How the Framework Convention on Global Health (FCGH) should address the right to health (right to health and health systems; clarifications of key standards; non-state actor obligations; humanitarian crises; national laws)

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Health systems: What health system changes would a right to health approach entail? In general? In specific countries?

In this regard, it seems very important to take into account the worldwide trend of healthcare privatization, and the impacts of this on the AAAQ. Human rights law is in principle neutral on this issue (States are free to organise their health system in the way they want to), but clearly there is a tension between guaranteeing a right to health as a State and healthcare privatisation and it seems important to point this out. General Comment 14 contains some helpful language in this respect.

Furthermore it seems important to take into account that due to their complex nature, health systems are very vulnerable to corruption. See Transparency International's useful 2006 report (http://archive.transparency.org/publications/gcr/gcr_2006) (which calls health systems the systems that are most prone to corruption), and also the work by William Savedoff and if you allow me - I try to establish links between the right to health and health sector corruption
here http://www.du.edu/korbel/hrhw/workingpapers/2011/64-toebes-2011.pdf

Clarifying equity, participation and accountability: What have human rights scholars, UN special rapporteurs, the Committee on Economic, Social and Cultural Rights, and domestic courts said about other aspects of the right to health, principles such as participation, accountability, equity and an emphasis on marginalized and vulnerable populations, and equality and non-discrimination? How have they interpreted and reacted to the minimum core obligation of the right to health, including its connection to available resources? (General Comment 14 described the core obligations as non-derogable, as does General Comment 15 on the right to water. But several early General Comments [General Comment 3 on overall state obligations and General Comment 12 on the right to food], include a link to resources.)

Accountability is still an ill-understood concept in the context of human rights and governance. Helen Potts' report on accountability [http://www.essex.ac.uk/hrc/research/projects/rth/docs/HRC_Accountability_Mar08.pdf] and also on participation [http://www.essex.ac.uk/hrc/research/projects/rth/docs/Participation.pdf] are quite helpful for mapping out the components of accountability and participation. Her reports could be helpful in further identifying the relevant accountability and participatory mechanisms. For accountability, it seems clear now that we should not only focus on legal accountability, but also on other forms (different authors distinguish different types of accountability - and it would be important to establish clearly what we are talking about). We are currently exploring these issues at the University of Groningen, in a seminar series, book, and PhD project focusing on China.

Obligations of non-state actors: Should the FCGH create direct obligations on corporations (and other non-state actors), as opposed only through states as the intermediaries, with requirements to regulate non-state actors? If so, how would the FCGH create these direct obligations, 9 particularly assuming that non-state actors are not direct parties to the FCGH? [Note question also in the Global Governance for Health section.]

While strictly speaking they are not bound by the human rights standards, General Comment 14 does a good job by pointing at the responsibilities of all the actors in the health sector.

Natural disasters and humanitarian crises: Should an FCGH address specific right to health responsibilities during natural disasters and other humanitarian crises (e.g., in the context of refugee and internally displaced populations)? What special right to health obligations do (and should) these crises create?

The right to health, in conjunction with humanitarian and medical-ethical standards, seems highly relevant when it comes to such crises. It would be possible to outline the specific responsibilities in terms of minimum core obligations to respect, to protect and to fulfil, see my attempt in Tilburg Law Review:
http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2340472
where I define the following obligations for States, which could potentially also fall upon non-state actors:

State duties to respect:
- accepting essential health-related services provided by foreign donor organizations, the international community, and assisting States (duty to consent);
- respecting equal access to available health-related services to all population groups (non-discrimination and medical neutrality);

- not obstructing humanitarian aid organizations and their workers in the exercise of their tasks, either wilfully or through negligence (medical neutrality).

State duties to protect:
- offering protection to civilians so as to secure their health (e.g., against attacks by armed opposition groups);
- offering protection to humanitarian aid workers, so as to ensure that they can carry out their tasks safely and adequately (medical neutrality).

State duties to fulfil:
- adopting and implementing a plan of action, addressing the health emergency;
- based on the definition of the 'minimum core' and in compliance with the criteria of the 'AAAQ', providing the following essential health-related services:
    - minimum essential food;
    - basic shelter, housing and sanitation;
    - adequate supply of safe and potable water;
    - essential drugs;
    - reproductive, maternal (pre-natal as well as post-natal) and child health care;
    - immunization against the major infectious diseases occurring in the community;
    - measures to prevent, treat and control epidemic and endemic diseases;
    - education and access to information concerning the main health problems in the community;
    - appropriate training for health personnel, including education on health and human rights.

National right to health laws: What are examples of national laws and policies explicitly based on the right to health? How effective are they? How might they inform an FCGH?

May I give one example from the Netherlands: a private health insurance market has been created; yet the now private health insurance companies are heavily regulated by the Dutch Government (i.e., the duty not to refuse anyone): while not explicitly based on the right to health, it is very much based on the notions of the AAAQ. It is interesting to see how the right to health can even be applied in a partly privatized system, where again, the 'obligation to protect' plays a vital role.