Third, it highlights the vital importance of underlying determinants of health, with particular reference to safe water and adequate sanitation. The report also includes an overview of the Special Rapporteur’s activities between November 2006 and July 2007.
3. Between July and December 2007, the Special Rapporteur undertook two missions - to Colombia (in September), focusing on aerial sprayings of illicit coca crops along the border with Ecuador, and India (in November) on maternal mortality. Reports thereon will be submitted to the Human Rights Council in September 2008.
4. In August 2007, as part of the John D. and Catherine T. MacArthur Foundation International Lecture Series on Population Issues, the Special Rapporteur gave a lecture on “The Millennium Development Goals and the Right to the Highest Attainable Standard of Health”, in Abuja, Nigeria.
5. On 19 September 2007, the draft Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines were launched, initiating a lengthy process of public consultation. In the light of this ongoing process, the revised final draft Guidelines will be published in 2008.
6. While at the University of Toronto, the Special Rapporteur also gave a public lecture on the right to the highest attainable standard of health. During the same month, he also addressed a London conference organized by Action for Global Health.
7. In October 2007, the Special Rapporteur was a keynote speaker at the 8th International Health Impact Assessment Conference, which took place in Dublin, Ireland. The Special Rapporteur also held a consultation, hosted by the British Medical Association, on accountability and the right to health. In New York, the Special Rapporteur met with the Open Society Institute to discuss his work on HIV/AIDS. Furthermore, he participated in a consultation, organized by the Brazilian Permanent Mission to the United Nations, on the draft Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines. Also in October, the Special Rapporteur spoke at the launch, which took place at the Women Deliver Conference in London, of the International Initiative on Maternal Mortality and Human Rights.

8. In November, the Special Rapporteur co-organized with the United Nations Population Fund (UNFPA) a workshop on mainstreaming sexual and reproductive health rights into the work of the United Nations human rights system. The workshop was hosted by the Office of the United Nations High Commissioner for Human Rights (OHCHR) in Geneva.
9. In December, the Special Rapporteur gave the first annual lecture on malaria and human rights, co-organized by the UK Coalition against Malaria and the European Alliance Against Malaria.
10. Throughout the reporting period, the Special Rapporteur had a number of consultations, in addition to those already mentioned, on the draft Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines, including with the International Federation of Pharmaceutical Manufacturers and Associations (IFPMA) and the pharmaceutical company Novo Nordisk.
11. The Special Rapporteur is extremely grateful to all those who have given him the benefit of their advice, support and time.

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

12. 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.¹
13. Yet according to a recent publication of the World Health Organization (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”.² 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.”³

¹ L. Freedman, “Achieving the MDGs: Health systems as core social institutions”, *Development* 2005, vol. 48, No. 1, p. 19-24 (available at <http://www.palgrave-journals.com/development/journal/v48/n1/pdf/1100107a.pdf>).

² *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes*, WHO, 2007, p. 1 (available at http://who.int/healthsystems/strategy/everybodys_business.pdf).

³ Ibid.

14. 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.”⁴

15. 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 realized.

16. 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.

17. In decision 2/108, the Human Rights Council requested the Special Rapporteur, when presenting his report, to consider the possibility of identifying and exploring “the key features of an effective, integrated and accessible health system”. He was asked to undertake this task “bearing in mind the level of development of countries and from the perspective of the right to the highest attainable standard of physical and mental health”.

18. This report looks at health systems from the perspective of the right to the highest attainable standard of health, drawing on numerous consultations, as well as consideration of extensive literature from the fields of both medicine and public health.⁵ Crucially, the chapter is informed by an understanding of health good practices, as well as the right to the highest attainable standard of health. All of the features and measures identified here are already found in some health systems, recognized in some international health instruments (such as the Declaration of Alma-Ata) or advocated in the health literature. But they are not usually recognized as human rights issues.

19. The report outlines how the right to the highest attainable standard of health underpins and reinforces an effective, integrated, accessible health system - and why this is important.

A. Health systems: some historical landmarks⁶

20. Health systems of some sort have existed as long as people have tried to protect their health and treat diseases, but organized health systems are barely 100 years old, even in industrialized countries. They are political and social institutions, and usually include the State,

⁴ Ibid., p. v.

⁵ This report has been enriched by consultations in the United Kingdom of Great Britain and Northern Ireland, the United States of America, New Zealand, Australia, Switzerland, Italy and Zimbabwe. The consultations have included a wide range of stakeholders from developing and developed countries, including indigenous people. The Special Rapporteur is very grateful to all those who organized, and participated in, these meetings.

⁶ This section draws extensively on *Everybody's Business ...* (note 2 above), p. 9.

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.

21. 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 on 12 September 1978 at the International Conference on Primary Health Care. This seminal Declaration does not seek to address health systems in their entirety;⁷ instead, it focuses on some vital components of an effective health system and still remains very relevant to health systems strengthening.

22. 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:⁸

- (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.

23. 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;

⁷ For a broader approach, see *The World Health Report 2000 - Health Systems: Improving Performance*, WHO, 2000.

⁸ This passage draws extensively on A. Green, *An Introduction to Health Planning for Developing Health Systems*, Oxford University Press, 2007, pp. 63-64.

- (d) Maternal and child health care, including family planning;
- (e) Immunization 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.

24. 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 recognized as important. When revisiting the Declaration, they need to be taken into account.

25. 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 Committee on Economic, Social and Cultural Rights general comment No. 14 (2000) on the right to the highest attainable standard of health (art. 12), paragraph 43, 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.

26. 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 emphasizes the vital role of multisectoral prevention and promotion in relation to many health problems.

27. 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 neoliberal 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.”⁹

28. This quotation is astonishing - and shaming. International and national policies were introduced that - predictably - brought health systems “to the point of collapse”.

⁹ *Everybody's Business ...* (note 2 above), p. 9.

29. As the health crisis deepened, efficiency became the watchword and health sector reform “focused above all on doing more for less”.¹⁰ 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.

30. 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 realization 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.¹¹

31. In 2005, recognizing that inadequate health systems were impeding progress towards improved immunization coverage, GAVI decided to support health system strengthening with an initial commitment of US\$ 500 million for 2006-2010.¹² Launched in 2007, the International Health Partnership - 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.

32. As increased resources are invested in health systems, the timeliness of the Human Rights Council’s decision 2/108 becomes apparent. 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.

33. 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. Definitions

34. 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

¹⁰ Ibid.

¹¹ For the Special Rapporteur’s report on the skills drain, see A/60/348, paragraphs 18-89.

¹² See http://www.gavialliance.org/resources/HSS_Background.pdf.

related sectors”.¹³ In 2007, WHO adopted a narrower definition: “A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health.”¹⁴ The literature reveals many other definitions, each with carefully nuanced differences.

35. 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

36. 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 organizations, international and national human rights mechanisms, courts, civil society organizations, 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.

37. Drawing on this deepening experience, and informed by health good practices, this section outlines the general approach of the right to the highest attainable standard of health towards the strengthening of health systems. Because of space constraints, this outline can only be brief and introductory.

1. At the centre: the well-being of individuals, communities and populations

38. 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.”¹⁵ The publication concludes, “health care and health systems must embrace a more holistic, people-centred approach”.¹⁶ 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.

¹³ E. Tarimo, *Towards a Healthy District. Organizing and Managing District Health Systems Based on Primary Health Care*, WHO, 1991, p. 4.

¹⁴ *Everybody’s Business...* (note 2 above), p. 2.

¹⁵ *People at the Centre of Health Care: Harmonizing Mind and Body, Peoples and Systems*, WHO, 2007, p. v.

¹⁶ *Ibid.*, p. vii.

2. Not only outcomes, but also processes

39. 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

40. 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 realization, 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 organizations, public private partnerships, business enterprises and civil society organizations.

4. Participation

41. 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.¹⁷ These issues have been explored in several of the Special Rapporteur's reports, including on Uganda and mental disability.¹⁸

5. Equity, equality and non-discrimination

42. 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.

¹⁷ See H. Potts, *Human Rights in Public Health: Rhetoric, Reality and Reconciliation*, PhD thesis, Monash University, Melbourne, Australia, 2006.

¹⁸ E/CN.4/2006/48/Add.2 and E/CN.4/2005/51.

43. 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”.¹⁹ 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

44. 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.²⁰ 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”.²¹

7. Medical care and the underlying determinants of health

45. 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.²² 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

¹⁹ *An Introduction to Health Planning ...* (note 8 above), p. 64.

²⁰ 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.

²¹ *Culture Matters - Working with communities and faith-based organizations: Case studies from country programmes*, UNFPA, 2004, p. v.

²² See, for example, article 24 of the Convention on the Rights of the Child: Health care includes dental care.

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.

8. Progressive realization and resource constraints

46. The right to the highest attainable standard of health is subject to progressive realization 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”.²³ Also, the right to health is realistic: it demands more of high-income than low-income States, that is to say, implementation of the right to health is subject to resource availability.

47. These two concepts - progressive realization and resource availability - have numerous implications for health systems, some of which are briefly explored later in this chapter. For example, because progressive realization 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 recognized 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 (for more on planning, see section E below).

48. Another implication of progressive realization 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 realizing 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.²⁴

²³ Paragraph VII (6).

²⁴ For a human rights-based approach to health indicators, see the Special Rapporteur’s report E/CN.4/2006/48.

49. A third implication arising from progressive realization is that at least the present level of enjoyment of the right to the highest attainable standard of health must be maintained. This is sometimes known as the principle of non-retrogression.²⁵ Although rebuttable in certain limited circumstances, there is a strong presumption that measures lowering the present enjoyment of the right to health are impermissible.

50. Finally, progressive realization 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.

9. Duties of immediate effect: core obligations

51. Although subject to progressive realization 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.²⁶ What, more precisely, are these core obligations? Some are discussed later in this report. 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.

52. Also, a State has a core obligation to ensure a minimum “basket” of health-related services and facilities, including essential food to ensure freedom from hunger, basic sanitation and adequate water, essential medicines, immunization 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 “basket” for those within their jurisdiction. Some international

²⁵ Committee on Economic, Social and Cultural Rights general comment No. 14 (2000), para. 32.

²⁶ *Ibid.*, paras. 43-45.

organizations have also tried to identify a minimum “basket” 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 “basket” may vary between countries. In some countries, the challenge is undernutrition, elsewhere it is obesity.

53. Much more work has to be done to help States identify the minimum “basket” 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 report. This report is not attempting to provide a list of essential services and facilities that are needed for a well-functioning health system. Rather, the report 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

54. 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

55. A health system should have an appropriate mix of primary (community-based), secondary (district-based) and tertiary (specialized) 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.

12. Vertical or integrated?

56. 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 jeopardize 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

57. 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 organizations) 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.

58. In the Special Rapporteur's experience, 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 cooperation²⁷

59. 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.

60. 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.²⁸ 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 Agenda on Aid Effectiveness (2005).

61. 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.

²⁷ This section draws extensively on *Health is Global: Proposals for a UK Government-Wide Strategy*, Department of Health, 2007, especially at p. 46.

²⁸ See S. Skogly, *Beyond National Borders: States' Human Rights Obligations in International Cooperation*, Antwerp/Oxford, Intersentia, 2006.

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.

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

15. Striking balances

63. 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 subsidize an effective but expensive cancer drug? A preliminary report of the Special Rapporteur submitted to the United Nations General Assembly addressed these challenging issues (A/62/214). 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.

64. 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

65. 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 specialized 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. The crucial role of accountability is explored further in section E below.

17. Legal obligation

66. 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;

a minimum “basket” 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.

D. The “building blocks” of a health system

67. 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.

68. What are these functional elements of a health system? 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:²⁹

(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”.

²⁹ *Everybody’s Business ...* (note 2 above), p. 3.

69. 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.

70. For present purposes, three short points demand emphasis. First, 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.

71. Second, 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.

72. Third, 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.

73. 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”.³⁰

E. Applying the general approach: some specific measures for health system strengthening

74. Because of space constraints, it is not possible in this report to apply the right to the highest attainable standard of health across the “building blocks” that together constitute a health system. Such an ambitious undertaking must be the subject of further studies. However, 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 this is a brief application of the right to the highest attainable standard of health, it gives a sense of the practical implications of the general approach outlined in section C above in relation to the health system “building blocks” signalled in section D above.

³⁰ Such as ex ante impact assessments (see paragraphs below on planning).

1. A health workforce

75. 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 approach outlined in section C were applied to health workers, the following points would be among those that need detailed examination.

76. 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.

77. 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, mid-level providers are already an essential part of the health systems in some countries, such as Mozambique.³¹

78. Recruitment of health workers must include outreach programmes to disadvantaged individuals, communities and populations, such as indigenous peoples.³²

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

80. The State should ensure that the number of domestically trained health workers is commensurate with the health needs of the population, subject to progressive realization 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.

81. The number of health workers should be collected, centralized 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.

82. Health workers' training must include human rights, including respect for cultural diversity, as well as the importance of treating patients and others with courtesy. This issue is explored in the Special Rapporteur's report on health workers and human rights education.³³

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

³¹ See *Health Systems Strengthening for Equity (HSSE): The Power and Potential of Mid-Level Providers* at www.midlevelproviders.org

³² "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.

³³ A/60/348.

84. 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.

85. There should be incentives to encourage the appointment, and retention, of health workers in underserved areas. When considering the situation of health workers in Uganda, this was one of the issues considered by the Special Rapporteur.³⁴

86. 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. In an earlier report, the Special Rapporteur examined the skills drain through the right-to-health lens.³⁵

2. Leadership, governance, stewardship

87. This is “arguably the most complex but critical building block of any health system”.³⁶ It encompasses many elements, including planning and accountability.

(a) Planning

88. In the Special Rapporteur’s experience, 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.”³⁷

89. However, from the perspective of the right to the highest attainable standard of health, effective planning is absolutely critical. Progressive realization and resource availability - two inescapable components of the international right to health - cannot be addressed without planning.³⁸

³⁴ E/CN.4/2006/48/Add.2.

³⁵ A/60/348.

³⁶ *Everybody’s Business...* (note 2 above), p. 23.

³⁷ *An Introduction to Health Planning...* (note 8 above), p. 18.

³⁸ See section C above on progressive realization and resource availability.

90. Recognizing 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.³⁹

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.”⁴⁰

91. 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.

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

93. 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.

94. 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).

95. 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.

96. 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 procedures, a detailed budget that is attached to the plan, financing arrangements (national and international), evaluation arrangements, and one or more accountability devices. In order to complete the plan, there will have to be a process for prioritizing competing health needs.

³⁹ General comment No. 14 (see note 25 above), paragraphs 43-45.

⁴⁰ Paragraph VIII.

97. Before their finalization, 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.⁴¹

98. 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

99. 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.

100. 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 organizations have a crucial role to play.

101. 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 realized, for all, including disadvantaged individuals, communities and populations.

⁴¹ With Gillian MacNaughton, the Special Rapporteur co-authored a report on impact assessments, poverty and the right to the highest attainable standard of health; for an outline see A/62/214 from paragraph 33. The full report is available from the website of Essex University, Human Rights Centre, Right to Health Unit (http://www2.essex.ac.uk/human_rights_centre/rth/projects.shtm).

102. In some States, the private health sector, while playing a very important role, is largely unregulated. Crucially, the requirement of human rights accountability 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.

103. 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.

104. The issue of accountability gives rise to two related points.

105. First, the right to the highest attainable standard of health should be recognized 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 recognized in the Constitution of WHO, as well as the Declaration of Alma-Ata. It is also recognized 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 recognized in the national law of all States.

106. 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 recognize 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.

3. Conclusion

107. 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 realization 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 finalization, key elements of the draft plan must be subject to an impact assessment and the final plan must include certain crucial features.

108. 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

109. How does it help to recognize 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.

110. 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.

111. 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.

112. 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.

113. 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.

114. 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.

115. 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.

116. Human rights have a second function. Anticipating that policymakers and others sometimes make mistakes, human rights require an effective mechanism to scrutinize 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.

117. 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.

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

119. 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 report. There must be, for example, an up-to-date health plan; outreach programmes for disadvantaged groups; publicly available data that is appropriately disaggregated; a minimum "basket" 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.

120. 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.

121. 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 or those living in poverty, officials can explain that the State has minimum, legally binding human rights obligations that cannot be compromised in this way.

122. 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.

123. Recent history is littered with misguided reforms that have brought many health systems “to the point of collapse”.⁴² 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.

III. CONCLUSIONS

124. **Health systems and human rights is a very large and complex topic. In a report of this length, it is impossible to address all of the important issues, such as the role of the State in relation to the private health sector. Elsewhere, the Special Rapporteur has looked at (and continues to examine) one dimension of this issue: pharmaceutical companies and access to medicines.**⁴³

125. **The report has identified urgently needed research, including detailed studies that consistently and systematically apply the general approach outlined in section C of the present report to all six of the WHO health system “building blocks” signalled in section D above.**

126. **In resolution 60/251, the General Assembly has mandated the Human Rights Council to “promote the effective coordination and the mainstreaming of human rights within the United Nations system”. All those responsible for strengthening health systems should recognize the importance of human rights. Moreover, they should embark on the integration of the right to the highest attainable standard into their work. This applies equally to those focusing on a component of health systems, such as the health workforce.**

127. **Today, there are numerous health movements, perspectives and approaches, including health equity, primary health care, health promotion, social determinants, health security, continuum of care, gender, development, biomedical, macroeconomic and so on. All are very important. The right to the highest attainable standard of health recurs throughout them all. It is the only perspective that is both underpinned by universally recognized moral values and reinforced by legal obligations. Properly understood, the right to the highest attainable standard of health has a profound contribution to make towards building healthy societies and equitable health systems.**

⁴² *Everybody’s Business...* (note 2 above), p. 1.

⁴³ A/61/338.