



**Consultation on Indicators for the Right to
Health**

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Meeting Report

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This document provides an overview of the presentations and discussions on the issue of right to health indicators from a workshop held 1-2 April 2004.

Part A (Background and rationale) explains the origins and aims of the concept of right to health indicators, as well as the ultimate objective of this series of consultations.

Part B (Proposed frameworks and related concepts/initiatives) describes the framework proposed by the UN Special Rapporteur on the right to health (Paul Hunt) on right to health indicators.

Part C (Related conceptual frameworks to human rights) provides an overview of two presentations on (1) the Commission on Human Security's work on human security and the social minimum and (2) WHO's work on Millennium Development Goals and equity.

Part D (Work in progress and mapping exercises) contains summaries of a number of presentations relating to ongoing work relevant to right to health indicators.

Part E (Conclusions) list ways forward and activities to be completed before the next meeting (tentatively planned for June 2005).

A. BACKGROUND AND RATIONALE

Governments that have ratified the International Covenant on Economic, Social and Cultural Rights (ICESCR) have agreed to be legally accountable in respecting, protecting and fulfilling the right to the highest attainable standard of physical and mental health [hereinafter referred to as the “right to health”] and for the UN Committee on Economic, Social and Cultural Rights (CESCR) to monitor their performance.¹ In 2000, CESCR issued General Comment 14 on the right to the highest attainable standard of health.² General Comment 14 states, in relevant part: “National health strategies should identify appropriate right to health indicators and benchmarks. The indicators should be designed to monitor, at the national and international levels, the State party’s obligations under article 12”. The Comment identifies WHO as one UN agency to guide States in this process.³ Other UN human rights treaty bodies have also identified indicators as useful tools to monitor the realization of the rights to health (e.g. Convention on the Rights of the Child). Finally, the Special Rapporteur of the Commission on Human Rights on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Paul Hunt) has underscored the importance of right to health indicators and benchmarks in monitoring the progressive realization of the right to health.⁴

In view of the above, a meeting was held in May 2003 in order to advance the identification of relevant indicators to monitor the progressive realization of the right to health. This follow-up meeting, held 1-2 April 2004, aimed to continue discussion of those issues raised at the May 2003 in light of information and experience gained during the past year.

The ultimate objective of the exercise is to produce a toolbox consisting of simple and effective indicators for use by different actors, particularly governments, in monitoring their own performance by selecting appropriate indicators against which they can set national benchmarks; this toolbox should be widely disseminated including to human rights monitoring mechanisms and at the international, regional and national levels. This toolbox would contain generic right to health indicators as well as indicators relating to specific health challenges and population groups.

The specific objectives for the April 2004 workshop were to (1) consider proposed frameworks for right to health indicators; (2) share work in progress to ensure coherence and avoid duplication; (3) take forward discussion on how to best address key issues integral to right to health indicators; and (4) identify possible next steps to take forward the process of identifying right to health indicators.

¹ International Covenant on Economic, Social and Cultural Rights. Adopted and opened for signature, ratification and accession by General Assembly resolution 200A (XXI) of 16 December 1966; *entry into force* 3 January 1976, in accordance with article 27. ICESCR currently has 149 State Parties.

² General Comments (sometimes referred to as General Recommendations) are documents issued by the treaty bodies in order to serve to clarify the scope and content of individual rights and States Parties (those that have ratified the treaty) obligations. When talking about General Comments, it is important to recognise that each human rights treaty monitoring body has developed its own approach. The Committee on Economic, Social and Cultural Rights has outlined the purpose of General Comments as follows: “The Committee endeavours, through its general comments, to make the experience gained so far through the examination of these reports available for the benefit of all States parties in order to assist and promote their further implementation of the Covenant; to draw the attention of the States parties to insufficiencies disclosed by a large number of reports; to suggest improvements in the reporting procedures and to stimulate the activities of the States parties, the international organizations and the specialized agencies concerned in achieving progressively and effectively the full realization of the rights recognized in the Covenant. Whenever necessary, the Committee may, in the light of the experience of States parties and of the conclusions which it has drawn therefrom, revise and update its general comments.” (Report of the Committee to the Economic and Social Council, Annex III (E/1989/22)) It is important to note that the drafting of general comments is also informed by information and advice provided by UN specialized agencies, individual experts and NGOs.

³ “...States may obtain guidance on appropriate right to health indicators, which should address different aspects on the right to health, from the ongoing work of WHO and the United Nations Children’s Fund (UNICEF) in this field...” (General Comment 14, paragraph 57).

⁴ See documents A/58/427 and E/CN.4/2993/58.

B. PROPOSED FRAMEWORKS & RELATED CONCEPTS/INITIATIVES

1. Right to health indicators: a proposed framework (UN Special Rapporteur on the right to health)

With the aim of clarifying the normative scope and application of the right to health as well as initiating discussion with regard to appropriate indicators to monitor the right to health, the UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, presented his interim report to the General Assembly⁵ and invited feedback. He had found a range of different labels used in the public health literature for classifying indicators and a lack of consistency in how these labels are used. For the sake of simplifying matters, he had chosen to classify indicators within the report's framework of structural, process and outcome indicators and with respect to the distinction (if any) between health indicators and right to health indicators. Indicators for national level monitoring were proposed, to be supplemented with international level indicators to monitor international assistance and cooperation particularly North-South.

In the discussion, Goal 8 of the MDGs was noted in this context; it addresses activities of developed States and details seven targets which include the needs of land-locked countries, work with pharmaceutical countries, aid and aid flows, debt and trade and youth employment. UNDP and OECD have been working on two documents: the UN Guidance Note on Country Reporting for MDGs and the proposal for a donor template to report on donor progress vis-à-vis Goal 8. This initiative resonates with Paul Hunt's proposal to include international-level indicators for the right to health although Paul argues in favour of "an enabling environment" which is broader than donor assistance.

The necessity of defining so-called "right to health indicators" was questioned. Rather, it was felt that indicators could be selected according to their appropriateness for effective monitoring of the right to health depending on the specific context. The Special Rapporteur differentiated between health and right to health indicators as follows: "a right to health indicator derives from, reflects and is designed to monitor the realization or otherwise of specific right to health norms, usually with a view to holding a duty bearer to account ... Thus, what tends to distinguish a right to health indicator from a health indicator is less its substance than (i) its explicit derivation from specific right to health norms; and (ii) the purpose to which it is put, namely right to health monitoring with a view to holding duty-bearers to account".⁶

Paul Hunt stated that the labels of structural, process and outcome indicators were chosen because they seemed to resonate most strongly with people; he suggested that the group agree upon them as working labels which can be improved and refined over time. Some discomfort with the use of outcome indicators as right to health indicators was expressed. It was noted that while structural and process indicators can often be generic (i.e. broader health systems-related) indicators, outcome indicators are necessarily health topic specific; the relationship between the three types of indicators therefore needs to be made explicit. The issue of how indicators collectively demonstrate an outcome, and, correspondingly, how to ensure simplicity in this process (because even perfected indicators will not give a complete picture) was discussed. Concern was expressed about when and whether the contextualization of these indicators will take place. It was also suggested that the sheer plethora of existing indicators constitutes a problem, and that although the three types of indicators were useful for labelling purposes, they did not necessarily fit within an overall conceptual framework relating to the normative scope and content of the right to health as reflected in the "respect, protect and fulfil" framework, or the framework outlined in General Comment 14 as AAAQ:

⁵ Document A/58/427. In particular, paragraphs 10, 11, 12, 13, 16, 18, 20, 21, 22, 25, 26, 27, 28, 29, 34, 36, and 37 were reviewed.

⁶ Document A/58/427, paragraph 10.

(1) availability; (2) accessibility, which has four overlapping dimensions: non-discrimination, physical accessibility, economic accessibility (affordability) and information accessibility; (3) acceptability; and (4) quality.⁷

The issue of disaggregation on all grounds for non-discrimination was raised; it was felt that it would be unreasonable to push for disaggregation along the numerous grounds enumerated in international human rights instruments. Rather, it would be important to identify vulnerable population groups and pertinent forms of discrimination within a particular context and disaggregate accordingly.

The difficulty of obtaining disaggregated data was highlighted, and it was suggested that one way around this problem would be "screening" indicators for their relevance to vulnerable groups, or alternatively that indicators could be chosen which are important for their impact on vulnerable groups (for example, if no data is available for lead poisoning in children under age five, substitute indicators could give similar information such as the type of fuel sold and emission systems in vehicles). Ideally, routine disaggregated data collection will eventually be established.

The right to participation in decision-making processes affecting one's health development is a key human right.⁸ In this context, the issue of addressing participation as a process indicator was raised. However, there was concern that including such an indicator in a set of right to health indicators would widen the framework and move the notion of the right to health into the broader realm of a human rights-based approach to health. The interdependence of all rights and the cross-cutting nature of the human rights to participation and non-discrimination raise the question of where to draw the line between right to health indicators and indicators for a rights-based approach to health.

Paragraph 24 of the Special Rapporteur's General Assembly Report notes that benchmarks are needed for process and outcome indicators (meaning both as benchmarks of accountability and benchmarks of progressive realization). Disagreement remained as to whether benchmarks are needed for structural indicators (which in Paul Hunt's report purport to have yes/no answers).

Progressive realization involves thinking about benchmarks and targets set primarily by governments. The use of benchmarks and targets can help by establishing goals towards which governments should be advancing. Another kind of accountability involves whether there is improvement or progress; data in time series must be prepared to measure this. A country with a "no" answer to a structural indicator (if a country has no constitutional or legal commitment to a convention it has ratified) will then have a responsibility to change that to "yes" in a short period of time.

The idea that qualitative data is subjective and contextual, whereas quantitative data is objective, was considered ill-founded. The way in which the two are discussed and their role in right to health indicators is important, and therefore it is helpful to use clear definitions in talking about these concepts. Some participants wanted to make all right to health indicators quantitative; others suggested that qualitative indicators should be used to complement and to explain quantitative indicators.

Possible sources of data at WHO to draw from in assessing the realization of the right to health include (1) Service Availability Mapping (SAM), which is a free, on-line service that includes only government-released data; (2) WHO country fact sheets; and (3) the WHO database which includes census data, vital registration and population studies.

⁷ General Comment No. 14 (2000). The right to the highest attainable standard of health, paragraph 12.

⁸ General Comment No. 14 (2000). The right to the highest attainable standard of health, paragraphs 11, 17, 43 and 54.

C. A RELATED CONCEPTUAL FRAMEWORK TO HUMAN RIGHTS

1. *Human security and the social minimum (Commission on Human Security)*

While traditionally security has been understood as the protection of the state from external threats, today security involves issues such as environmental pollution, transnational terrorism, massive population movements, infectious diseases and long-term conditions of oppression and deprivation that go beyond traditional notions of security and shift attention to the security of people inside and across borders – to human security. As a result of these trends, the idea of an independent commission on human security was launched at the Millennium Summit.⁹ After two years of deliberation, the final report was presented.¹⁰ The Commission on Human Security defines human security as the protection of "the vital core of all human lives in ways that enhance human freedoms and human fulfilment". Human security seeks to protect people against a broad range of threats and, further, to empower them to act on their own behalf. It gives equal importance to civil, cultural, economic, political and social rights; it complements expansionist principles of human development by looking at downside risks and represents a new commitment towards "downturn with security". As such, human security helps address insecurities in ways that are systematic not makeshift, comprehensive not compartmentalised, preventive not reactive. Health is one of six principle themes that have been identified in the area of security; conflict, infectious disease and poverty were considered the greatest health threats. In terms of considering a conceptual framework for right to health indicators, the concept of the social minimum advocated as a foundation for human security was considered relevant to the notion of the minimum core content of the right to health.¹¹

2. *Equity and the MDGs (EIP/WHO)*

The Millennium Development Goals (MDGs) constitute another tool to tackle health inequalities. The MDGs, adopted at the Millennium Summit of the United Nations in September 2000, call for a dramatic reduction in poverty and marked improvements in the health of the poor. WHO's cluster of Evidence and Information for Policy (EIP) gave a presentation defining inequities as unfair inequalities in health; key determinants include health care or the consequences of ill health among populations grouped according to socio-economic position or other form of advantage in society. Pursuing equity in health means working towards reducing these systematic unequal opportunities to be healthy associated with membership in less privileged social groups. Equity as an area of work refers to studying, understanding and intervening with respect to factors related to social hierarchies, which lead to unequal opportunities to be healthy. It necessarily entails the study, understanding and intervening of upstream determinants that lead to social disadvantage. The Diderichsen Model,¹² which shows the relationship between the social sphere and the individual sphere and corresponding increases in exposure or vulnerability, was presented in light of the MDGs related to health; issues related to health equity and the MDGs were defined as measurement, understanding pathways and delivering successful interventions. In measuring inequities in MDGs, there are wide and increasing gaps between rich and poor countries for several indicators as significant inequities within countries exist, e.g. poor children have less chance of survival and healthy development and interventions designed to meet the needs of poor children are not reaching them. For example, higher rates of poor nutritional status were observed with lower socio-economic status in rural Bangladesh. In conclusion, increasing equity in MDG-related interventions will require policy steering mechanisms (such as quantitative equity policy targets); intersectoral policies (such as early

⁹ New York, 6-8 September, 2000.

¹⁰ *Human Security Now*. New York, Commission on Human Security, 2003.

¹¹ General Comment No. 14 (2000). The right to the highest attainable standard of health, paragraphs 43-45.

¹² Whitehead M., Bursstrom B., Diderichsen F. Social policies and the pathways to inequalities in health: a comparative analysis of lone mothers in Britain and Sweden. *Soc Sci Med*. 2000 Jan;50(2):255-70.

intervention programs in education); programs addressing health related behaviours (i.e. drug prevention programs); health care programs (i.e. IMCI); and territorial approaches (involving comprehensive strategies for deprived zones). Efforts to incorporate equity into MDG health indicators could be linked to those to identify right to health indicators given common objectives between the two normative frameworks of equity and human rights.

It was regarded as essential to consider the existing health-related MDG goals¹³ and MDG indicators as a basic pillar to incorporate into the framework of right to health indicators. However, it was also suggested that MDG indicators are not necessarily compatible with the right to health, as they can be realized without concentrating specifically on the most vulnerable and poorest groups, do not cover a range of health challenges important to the attainment of the highest level of physical and mental health (e.g. mental and reproductive health) and are not of universal relevance as they focus mainly on poor countries and their corresponding health challenges.

D. WORK IN PROGRESS AND MAPPING EXERCISES

1. *Survey of initiatives and frameworks for human rights indicators (OHCHR)*

The Office of the High Commissioner for Human Rights (OHCHR) described a mapping exercise of different initiatives in the area of human rights indicators which views indicators as complementary tools for positive assessment of the fulfilment of human rights obligations. In the context of this work, OHCHR is looking at other international initiatives, including the METAGORA project, which is hosted at OECD/Paris21. It was emphasized that so-called human rights indicators should reflect human rights principles and support a rights-based approach to development. In this regard, indicators for specific rights such as health should incorporate the elements of the rights-based approach such as accountability, participation and special attention to vulnerable groups. All initiatives to identify indicators for substantive rights such as education, food and housing need to be anchored in a coherent overall conceptual framework.

2. *Proposed indicators for the right to housing - a related human right (COHRE)*

To share "lessons learned" from a related economic and social right, indicators for monitoring the realization of the right to housing were presented. Two UN agencies, UN-HABITAT, and OHCHR took the lead in facilitating a process together with an NGO - the Centre on Housing Rights and Evictions (COHRE) - to identify right to housing indicators. An underlying challenge was the issue of the lack of common understanding as to what housing types are socially acceptable. UN-HABITAT proposed 15 indicators in the housing field, such as number per 1000 households with potable water, number per 1000 households with sanitation facilities, presence of legislation forbidding discrimination in housing and presence of national legislation recognizing the right to housing.¹⁴ Right to housing indicators help to assess whether the government is using public funds for vulnerable groups and to identify appropriate policy prescriptions.

It was considered useful to restrict the number of indicators initially to determine who is using these indicators, in what context, and in what form. National level indicators may be applied across countries, but this does not stop countries from developing their own indicators.

¹³ MDGs related to health include: Goal 1 (Eradicate extreme poverty and hunger); Goal 4 (Reduce child mortality); Goal 5 (Improve maternal health); Goal 6 (Combat HIV/AIDS, malaria and other diseases); Goal 7 (Ensure environmental sustainability); Goal 8 (Develop a global partnership for development).

¹⁴ See <http://www.unhcr.org/programmes/housingrights/documents/Monitoring-Housing-Rights.pdf>

3. *Gender (WHO Kobe Centre, GWH/WHO & Humanist Committee on Human Rights)*

This presentation described a WHO Kobe Centre Women and Health project to improve women's health and quality of life. The project focused on selecting a limited number of gender-sensitive leading health indicators to influence and modify mainstream health indicators systems. An expert group meeting in November 2003 commenced the selection process of a small set of leading indicators to be tested over the following year. The Expert Group considered the comparative evaluation of indicators for gender equity and health in a report commissioned from the La Trobe consortium by the WHO Kobe Centre.¹⁵ The 2003 report mapped indicators using a Health Information Framework (developed originally by the Organization for Economic Cooperation and Development (OECD) and the International Organization for Standardization (ISO)) with tiers for health status, health determinants and health systems performance and community, health and welfare systems characteristics. This comprehensive framework incorporated the breadth of issues in the literature without being aligned to particular conceptual models about gender relations. The Consortium audited 1095 indicators used or proposed by key international organizations, and also compiled an annotated bibliography on indicators for gender equity, gender equality and health (including conceptual frameworks, development of indicators and indices, and monitoring strategies).

A co-presentation by the Department of Gender and Women's Health at WHO described a parallel, ongoing process to select 10-15 indicators (from the draft set compiled in collaboration with the WKC above) in the area of gender and women's health issues, with the hope that the indicators will be used by international organizations and by Member States. The principal concern is to avoid over-burdening resource poor settings and weak Health Information Systems – especially given the fact that not all health data is routinely collected by sex. The objective is that the selection of indicators, in collaboration with regional offices, will produce a manageable and condensed list of indicators which can then be used as a basis to consult with countries about acceptability and feasibility.¹⁶

The Humanist Committee on Human Rights (HOM), an NGO based in the Netherlands, is developing an assessment instrument for the human rights of women in development co-operation which focuses on women's rights and international cooperation. The objective of the Health Rights of Women Assessment Instrument (HeRWAI) is to generate findings showing the impact of national and international policies on women's health rights; NGOs can then use these findings for policy advocacy at the national and international levels. The target group includes national governments in the North and South, international institutions, and CEDAW and ICESCR committees; the instrument is primarily designed for use by NGOs in the field of human rights and health in recipient and donor countries for advocacy work and awareness raising strategies. The basis of analysis is CEDAW, ICESCR and their General Comments. HeRWAI's process consists of three phases: these are (1) "Quick Scan", which assess whether HeRWAI is relevant to assess a certain policy; this step asks questions such as, "is it possible that the policy violates women's health rights?" and, "is it possible that the policy does not fulfil the state obligations with regard to women's rights?"; (2) "Analysing the policy" in order to understand the nature and extent of the policy impact as well as causes and solutions of the possible problems for women's health; this stage involves data collection and analysis in order to examine how and to what extent the policy impacts women's health rights and in what sense the state is failing to fulfil its obligations; and (3) "Action", or recommendations for improvement and dialogue with the responsible authorities. It was explained that General Comments clarify state obligations from which relevant elements will be rephrased as questions/indicators, while more detailed, subject-specific indicators will be

¹⁵ See report at: http://www.who.or.jp/women/publications/tf1_report.pdf.

¹⁶ Please note that the GWH gender and health indicators initiative is currently being reoriented to take into consideration current efforts within WHO and through the MDG Interagency Working Group on Gender Indicators. For more details, please contact Dr. Claudia Garcia-Moreno (garciamorenoc@who.int) or Ms. Shelly Abdool (abdools@who.int).

drawn from consensus documents and other sources. Issues for discussion included the limited role of indicators that can be used in a lobby approach, how to limit indicators in number and detail and whether there are accepted baselines for core obligations. In terms of protection, respect and fulfilment of human rights, this instrument was considered to provide a helpful way of organizing claims towards government.

4. *Child and adolescent health indicators (CAH/WHO)*

The Department of Child and Adolescent Health and Development (CAH) at WHO uses child health indicators in its work. However, the feasibility of acquiring data on selected indicators has presented some concern. Though information from health surveys is useful, these surveys are expensive; accordingly CAH works to extract data from existing surveys such as multi-cluster surveys conducted by UNICEF and the immunization program at WHO. On a global level, CAH prefers a limited set of indicators. At this stage in the process, the objective is to obtain information that could be used by everyone at the programmatic level. Questions and discussion addressed the resources available to determine low-cost interventions and core adolescent health indicators, as well as the difficulty in determining the budgetary allocation between children, adolescents and other age groups.

5. *Reproductive health indicators (RHR/WHO)*

WHO's Department of Reproductive Health and Research (RHR) in partnership with the International Health and Human Rights Program of the FXB Center for Health and Human Rights is developing a tool which aims to help countries use a human rights framework to identify and address legal, policy and normative barriers to women's access to and use of reproductive health care services. This tool constitutes both an instrument and a process, with three phases: (1) commitment and leadership; (2) adaptation, data compilation and analysis; and (3) prioritizing for action. It is grounded in the human rights framework, and integrates norms, policies and standards of international human rights instruments into national laws and policies. New indicators were not developed for this tool; rather, existing indicators were selected according to their suitability. These could be considered for purposes of assembling a useful collection of "reproductive right to health" indicators for the toolbox.

6. *HIV/AIDS Indicators (International Health and Human Rights Program François-Xavier Bagnoud Center for Health and Human Rights)*

This presentation provided an overview of existing HIV indicators that consider human rights issues, classified into four categories. These indicators coexist but have been constructed for different purposes and measure different sorts of things; their variation in approach may be helpful in thinking about right to health indicators more generally.

- (1) Indicators from the first category are those that countries report on in relation to their own compliance with human rights under the "UNGASS Declaration of Commitment"¹⁷. They aim to measure whether laws and policies protect against discrimination for people living with HIV/AIDS, and identified as being "especially vulnerable"; whether policies aim to ensure equal access to prevention and care for men and women and whether protocols are in place for HIV research involving human subjects. While these measure national commitment to some degree, they only measure the existence of laws and policies, not their quality, nor whether and how they are implemented.
- (2) The second category of indicators focuses on stigma and discrimination in the context of HIV/AIDS – mostly in the category of stigma. These include attention to individual attitudes, beliefs, behaviours and experiences, factors related to services and programs, stigmatizing behaviours and their outcomes on the lives of people living with HIV and some on statutory and legal protections. While useful, concerns with this second group

¹⁷ Declaration of Commitment on HIV/AIDS: United Nations General Assembly Special Session on HIV/AIDS, 25-27 June 2001.

involve confusion about definitions and approaches to stigma and discrimination, as well as the fact that this data is seldom disaggregated by affected groups.

- (3) The third category of indicators involves those indicators used by human rights organizations and human rights bodies to examine the HIV epidemics. While the treaty monitoring bodies will use the information collected by UNAIDS and other health related institutions in order to make their assessments, the indicators which are used have generally not been designed to capture human rights considerations, per se. On the flip side, the indicators used by human rights NGOs are generally oriented towards capturing the violations of human rights that occur in the context of HIV, and these are primarily concentrated around the egregious discrimination that occurs against people living with HIV.
- (4) The fourth category of indicators involves HIV programming indicators, used to assess HIV/AIDS programs and national responses and whether they were initially designed to be sensitive or not to human rights concerns. Beyond looking at pregnant women and those infected with tuberculosis in some cases, it is difficult to find data which disaggregates sufficiently to get at other factors of discrimination in access to treatment, care and even prevention. Likewise, the availability, accessibility, acceptability and quality of HIV services from a rights related perspective are not captured. While the GIPA (Greater Involvement of People Living with HIV/AIDS) principle can be understood to capture the right of participation and is recognized as key to effective programming, there are few examples of indicators which attempt to capture this important principle.

Discussion noted the lack of indicators sensitive to human rights concerns in the indicators developed, regarding access to antiretroviral treatment, despite access to essential drugs being a core element of the realization of the right to health.¹⁸

7. *Health financing indicators (EIP/WHO)*

This presentation by WHO's cluster on Evidence in Information and Policy (EIP) explained that a main concern in health economics involves what information is routinely available across different systems and what this information signifies. Important questions include whether tracking expenditures help to show progress towards the right to health and how to identify potential intervention packages that ensure the realization of the right to health.

Useful data in the World Health Report includes total health expenditure by source and amounts of expenditure as a percent of Gross Domestic Product (GDP), as well as external sources as a percent of total and external risk pooling. In terms of reliable external data, only OECD countries regularly perform data collections that provide reliable information. Despite this imbalance in data availability, it is still useful to do inter-regional comparisons on regional health-spending by source (i.e. tax, social security). There is no disease-specific budget allocation data available. There is substantial variation across countries in non-governmental budgetary sources (i.e. out of pocket) and the number of households with catastrophic expenditure (more than 40% of non-subsistence income) is increasing with rising out-of-pocket payments and co-payments.

The packages of interventions have risk factors that vary substantially. A key question is how resources should be allocated to reduce these risk factors, bearing in mind that every mix chosen would have to be tailored to the particular country. Some criteria for public spending on health care included catastrophic cost, poverty, vertical equity, horizontal equity, externalities, public goods, public demands, rule of rescue and cost-effectiveness. It was noted that "human rights criteria" (such as the principle of non-discrimination, the right to participation and the progressive realization of the right to health) could be incorporated here.

¹⁸ Commission on Human Rights resolution 2001/33: Access to medication in the context of pandemics such as HIV/AIDS, adopted 20 April 2001 (E/CN.4.RES.2001.33).

8. *Budget analysis (FUNDAR)*

The Mexican NGO Fundar (Centro de Análisis e Investigación) presented a methodological framework stemming from an initial attempt to analyze the right to health through budget analysis. The analysis involved four steps: (1) identification of the legal and conceptual framework that defines the right to health at the international level; (2) comparative analysis of identified elements and legal provisions at the national level; (3) evaluation of compliance with general obligations related to the right to health, such as progressive achievement with respect to the fulfilment of the right to health and full use of maximum available resources; and (4) analysis of three components of ICESCR Article 12: (a) maternal and child health, (b) prevention, treatment and control of diseases and (c) creation of conditions that assure medical service and medical care in the event of sickness.

In Mexico, the total health spending is divided between various public institutions. Two main social security institutions address "rights holders": those who are formally employed. The Ministry of Health (SSA) and FASSA (decentralized funds for the sub-national government's health departments) are the source of services for those who are informally employed or unemployed. Fundar was able to pinpoint which groups were being allocated resources. The group highlighted two problems: inadequate budgets and the vagueness of the term "maximum available resources". Fundar contrasted the total amount of health spending with GDP and with total government spending, allowing them to put the total health expenditure into perspective, and proceeded to compare the health sector with other government sectors. Though the Mexican Ministries of Finance, Foreign Affairs and Tourism spent more than their allocated budgets in 2001, the Ministry of Health failed to use half of its allocated budget.

Fundar then discussed the analysis of two components of ICESCR Article 12. An analysis of maternal and child health in Mexico showed that 65% of the women who died from pregnancy, birth or post partum were not covered by the social security system. There is a visible upward trend in the allocation of funds to reproductive health, but there has been a consistent tendency to spend less than the amount allocated. Secondly, an analysis on the creation of conditions showed that assurance of medical service and care directly relates to the equitable distribution of services and trained health professionals.

Conclusions from the project included the following: (1) even though resources to SSA and FASSA have increased in recent years, the allocation of budget to those employed in the formal sector remains disproportionately higher (prima facie violation of principle of non-discrimination); (2) while overall government spending has increased over the past few years, the government has failed to direct an increased share of budget resources to the health sector - this is in part due to the Ministry of Health's failure to use all of the funding allocated to it (prima facie violation of "maximum available resources being directed to and used for the protection of health"); (3) the General Office of Reproductive Health appears to consistently underspend its budget with respect to maternal and infant health (prima facie violation of "maximum available resources"); (4) there appears to be a discriminatory pattern in the allocation of resources in programs directed to pregnant women, so that areas of the country with greater numbers of marginalized women are receiving fewer per capita resources (prima facie violation of right to health provisions on maternal mortality); (5) the government appears to have actually decreased resources available for immunization, though not all children have yet been immunized (prima facie violation of responsibility of "progressive achievement" with respect to guarantees to provide immunization against principal infectious diseases); and (6) areas of the country with the largest shares of marginalized population are receiving fewer per capita resources, the government is contributing insufficient funds to build and maintain infrastructure to close this gap, and the SSA is significantly underspending the funds allocated to it for infrastructure development (prima facie violation of the right of the marginalized with respect to access to health facilities and violation of maximum available resources). Participants' questions were also addressed: the research did not take into account private resources as they considered government expenditure to be more in tune with human rights obligations; the underspending in health exists because of contractual

reasons and because money is not granted in time; and infrastructure was considered to include hospital buildings, materials, etc. In the future, Fundar hopes to extend this analysis to additional countries.

9. A report card on health-related human rights (Emory University Institute of Human Rights)

The Institute of Human Rights at Emory University is in the process of developing a human rights report card which identifies human rights norms and proxy indicators. Nine indicators have been selected as a proxy for Article 12 and General Comment 14 obligations. They are assuming that these indices and outcomes are resource-dependent. Following from that, the reasoning is that with a given GDP level it should be possible to identify the appropriate percentage of investment in health and assess whether the State has achieved that level of investment. Looking at expenditures and GDP should allow an analysis of what States are doing and what they should be doing.

10. Structural Indicators (AAAS)

The American Association for the Advancement of Science (AAAS) is currently developing a manual for monitoring structural obligations based on the core obligations identified in General Comment 14. This takes the core obligations, translates them into structural indicators and provides examples and discussions about sources of data. It was noted that though the distinction between structural and process indicators is quite clear on paper, in practice the boundaries can become blurred. Also, simple "yes/no" answers are sometimes problematic. There the problem of a law or policy that exists in theory but has not been implemented in practice, as well.

Another AAAS project is the development of a manual for monitoring the environmental components of the right to health. The environmental group that is collaborating with AAAS identified 500 potential indicators and screened them from a human rights perspective using five criteria: (1) impact on vulnerable population groups; (2) ability to identify the source of the problem; (3) whether the indicator can be applied by a regulatory agency; (4) whether the indicator signifies a gap in national or international regulatory provisions; and (5) whether the indicator measures direct causes. The screen was weighted, with the impact on vulnerable groups getting the highest rating. The manual is undergoing its final revisions.

E. CONCLUSIONS

Recognizing that a great deal of work would be necessary to advance this project and achieve the ultimate objective of developing a toolbox of right to health indicators, ways forward include: (1) cooperation on the development of a conceptual framework and methodology; (2) exploring linkages with ongoing work in relation to indicators on specific health topics; (3) expanding the group to include Member States as well as other UN agencies; and (4) comparison and further sharing of individual projects in the future.

If funding permits, activities before the next meeting, which will be held next June, should include the following: (1) a conceptual framework for right to health indicators should be developed and shared widely among relevant stakeholders; (2) current WHO activities on indicators should be reviewed to see how far these can be built upon; and (3) papers should be commissioned to identify core issues in this field, good practice examples and examples of human rights sensitive, health-topic specific and health systems indicators.

ANNEX ONE: LIST OF PARTICIPANTS

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