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STATUS OF PREPARATION OF PUBLICATIONS, STUDIES AND DOCUMENTS FOR THE WORLD CONFERENCE

Addendum

Contribution from the World Health Organization

1. The attention of the Preparatory Committee is drawn to the attached contribution submitted by the World Health Organization entitled "Health as a fundamental human right and as a worldwide social goal". In part one of the document, the World Health Organization gives an account of its perspective on the implementation of the international covenants on human rights; in part two, WHO illustrates, through a series of examples of activities carried out by various WHO technical programmes, the principles discussed in part one; these topical papers cover the following areas:

1. The rights of patients;

2. The rights of the mentally ill, and the improvement of mental health care;

3. The rights of the child;

4. The rights of the elderly;

5. The rights of the disabled;

6. Human rights aspects of HIV/AIDS;

7. The rights of vulnerable groups and indigenous peoples;

8. The health status of least developed countries;

9. The role of health legislation;

10. Humanitarian emergency health assistance and rights of displaced populations; and

11. Equity in health care.

2. In addition, the World Health Organization has submitted, for information, three documents* related to human rights issues: (a) the final report of the WHO/FAO International Conference on Nutrition (Rome, December 1992) containing the World Declaration and Plan of Action for Nutrition; (b) a report entitled Health Dimensions of Economic Reform prepared for the International Forum on Health: a Conditionality for Economic Development (Accra, 4-6 December 1991); and (c) a report entitled A Call for New Public Health Action which is the report of the Saitama Public Health Summit, organized by the World Health Organization and the Saitama Prefectural Government in Omiya City (Saitama Prefecture, Japan, 17-20 September 1991), and which contains the Saitama Declaration.

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* These documents, in English, French and Spanish, are available for consultation in the files of the Secretariat of the World Conference on Human Rights.

HEALTH AS A FUNDAMENTAL HUMAN RIGHT AND A WORLDWIDE SOCIAL GOAL

Part One

1. The purpose of this report is to provide the United Nations Centre for Human Rights with a contribution to the six studies prepared as background documents to the forthcoming Conference on Human Rights. It first gives an account of the World Health Organization's perspective on the implementation of the international covenants on human rights and then provides further reflections on specific rights and issues addressed in WHO's programmes. WHO has a constitutional mandate to act as the directing and coordinating authority on international health work, so as to bring about steady improvement in the public health situation and in the health status of all peoples. This central concern with public health goals and provision of medical services has enabled WHO to keep human rights concern as an integral part of its overall strategies, policies and programmes.

1. The right to health for all

2. The WHO Constitution, adopted in 1946, not only defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease and infirmity", but also stresses that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political beliefs, economic or social condition". Two years later, the Universal Declaration of Human Rights, which was adopted in 1948 by the General Assembly of the United Nations, reiterated in Article 25 (i) that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care, and necessary social services".

3. In May 1977, the World Health Assembly adopted Resolution WHA3O.43 which stated that the main social target of Governments and WHO in the coming decades should be the attainment by all citizens of the world by the year 2OOO of a level of health that will permit them to lead a socially and economically productive life. In 1979, Resolution WHA32.3O not only endorsed the report and the Declaration of the International Conference on Primary Health Care held in Alma-Ata in 1978, but invited member States to formulate national policies, strategies and plans of action based on primary health care for attaining the goal of health for all by the year 2OOO.

4. While the goal of health for all, as well as the basic strategy of primary health care remain valid, new answers are required in a world characterized by rapidly changing political, demographic and socio-economic conditions, poor lifestyles and behavioural patterns, obliging mankind to cope with old, as well as new, health hazards. This led the Director-General of WHO, Dr. Hiroshi Nakajima, to develop a new paradigm for public health action in order to accelerate the achievement of health for all member States and thus health for all people in the world over all phases of their life cycles. Through analysis of the global health situation and related operational issues, some major concerns were identified that countries and the

international health community will have to face well into the twenty-first century. These relate in particular to respect for human rights, especially for the underprivileged, to health and social development, to universal access to care and to promoting health behaviour and lifestyles, including nutrition, using public policy to influence and shape social, economic and physical environments, and to enable individuals and communities to make choices that are positive for health.

5. The political, economic and social changes that have taken place have led to the realization that health and economic development are inseparable, and that development is meaningless without enlarging of people's choices, the essential choices being those which allow people to lead a long and healthy life, to acquire knowledge and to have access to resources needed for a decent standard of living. To achieve such development, it would be necessary, as underlined by the Director-General, to devote more attention to fundamental questions of individual and community rights, indicators of human need, health development and the quality of life, and the application of resources for overall health and human development.

6. While health has lost nothing of its significance as an essential condition for human well-being and development, the goal of health for all requires a holistic approach encompassing all sectors related to human existence, including physical or social environments. Health as a basic human right (and as a condition for human development) cannot be achieved without due attention to the environment with which we continuously interact, such as the social, political, economic or physical environment, including of course, nature with its finite resources.

7. Resolution WHA39.22 (1986) on the role of intersectoral cooperation in national strategies for health for all; the Accra Initiative for Health adopted at the "International Forum on Health: A Conditionality for Economic Development - Breaking the cycle of poverty and inequity"; the report of the WHO Commission on Health and Environment prepared for the United Nations Conference on Environment and Development (Rio de Janeiro, 1-12 June 1992); and the technical discussions during the Forty-fourth World Health Assembly in 1991 on strategies for health for all in the face of rapid urbanization, are all recent examples of WHO's endeavour to provide leadership and guidance in securing the conditions for healthy living and sustainable health development at individual and collective levels. These and other activities are essential components of health protection and promotion, a concept involving a synthesis of various activities that enhance health most effectively when applied in a coherent, consistent and purposeful way. The International Conference on Nutrition in December 1992 constitutes an important milestone in a process which started two years earlier at country level. Organized jointly by the Food and Agriculture Organization of the United Nations and the World Health Organization, the Conference took a comprehensive look at nutrition and resulted in a World Declaration and Plan of Action which will provide the framework for further action at country level that aims at achieving adequate household food security, health and nutritional well-being for all through sustainable an environmentally sound development interventions.

8. The evolution of WHO's concept of health has many implications which influence political, sectoral and professional action aimed at providing all people with the opportunity of being healthy, as a human right. While on one side there is the need to implement strategies that will ensure for the many still deprived, the basic conditions of health, even in the presence of adverse social, economic and other conditions, and on the other side, develop broadly-based, people-centred concepts whereby individuals, communities and societies become motivated and active in the improvement of their own health.

2. WHO goals and the United Nations human rights covenants

9. The goal of Health for All, adopted collectively by all countries at the initiative of WHO, has relevance not only to the provision of health care to everyone but also the provision of care throughout the life of every person, from conception to death. This profound and complete responsibility has a wide ambit: it covers access to knowledge throughout different phases of life about how to live healthily; access to protection against major health risks from others, environment or indeed the result of other development processes; and finally access to suitable promotive, preventive, curative and rehabilitative care.

10. How close and convergent are the WHO goals set out above and those articulated in the International Covenant on Economic, Social and Cultural Rights may be seen from a historical perspective:

(a) Article 25 of the Universal Declaration of Human Rights refers to the right to "a standard of living adequate for the health and well-being ... of the individual and family ... including food, clothing, housing and medical services ... (and) the right to social security in the event of ... sickness, disability ...".

(b) Article 12 goes on to recognize "The right of everyone to the highest attainable standard of health and refers specifically to reduction of infant mortality, healthy child development, industrial and environmental hygiene, prevention and control of occupational, epidemic and other diseases and access for all to medical attention in case of need.

(c) Article 12 arose from a proposal of WHO itself made to the United Nations Commission on Human Rights in 1951; that proposal would have enlarged the present text, with emphasis being laid on (i) inclusion of medical education and training standards and mental health activities as part of Article 12 (2), and (ii) provisions for an undertaking by Governments that adequate social and health measures would be taken to that end, giving due allowance for differences in resources and traditions and for local conditions and disparities among countries in initial levels of development.

(d) The final text for Article 12 did not include item (ii) of the previous paragraph (though Principles for the treatment of the mentally ill became an issue of significance, since successfully resolved with WHO participation in its drafting). It must be recognized that, with dynamic

changes in science, technology and popular expectations, Article 12 might be drafted somewhat differently today. Its emphasis would have been more in keeping with the notion of Health for All through the primary health care approach as adopted at Alma-Ata in 1978.

(e) In 1977, the Thirtieth World Health Assembly adopted a historic Resolution stating that the main social target of Governments and the WHO in the coming decades should be the attainment by all citizens of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life.

(f) Clearly within its constitutional mandate in international health, notably responsibilities for direction and coordination (including development of technical consensus and norms) on the one hand, and technical cooperation on the other, WHO stands committed to keep the human rights orientation as an integral part of its programming. The key to such an integration is a steadfast objective of greater social justice and equity in all countries and to all peoples. The elaboration of this central objective through programmes and policies provided for WHO the necessary scope for implementing human rights concerns set out in the United Nations Covenants.

11. It may be worthwhile at this stage to point out that the traditional instruments for implementation viz. conventions, agreements, regulations etc., though provided for in the WHO Constitution, have not been used for implementing human rights, as in the case of sister agencies dealing, for instance, with the right to work. This distinction arises directly from the nature of issues in health. In so far as health outcomes affect an individual, they are the complex result as much of obligations of State to protect his health as of the very different (ethically charged) obligations of physicians in dealing with patients. There is further the patient's own responsibilities to take care of his own health. These interrelationships are complex and not easy to juxtapose; rapid developments in science and technology affecting medical practice make this position even more complicated. Hence a right to health per se is not amenable to easy definition. Indeed, WHO developed an approach based on consensus building among member countries on such questions as goals, resources and services, taking into account the fact that the political, public policy process, to a large extent, decides health issues.

12. The rapid advances in biotechnology call for renewed concern for human rights promotion and protection in this respect. WHO's activities in the field of bioethics have been conducted in close cooperation with the Council for International Organizations of Medical Sciences (CIOMS). Among the most recent examples of such long-term cooperation one can quote the development of New International Guidelines for Ethical Review of Epidemiological Studies issued in 1991 and the development of revised International Ethical Guidelines for Biomedical Research involving Human Subjects. It is also worth mentioning that in 1991 the Forty-fourth World Health Assembly adopted a set of Guiding Principles on Human Organ Transplantation with the aim to combat trade for profit in human organs among living human beings which is in contravention to the Universal Declaration of Human Rights and the WHO Constitution.

13. Clearly, human rights issues in health arise from both Covenants attracting more individual-oriented issues of patient rights, physician obligations and physician-patient relationships and broader issues involving distributional justice and equity covering groups denied access to health care. Indeed this situation is an earnest of the indivisibility and interconnectedness of civil/political rights and economic/social/cultural rights referred to so often. Despite the trend towards pluralism and market economy, the real disparities in the provision of health for the coverage of poor populations leads to an even greater need for a redefinition of the role of Governments in ensuring optimum equity in health. WHO has the twin responsibility (a) of achieving a technical consensus on courses of action that can be sustained by all countries on a reasonably self-reliant basis, and (b) for translating such consensus into national and global programmes that take due account of vastly diverse social, economic and cultural structures, nurture the scope for maximum international solidarity and strengthen the ways of greater political commitment and resource mobilization within the countries.

14. In searching for such a conscious consensus, experience has revealed, that greatest convergence will occur by concentrating on the right of access to health care. Macrodistributional issues of the due share to public health and its internal priorities are decided ultimately by political forces. Campaigning for due regard to equity of access, could be not only a common rallying point, but also enable more technical options to be identified. The process is often immeasurably slow. Such broad national level distributional decisions would need to be followed by a cascade of subsequent allocating decisions at lower levels in which health personnel have influence; and, as the decision descends closer to individuals in actual need of care, they would be influenced by the culturally validated practices and orientation of health personnel regarding the degree of respect for autonomy and dignity of the individual. By enhancing physicians' capacity to see issues of individual human rights clearly at this stage, it is possible to enhance respect for civil and political rights. There is, however, no doubt that a lasting solution can be reached only if the political public policy process is persuaded to internalize gradually equity approaches to health based on the fact that these socio-economic rights indeed underscore the moral worth of each individual.

15. In its search for fulfilling its mandate for rapid improvement in health status of all countries and peoples, and keeping in mind equal access to care on a sustainable basis as the critical aspect of strategy, WHO had to view the issue of implementation of a right to health as essentially one of mobilizing political commitment to the goal, of strengthening technical cooperation with countries, creating professional consensus around a primary health care strategy calling for intersectoral cooperation, community participation and decentralized decision-making, promoting equity and self-reliance in the process.

3. The primary health care approach

16. One of WHO's major contributions to human rights is the collective adoption of the goal of Health for All and of the Primary Health Care (PHC) strategy, calling for mobilization of all resources within nations or

internationally. Health for All was indeed conceived as a complex of strategies and plans of action collectively arrived at by member States and subjected to evaluation and monitoring done through WHO using indicators developed and periodically refined to assess progress. Such a procedure allowed each member State and each WHO Region to take stock of their own circumstances and to formulate their own health possibilities, goals and targets within the principles adopted by WHO at Alma-Ata. The evolution of the PHC approach to Health for All goal was the result of the experience gained from earlier attempts such as health care with a curative orientation and vertical programmes functioning independently to integrated approaches to PHC. The key concern in the ongoing transition to PHC remains as to how to create a sustainable infrastructure with appropriate physical structures and functional capacities to support all programmes as necessary from the disease and vulnerability patterns of the country; for the existence of such a functioning infrastructure is the most explicit guarantee to the poorer regions and groups that access to medical care and minimal health related infrastructure is available. Only then could a PHC system assess the health problems of a population, extend health care to those with special needs and monitor programme effectiveness. Equity and access were conceived indeed as the essence of Health for All and PHC was the mechanism to achieve them.

4. Addressing Article 12 (2) of the International Covenant on Economic, Social and Cultural Rights

17. For the details and the implementation of the Covenant by WHO it may be more relevant to look at its technical cooperation programmes elaborated on the basis of HFA/PHC strategy, rather than look to binding regulatory treaty standards and norms. Keeping WHO programmes in mind, we may examine to what extent the four specifics in Article 12 (2) of the Covenant have been realized.

18. As for Article 12 (2) (a), the healthy development of the child has remained a significant focus of attention culminating in the comprehensive convention on the rights of the child. In fact the preamble to the WHO Constitution bears specific reference to mother and child care and healthy development of the child and its ability to live harmoniously in a changing total environment. Health of the child in different ways has remained amenable to initiatives and programmes through joint WHO/UNICEF policy planning.

19. In 1981, the World Health Assembly adopted the International Code of Marketing of Breast-milk Substitutes. The promotion of practices in favour of breast-feeding has been a success in all parts of the world. In 1988, having regard to the stability and coverage achieved in the expanded programme on immunization, the target was adopted for global eradication of poliomyelitis by the year 2000. Maternal and child health and school health programmes figure significantly in WHO support. The perspectives for sustainable programme and future vaccine development as part of the expanded programme of immunization are under constant scrutiny; similarly there has been constant exploration as to how far immunization can be integrated into primary health care.

20. Under Article 12 (2) (b) the Covenant calls for improvement of all aspects of environmental and industrial hygiene. In effect it is symbolic of the right to protection of all peoples against environmental hazards, natural or man-made. In addition to sustained attention to the first generation environmental needs of consequence to public health, such as drinking water and basic sanitation, WHO took the initiative to set up a commission to follow up on the state of knowledge about the effects of the environment on health and available options. The report was both a follow-up to the Bruntland report on environment and a prelude to the United Nations Conference on Environment held in Rio de Janeiro; health aspects arising from long-range environmental changes continue to be a priority for research and investigation. It is, however, realized that the backlog in relation to sanitation and water supply remain significant in much of the developing world, the former more so. Under its norm setting role, WHO has laid down water quality standards and continues to participate closely in global environmental monitoring activities. The effects of nuclear radiation on health following the Chernobyl accident led to a WHO initiative for the setting-up of an international centre for studying the effects of the disaster; the database and the transparent exchange of information in this regard would remain a significant scientific contribution, of as much significance to the right of individuals to life and to protection from environmental hazards.

21. The remaining two provisions of Article 12 (2) concern the prevention, protection and control of diseases and the availability of medical attention and services to all in times of sickness. Together they constitute the traditional core of WHO's objectives and activities. In 1977 the World Health Assembly resolved that the main social target of Governments and of WHO should be the attainment by all citizens of the world by the year 2000 of a level of health that would permit them to lead a socially and economically productive life. In 1978 the International Conference on Primary Health Care, held in Alma-Ata, USSR, affirmed that the primary health care approach was the key to attaining this target.

5. The health for all strategy

22. The Thirty-second World Health Assembly endorsed the PHC approach in using health as a powerful lever for socio-economic development and peace and for attaining the goal of health for all by the year 2000. In 1981 the Global Strategy for Health for All was adopted by all member States collectively according to the following policies:

> The basic policies embodied in the Strategy are that health is a fundamental human right and a worldwide social goal; health is an integral part of development; the existing gross inequality in the health status of people is of common concern to all countries and must be drastically reduced; people have the right and the duty to participate individually and collectively in the planning and implementation of their health care; Governments have a responsibility for the health of their people; countries must become self-reliant in health matters; and fuller and better use must be made of the world's resources to promote health and development.

23. The collectively agreed goals contained the common elements of essential care, community involvement, appropriate technology and intersectoral cooperation. The significance of the strategy was the degree of flexibility allowed to member States to decide on their own strategies and plans of action within the collectively agreed principles, the non-negotiable essence for access to and quality of care, which should encompass preventive, promotive, curative and rehabilitative tasks. The concept of primary health care, as outlined in the report of a joint WHO/UNICEF conference in Alma-Ata, USSR, in 1978, was a breakthrough towards a worldwide movement to reduce the gap between "haves" and "have nots" popularly known as Health for All by the Year 2000 (HFA 2000).

24. Primary health care is essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community through their full participation and at a cost that the community and country can afford ... It forms an integral part both of the country's health system, of which it is the central function and main focus, and of the overall social and economic development of the community.

25. The second evaluation of implementation of the Global Strategy for Health for All by the Year 2000 has just been completed. It shows that there have indeed been achievements over the past few years; it also reveals just what gaps remain, especially between the rich and the poor.

26. Achieving the goal of health for all by the year 2000 requires concerted efforts from countries to organize their health systems based on PHC. The past decade has seen both solid progress and serious setbacks. Some countries maintain a priority commitment to PHC and can demonstrate success in improving the accessibility and quality of health care. In others, falling living standards, massive indebtedness, and ecological decline have had a negative impact on both health services and health status.

27. A health system consists of interrelated components that contribute to health in homes, educational institutions, workplaces, public places, and communities, as well as in the physical and psychosocial environment and the health related sectors, like agriculture, education, environment, etc. A health system is usually organized at various levels, starting at the peripheral community level or the primary level of care, and proceeding through the intermediate (district, regional, or provincial) level to the central level. At the same time it includes individuals and families taking an active interest and participating in solving their own health problems, thus becoming full members of the health team. The intermediate and central levels deal with those elements of the health system for which they are given responsibility by the country's administrative organizations, and they also provide progressively more complex and more specialized care and support. It is only through such a coordinated mutually reinforcing set up that all members of society can realize their fundamental rights to levels of health care according to need and get referred to the appropriate level when necessary.

6. Disparities in health

28. In the 10 years since the Global Strategy was adopted by the World Health Assembly, and the 6 years since the first evaluation, health status — as measured by such indicators as life expectancy and infant mortality — has improved globally. However, the pace of improvement has been distinctly slower for the least developed countries and, as a result, inequities between the developing and least developed countries are greater now than they were a decade ago. These disparities when disaggregated highlight unacceptable conditions at the periphery where the poor and the underprivileged are most at risk.

29. The availability of essential health care has also increased globally. Yet, millions of people remain without access to either all or some elements of care. If the availability of certain elements of care increases, while the availability of other complementary elements does not, the positive impact on health status of the one, can be offset by lack of the other. Similarly, if the infrastructure is expanded but the means to use that infrastructure to provide care is weak, no improvement in health status will be evident. In other words, in the development of health systems based on primary health care, the right things are being done, but not necessarily in all instances in the right form.

30. The underlying common cause of infrastructure deterioration is the poor economic performance of countries. The most common policy response, aimed at restoring economic growth by eliminating deficits in the Government's domestic and foreign trade situation, has frequently meant disproportionately large cuts in social expenditure. In too few countries can this policy response be shown to have restored growth, nor has the design and operation of "safety nets" to support those hardest hit by social sector cutbacks been easy or failure-proof.

31. The neglect of health infrastructures, both as a result of structural adjustment policy and of the recent focus of donor interest on selected actions for priority problems, now threatens not only the long-term goals of Health for All, but also the widely accepted strategies for achieving these goals. These strategies include a pluralistic and developed approach to health development, with a revitalized public sector regulating and coordinating governmental and non-governmental sources of health care financing and provision, and increased local autonomy and public accountability.

32. It can be stated that improvements have been made in health status in terms of life expectancy at birth and infant mortality rates, and coverage levels by various elements of primary health care. Because such improvements seem to be more rapid in the developing countries than in the least developed ones, the disparities in health status between the developed and developing countries appear reduced but those between the least developed and other developing countries have increased. There is also some evidence that disparities in health status have increased within countries between certain population groups. Coverages by various elements of primary health care have sometimes been unbalanced and distorted, thus having insufficient impact in terms of health.

33. Looking to the future, there are strategies that are essential if we are to reduce the gaps between the rich and the poor and ensure that all people enjoy their right to social justice and equity. Austerity measures adopted in response to economic recession should be implemented in ways which protect the poor as much as possible. Targets should be pursued for reducing disparities in health status and access to health services. National policies are often notable for their reluctance to face up to key decisions that will directly help the poor or at the least not make them worse off. Often, this is due to the absence of a consistent policy frame and to the grave lack of resources available.

34. WHO, in collaboration with other agencies, will continue to play an important role in mobilizing information, skills, and technical support for strengthening health systems by supporting research and development on country-specific priorities; by supporting the development and use of tools, procedures and methodologies, as well as institution strengthening; by fostering an exchange of information and experience, by fostering partnership.

7. Equity in health

35. The concept of equity in health and the right to health both together constitute an enlarging of human rights' consciousness for which the time has come. The forthcoming Conference must provide an occasion for major international institutional reflection on how close human rights and unmet basic needs can converge. Such reflection might influence to good purpose strategies for the current international development decade, besides elaborating the rights themselves.

36. As a concept, equity in health has a complex overlay of meanings. It should, of course, be distinguished from the notion of equality, for the latter refers to equalization of differences in outcomes, quality, status or inputs. The distinguishing feature of equity is an ethical dimension providing norms for action and, in turn, provoking thought on alternative perspectives for the determination of such norms. Equity in health would broadly seek to redress differences which are not only unnecessary and avoidable but are at the same time unjust and unfair. These may be differences in level of health or quality of life which involve wider socio-economic or developmental variables, or they may be differences in services or in access to health care.

37. Equity in health implies that everyone should have a fair opportunity to attain full health potential - over a period of time and throughout one's life cycle. One can operationalize this approach only if equal access to available care remains the guiding principle.

8. Holistic view of the right to health

38. The right to health as part of a group of economic, social and cultural rights is already enshrined in the Covenant on Economic, Social and Cultural Rights, and all rights inscribed in both Covenants are to be realized in an interconnected and indivisible manner according to repeated averment. It could be said that the right to health seen as a composite right, consists of a large number of "surrogates", each one of which could become a right in

itself. Indeed, the concept of "right to health-care", "right to social security", "right to reliable services from a functioning social infrastructure" or the "right to redress against iniquitous action" could well constitute the first level of such surrogates. In turn, each of these surrogates, whether enshrined as a right, in the constitution and the law or as judicial or administrative procedure, part of a citizens' charter or otherwise, would indicate what citizens can demand through appropriate authorities either as an outcome or procedure. The right to health-care means an equal opportunity for everyone to have recourse to due medical care, to educational counselling, to preventive protection from public health hazards, and to the creation of conditions, through regulatory or other devices, to a reasonable expectation for an equitable share in total health-care resources. Medical care always constitutes a primary foundation of a right to health. The basic right of access to medical services and attention is totally in accordance with Article 12 (2) (d) of the International Covenant.

39. No doubt rights to social security, reliable social services and redress against inequity are common to the enjoyment of many rights, not to the right to health alone. The advantage of picking on these "surrogates" for elaborating the right to health is the possibility that within each relatively narrow field of action, appropriate indicators of progress could be identified and periodic trend surveys of the achievement of such indicators could provide evidence of the evolving nature of the right to health. In fact, formulated in such a composite manner, there is a possibility that the situation in regard to the enjoyment of the right to health, in both developed and developing countries, can be tested on reasonably similar yardsticks always having due regard to differential initial bases. To accomplish this, the health sector as a whole needs alliances; and it will stand to gain from allying to its objectives, the influential pressures born of current human rights concerns covered under both Covenants thus gaining universal acceptance. The rights covered by the two Covenants must be viewed holistically to guarantee individual and community rights and values.

Part Two

1. The rights of patients

40. Reaffirming fundamental human rights in health care, and in particular protection of the dignity and integrity of the patient as a person, is particularly important, since the vulnerability of sick persons renders them easily subject to violations of their rights and more readily affected by gaps and shortcomings of social and health administrations.

41. Various social, economic, cultural, ethical and political considerations have given rise to concern for a fuller elaboration and realization of patients' rights. New and more positive concepts of patients' rights are being advocated. In part, this has been a reflection of the central place given both to full implementation of the concept of respect for persons and to equity in health as a policy objective in WHO's Member States. As a consequence, there is now greater emphasis on, inter alia, the encouragement of individual choice and the opportunity to exercise it freely, and the commitment to build mechanisms for ensuring quality of care.

42. Developments within health care systems, such as the increasing complexity and often the growing bureaucracy, as well as developments in medical and health science and technology, have all prompted a new emphasis on the importance of recognition of the right of the individual to self-determination and, in many cases, the need to formulate guarantees to assure patients' rights. Governments are increasingly giving active consideration to such issues as the provision of information to the patient, informed consent, confidentiality and privacy, data protection, access to medical records, the right to health care and relief of suffering, respect for human dignity and cultural and religious values and the availability of institutional mechanisms for dealing with patients' complaints.

43. In this sense, a highly distinctive feature of the present time is the development not only of the individual but also the social dimension of patients' rights, taking into account living and working conditions and public health in its broad sense. Hence derives the trend to reaffirm the right to treatment and care, to adequate social cover and to proper information about health services, in other words, the right to benefit from progress in the health field. Account needs to be taken not only of the changing mentality of a public that aspires to becoming not merely users but also active partners in sharing responsibility for the health system as a whole. Inseparable from this social approach is the growing impact of economic factors on health policy and management, and the growing recognition of the limits imposed on the provision of health care as a result of economic constraints. The resulting challenge is a search for ways to curb rising costs without undermining the basic right to health of the population in terms of access to care and services, equity in treatment and quality of care.

44. Another factor that is greatly influencing the recognition of patients' rights is to be found in the very manner in which modern medicine functions, with the dispensing of care becoming increasingly complex and changing so rapidly that it generates in adaptation of the health care system. This is the case, for instance, in the way hospital care is structured, with its harsh and complex realities as experienced by the patient. Modern medicine also tends to foster both excessive bureaucracy and situations that may give rise to conflicts. The imperatives of management, or profit, can be at odds with the well-being of patients. Despite certain established principles of respect for patients of a fairly protective nature, it is undeniable that users' expectations are not being met. This is widely attested by the numerous petitions and claims made and by the emergence of consumer associations and pressure groups that highlight the practical difficulties met in implementing patients' rights.

45. Finally, the factors that have contributed to a new recognition of patients' rights certainly include the appearance of a "new biomedical ethics", or bioethics, aimed at reconciling the imperatives of research indispensable to the improvement of care techniques, with the protection of the fundamental rights and freedoms of individuals participating in research on human beings. This concept of bioethics is one that is also shaping the attitude of the individual patient, as well as of others involved, in crucial decisions pertaining to life and death and which demand respect for fundamental ethical principles.

2. The rights of the mentally ill, and the improvement of mental health care

46. On 17 December 1991, a set of Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care was approved by the United Nations General Assembly (resolution 46/119 of 17 December 1991). WHO considers these Principles to be a landmark achievement of the United Nations system. The Principles provide comprehensive protection for a particularly vulnerable group that is readily susceptible to stigmatization. Persons in this group are vulnerable because of their disturbed mental state, which prevents them from making reasonable judgements about their own needs; and, as a corollary of their vulnerability, such persons are often given least priority in terms of access to care and services. It is true that mentally ill persons can sometimes be dangerous to themselves or to others, although this hazard is often exaggerated. The Principles attempt to set forth due safeguards against such hazards, without ignoring the fact that such provisions are particularly liable to be abused by family members, other members of the community or State authorities. If a national jurisdiction follows this balanced set of Principles in drafting domestic law and in instituting procedural modalities, both the rights of the mentally ill and improvements in mental health care can be accomplished. Just as WHO played a prominent role in assisting the Commission on Human Rights in drafting the Principles, it could certainly take the lead in disseminating them to its vast network of professional contacts, so that national systems evolve with sensitive consideration to all aspects of the problem.

47. It is not the task of WHO to monitor the implementation of the Principles, and any possible abuses of the rights of the mentally ill. This should, quite appropriately, be left to non-governmental groups and other independent bodies. Indeed, such groups and bodies should constitute a decentralized human rights monitoring network. WHO's responsibility will be to provide technical advice to the health authorities of Member States, at their request, so as to enable them to adjust their services to function in ways that are consonant with the Principles. WHO is also in a position to cooperate with countries in amending their mental health laws in line with the Principles.

3. The rights of the child

48. The Convention on the Rights of the Child represents, as far as WHO is concerned, an affirmation of the validity of the definition of "health" included in the Preamble to the WHO Constitution. In addition to providing a legal framework for the protection of children, the Convention covers specific health and family planning needs of the mother, in addition to direct health-promotion and disease-prevention requirements of the child. This inclusion of maternal health within the framework of children's rights reflects the recognition of the social, psychological and biological bonds between mother and child. The rights of children to health care are not merely a matter of access to preventive and curative medical technologies, drugs, etc. In order for the child's health rights to be realized, many other provisions in the Convention need to be implemented; it must, in particular, be assured that activists in other sectors, do not compromise or neglect health when they formulate projects, activities, or even laws or regulations.

WHO is actively pursuing its responsibilities to assist States Parties to the Convention to realize and maintain the health-related rights set out in Article 24 of the Convention, and indeed progress in this respect forms part of WHO's endeavours to monitor progress towards the goal of Health for All. In association with UNICEF and the International Paediatric Association and other non-governmental organizations, WHO has been active in advocacy and support for ratification, implementation and monitoring of the Convention.

49. Children in vulnerable and difficult circumstances, street children, and children subject to exploitative child labour, have special health needs that are not readily met by existing health structures. Even more difficult has been the ability to respond to the needs of children caught up in conditions of civil conflict. Together with other recognized humanitarian organizations and agencies, WHO has been engaged in providing and coordinating emergency relief programmes for such children.

50. Monitoring activities have revealed significant successes in regard to immunization coverage of children. However, WHO is also aware of large and continuing disparities in pockets, particularly in Africa, where more women are dying in childbirth and more infants are born malnourished in utero than five years ago.

51. Scientific information on the adverse effects of child labour on the health of the child is limited. In the vast majority of work situations, important features of child labour that affect health, such as the "critical age" during which the child is more liable to the hazardous effects of labour, the duration of specific forms of work, and the type of work causing damage to child health, have not been scientifically documented and much more needs to be done in this area.

52. WHO has been involved in research, training and developmental aspects of action programmes in the area of child labour since 1980. The objectives have been as follows: (a) to define possible health implications of child labour; (b) to make recommendations for relevant intersectoral action; and (c) to prompt greater cooperation among individuals and groups working in the field of child labour and its health implications, including the provision of technical support. Scientific reference should be made to an informal Inter-Agency Task Force, which is being reactivated and whose members include Defence for Children International; the ILO; the International Society for Prevention of Child Abuse and Neglect; UNICEF; and WHO. WHO intends to continue to provide technical support and to disseminate information on the relationships between child labour and health. It intends to advocate and promote intersectoral action programmes, in close cooperation with other agencies and non-governmental organizations.

4. The rights of the elderly

53. A number of human rights concerns in respect to the care of the elderly are set forth in the Preamble to the International Plan of Action on Aging, held in Vienna on 26 July-6 August 1992, and is currently the principal international instrument that guides policies and programmes in this area.

54. The elderly, defined in 1991 by the Bureau of the Census, Economics and Statistics Administration of the United States Department of Commerce, as persons who are 60 years of age and over, currently account for between 17 per cent and 23 per cent of the population of most countries in the developed world, and for 5 per cent to 10 per cent of the population of countries in the developing world (in a few developing countries, the percentage is higher). Of great interest is the fact that it is this segment of the world's population that is growing most rapidly; by far the greatest increase is taking place in the developing world. For example, according to Golini and Lori (in Aging, 2: 319-336, 1990) the percentage of the population 65 years of age and over is projected to triple in China and quadruple in the Republic of Korea and Malaysia by the year 2025.

55. The elderly have distinct human rights, which were not addressed specifically in the 1948 Universal Declaration of Human Rights or other relevant human rights instruments. Indeed, the elderly represent a minority that all of humanity hopes to join, in contrast to other minority groups such as the disabled, refugees and ethnic minorities that remain distinct throughout life. Various forms of "ageism" may lead, in the event of medical care, to misdiagnosis, inappropriate treatment, and unnecessary institutionalization. Health and well-being of the elderly can be assured only through a better understanding of the subtle and pervasive effects of age-related discrimination in all its forms.

56. Two notable instruments merit particular mention: the ILO's Older Workers Recommendation, 1980 (Recommendation No. 162), addresses the right of all workers, liable to confront special difficulties in employment and occupation because of advancement of age. This is of special importance as the elderly are not a homogeneous group with respect to levels of physical and mental health. The other is United Nations General Assembly resolution 46/91, adopted on 16 December 1991, which sets forth "United Nations Principles for Older Persons". The latter text identifies 18 key principles relating to independence, participation, care, self-fulfilment and dignity. In the area of care, for example, the resolution stresses the right of an older person to benefit from family support and access to health care, and to retain fundamental human rights and dignity if residing in a treatment or care facility. Guidelines are required to implement these Principles. WHO intends to participate fully in the development of such guidelines.

5. The rights of the disabled

57. WHO has promoted the rights of people with disabilities through community-based rehabilitation (CBR), a strategy for ensuring that rehabilitation is available to disabled people in the same way that health services are available to all people in the community. CBR includes the transfer of knowledge and skills for rehabilitation activities to disabled persons, their families and the community, and the integration of disabled children into school work and adults into social settings within the community. The support required for CBR is multisectoral, and involves in particular the health, education, labour and social services. WHO remains committed to work with other United Nations agencies, Governments, and non-governmental organizations to promote the expansion of CBR and the necessary support services.

6. Human rights aspects of HIV/AIDS

A. The protection of human rights and the Global AIDS Strategy

58. In May 1992, the Forty-fifth World Health Assembly endorsed an updated, expanded, and refined global strategy for the prevention and control of AIDS; this establishes the new direction to be taken by all partners in the global efforts to combat AIDS in the years ahead. The Strategy sets out ethically and technically sound approaches, of known effectiveness, for meeting the new challenges posed by the pandemic, viz.: increased emphasis on care; better treatment for other sexually transmitted diseases; a stronger focus on HIV infection through an improvement of women's health, education, and status; a more supportive social environment for prevention programmes; anticipatory planning in respect of the socio-economic impact of the pandemic; and greater emphasis on the public health dangers of stigmatization and discrimination. The three main objectives of the Strategy are identical to those of the original (1987) version of the Strategy: (a) to prevent infection with HIV; (b) to reduce the personal and social impact of HIV infection; and (c) to mobilize and unify national and international efforts against AIDS.

59. In implementing this Strategy, WHO's Global Programme on AIDS (GPA) is continuing to unify and mobilize international efforts in the area of human rights and HIV/AIDS. For example, GPA has participated in international conferences on HIV/AIDS, convened or supported seminars on the subject, cooperated with the United Nations Centre for Human Rights and with other United Nations agencies, played an advocacy role with Governments, supported and funded non-governmental organizations, and financed a number of studies, all focusing on the human rights dimensions of AIDS. At international and national conferences, GPA has continued to ensure that the promotion of human rights for people with HIV/AIDS remains on the agenda, both internationally and nationally. Resolution WHA41.24, adopted by the Forty-first World Health Assembly in May 1988, called upon WHO to take all measures necessary to advocate the need to protect the human rights and dignity of HIV-infected people and people with AIDS. As part of GPA's objectives in respect to advocacy, WHO has decided not to sponsor, co-sponsor, or financially support international conferences or meetings on AIDS in countries having HIV/AIDS-specific short-term travel restrictions.

60. As regards education, GPA has conducted human rights-oriented training programmes for its own staff at WHO headquarters in Geneva, and is planning to hold similar seminars for WHO staff in the Organization's six regional offices. Moreover, it has held a series of consultations on human rights aspects of HIV/AIDS, in such areas as: short-term travel restrictions; prisons; and testing. Furthermore, GPA supports WHO's Health Legislation Unit, which regularly produces a tabular listing of HIV/AIDS legislation (see "Tabular Information on Legal Instruments Dealing with HIV Infection and AIDS" (WHO/GPA/HLE/92.1, June 1992); an update is scheduled to appear in June 1993). Consideration is being given to the establishment of other databases dealing with HIV/AIDS and human rights.

61. As regards cooperation with international organizations, GPA has cooperated closely with other United Nations agencies that are involved in human rights issues, including the United Nations Centre for Human Rights, the ILO, UNHCR, and UNDP.

62. With regard to advocacy to Governments, WHO has provided technical cooperation, discussed proposed and enacted legislation, and responded to requests for information from Governments on human rights and on HIV/AIDS laws and regulations. It is developing a course for AIDS Programme Managers (i.e. government officials who serve as national focal points for AIDS), where a component of the course will deal with training on the promotion of human rights. GPA also reviews Medium-Term Plans prepared by Governments, so as to ensure the promotion of human rights. Finally, GPA is cooperating with non-governmental organizations, and has funded and is continuing to fund NGO work on human rights; it regularly responds to inquiries from NGOs concerning the human rights aspects of HIV/AIDS.

B. Perspective actions

63. The AIDS pandemic is still increasing. Associated with the pandemic is the profound negative personal and social impact of discrimination. Non-discrimination is good public health policy. Fortunately, sustained and effective advocacy can play a powerful and positive role in avoiding discrimination against persons with HIV infection and AIDS. It may be affirmed that success in the campaign against AIDS will to a significant extent be measured on how well Governments throughout the world implement non-discriminatory policies and practices.

64. Discrimination against HIV-infected persons and persons with AIDS continues to be a major obstacle to the prevention of HIV infection and the provision of care for persons with AIDS, and is also retarding efforts to reduce the personal and social impact of HIV infection and AIDS.

65. GPA's human rights activities build on prior accomplishments, viz.: the establishment of a worldwide information-sharing network, with a central information bank on HIV-infected individuals whose human rights have been violated; distribution of guidelines on HIV/AIDS in prisons; compiling documentation on legal instruments dealing with HIV/AIDS; collaboration with other United Nations agencies engaging in human rights activities; maintaining and expanding the existing collection of reference documents and database of human rights aspects of HIV/AIDS; producing other operational and training materials in this area; and training key decision makers at the country level (e.g. AIDS programme managers, government officials, and NGOs) concerning issues relating to discrimination against HIV-infected persons and people with AIDS (emphasis in such training will be placed on the significance and value of human rights promotion in accomplishing AIDS-specific public health objectives).

66. GPA will continue to conduct (in cooperation with the United Nations and other specialized agencies) meetings and consultations designed to develop and formulate standards and norms that can be relied upon for advancing human rights objectives and avoiding discriminatory practices. These include

policies, guidelines, and norms on HIV/AIDS and human rights in those areas in which discriminatory practices have a significant impact, for example in: international travel and migration; the workplace; and other areas to be determined.

7. The rights of vulnerable groups and indigenous peoples

67. The goal of Health for All by the Year 2000 is, in the final analysis, about the underprivileged. Thus, in order to achieve the goal, it is essential to identify the underprivileged in each country, whether developed or developing; it must cover those who are currently excluded from the word All in order to make sure that they are included as soon as possible - at least by the year 2000.

68. Population groups that have been found to be underprivileged as far as health is concerned include: disabled persons; the unemployed; commercial farm labourers; the lower castes; indigenous populations; homeless persons; one-parent families; migrants; large families; population groups residing in remote areas that are not readily accessible; orphans and street children; and persons who are illiterate. Many of these underprivileged groups do, of course, overlap.

69. The major differences in levels of health are of concern for several reasons. Firstly, because substantial progress has been made in improving health in the aggregate. Secondly, few countries have data on the health of socially and economically underprivileged groups that are adequate and reliable enough to monitor differences in trends. Thirdly, from the few instances where such data is available, it is clear that the gaps are stable or even increasing. One of the targets of the countries in WHO's European Region, viz. by the year 2000 the actual differences in health status between countries and between groups within countries should be reduced by at least 25 per cent, by improving the level of health of disadvantaged nations and groups, will not be achieved. On the contrary, if the health situation is compared between countries, there is an increasing gap between North-Western and Central-Eastern Europe, with Southern Europe occupying an intermediate place in most respects. Closing this gap as far as possible, probably to level of differences which existed at the beginning of the 1970s, is the task for the coming decades. Another example is from the United Kingdom, where the 1992 Black Report entitled Inequalities in Health concluded that the relative differences in mortality of unskilled manual workers as compared with professionals and managers did not narrow in the 20 years between 1950 and 1970 and in some cases actually widened.

70. A fourth reason is the current inertia to undertake fundamental reforms to improve the health of the underprivileged. Although the intrinsic reasons for the differences are not precisely known, enough is known to ameliorate the situation where there is indicative primarily of weak political will. Studies in developed countries have shown that excess mortality is due to accidents, cardiovascular diseases, and unhealthy living and working conditions, for which a number of specific preventative measures can be instituted. In the developing countries, readily preventable diseases (including malnutrition,

infectious diseases and problems associated with pregnancy) are responsible for the gaps. Many of these countries have to confront a double jeopardy, in so far as they have to content with the burden caused by non-communicable diseases even while efforts to combat communicable diseases are far from complete. In spite of these major factors, an equity-supported social policy and "health transition", including a rapid decline in morbidity and mortality from high to fairly consistent low levels is feasible, and has indeed occurred in a number of countries with a low GNP, such as Sri Lanka.

71. Under the terms of Article 20 of ILO Convention No. 107 (Convention concerning the Protection and Integration of Indigenous and Other Tribal and Semi-Tribal Populations in Independent Countries) requires Governments to assume responsibility for providing adequate health services for the populations concerned. WHO has constantly made its position known with regard to these provisions, and has pointed out that they are in line with WHO’s own Constitution.

72. As the year 2000 approaches, it is urgent that new strategies be developed to improve the health of underprivileged people. These strategies will include: overcoming inertia; establishing broad-based intersectoral action; establishing targets; ensuring community participation; and learning-by-doing. The content of each of these strategies will vary between developed and developing countries. Strategies will have to deal mainly with overcoming cultural and individual financial barriers to utilization of health care (based on the existing infrastructure), the promotion of healthy lifestyles, and the achievement of greater equity in the distribution and allocation of resources. Support from the developed countries to address the needs and rights of vulnerable groups and indigenous peoples is needed to find new ways of overcoming entrenched problems. Within individual countries, this implies a willingness to recognize the problems and to actively search for data on the epidemiological contours of the problem, as well as a political will to design strategies and policies that ensure at least a minimum level of income and employment. The health sector needs to promote and support such broad-based approaches and initiatives, that are fully within the mandate of the sector itself.

73. One can see a number of problems ahead. The formulation of health targets for vulnerable groups and indigenous peoples may give rise to political problems in the present context, where there are a number of international and national political conflicts involving minority groups. The term "underprivileged populations" may itself become an issue. Whether this or another term is used, it should engender concern, and stimulate a need for urgent action within the framework of efforts to achieve Health for All. In dealing with the issue of the health of vulnerable groups and indigenous peoples, there are bound to be strong and sometimes differing views on how to deal with the issue, as well as vested interests in maintaining the status quo. Consequently, as compared with the past, the health system is likely to enter an area of some instability.

8. The health status of least developed countries

74. As a follow-up to the Second United Nations Conference on the Least Developed Countries (Paris, 3-14 September 1990), WHO has taken the initiative in giving holistic attention to the continuing adverse level of health in the least developed countries (LDCs). This is in line with the Declaration of Alma-Ata, in the sense that international solidarity to cope with disease and ill-health in one part of the world is of importance to all countries.

75. All the socio-economic indicators, and particularly the health indictors, are "in the red" in the LDCs: life expectancy is under 50 years, as against 74 years in the developed countries; and 150 children in every 1,000 die during the first year of life, compared with 15 in the industrialized countries. Barely two deliveries in five are supervised by qualified personnel. It is scarcely surprising that, under such circumstances, some 500,000 women die in childbirth every year in the developing countries. In addition, the burden of AIDS, closely related as it is to poverty and ignorance, can be expected to have a significant negative impact. Of the estimated 11-13 million HIV infections throughout the world, at least half are in the LDCs. What this implies is that about one in every 80 adults in these countries is HIV-positive. If we consider the LDCs in Africa alone, this proportion increases to about one in 40.

76. The fact that the LDCs have not yet succeeded in meeting the basic health needs of their people should not be concealed. In fact, during the decade of the 1980s, the demand for health services in these countries increased, while the supply diminished. WHO considers this kind of imbalance to be unacceptable. It is the Organization’s view that, in order for it to be corrected, substantial investments in health will have to be made in the LDCs by the end of the century.

77. While primary health care (PHC) remains the optimal method for enabling the LDCs to make progress towards the goal of Health for All, its implementation requires a firm commitment on the part of political leaders at the highest level to reduce social inequities. But how can these countries hope to develop PHC when three quarters of the funds available for health are spent on hospitals in cities, benefiting only a tiny proportion of the population? Aware of the difficulties and obstacles encountered by the LDCs in trying to implement PHC effectively, WHO has launched a new initiative aimed at concentrating efforts on the countries and populations in greatest need. The aims are to improve the integration and coordination of WHO’s programmes within a country, and to bring activities more closely into line with national health priorities. Special emphasis is laid on the need to help these countries increase their capability to deal with the analytical, managerial, economic and financial aspects of health strategies.

78. This new approach by WHO presupposes a commitment by the national authorities to take a new and realistic look at their health priorities and their resources. Within this intensified cooperation, the establishment by the national authorities of rational, realistic and consistent health plans that are based on resources actually available, provides a logical framework within which these resources can be used more effectively for the country’s development.

79. WHO has already analysed in-depth the situation of 23 countries, including 18 LDCs, and technical and financial commitments have been entered into with countries such as the Central African Republic, Chad, Djibouti, Guinea, Guinea-Bissau, Malawi, Nepal, Sudan and Yemen. In the short-term, efforts are being made to speed up the control of certain diseases (meningitis, malaria, tuberculosis, and leprosy), to overcome the inadequate supply of equipment and essential drugs, and to provide Governments with technical experitise on urgent issues. In the medium- and long-term, the objective is to harmonize activities, to overhaul and strengthen the health sector within the b=national economy, and to promote national self-reliance.

80. It is WHO's conviction that there is no other possible choice if it is to take up the challenge of the intolerable persistence of high rates of mortality and avoidable diseases in the LDCs. Their persistence is intolerable to WHO because it is thwarting the efforts for "the attainment by all peoples of the highest possible level of health", the Organization's constitutional objective. The international community must consequently make a greater commitment by mobilizing a willing and active partnership that is capable of breaking the "vicious circle of disease and poverty" and constructing in its place a "spiral of health and development".

9. The role of health legislation

81. The contribution of health legislation in improving the health of the community, at least in the developed countries, has been significant. As the editorialist of one of the most distinguished medical journals put it some 15 years ago:

> "Public-health legislation and related measures have probably done more than all the advances of scientific medicine to promote the well-being of the community in Britain and in most other countries." (Lancet, 2, 1978).

No doubt the term "well-being" is to be interpreted in the same comprehensive way as in the first of the principles declared (in the Preamble to WHO's Constitution) to be "basic to the happiness, harmonious relations and security of all peoples". Can this contribution of "legislation and other measures" be quantified? What about the "minority of countries" to which the editorialist implicitly refers? Are there intrinsic or extrinsic factors that have prevented health and related legislation from playing its due role in advancing community and individual health? These are some of the questions that merit careful consideration by human rights scholars, in conjunction with public health leaders, ethicists, moral philosophers, and others.

82. As far as is known, contemporary medical curricula in most countries generally accord little place to the language and literature of ethics, and less to the principles of human rights enshrined in the International Bill of Human Rights and in other international and regional human rights instruments. Practising physicians hence tend to be unaware of the health-related human rights to which their patients or the community which they serve are entitled. How many, for example, are familiar with paragraph 16 of the Proclamation of Teheran, in spite of its relevance to family and child health throughout the world? How many are aware that the International Conference on Human Rights,

held in Teheran on 22 April-13 May 1968, urged "all peoples and governments to ... redouble their efforts to provide for all human beings a life ... conducive to physical, mental, social and spiritual welfare" (language that partially echoes the definition of "health" embodied in WHO's Constitution)? Does Article 12 of the International Covenant of Economic, Social and Cultural Rights mean very much to the health policy makers in developed or developing countries? This disjunction could perhaps be ameliorated by an effort, on the part of interested organizations, to produce a manual on how the philosophy and principles of those human rights that related to human health - in the widest sense - can be incorporated in the medical curriculum. (Important pioneering work has been accomplished by the Council of Europe and the Trieste-based International Institute for Human Rights Studies. See, for example, Le Médicin Face aux Droits de l'Homme. CEDAM, Padua, Italy, 1990). This would be accompanied by another product that would guide legislators and health administrators on how to translate these principles into enlightened health legislation, in line with WHO's Health-for-All Strategy and at the same time imbued by the ideas of René Cassin, Eleanor Roosevelt, and other progenitors of contemporary human rights.

83. It may be argued by some that the very language of Article 12 is "dated", and reflects the generally prevailing philosophy of health at the time. It contrasts with the much more progressive, and equity-centred, language of (for example) the 1988 Protocol of San Salvador to the Pact of San José (Organization of American States). It would be illusory to suggest that Article 12 be revised to reflect what might be described as the philosophy of Alma-Ata (after the city of Kazakhstan at which the WHO/UNICEF International Conference on Primary Health Care was held in September 1978), and the emerging new health paradigm being developed under WHO's leadership. What would be less illusory, perhaps, would be the development of a scholarly guide to the implementation of Article 12 (possibly also embracing Article 25 of the Universal Declaration of Human Rights) in the light of contemporary approaches to health and to the health (and associated environmental) problems with which the societies of the twenty-first century are likely to be confronted.

84. As suggested above, the Lancet editorial implicitly identifies two groups of countries - one in which health legislation has greatly improved the public health, and one in which it had failed to do so (at least as of 1968). If this is indeed the case, can the gap be due to factors that can (1) be identified, and (2) be remedied by the global health community? Is the still-prevailing colonial legislative heritage to blame? Are there discernible constraints in terms of manpower, resources, or other elements? These are questions that merit an answer or at least in-depth study by the academic community in conjunction with interested international organizations.

85. The need for studies on "protection of the human personality and its physical and intellectual integrity, in the light of advances in biology, medicine and biochemistry" was noted by the General Assembly in resolution 2450 (XXIII), adopted on 19 December 1968. (See in this connection the WHO study entitled Health Aspects of Human Rights with Special Reference to Developments in Biology and Medicine (1976) and United Nations Commission on Human Rights document E/CN.4/1172 and Add.1-3 of 1975 entitled "Protection of the human personality and its physical and intellectual integrity in the light of advances in biology, medicine and biochemistry"). The intervening

quarter of a century has witnessed substantial national legislative activity designed to assure such protection. What is perhaps required at this juncture is a determination of the effectiveness of the legislation enacted to date, and the emerging areas in which legislative intervention, international, regional, or national, may be called for.

86. The time may well be opportune for the agencies in the United Nations system concerned with social and cultural rights (notably UNESCO, FAO, ILO, WHO, and UNFPA) to endeavour to formulate jointly agreed guidelines on the implementation of these rights by national legislation. All these agencies have been actively engaged in strengthening national legislative capacities in their respective sectors. All have gained much experience on alternative approaches to legislation, and a common effort to provide guidance to countries could yield useful results.

10. Humanitarian emergency health assistance and rights of displaced populations

87. The Preamble to WHO's Constitution proclaims that "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition". Thus, WHO's activities in regard to humanitarian emergency health assistance are directly in line with the Constitution.

88. Human rights are not limited to freedom from torture and physical oppression. Human rights also include those rights that are essential not just for human security, but also for human survival and dignity. These include the fundamental right to a standard of living that is adequate for health and well-being, including food, clothing, housing, medical care and necessary social services. Thus, WHO not only addresses the plight of refugees, but also the plight of displaced persons, returnees and the host community.

89. In line with its mandate, WHO promotes:

(a) respect for human rights amongst all groups in an equitable manner;

(b) improvement of health, education, training and environmental quality; this leads to economic development of the local community;

(c) the democratic process and the circulation of information; and

(d) links between refugees, returnees, displaced persons and the host community, and the civil society of the donor countries.

90. The operations activities carried out in the Republics of former Yugoslavia illustrate the role WHO plays in humanitarian assistance. WHO supports war-devastated populations, refugees, displaced people and the host community by:

(a) organizing international efforts to prevent deaths and unnecessary suffering;

(b) helping those affected by the conflict to maintain their good health in a hostile and hazardous environment;

(c) ensuring that local health staff have the means to reduce suffering;

(d) exercising pressure at all levels to ensure that health staff and humanitarian relief workers are free to carry out their duties under conditions of safety and protection under international humanitarian law;

(e) mobilizing emergency health relief based on objective and sound technical assessment of health needs;

(f) seeking voluntary donations for the health component of the Consolidated United Nations Programme of Action, giving priority to the needs of war-devastated populations; and

(g) ensuring that the lives and rights of dependent and disabled persons, such as those with mental illness, are respected.

91. The Charter of the United Nations itself emphasizes the role of the United Nations in promoting economic and social welfare. Article 55 commits the United Nations to promote higher standards of living, full employment and conditions of economic and social progress and development, and solution of international economic, social and health-related problems.

11. Equity in health care

92. In many countries, the right to health care is embodied in health legislation and in some is even a constitutional right. For many groups, however, there is frequently a large gap between the existence of this legal right and actual equity in access to health care. Dahlgren and Whitehead have described geographic, economic and cultural barriers to health care in a recent WHO discussion paper entitled "Policies and strategies to promote equity in health" (document EUR/ECP/RPD 414(2), Copenhagen, 1992). These include the difficulties in providing high-quality care in isolated, rural, mountain or island areas, and the reluctance of health personnel to serve in depressed urban areas, phenomena that exist in both the industrialized and developing countries. Systems of health care financing can restrict equity in access to health care, as can cultural barriers when the professional-patient contact is inappropriate, or migrants and guest workers are faced with language barriers. A low level of education can be an important deterrent to the demand for health care and particularly for preventive services. Those most in need of care are often least likely to receive a high standard of care, a phenomenon which has been termed by J.T. Hart the "inverse care law" (in Lancet, 1, 1971). The above-mentioned paper suggests some ways of dealing with these issues.

93. In various European countries, such as Norway, Sweden and the United Kingdom, resource allocation formulae have been used to take account of differential needs for care in different parts of the country. In Finland, the strategic planning system has been used with considerable success to

ensure the provision of high-quality services in rural areas and some health regions in England have been innovative in adapting the provision of care to meet the needs of ethnic minorities.

94. Poor economic growth has led to calls for cost containment in the provision of health care in many countries. Direct user charges are being increasingly introduced. Many of these changes harbour real dangers for equity in access to health care, as do some of the major changes in the financing of health care now being contemplated in Eastern Europe.

95. The increasing demand for high-technology care can be only too attractive to politicians due to its high visibility. This demand, if met, can have the effect of providing access to care for the few, whilst restricting access to basic services for the many.

96. Unfortunately, the possible impact of many of the changes in health care financing, of measures for cost constraint and of the balance between high technology and basic care, on equity in access to health care, is frequently not explicitly discussed. These issues merit much greater attention from researchers and decision makers.

97. The criteria for deciding on the content of the "minimum essential care basket" needs to be more explicitly defined. Restrictions of access to health care through lengthening waiting lists, etc. must be an explicit part of the political agenda, rather than the implicit rationing which presently occurs. The expected continuation of poor economic growth for some time to come, and the further restriction of resources for the health sector, makes this explicit definition of criteria essential.

98. In a recent report issued in 1992 by the Netherlands Ministry of Welfare, Health and Cultural Affairs, entitled Choices in Health Care, it is suggested that, in transferring existing types of care to the "package" covered by basic health insurance, a series of four criteria should be applied, viz.: (a) Is it necessary care, from the community point of view? (b) Has it been demonstrated to be effective? (c) Is it efficient? and (d) Can it be left to individual responsibility? It is of course possible to agree or disagree with these criteria, but the important point is that they are openly debated and discussed.

99. Organizations in the United Nations system, such as WHO, ILO and UNICEF, as well as the World Bank and other intergovernmental organizations such as the Commission of the European Communities and the OECD, all of which are involved in providing support to countries to develop their health care systems, need to work together to develop guidelines to assist countries in conducting a transparent political discussion of these important issues.
