Health Systems and the Right to the Highest Attainable Standard of Health

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The right to the highest attainable standard of health depends upon the interventions and insights of medicine and public health. Equally, the classic, long-established objectives of medicine and public health can benefit from the newer, dynamic discipline of human rights. At an abstract level, a few far-sighted people understood this when the World Health Organization (WHO) Constitution was drafted in 1946, and the Declaration of Alma-Ata was adopted in 1978, which is why both instruments affirm the right to the highest attainable standard of health. The Ottawa Charter of Health Promotion of 1986 also reflects the connections between public health and human rights.

However, these connections were general and abstract. At the time, the right to the highest attainable standard of health was only dimly understood and attracted limited support from civil society. It was little more than a slogan. Others have surveyed the evolution of health and human rights since Alma-Ata and Ottawa, and we will not repeat this exercise here.[1] To the credit of everyone responsible, *The Health and Human Rights Journal* has played an indispensable role in this evolution.

One vital part of this evolutionary process has been a deepening understanding of the right to the highest attainable standard of health. Although neglected in much of the literature, this fundamental human right must surely be the cornerstone of any consideration of health and human rights. Through the endeavours of innumerable organizations and individuals, the content of the right to the highest attainable standard of health is now sufficiently well understood to be applied in an operational, systematic and

sustained manner. Crucially, this understanding is new: It dates from within the last ten years or so. Of course, much more work is needed to grasp all the implications of the right to the highest attainable standard of health, but it can no longer be seen (or dismissed) as merely a rhetorical device. In these circumstances, it is timely to revisit Alma-Ata, and examine health systems, from the new, operational perspective of the right to the highest attainable standard of health.

In any society, an effective health system is a core institution, no less than a fair justice system or democratic political system.[2] In many countries, however, health systems are failing and collapsing,[3] giving rise to an extremely grave and widespread human rights problem. At the heart of the right to the highest attainable standard of health lies an effective and integrated health system, encompassing medical 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. 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.

There is an analogy between, on the one hand, court systems and the right to a fair trial and, on the other hand, health systems and the right to the highest attainable standard of health. The right to a fair trial is widely recognized to have strengthened many court systems. It has helped to identify the key features of a fair court system, such as independent judges, trials without undue delay, the opportunity to call witnesses and make legal argument, legal aid for impecunious defendants in serious cases, and so on. The right to a fair trial has exposed unfair judicial processes and led to welcome reforms. Significantly, many features arising from the right to a fair trial have major budgetary implications.

In much the same way, the right to the highest attainable standard of health can help to establish effective, integrated and accessible health systems. If this is to happen, however, greater clarity is needed about the key features of a health system that arise from the right to the highest attainable standard of health.

Importantly, the right to the highest attainable standard of health is recognized in the constitution of many states.[4] Also, it is enshrined in numerous binding international human rights treaties, such as the International

Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Rights of the Child (CRC), which has been ratified by every state of the world, except for two (the United States of America (USA) and Somalia).

This chapter identifies some of the key right-to-health features of a health system. It considers health systems from the new, operational perspective of 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. The chapter 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.[5]

A right-to-health approach to strengthening health systems

In the last decade, states, international organizations, international and national human rights mechanisms, courts, civil society organizations, academics and many others have begun to explore what the right to the highest attainable standard of health means and how it can be put into practice.[6] Health workers are making the most decisive contribution to this process.[7] Drawing upon 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.

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 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."[8] The publication concludes, "health care and health systems must embrace a more holistic, people-centred approach."[9] 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.

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).

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 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.

Participation. All individuals and communities are entitled to active and informed participation on issues bearing upon their health. In the context of health systems, this includes participation in identifying overall strategy, policy-making, 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.[10]

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 definition is "equal access to health-care according to need."[11] 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.

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 peoples, for example, to study medicine and public health. Moreover, training in some traditional medical practices should also be encouraged.[12] Of course, cultural respect is right as a matter of principle. But, additionally, it makes sense as a matter of practice. As Thoraya Obaid, Executive Director of the United Nations Population Fund (UNFPA), observes: "Cultural sensitivity ... leads to higher levels of programme acceptance and ownership by the community, and programme sustainability."[13]

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 not only extending to timely and appropriate medical care, but also to 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.[14] 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 first United Nations Special Rapporteur on the right to health 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.

Progressive realization and resource constraints. 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."[15] 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.

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 General Comment No. 14 on the right to the highest attainable standard of health of the United Nations Committee on Economic, Social and Cultural Rights.[16]

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.[17]

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.[18] 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 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.

Duties of immediate effect: Core obligations. 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.[19] What, more precisely, are these core obligations? Some are discussed later in this chapter. Briefly, they include an obligation to:

___ Prepare a comprehensive, national plan for the development of the health system.
___ 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.
___ Ensure the equitable distribution of health-related services and facilities e.g. a fair balance between rural and urban areas.
___ 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 "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, pre-natal and post-natal services, and emergency obstetric care. Some states have already identified a minimum "basket" for those within their jurisdiction. Some international 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 and therefore, in practice, the minimum "basket" may vary between countries. In some countries the challenge is undernutrition, elsewhere it is obesity.

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 chapter. The aim here is 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.

Quality. All 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 rejected in the North because they are beyond their expiry date and unsafe, medicines 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.

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 (specialized) facilities and services, providing a continuum of prevention and care. The system also needs an effective process when a health worker assesses that their client may benefit from additional services, and the client is referred from one facility or department to another. Referrals are also needed, in both directions, between an alternative health system (e.g. traditional practitioners) and "main-

stream" health system. The absence of an effective referral system is inconsistent with the right to the highest attainable standard of health.

Vertical or integrated? There is a longstanding 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 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.

Coordination. A health system, as well as the right to the highest attainable standard of health, depends upon 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 upon 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 policy-making 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.

Health as a global public good: The importance of international cooperation.[20] 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.[21] 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 to fulfil 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.

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 anti-retrovirals, or subsidize an effective but expensive cancer drug? Human rights do not provide neat answers to such questions, anymore 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.[22]

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.

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, that 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 monitoring and accountability is explored later in this chapter.

Legal obligation. The right to the highest attainable standard of health gives rise to legally binding obligations. A state is legally obliged to ensure 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.

The "building blocks" of a health system

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 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:[23]

___ Health services (medical and public health)
___ Health workforce
___ Health information system
___ Medical products, vaccines and technologies
___ Health financing
___ Leadership, governance, stewardship

Each "building block" has generated a huge literature over many years. 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 realizing 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.

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.

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.

The systematic application of the right to health to the six "building blocks" is likely to have a variety of results. In some cases, a focus on 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".[24]

Applying the right-to-health approach to one of the "building blocks" of a health system

By way of illustration, this section begins to apply the right to the highest attainable standard of health to one of WHO's six "building blocks": Leadership, governance and stewardship. This is "arguably the most complex but critical building block of any health system."[25] It encompasses many elements, including planning, monitoring and accountability.

Planning

Planning 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."[26]

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.[27]

Recognizing the critical role of effective planning, the United Nations Committee on Economic, Social and Cultural Rights designated the preparation of a health "strategy and plan of action" as 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.[28] 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."[29]

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. One example where the participatory approach was used was in the village of San Jose de Secce and the communities of Oqopeqa, Punkumarqiri, Sanuq and Laupay in the Ayacucho district, Peru, where high maternal mortality rates were registered. It was estimated that 94 per cent of the women gave birth at home, compared to 6 per cent in the health centres. This was due to various barriers, such as because the state health services did not take account of local cultural conceptions of health and sickness. In an attempt to reduce the maternal mortality, a culturally-adapted project was introduced which provided sexual and reproductive health services and promoted a participatory approach between health workers and the community, including the traditional birth attendants (TBA). As a result, the delivery room and care given during prenatal checkups, delivery and the postnatal period, were made culturally acceptable, for example, by providing a bed as well as sturdy rope, so that the women could give birth squatting and gripping the rope, as they were accustomed to. The protocol for care outlined, among others, that the person attending the birth should speak Quechua and preferably be female. Further, in line with the beliefs in the communities, the protocol included the requirement to deliver the placenta to the family member present so that it could be buried, and the opportunity for the user to remain in the health facility for up to eight days. An evaluation after the measures had been taken demonstrated a great increase in deliveries at health centres.[30]

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 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.

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.[31]

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.

Monitoring and accountability

As already discussed, monitoring and accountability have a crucial role to play in relation to human rights and health systems. Monitoring is a precondition of accountability. 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.

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, maternal death audits, 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 as well.

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.

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.

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 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 WHO's Constitution, as well as the Declaration of Alma-Ata. It is also recognized in numerous binding international human rights treaties. 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.

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.

In summary, there is a legal obligation arising from the right to the highest attainable standard of health to ensure that health planning 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. These (and there are others) 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 monitoring and accountability mechanism.

Conclusion

Like other human rights, the right to the highest attainable standard of health is a site of struggle.[32] It is not, and never will be, a substitute for struggle. In recent years, the contours and content of the right to the highest attainable standard of health have become clearer, making it possible to tease through its practical implications for health policies, programmes and

projects. The right brings a set of analytical, policy and programmatic tools. As always, the right retains its powerful rhetorical, campaigning qualities. The right to the highest attainable standard of health should be seen as one important element in a multidimensional strategy for progressive social change.

Whether the right to the highest attainable standard of health can successfully shape health systems depends upon multiple variables. Progressive governments must be persuaded to integrate the right across their policy-making processes, in accordance with their legal obligations. WHO and other international organizations must be prevailed upon to champion the right to the highest attainable standard of health. Civil society organizations have to campaign around health and human rights. Judges and lawyers have to be willing to learn from health workers and find innovative ways to vindicate the right to the highest attainable standard of health. Health workers must grasp the potential of the right to the highest attainable standard of health to help them achieve their professional objectives. Human rights mechanisms must take this fundamental human right seriously and its meaning must be further clarified. More right to health tools must be fashioned. Disadvantaged individuals, communities and populations must apprehend that the right to the highest attainable standard of health empowers them by granting entitlements which place legal and moral obligations on others.

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 the highest attainable standard of health 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.

* This article is a shortened and revised version of the report of the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/HRC/7/11, 31 January 2008. Also see Hunt and Backman, "Health Systems and the Right to the Highest Attainable Standard of Health", *Health and Human Rights: An International Journal,* Vol. 10, No. 1 (2008); and Backman and others, "Health Systems and the Right to Health: an Assessment of 194 Countries", *Lancet*, Vol. 372, No. 9655 (2008), at 2047–2085. In this article "the right to the highest attainable standard of health" or "the right to health" are used as short hand for thew full formulation of the right.

1 See for example J. Mann, S. Gruskin, M. Grodin and G. Annas (eds), *Health and Human Rights: A Reader* (New York and London: Routledge, 1999); S. Gruskin, M. Grodin, G. Annas and S. Marks (eds.), *Perspectives on Health and Human Rights* (New York and London: Routledge, 2005); A. Yamin, 'Journeys towards the Splendid City', 26 *Human Rights Quarterly* (2004), at 519; the report of the UN Special Rapporteur on the right to the highest attainable standard of health, A/HRC/4/28, 17 January 2007; and P. Hunt, 'The Health and Human Rights Movement: Progress and Obstacles', 16(1) *Journal of Law and Medicine* (2008) 15 JLM 714–724.

2 L. Freedman, 'Achieving the MDGs: Health Systems as core social institutions', 48 *Development* (2005), at 1.

3 World Health Organization, *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes* (Geneva: WHO, 2007), at 1.

4 E. Kinney and B. Clark, 'Provisions for Health and Health Care in the Constitutions of the Countries of the World' 37 *Cornell International Law Journal* (2004) 285–355.

5 The literature reveals many definitions of a health system, each with carefully nuanced differences. In 2007, for example, WHO defined a health system as "all organizations, people and actions whose *primary intent* is to promote, restore or maintain health." Ibid. at 2 (italics in the original). For present purposes, there is no need to favour one definition over another because all the features and measures identified in this chapter should be part of any health system, however defined.

6 For surveys of the key international instruments and a selection of the case law, see the reports of the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, E/CN.4/2003/58, 13 February 2003, and A/HRC/4/28, 17 January 2007.

7 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.

8 WHO, *People at the Centre of Health Care* (Geneva: WHO, 2007), at V.

9 Ibid., at VII.

10 See H. Potts, *Human Rights in Public Health: Rhetoric, Reality and Reconciliation,* unpublished PhD thesis, Monash University, Melbourne, Australia, 2006. Also, participation in the context of the right to health has been explored in several reports of the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, including E/CN.4/2006/48/Add.2 (on Uganda) and E/CN.4/2005/51 (on mental disability).

11 A. Green, *An Introduction to Health Planning for Developing Health Systems* (Oxford: Oxford University Press, 2007) at 64.

12 For more on indigenous peoples and the right to the highest attainable standard of health see, for example, the reports of the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/59/422 and E/CN.4/2005/51/Add.3.

13 UNFPA, *Culture Matters* (Geneva : UNFPA, 2000), at V.

14 See, for example, Article 24 of the Convention on the Rights of the Child. Medical care includes dental care.

15 Paragraph VII(6).

16 For more on planning, see page 52.

17 For a human rights-based approach to health indicators, see the report of the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, E/CN.4/2006/48, 3 March 2006.

18 Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14 on the right to the highest attainable standard of health,* 11 August 2000, UN Doc. E/C.12/2000/4, at para. 32.

19 Ibid., paras. 43–45.

20 This section draws extensively from United Kingdom Department of Health, *Health is Global: Proposals for a UK Government-Wide Strategy,* (London: Department of Health, 2007) especially at 46.

21 See S. Skogly, *Beyond National Borders: States' Human Rights Obligations in International Cooperation,* (Antwerp: Intersentia, 2006).

22 On prioritization, see the report of the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, A/62/2/214, 8 August 2007.

23 WHO, *supra* note 3, at 3.

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

25 WHO, *supra* note 3, at 23.

26 Green, *supra* note 11, at 18.

27 See previous section on progressive realization and resource constraints.

28 General Comment No. 14, *supra* note 18, paras. 43–45.

29 Para. VIII.

30 P. Hunt and J. Bueno de Mesquita, *Reducing Maternal Mortality: The Contribution of the Right to the Highest Attainable Standard of Health* (2007), available at http://www2.essex.ac.uk/human_rights_centre/rth/docs/ReducingMaternalMortality.pdf.

31 See P. Hunt and G. MacNaughton, *Impact Assessments, Poverty and Human Rights: A Case Study Using the Right to the Highest Attainable Standard of Health,* 2006, available at http://www2.essex.ac.uk/human_rights_centre/rth/projects.shtm.

32 P. Hunt, *Reclaiming Social Rights: International and Comparative Perspectives,* (Aldershot, UK: Dartmouth, 1996) at 186 and Yamin, *supra* note 1, at 528.

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