Right to Health

Fundamental human rights standards

Maximum available resources: How could the FCGH further operationalize, with respect to the right to health, the ICESCR obligation that states spend the maximum of their available resources towards fulfilling the rights in the Covenant? What are appropriate metrics for determining maximum available financial (including international sources of funding) and other resources? How to determine the "maximum" available resources? What should be considered the "available" resources? How, for example, to address resources that the state could potentially use but are not currently utilized by the state, such as because of capital flight, low royalties for natural resources, low tax rates, or corporate tax exemptions? Should there be required or presumptive benchmarks in these (capital flight, tax rates, etc.)? If so, what should they be? Is the FCGH the place for this? How should spending levels in comparable states factor into determining the "maximum"? How to address the fact that the maximum available resources requirement is not only for the right to health, but cuts across all economic, social, and cultural rights? Should the FCGH address maximum of available resources requirement with respect to other resources (e.g., human, financial)? If so, how?

Progressive realization: How should the FCGH operationalize the ICSECR requirement that states progressively realize the right to health? What are the appropriate metrics to measure progressive realization? Should progressive realization be measured through comprehensive metrics (such as changes in life expectancy)? Changes in key indicators (such as maternal mortality)? With metrics for a wide range of health issues (e.g., improvements with respect to HIV, different non-communicable diseases, maternal mortality, and so forth)?

Core obligations and immediate realization: What aspects of the right to health should be immediate obligations, and what aspects should be subject to progressive realization? What should the immediately realizable core obligations encompass?

Highest attainable standard of health: How has the "highest attainable standard" element of the right to health be interpreted, and how should it be interpreted? Attainable globally with a high degree of cooperation? Or something less than the highest global standard, in which case, what and how is this to be determined? The highest degree of health as attained by the healthiest people (top quintile? Top 5%?) of that country's population? Or by the wealthiest people (so as to minimize differences based on biological factors)?

Universality: How should the FCGH simultaneously respond to the universal nature of the right to health, and the equal human dignity on human rights are based, with current health realities (including, e.g., health system weaknesses that cannot be immediately resolved) and vastly different domestic resources available?

ICESCR obligations and current interpretations: What have human rights scholars, UN special rapporteurs, the Committee on Economic, Social and Cultural Rights, and domestic courts said

about measuring and operationalizing these explicit elements of the ICESCR (maximum available resources, progressive realization, highest attainable standard)? In the context of the right to health? For maximum available resources and progressive realization in the context of other rights in the ICESCR? What can we learn about current approaches to understanding these obligations from how they have been interpreted in the context of the right to food, water, and other economic, social, and cultural rights?

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.)

Calibrating guaranteed health goods and services to certain level of health: Is there a certain level of health that any minimum standards in an FCGH should guarantee? If so, what level, or how to determine that level? What implications does this have for level and nature of health systems and services to be guaranteed to all people under and FCGH? For how an FCGH would address underlying determinants of health and the broader social determinants of health?

Universal conditions for good health and variations in country wealth: Under the right to health, would there be any differences with respect to the health goods and services that should be guaranteed to all people (i.e., those included as part of the core minimum obligations) through the FCGH based on different wealth and development levels of countries, or the current health status of their populations? To what degree might specifics vary by country (potentially being less in less wealthy countries)? Or if by their nature these guarantees must be the same for all people, in every country, how might (if at all) required timelines for achieving them vary by country (including based on wealthy and current level of ensuring conditions in which all people can be healthy?)? What flexibility should countries have in these timelines? Should only other aspects of the right to health, those subject to progressive realization, that are the basis for differences in state obligations towards their populations, to ensure that wealthier countries that are largely already providing the health goods and services to be secured for all people expand beyond these goods and services, whereas the core obligations should be the same across all countries in terms of level of health that they should achieve?

International assistance responsibility under the right to health: Under the right to health, how far does – and should – the international assistance responsibility extend beyond minimum core obligations?

Avoiding undermining right to health in other countries: Beyond obligations related to specific areas (e.g., trade; see section on global governance for health), should the FCGH include a general provision on respecting (not undermining) the right to health in other countries? What are circumstances such a provision would come into effect? How could such a provision be

operationalized given the extent to which current policies (e.g., excessive greenhouse gas emissions) do undermine the right to health elsewhere? Or is it just the simplicity of this command and far-reaching implications that would give such a provision great potential?

Right to health accountability and education

Right to health education: What are the most effective approaches to enabling people to understand and claim their rights? What are good models (e.g., comic books explaining rights)? How, and how often, are human rights incorporated into school curricula? What is the role of the media? How can and should the FCGH facilitate these approaches? How can it help transform knowledge into true understanding and the ability to act on this understanding?

Current right to health education efforts: What are the main organizations/efforts underway to enable people to understand and claim their rights, in particular the right to health? How could an FCGH enhance these present efforts? Beyond the FCGH, can JALI support these efforts in any way (networking, compiling lessons learned, evidence)?

National human rights bodies: How do governments bodies mandated to raise public awareness on human rights (e.g., South Africa Human Rights Commission) do so? How effective are these approaches? What are challenges and lessons to be learned? How might these inform an FCGH?

Health worker right to health training: Should the FCGH require health workers to be trained on human rights, including the right to health, to ensure non-discriminatory, respectful treatment of all patients? Are there also other ways for the FCGH to promote health worker understanding of, respect for, and promotion of the right to health?

Right to health knowledge and evidence of impact: Is there any evidence for improvements in health outcomes from education on the right to health? If so, what is the evidence? What is other evidence of the benefits (besides improvements in health outcomes) of this information?

Local right to health accountability mechanisms: What is the evidence for improvements in health outcomes and improved health services from right to health accountability mechanisms (e.g., village health committees, community scorecards)? Do these address health care as well as underlying and broader determinants of health? How might an FCGH support these mechanisms?

Specific right to health topics

Transnational corporations and other transnational non-state actors: How could the FCGH exert control over transnational corporations (and other transnational non-state actors)? Upon which states should the obligations to regulate these corporations fall (e.g., states where corporation is incorporated?)? What regulatory mechanisms should states employ? [Note question also in the Global Governance for Health section.]

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,

particularly assuming that non-state actors are not direct parties to the FCGH? [Note question also in the Global Governance for Health section.]

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?

States in conflict: Should an FCGH address directly situations where governments do not have full control over all of their territory? If so, how should the FCGH address these situations? What are obligations of governments, non-state actors controlling territory not controlled by the government, and international actors?

Right to health assessments in non-health sectors: Should the FCGH require right to health assessments of planned non-health sector activities? Which sectors? Under what conditions should these assessments be required? That is, what circumstances should trigger these assessments? How specific or general on situations where laws require environment impact statements, and what are the possible lessons for right to health assessments?

National, provincial, and local right to health capacity: Where is national capacity for right to health implementation? In national human rights commission, judiciary? How could an FCGH support capacity for these institutions? What about local capacity (e.g., municipal health authorities, village health committees), and how could an FCGH support capacity of these institutions?

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?

Laws undermining the right to health: What are examples of national laws and policies that directly or indirectly oppose or undermine the right to health (e.g., budgeting restrictions)? How might an FCGH address such laws and policies? Are there specific types of laws and policies that the FCGH should prohibit? Should the FCGH include a general ban on laws and policies that undermine the right to health?

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

Patient safety: How should the FCGH address the rights of patients to safe health care (an integral part of quality care)?

Global organizations: How should the FCGH address the roles of global institutions (e.g., WHO, the Global Fund, the World Bank) in advancing the right to health?

Right to health capacity fund: Should the FCGH develop a special right to health capacity building funding channel to increase the ability of all segments of society – including communities, civil society organizations, government, the media, health workers, the legal

system, and academic institutions – to (as appropriate) understand, claim, advocate for, implement, protect, monitor, institutionalize, and otherwise advance the right to health? If so, what should it cover (e.g., right to health education of the population and authorities, national right to health infrastructure such as units within health ministries, right to health ombudspeople and commissions, community and civil society organizations addressing the right to health, local health accountabilities mechanisms)? How could it directly support the ability of communities to understand and claim their right to health? Should the fund include support to both non-state actors (e.g., civil society organizations, media, academic institutions) and governments? Should institutions in high-income countries (only non-state institutions, or governments as well?) be eligible? How should such a funding channel be structured and funded? Should it be an independent fund? Or should the funding channel(s) be incorporated into or otherwise linked to other health (or human rights) funding streams? Should the capacity fund's funding be encompassed within the overall funding framework of the FCGH? How should the funding channel(s) relate to or be incorporated into other health (or human rights) funding streams? [Note question also in the Capacity Building section.]

Health worker professional responsibilities: Should the FCGH include a requirement that governments respect the professional obligation of health workers to the health (and rights) of their patients (e.g., by not requiring them to report violations of e.g., immigration, drug, abortion laws to authorities, as this might reduce utilization of health services and reduce trust between health workers and patients)?

Health worker rights: How should the FCGH address the rights and needs of health workers (e.g., safe working conditions)?

International human rights machinery: How should an FCGH relate to existing international human rights machinery (e.g., human rights treaty bodies, UN special rapporteurs)?