

INDICATORS FOR A HUMAN RIGHTS-BASED APPROACH TO HEALTH

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Abstract

This background paper shows that from the links between human rights principles, categories, and dimensions there are necessarily multiple indicators for all human rights, and that the right to health is no exception. Through reviewing the extant types of human rights indicators it demonstrates the pressing need for the development of indicators that either measure the right to health more directly or at least begin to capture a rights-based approach to measuring health. Derivative measures that draw on socio-economic and administrative statistics have been assembled to approximate the right to health, but providing measures specific to the right to health has been problematic since it is difficult to establish the agent of the violation. Rather, existing measures capture the state of health of any society and significant differentiation in health experiences across different groups in society.

Introduction

This paper provides an overview of the issues surrounding any human rights indicators system with particular reference to the area of health. It argues that ‘right to health’ indicators have not yet been developed, but that there are many rights-based measures related to health that have been used in assessing the degree to which the right to health is being respected, protected, and fulfilled in any one country. The paper sets out to review:

- The main use of indicators
- The principles, categories, and dimensions of human rights
- The types of available human rights indicators
- Health and human rights in the UK

The Use of Indicators

Human rights indicators serve a variety of inter-related functions for the academic and non-academic sectors of the human rights community. They allow for *contextual description and documentation*, which provide the raw information upon which measures of human rights are based. They help efforts at *classification*, which differentiates rights violations across their different categories and dimensions. They can be used for *monitoring* the degree to which states respect, protect, and fulfil the various rights set out in the various international human rights treaties to which a state is a party. They can be used for *mapping and pattern recognition*, which provide time-series and spatial information on the broad patterns of violations within and across countries. They are essential for *secondary analysis*, including hypothesis-testing, prediction, and impact assessment, the inferences from which can be fed into the policy making process. Finally, they can serve as important *advocacy tools* at the domestic and international level.

Principles, Categories, and Dimensions of Human Rights

There are different principles, categories, and dimensions of human rights. The international community has reached consensus on a collection of human rights principles that ought to be adopted in any rights-based approach to policy. These principles include:

1. Universality and inalienability
2. Indivisibility
3. Interdependence and interrelatedness
4. Equality and non-discrimination
5. Participation and inclusion
6. Accountability and the rule of law

Categories are those human rights delineated through the evolution of normative theory and international human rights standards developed since the 1948 Universal Declaration

of Human Rights. Dimensions are those state obligations to respect, protect, and fulfil human rights. The combination of categories and dimensions provides a useful way of thinking about the development of indicators. Finally, human rights principles represent a consensus within the international community on how rights based approaches

Civil and political rights uphold the sanctity of the individual before the law and guarantee his or her ability to participate freely in civil, economic, and political society. *Civil rights* include such rights as the right to life, liberty, and personal security; the right to equality before the law; the right to protection from arbitrary arrest; the right to the due process of law; the right to a fair trial; and the right to religious freedom and worship. *Political rights* guarantee involvement in public affairs, and include such rights as the right to speech and expression; the right to assembly and association; and the right to vote and political participation.

Economic, social, and cultural rights promote individual flourishing, social and economic development, self-esteem, and identity. *Economic and social rights* include such rights as the right to a family; the right to education; the right to health and well-being; the right to work and fair remuneration; the right to form trade unions and free associations; the right to leisure time; and the right to social security. *Cultural rights* maintain and promote sub-national cultural affiliations and collective identities, and protect minority communities against the incursions of national assimilationist and nation-building projects. They include such rights as the right to the benefits of culture; the right to indigenous land, rituals, and shared cultural practices; and the right to speak one's own language and to 'mother tongue' education.

The obligation to *respect* human rights requires the State and all its organs and agents to abstain from carrying out, sponsoring or tolerating any practice, policy or legal measure violating the integrity of individuals or impinging on their freedom to access resources to satisfy their needs. It also requires that legislative and administrative codes take account of guaranteed rights. This understanding is more akin to the notion of negative liberty since it requires the state to abstain from committing any type of violation.

The obligation to *protect* obliges the State and its agents to prevent the violation of rights by other individuals or non-state actors. Where violations do occur, the State must guarantee access to legal remedies. This goes beyond the traditional understanding of the state abstaining from interfering to one that requires the state to take positive action to protect individuals and groups from third party violations and to provide legal redress in the event that such violations occur.

The obligation to *fulfil* involves issues of advocacy, public expenditure, governmental regulation of the economy, the provision of basic services and related infrastructure, and redistributive measures. The duty of fulfilment comprises those active measures necessary for guaranteeing opportunities to access entitlements. This obligation was traditionally understood as aspirational on the part of the state since it implied a time dependent commitment and some notion of progressive realisation that was isolated to social and economic rights. But this obligation extends to the fulfilment of civil and

political rights as it includes that provision of governmental resource for guaranteeing equal access to justice and equal treatment under the law.

Combining the different categories and dimensions of human rights means that there are six main ways in which human rights indicators have been and can be developed. Table 1 depicts a matrix for the different categories and dimensions of human rights, and includes examples of how their different understandings have implications for the development of indicators.

Table 1. Categories and Dimensions of Human Rights

		<u>Dimensions of human rights</u>		
		<u>I</u> <u>Respect</u> (no interference in the exercise of the right)	<u>II</u> <u>Protect</u> (prevent violations from third parties)	<u>III</u> <u>Fulfil</u> (provision of resources and the outcomes of policies)
<u>Categories of human rights</u>	Civil and political	1 Torture, extra-judicial killings, disappearance, arbitrary detention, unfair trials, electoral intimidation, disenfranchisement	2 Measures to prevent non-state actors from committing violations, such as torture, extra-judicial killings, disappearance, abduction, and electoral intimidation.	3 Investment in judiciaries, prisons, police forces, and elections, and resource allocations to ability
	Economic, social, and cultural	4 Ethnic, racial, gender, or linguistic discrimination in health, education, and welfare and resource allocations below ability.	5 Measures to prevent non-state actors from engaging in discriminatory behaviour that limits access to health, education, and other welfare	6 Progressive realisation Investment in health, education, and welfare, and resource allocations to ability

See UNDP (2006) *Indicators to Human Rights Based Approaches to Development In UNDP Programming: A Users' Guide*, Oslo and New York: UNDP Oslo Governance Centre and HURIST, p. 5.

What is clear from the table is that the right to health, like all other rights, has three critical dimensions. First, states have the obligation to *respect* the right to health (cell 4 in Table 1), which means that they cannot wittingly or unwittingly engage in practices that disproportionately exclude certain individuals or groups from having access to health services, as well as the highest attainable standard of health given the availability resources. For example, if a state hospital refuses treatment to a patient on the basis of their gender, race, ethnicity, religious affiliation or other category of social identity, then that practice constitutes a violation of the right to health, and such practices can be measured using a ‘violations’ approach to indicators (see below).

Second, states have an obligation to *protect* the right to health (cell 5 in Table 1), which means that the state must prevent non-state actors and other third parties from violating the right to health. For example, a partial privatization of the health service may mean that certain individuals no longer have access to particular kinds of health services, a pattern of exclusion that can be measured through certain kinds of indicators.

Finally, states have the obligation to fulfil the right to health (cell 6), which means that the state must provide the necessary resources for the progressive realization of the right within available resources. While a direct causal connection between investment in the health service and health indicators for the population is tenuous at best, the state must invest resources in the health service and can commit itself to milestones of achievement through the use of benchmarks.

Indicators for Human Rights

Human rights indicators include measures of the *de jure* commitments of states to protect human rights (i.e. rights in principle), measures of the *de facto* realisation of human rights across their different categories and dimensions (i.e. rights in practice), and proxy measures using administrative and socio-economic statistics.

Rights in principle

Indicators for rights in principle code country legal commitments to human rights at the domestic level and at the international level through the ratification of international human rights treaties and can include special weighting for those states that file reservations. The source data are well known, publicly available and relatively easy to code. Right to health commitments can be coded alongside other human rights commitments.

Rights in practice

Rights in practice are those rights actually enjoyed and exercised by groups and individuals regardless of the formal commitment made by a government and are crucial in demonstrating an implementation gap. The three main types of data available for measuring human rights in practice include **events-based data**, **expert judgments**, and **survey-based data**.

Events based data

Events-based data chart the reported acts of **violation** committed against groups and individuals by state and non-state actors, and therefore address the dimensions of **respect** and **protect** (e.g. state or private denial of healthcare on the basis of ethnic identity). Such data come from a variety of sources, including: (1) narrative and qualitative reports foreign and domestic governmental and non-governmental organizations; (2) newswire sources that count events and acts

carried out by state and non-state actors that may have a bearing on human rights; (3) ‘who did what to whom’ data sources that disaggregate human rights events to the level of the individual violation. There are a limited number of examples in which events-based data have been used for measuring the right to health.

Expert judgments

Data generated from experts’ judgment establish how often and to what degree violations occur, and then translate such judgments into quantitative scales that are designed to achieve commensurability across the world over time. To date, no such data have been developed for the right to health.

Survey based data

Survey-based data track individual level perceptions of rights violations and may even capture direct or indirect individual experiences of rights violations. Dominant cross-national examples of such survey data projects include The World Values Survey, the various ‘barometer’ surveys, and The World Governance Assessment project. There are national level survey projects on general perceptions of human rights, the human rights policies and performance of government, and retrospective evaluations of human rights violations, as well as surveys of ‘at risk’ populations in conflict and post-conflict societies. Mass surveys and panel surveys (e.g. the British Household and Panel Survey and British Social Attitudes Survey) represent an effective means measuring right to health issues in the UK.

Administrative and socio-economic data

Administrative and socio-economic statistics produced by national statistical offices or recognized international governmental organizations provide the largest share of data resource for measuring right to health issues. Aggregate indicators used by some as proxy measures of economic and social rights include Physical Quality of Life Index (PQLI) and the Human Development Index (HDI),¹ which have been used to track both the level of development and the change in development, which are then linked to the notion of **fulfilling** social and economic rights. These are imperfect measures since they provide little information on the degree to which different groups in society enjoy the benefits of development and thus do not capture the rights dimension explicitly.

Other measures, such as the percentage of women or other minority groups in society that achieve levels of literary and/or education; and the breakdown of households with access to available housing, health, and other social welfare services can serve as indicators for the presence of possible discrimination against certain groups in the exercise of their

¹ There is no single source for the PQLI as it is derived from other measures available from various international sources. In contrast, the UNDP provides annual HDI figures; see <http://hdr.undp.org/statistics/>. See also the statistical databases available from the United Nations <http://unstats.un.org/unsd/>

social and economic rights, but omit the intentional dimension that lies behind a violations approach to rights.

At the national level, it is typical of national statistical offices to collect on an annual basis a variety of socio-economic indicators that in principle should be disaggregated by gender, age, income, and geography in ways that can provide proxy indicators for economic and social rights, as well as social exclusion. Such data are normally collected through some form of household income and expenditure surveys carried out on random and representative samples of the population. Sample sizes make it difficult to disaggregate the data along lines of ethnicity, religion, or other social categories beyond age, gender, income, and geography.

Health and Human Rights in the UK

Any robust assessment of the right to health in the UK, and in Northern Ireland in particular would need to combine the different types of indicators (rights in principle, rights in practice, and socio-economic and administrative statistics) in ways that highlight significant areas of achievement and progress on the one hand, and remaining gaps, challenges and lacunae on the other hand.

In terms of rights in principle, the UK has ratified all the main international human rights treaties and at the national level has enacted the National Health Service Act 1977 and the Human Rights Act 1998, while there has been significant jurisprudence surrounding key right to health issues.² Any such measurement of formal commitment is simply that. It provides only a measure of the declared legal commitment of a state to set of internationally recognized set of human rights (indeed the HRA merely domesticates European Human Rights law) and says nothing about the lived experiences of British citizens (or non-citizens).

Rights in practice measures are therefore crucial for understanding the key right to health challenges in the UK. While there may be considerable anecdotal and case-based evidence about particular individuals experiencing right to health violations, there has yet to be a systematic effort made to collect events-based data on the right to health in the UK. Such ‘violations’ approaches to the right to health are challenging and problematic, and have been to date circumscribed to documenting gross violations of civil and political rights. There have not been any systematic efforts to develop expert judgment data on the right to health. The available scales are dedicated to measuring civil and political rights and to date, only the Cingranelli and Richards human rights data project has ventured into worker rights, and women’s political and social rights.³

² For a comprehensive review of right to health issues in the UK, see Mesquita, J. (2006) ‘New Life for Health?’ in Weir, S. (ed) Unequal Britain: Human Rights as a Route to Social Justice (London: Politics), pp. 149-181. Interestingly, in the absence of a domestic or European instrument on the right to health, legal action in the area of health has sought to argue cases in terms of civil rights protections found in the European Convention for Human Rights.

³ See <http://www.humanrightsdata.com>

Given the dearth of events based and expert judgment data on the right to health in the UK, analysts have resorted to socio-economic and administrative statistics to measure the right to health. But rather than providing right to health measures, such use of these data constitutes a series of health measures that may well be related to right to health questions. For example, life expectancy at birth and infant mortality rights, even if they are disaggregated by all known categories of social identity, will only ever approximate a measure of the *right* to health. If such measures show that people of Afro-Caribbean descent have lower life expectancy at birth and higher rates of infant mortality, does this necessarily mean that their right to health has been violated in some way? Or are there many other social factors that need to be taken into account that help explain the differential statistics?

The work on discrimination in the labour market illustrates this point clearly. Since discrimination can be an unintentional or intentional act carried out by institutions, individuals, and groups, estimating its presence can present a number of significant methodological challenges. An Australian study on disability used a two-stage analysis to analyse the presence of discrimination against the disabled in the labour market.⁴ The first stage is a Heckmann selection model that determines the likely reasons why people enter the labour market in the first place. It carries out logistic regression on the probability of any one individual entering the labour market.

The second stage is a vector decomposition regression analysis that examines the explained and unexplained variance in wage differentials between those that are disabled and those that are not. The analysis controls for social demographics that may also account for wage differentials, but if the differences are still statistically different, then the analysis assumes some form of discrimination is taking place.

The analysis in the study shows that between 20 and 44 percent of the wage differential between disabled and non-disabled women can be explained by other determinants, while for men, the unexplained differential is between 27 and 49 percent. This type of analysis is subject to omitted variable bias (i.e. many factors that may account for wage differentials have not been included in the analysis) and therefore its results should be seen as tentative.

The UK regulatory impact assessment on age discrimination used the measure of those aged over 49 not looking for work because they believed there were no jobs available. Clearly, such a measure is based on a perception of the conditions of the labour market and not actual discriminatory practices. Nevertheless, such a measure features as a key variable in projecting the likely impact of age discrimination in the UK.

⁴ Review of the Disability Discrimination Act 1992, Report, no. 30, Productivity Commission (2004) Melbourne: Commonwealth of Australia; see www.pc.gov.au/inquiry/dda/finalreport/dda1.pdf (Vol 1) and www.pc.gov.au/inquiry/dda/finalreport/dda2.pdf (Vol 2)

This example suggests that devising right to health indicators will involve attempting to capture discriminatory practices as much as discriminatory outcomes, even though demonstrating such practices is methodologically challenging. Initial attempts to devise a set of right to health indicators in the UK include general indicators for health (e.g. life expectancy, longevity, mortality), determinants of the right to health (e.g. nutrition and obesity statistics), data on children and infants (e.g. infant mortality, obesity and poverty in children), sexual and reproductive health (e.g. STDs, teenage pregnancies), mental health, violence against women and children, and the availability, accessibility, and acceptability of health care.⁵ Of these, a rights based approach to health indicators emphasizes these latter questions of availability, accessibility and acceptability as they are most closely related to the state obligation to respect, protect, and fulfil outlined above.

Summary

The links between human rights principles, categories, and dimensions shows that there are necessarily multiple indicators for all human rights, and that the right to health is no exception. There is a pressing need for the development of indicators that either measure the right to health more directly or at least begin to capture a rights based approach to measuring health. To date, there are very few examples of events-based and expert judgment indicators on the right to health. Derivative measures drawing on socio-economic and administrative statistics have been assembled to approximate the right to health. Providing measures specific to the right to health has been problematic since it is difficult to establish the agent of the violation. Rather, these measures capture the state of health of any society and significant differentiation in health experiences across different groups in society.

⁵ See Mesquita, 'New Life for Health?' pp. 160-180.