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Mainstreaming wellbeing: an impact assessment for the right to health

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The World Health Organization has written that 'without health, other rights have little meaning' (Jamar 1994). Over the past decade, the full ramifications of this statement have become clearer, as the health and human rights movement has endeavoured to establish conceptual and analytical bridges between the two disciplines of health and human rights, to create a field of discourse that goes to the very essence of human wellbeing.

That discourse now faces the challenge of evolving itself from the conceptual to the operational, so that the linkages between health and human rights are explicitly recognised and incorporated in decision-making processes. There is therefore a rising call for new methodologies that can advance this ongoing evolution. A right-to-health impact assessment has been suggested as one such methodology, on the basis that it might provide decision makers across sectors with an evidence-based mechanism for analysing and anticipating the effects of their decisions.

This article seeks to explore that possibility by examining the experiences of health impact assessment and human rights impact assessment and considering whether a right-to-health impact assessment offers anything more than these existing methodologies. These considerations belie complex conceptual and methodological issues, and the article offers some preliminary thoughts on the issues with which the health and human rights movement will need to grapple as it continues its struggle to mainstream human wellbeing.

Health as a human right

Written in 1946, the Constitution of the World Health Organization (WHO) contains in its preamble one of the most enduring statements of health as 'a state of complete physical, mental and social wellbeing' and its conception as a fundamental human right (Toebes 1999, 36). While this definition catapulted health into the human rights framework, there has been a degree of inconsistency in the articulation of the right to health and the more delimited right to the 'highest attainable standard of health' in

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the human rights documents that have emerged since that time (Leary 1994).[1] Such inconsistency can be partly attributed to the lack of conceptual clarity that has been associated with the normative content and scope of the right to health. As one of the bundle of economic, social and cultural rights, it was long overlooked on the basis that it was too vague and predominantly aspirational (Alston and Quinn 1987, 159; Meier 2006, 733; Chapman 1998, 390). However, in more recent times, the health and human rights movement has sought to revolutionise the linkages between health and human rights, and to give much-needed substance to the right to health as enshrined in international human rights law (Mann 1994; Gruskin and Tarantola 2005).

Through this process, there is now an understanding that the right to health is an inclusive one, and is inextricably related to and dependent on the realisation of other rights, which are also essential determinants of human wellbeing (CESCR 2000, para 3; Toebes 2001, 175). There is also a growing consensus that, notwithstanding the qualifying principles of progressive realisation and resource availability, the right to health has a core content that imposes immediate obligations upon states. That core content mandates state adherence to the fundamental principles of non-discrimination and participation (CESCR 2000, paras 11, 18 and 19) and compels states to provide minimum essential levels of primary health care, food, housing, sanitation and essential drugs, and to adopt and implement a national public health strategy (CESCR 2000, para 43). At the same time, the interrelated and essential elements of availability, accessibility, acceptability and quality provide a concrete standard against which state conduct can be measured (CESCR 2000, para 12; Toebes 2001, 177; Asher 2004, 37).

The right to health has therefore been invested with a substantive meaning that is capable of being operationalised. Such an evolution, from conceptual to operational, is essential if the right to health is to move beyond a slogan to something that has meaningful and useful application in the real world. This task presents a series of significant challenges, and the United Nations Special Rapporteur for Health has articulated the need for new techniques that are capable of engaging with relevant players, including policy makers and health practitioners, so as to mainstream the right to health (Hunt 2007a, paras 9 and 26;

1 See the various articulations of the right to health in the Universal Declaration of Human Rights, Art 25(1); International Convention on the Elimination of All Forms of Racial Discrimination, Art 5(e)(iv); International Covenant on Economic, Social and Cultural Rights, Art 12(1); Convention on the Elimination of All Forms of Discrimination Against Women, Arts 11(1)(f) and 14(2)(b); and Convention on the Rights of the Child, Art 24(1).

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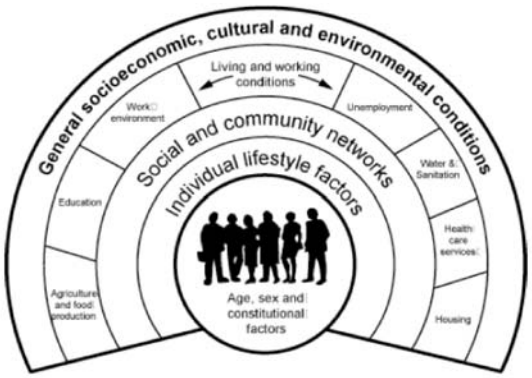
Figure 1



Farmer and Gastineau 2002, 663; Roth 2004). Impact assessment, particularly a right-to-health impact assessment, has been suggested as one such technique (Hunt 2007b, para 44; Gruskin et al 2007, 453).

Health impact assessment

The past decade has seen the emergence of health impact assessment (HIA), which has been defined as:

> … a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population. [ECHP 1999.]

While HIA traces its origins to earlier methodologies of impact assessment, such as environmental impact assessment and social impact assessment, it also owes much of its existence to public health practitioners who perceived the potential of HIA as a means of promoting 'healthy public policy' (Kemm and Parry 2004, 16; Mahoney and Durham 2002; Mittelmark 2000). Through the influence of these practitioners, HIA has embraced a broad definition of health and has developed a clear understanding that the wellbeing of people is dependent on a spectrum of factors (ECHP 1999). These determinants of health have been illustrated as layers of influence, as depicted in Figure 1 (Dahlgren and Whitehead 1991).

By adopting this multidimensional model of health, HIA recognises that most policies or programs, including those in non-health sectors, have the potential to impact significantly through these layers of influence (Lock 2006, 11). In doing so, HIA advocates for a multidisciplinary approach to health, so that the responsibility

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for health is necessarily expanded to a range of sectors that would not otherwise give explicit consideration to health-related issues.

At the same time, this model of health enables HIA to provide a practical means of assessing potential health impacts. The links between health outcomes and health determinants are complex and multifactorial, so that it is often impossible to identify clear causal relationships. HIA offers a mechanism for overcoming that complexity by considering impacts in terms of health determinants rather than health outcomes, and by examining those determinants as categories and subcategories which correspond to the layers of influence depicted in Figure 1 (Lock 2006, 11). An assessment of the likely impact of a proposal on the various categories of determinants then provides a basis for drawing conclusions as to anticipated effects on the health of a community (Birley 2002).

Another significant dimension of HIA is health equity, and its recognition that the impacts of a policy or program will rarely be uniform throughout a population. HIA is therefore concerned to identify both the potential impacts of a proposal on the health of a population and the distribution of those impacts within the population. To that end, HIA has developed its capacity to ascertain how a proposal will impact on different population groups, including whether it might compound the distribution of existing health inequalities or impose new health burdens on specific groups (Taylor et al 2003; Harris-Roxas et al 2004).

One of the key methodologies for identifying such health inequalities is the use of a participatory approach to HIA, which allows those most likely to be affected by an intervention to identify the anticipated impacts on their state of wellbeing (ECHP 1999; Douglas et al 2001, 152; Elliot et al 2004, 81). It also democratises both the process of HIA and the decisions that HIA seeks to influence, by emphasising community participation in a transparent process for the formulation, implementation and evaluation of policies that affect the community (Kemm 2005; ECHP 1999). In this way, the process of HIA becomes as important as its outcomes, as it provides an empowering and consensus-building experience for community participants (Taylor et al 2003; Kemm 2005; Mahoney and Durham 2002; Mahoney and Potter 2005, 19; Gillis 1999; O'Mullane 2007).

As HIA enters its second decade of experience, while many of the underlying principles of HIA have gained general acceptance, HIA practitioners have identified that if HIA is to achieve its ultimate goal of promoting healthy public policy, a vital challenge will be its ability to become entrenched within the decision-making process (Kemm 2005; Banken 2003; Davenport et al 2006). Assuming HIA is up to this challenge, HIA has the potential to facilitate an awareness and understanding of

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health and its determinants across policy spheres and, in doing so, to introduce the core values of equity and democracy into decision-making processes. Expressed in these terms, it is not difficult to recognise that in bringing health into the consciousness of decision makers, HIA is also emphasising many of the core values that underpin the right to health. However, the concept of health as a human right has received little explicit consideration within HIA methodologies.[2] In terms of impact assessment, that discussion has been left to the relatively embryonic field of human rights impact assessment.

Human rights impact assessment

Much of the activity around human rights impact assessment (HRIA) has been in the field of business and human rights, as a result of the recent calls for businesses to take active steps to avoid human rights violations within their spheres of influence. HRIA has been perceived as one means of operationalising this call to action, with a number of different HRIA tools being developed to assist businesses in assessing the human rights impacts of their activities.

For example, the International Business Leaders Forum and the International Finance Corporation (IBLF/IFC) have collaborated in developing a self-assessment tool for businesses (IBLF/IFC 2007; Ersmaker 2007). The tool emphasises consultation with stakeholders, and encompasses eight steps sequencing from knowledge building to impact assessment, to final monitoring and evaluation (IBLF/IFC 2007, 40). In its summary of the human rights issues that may require assessment, IBLF/IFC categorises rights by those of workers, communities and customers (IBLF/IFC 2007, Appendix 4). Within each of these categories, the right to health is addressed in terms of the entitlement of workers to protection from risks to their health and safety in the workplace; the right of communities to be protected from adverse impacts on their health and safety arising from a company's operations; and the obligation on companies to ensure that their products are not detrimental to the health of customers.

The human rights concerns associated with corporate involvement in foreign investment projects have also prompted Rights and Democracy to propose the use of HRIA for such projects (Rights and Democracy 2005; 2007; Brodeur 2007). The methodology developed by Rights and Democracy is intended as a community-led impact assessment of existing investment projects, and has been the subject of five

2 Although, see the discussions in Scott-Samuel and O'Keefe (2007); Ingram (2006, 32); and Marks (2002, 748).

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reported case studies (Rights and Democracy 2007, 35). With respect to the right to health, the results of the case studies usefully illustrate how dependent the outcome of the assessment process is on the substantive meaning given to the underlying right. While Rights and Democracy cites the WHO definition of health, the main focus of its right-to-health questions is the impact of a project on health care and health services, as assessed using the criteria of accessibility, availability, acceptability and quality (Rights and Democracy 2005, 53). As a result, the consideration given to the right to health in the reports of the case studies is limited and in two of the five case studies an impact on the right to health is not identified at all as a concern.

The Halifax Initiative Coalition has also proposed the use of HRIA to develop a rights-based approach to trade and finance (Halifax Initiative Coalition 2004). The Coalition has outlined an impact assessment process that applies a human rights framework to existing impact assessment methodologies, such that the values of accountability, participation, equity and sustainability are placed at the core of the assessment process (Halifax Initiative Coalition 2004, 17). This approach is intended to produce an integrated impact assessment that identifies potential cultural, economic, social, civil and political rights impacts of a proposed project (Halifax Initiative Coalition 2004, 14).

There has also been consideration given to the use of HRIA to inform government decision-making processes. One of the earliest proposals was expounded by Larry Gostin and Jonathan Mann, who envisaged the use of HRIA in the formulation and assessment of public health policies (Gostin and Mann 1994). Their proposed tool was designed to provide policy makers with a systematic approach to exploring the human rights dimensions of such policies, and to assist them in balancing the public health benefits of a policy against its human rights burdens on individuals. In doing so, the tool recognised that human rights and public health may have competing priorities, and required assessors to explore how those priorities could be counterpoised (Watchirs 2002, 723).

More recent HRIA activity has focused on the application of HRIA as a means of mainstreaming human rights in policies or programs with international application. For example, the Norwegian Agency for Development Corporation (NORAD) has developed a handbook aimed at integrating human rights into development programs (NORAD 2001), while the Netherlands Humanist Committee on Human Rights (HOM) has similarly proposed the application of HRIA to policy measures of the European Union with an external effect (Radstaake and Bronkhurst 2002). In an early case study undertaken by HOM, the criteria used to assess the right to health, such as mortality rates and access to health-care facilities, suggest that within the

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overall HRIA process health is given a narrower meaning, with the broader determinants of health left to be considered in the context of other rights (Radstaake and de Vries 2004).

HOM has also developed a 'Health Rights of Women Assessment Instrument' (HeRWAI) as an advocacy tool for non-government organisations seeking to influence government policies that affect women's health (Bakker 2006). The impact of a policy is assessed by considering a set of questions, which are accompanied by a checklist of qualitative indicators. These questions and indicators are derived from a right-to-health framework which recognises that the right to health requires the availability, accessibility, acceptability and quality of health care and other determinants of health; people have the right to participate in decisions that affect their health; and violence against women is a violation of women's right to health.

In addition to these initiatives, the Commission of the European Communities (CEC) has outlined a methodology for ensuring that legislative proposals are scrutinised for compatibility with the Charter of Fundamental Rights of the European Union (CEC 2005a). The CEC's methodology integrates the assessment of human rights impacts into its existing impact assessment framework by including a series of additional questions into the CEC's impact checklist. That checklist is divided into economic, environmental and social impacts, with questions directed towards the assessment of fundamental rights being incorporated within those categories, although such questions are not explicitly framed in terms of human rights (CEC 2005a, paras 18–19; CEC 2005b).

HRIA and the right to health

A clear indication to emerge from a brief review of existing HRIA methodologies is that the consideration expressly given to the right to health within HRIA is relatively limited where the HRIA process is intended to assess the full spectrum of rights enshrined in international human rights law. In these circumstances, despite the interconnectedness and indivisibility of human rights, as a practical matter, HRIA is forced to consider individual human rights in a relatively piecemeal fashion. That is, the most common approach is to identify a given right and attribute to it a series of questions that act as indicators as to the likely impact of the relevant intervention on that right. In ascribing those indicators, to avoid duplication within the HRIA methodology, the questions for each right will generally have a relatively specific focus. Accordingly, in relation to the right to health, questions tend to focus on health in a more biomedical sense. As a consequence, the assessment procedure may not identify that the right to health is

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likely to be impacted, even though impacts on a number of rights which are themselves determinants of health are predicted.[3]

Of course, given that HRIA needs to be undertaken in the real world, HRIA cannot be all things to all rights, and it is likely that HRIA will tend to focus on certain human rights depending on the circumstances in which it is being applied (Hunt and MacNaughton 2006, 30). The HeRWAI developed by HOM demonstrates how different the assessment procedure looks where the focus of HRIA is specifically trained on health. However, this leads us back to HIA. HIA has developed increasingly well-established methodologies for examining health impacts; it is not distracted by the need to conceptualise impacts in terms of a range of different rights; and there are a number of clear synergies between HRIA and HIA. Indeed, in many ways, HIA is already implicitly operating in relation to a human rights discourse (O'Keefe and Scott-Samuel 2002, 737). These characteristics of HIA might therefore suggest that it is just as able as, and in many circumstances better able than, HRIA to operationalise the right to health.

The synergies between HIA and HRIA

There are four features of HIA and HRIA that usefully elucidate the synergies between these two forms of impact assessment. First, both HIA and HRIA are generally democratic processes that emphasise the importance of participation. Engagement with relevant stakeholders as part of the assessment process is seen as both an empowering experience for affected communities and a means of gathering evidence about the likely impacts on the community (IBLF/IFC 2007, 6; Rights and Democracy 2007, 18; Halifax Initiative Coalition 2004, 19). In relation to HRIA, in particular, participation is an enabling mechanism, which allows communities to actively assert their human rights (Rights and Democracy 2007, 18). At other levels, it is a key aspect of both HIA and HRIA that people are able to participate in the preparation, implementation and evaluation of the relevant program or policy. Such emphasis on participation means that in both HIA and HRIA, the assessment process is as important as its outcomes.

Second, HIA and HRIA are equally concerned to identify the differential impacts of a proposed intervention. HRIA endeavours to do this through its consideration of the right to non-discrimination. It asks assessors to consider whether an intervention is likely to have a discriminatory effect on a group within a population, either at a

3 As demonstrated by the case studies undertaken by Rights and Democracy, discussed above.

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general level or in relation to the exercise of specific rights by that group.[4] HIA asks assessors to consider the same issues when it speaks to them in the analogous language of health equity, and seeks to ensure both that existing inequalities are not deepened and that new inequalities are not created by a particular intervention (Braveman and Gruskin 2004).

Third, there is a concurrence between HIA and HRIA in terms of their ability to assess how a policy or program is likely to impact on the broader determinants of health. That is, given the interconnections between health and human rights, when HIA sets out to assess likely impacts on the determinants of health, it is inevitably giving consideration to a similar set of questions as HRIA when it assesses the impact of an intervention on a bundle of identified human rights. Conversely, even though HRIA tends to focus its assessment on a biomedical model of health, it nevertheless implicitly addresses each of the determinants of health by reason of its consideration of those additional rights that are necessary to the full enjoyment of the right to health. Indeed, in many ways, the practice in HIA of categorising and assessing the determinants of health in order to facilitate a systematic method of impact assessment is akin to the methodologies of HRIA, which segregate individual human rights and consider the likely impact on each of those rights.

Finally, both HIA and HRIA advocate for a multidisciplinary approach to impact assessment. While HRIA, in practice, has not developed its methodologies to the same stage as HIA, it is nevertheless clear that HRIA is seeking to assess impacts on rights that span a spectrum of sectors. To do this most effectively, it is necessary to involve practitioners from those other sectors in the assessment process. Similarly, HIA, in its endeavour to assess the impact of a policy or program on the determinants of health, seeks to engage with a broad audience both inside and outside public health. In adopting this intersectoral approach, both HRIA and HIA are concerned not only to call on the technical assistance of experts in a range of disciplines but, even more importantly, also to enhance recognition among decision makers across sectors of the human rights or health implications of their decisions.

These synergies demonstrate that there is considerable affinity between the core values and principles of HIA and HRIA. Yet, it is also clear that, despite this affinity,

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4 NORAD, for example, asks an assessor to consider, 'What is the programme's assumed/actual impact on equality and non-discrimination?' (NORAD 2001, 22), while Rights and Democracy asks, in relation to the right to health, 'Has there been the denial of access to health facilities, goods and services to particular individuals or groups as a result of discrimination?' (Rights and Democracy 2005, 54).

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the focus of HIA remains embedded in the public health space rather than in the human rights paradigm. This, therefore, raises for consideration the question of whether a focus on the right to health rather than health itself offers anything over and above what HIA already provides.

Why an impact assessment for the right to health?

Accountability

International human rights law is a formal body of law which imposes legal obligations on states. Accordingly, to speak of the right to health is to speak of a legal norm which is embedded in a framework that imposes clear and enforceable duties on states as duty-bearers. A failure to comply with those duties represents a violation of a state's legal obligation and gives rise to enforceable claims by rights-holders.

Health, as understood from the public health perspective, is not invested with the same legal authority. Public health is quintessentially a social movement, and HIA is therefore a methodology that is founded on notions of social democracy (Mann 1997). This is reflected in the language of public health practitioners who describe HIA as deriving from 'a belief that governments are benevolent in purpose and have the capacity to play an active role in developing a society based on principles of social justice' (Mahoney and Durham 2002, 18). Within this paradigm, the failure of a government to act in the interests of good public health may give rise to moral culpability, but does not give rise to any form of legal accountability (Scott-Samuel and O'Keefe 2007, 213).[5]

A method of impact assessment that focuses on the right to health therefore offers a legal framework of accountability that is not available through HIA. Where an assessment is made that a proposed intervention is likely to result in a violation of a government's legal obligations, government decision makers are legally bound to take action in response to that assessment. This represents a significant advantage over HIA, which is ultimately reliant on the largesse of the decision maker to respond to a negative assessment in an appropriate way. In this regard, the accountability framework provided by a right-to-health impact assessment also has the potential to equip HIA with at least one mechanism for attempting to overcome

5 See also the discussion in relation to the use of obligations arising under the European Convention on Human Rights to compel public health authorities to take appropriate action in response to HIA in Hart (2004).

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the difficulties that it has experienced to date with respect to successfully influencing the decision-making process (Hunt and MacNaughton 2006, 13).

International legal standards

The legal nature of human rights obligations also means that an impact assessment for the right to health emphasises standards that are established by international law, and focuses on measuring the gap between those standards and the experience created by an intervention (Rights and Democracy 2007, 16). This may be contrasted to HIA, which lacks a clear conceptual framework for identifying the conditions required for public health, and so tends to use an existing situation as a baseline from which all else is measured. Further, even once an assessment has been made that an intervention is likely to have a health impact, there may be a lack of clarity in relation to the nature and extent of any changes that are required in response to that assessment (Mann 1997). For example, an HIA conducted on proposed changes to Slovenia's agricultural and food policies identified a number of key determinants of health that were likely to be affected by the changes. One of the predicted effects was increased rural unemployment and a consequent increase in ill-health in a region that already had high rates of alcohol-related deaths and suicides. To address these anticipated problems, the HIA recommended that steps be taken to maintain small farms, so as to avoid farm intensification and greater unemployment (Lock and Gabrijelcic-Blenkus 2004; Lock et al 2003). While this prediction and recommendation are clearly useful, it essentially begins with the premise that the existing situation was bad, and ends by concluding that steps need to be taken to ensure things do not get any worse as a result of the proposed policy.

A right-to-health impact assessment has the potential to begin and end in a different position. It begins by considering the pre-existing conditions in light of the international legal standards by which the state is bound, and almost certainly reaches the conclusion that violations of the state's core obligations, such as with respect to non-discrimination, are already occurring. From that starting point, a right-to-health impact assessment may then predict the same impacts as HIA, but its end point differs. It will recommend not only that steps be taken to avoid a deterioration of pre-existing conditions, but also that pro-active and concrete steps be taken to improve upon the conditions of rural communities, with a view to moving towards the full realisation of their right to health.

This example emphasises a further aspect of a method of impact assessment that sees health as a human right — namely, its recognition that governments have positive obligations with respect to the right to health. Of course, HIA also has the goal of achieving healthy public policy, which inherently requires governments to take

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positive steps towards the creation of optimal conditions for people's wellbeing. However, entrenched as it is in more traditional forms of impact assessment, HIA has a tendency to nevertheless focus on the negative or unintended impacts of a particular intervention, with a view to ultimately minimising or mitigating those impacts. A right-to-health impact assessment therefore advocates an expansion of the assessment process to a consideration of whether a government has taken, or needs to take, positive action in order to comply with its legal obligations with respect to the right to health (Evans 2005, 692).

Consensus

Given its emphasis on an intersectoral approach to health, it is an important element of HIA that it seeks to assimilate a wide variety of perspectives from different disciplines. This is a difficult task under any circumstances, and HIA suffers particularly from its inability to speak to different disciplines in a consensual language (Mann 1997). So long as HIA speaks of health, a term that lacks a degree of conceptual clarity even within the health sector, it will always be at risk of being misunderstood by those outside the health sector. Further, health is likely to be seen as something that competes with, and is to be traded off against, the foci of other sectors, such as employment, housing or transport (Lee et al 2007).

A right-to-health impact assessment offers a potential solution to this problem, by providing a consensual language that is capable of engaging across sectors (Gostin et al 2003). Predicated as it is on an internationally sanctioned legal framework, a right-to-health approach to impact assessment compels every sector to consider whether its policies or programs are likely to impact on that right. Further, in speaking the language of law and human rights, a right-to-health impact assessment is able to engage with powerful and political vested interests to mainstream health concerns, and give them the same priority as matters such as economic prosperity and national security. It also provides all sectors with a clear statement that the right to health is interconnected with other human rights and extends to the enabling conditions required for a complete state of wellbeing. In this way, a right-to-health impact assessment not only advocates for an intersectoral approach, but goes a step further by providing a framework that facilitates a coherent and consistent application of the right to health across sectors.

The determinants of the determinants of health

There is no question that HIA is concerned to explore the impact of an intervention on the broader determinants of health. However, the ability of HIA to

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explore the determinants of health is nevertheless constrained by its public health origins, which have historically been concerned with disease prevention and the promotion of physical health at a community level (Gostin 2001). While public health has evolved to embrace broader notions of social wellbeing, public health practitioners have recognised the problem with adopting an overly expansive view of public health, such that its scope becomes limitless. The reach of public health is therefore constrained by both its traditional role and its need to contain itself so as to maintain a meaningful function and agenda (Gostin 2001). In addition, the primary research and analytical tool of public health is epidemiology, in which researchers seek to understand the causal relationships between risk factors and public health (Freedman 1999). This is very much a scientific inquiry, which is limited by the need to be able to analyse and understand the pathways that connect health and its underlying determinants.

Against this background, if we envisage the determinants of health as the layers of influence depicted in Figure 1, then it becomes apparent that HIA is inherently limited in its ability to reach all of those layers. Certainly, it is able to extend to a consideration of individual lifestyle factors, social and community networks, and living and working conditions. However, despite its rhetoric, it is less clear that it is truly able to extend as far as a robust assessment of the general socioeconomic, cultural and environmental conditions that are the outermost layer of the spheres of influence, or the determinants of the determinants of health. These layers would seem to be beyond the causal reach of HIA.

Modern human rights, on the other hand, are fundamentally concerned with articulating the societal conditions for wellbeing (Mann 1996–97), with an object of the human rights discourse being to define the individual rights that are necessary for the achievement of those conditions. It follows that by reason of its grounding in the human rights framework, a right-to-health impact assessment promises a methodology that is capable of considering the impact of an intervention on the so-called determinants of the determinants of health. Indeed, it is the examination of those outer spheres of influence that, on one view, ought to be the primary concern of a model of impact assessment that is grounded in the human rights paradigm. This represents an opportunity to radically transform HIA, which presently trains its focus on health, and then moves outwards through the spheres of influence to explore the full impact of an intervention. A right-to-health impact assessment could begin its inquiry by considering the state of general socioeconomic, cultural and environmental conditions and then narrow its focus until it understands how those conditions impact on the enjoyment of the right to health.

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Individual rights and public health

From the above discussion it is apparent that, theoretically, a right-to-health impact assessment promises to provide a number of normative and conceptual advantages over HIA. However, the above discussion is predicated on an assumption that a right-to-health impact assessment conceptualises the right to health in the same broad terms advocated by the modern health and human rights movement. It is essential to recognise that an expansive vision of the right to health is not explicitly reflected in the language of international human rights instruments, which express the right to health as a positivist individual right that may be asserted by individuals against state actors. Further, despite endeavours to reconceptualise the right to health in broad terms, at an operational level the right to health has, to date, most often focused on individual access to health services (Meier 2006).

This is very much reflected in many of the existing HRIA methodologies in which the consideration of the right to health has generally been confined to a clinical and individualistic model of health and an assessment of access to, and availability of, health-care services. While it is possible to understand this approach as being the result of HRIA's methodological need to compartmentalise its assessment of a bundle of interconnected rights, it nevertheless demonstrates the tendency of human rights discourse to discuss the right to health in narrow terms. By comparison, public health and, as a consequence, HIA have evolved to embrace an expansive conception of health and a clear understanding of its location within personal, social, cultural and environmental structures.

If a right-to-health impact assessment is intended as a tool for operationalising the right to health, it is essential that the right be understood in a broader sense — that is, it must not be limited to the atomised version that comes from a narrow, strictly textual interpretation of the right to health as enshrined in international human rights instruments. General Comment 14 of the CESCR goes a long way towards providing an authoritative exposition of a new conceptual framework for the right to health, as do the efforts of the Special Rapporteur on Health (Meier 2006; Gostin and Gable 2004, 109; Hunt 2003a).[6] This framework, although not explicitly, moves the right to health away from its individualistic origins towards a social or public health interpretation. In this evolutionary, or perhaps revolutionary, process, properly applied, a right-to-health impact assessment in fact offers a mechanism for operationalising the synergies between public health and the right to health, by providing what might be described as a public health approach to the right to health.

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6 And see, for example, the outline by the UN Special Rapporteur for Health of the 'contours and content of the right to health' (Hunt 2003a).

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To the extent that this is seen as advancing a collectivised form of the right to health, then, notwithstanding the controversy that surrounds the notion of collective rights, it is submitted that this approach is necessary if the full spectrum of right-to-health concerns within society are to be addressed (Meier 2006, 748–52).

In adopting this approach, a right-to-health impact assessment can, and should, draw on the practical experiences of HIA, which has its foundations in the public health paradigm. HIA has already been through the experience of attempting to put into practice methodologies that seek to operationalise a broad conception of health and are underpinned by core values of equity and democracy. Accordingly, while it is possible to anticipate the advantages that a right-to-health impact assessment ultimately offers over HIA, a right-to-health impact assessment should nevertheless draw on the lessons learned by HIA as it seeks to embed a broad understanding of the right to health in decision-making processes (Krieger et al 2003).

Developing a right-to-health impact assessment

The idea of developing a form of impact assessment that is intended to focus on the right to health has begun to be explored by a small number of practitioners (Bakker 2006; People's Health Movement 2006; Center for Economic and Social Rights — Latin Program 1999; Hilber 2007; Nhelko 2007). Paul Hunt and Gillian MacNaughton have also proposed an approach to HRIA using the right to health as a case study (Hunt and MacNaughton 2006). Their rights-based approach to impact assessment requires that the methodology be explicitly grounded in a human rights normative framework, and be based on the fundamental principles of progressive realisation; equality and non-discrimination; participation; provision of information to stakeholders; accountability; and the interdependence of rights (Hunt and MacNaughton 2006, 32).

In the case study of a right to health, the normative framework for an impact assessment is drawn from General Comment 14, while the fundamental principles identified by Hunt and MacNaughton are consistent with approaches proposed in existing HRIA methodologies. There therefore appears to be an emerging consensus as to the principles that ought to underpin both HRIA and a right-to-health impact assessment. However, a number of difficult questions remain unresolved. These include whether integration of a right-to-health impact assessment into other forms of impact assessment is desirable and necessary for the mainstreaming of the right to health; how and whether existing methodological variations should be resolved; what type of evidence a right-to-health impact assessment should rely upon; and how it should deal with indicators.

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Integration and mainstreaming the right to health

With the impact assessment space becoming ever more crowded,[7] a key consideration for a right-to-health impact assessment is whether it is realistic to expect policy makers to undertake yet another form of impact assessment. Hunt and MacNaughton have suggested that such an expectation is not realistic, and have therefore proposed that any right-to-health impact assessment, along with HIA, be integrated into existing assessment processes (Hunt and MacNaughton 2006, 31). This is proposed both on the basis that policy makers are more likely to integrate right-to-health considerations into an impact assessment that they are already required to undertake, and because such an approach is consistent with the desire to mainstream human rights into all government processes.

However, attempts to integrate health into other forms of impact assessment do not bode well for the integration of a right-to-health impact assessment. While advocates of integration have claimed that impact assessment methodologies such as environmental impact assessment are sufficiently flexible to tackle health concerns,[8] experience suggests there is a considerable risk this theoretical flexibility will not translate into practice.[9] Indeed, practical experience clearly demonstrates the difficulties associated with effectively integrating health concerns into a broader impact assessment, where the agencies controlling the assessment process have no direct stake in the health of a population, and their interests in fact lie elsewhere (Lock 2006; Birley 2003; Bond et al 2001).

The approach taken in the EU with respect to the development of an integrated impact assessment also raises concerns as to the efficacy of integrating human rights into an all-encompassing impact assessment process. Where decision makers, who do not speak a language of human rights in the first place, are being asked to consider a number of different impacts and then balance and trade those off against each other, it is difficult to see how that process is likely to instil a genuine commitment to human rights. Far from mainstreaming human rights, the assessment process seems to be at real risk of becoming an administrative compliance check, undertaken by people with little or no understanding of human rights (Toner 2006, 319; de Schutter 2005, 37).

So what is the future of a right-to-health impact assessment, if a standalone model is likely to be seen by decision makers as just another procedural headache, while

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7 Hunt and MacNaughton (2006, 9) refer to over 50 topical streams of impact assessment.

8 See, for example, the discussion in Mercier (2003).

9 See, for example, Jobin (2003).

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integration risks diluting right-to-health concerns beyond any substantive meaning? One answer is that, given the synergies between HIA and HRIA, there may be a possibility of effectively integrating a right-to-health impact assessment into HIA. Unlike attempts to integrate health or human rights within an integrated impact assessment model, integration of a right-to-health impact assessment within HIA would not require assessors to consider a number of different impact categories. Instead, because both health and human rights are concerned with the promotion and protection of human wellbeing, there is substantial concurrence between the considerations that are given to health and its underlying determinants within both HIA and a right-to-health impact assessment. Further, while a right-to-health impact assessment is based on a normative framework that derives from international human rights law, many of those underlying norms are consistent with the values that underpin HIA. Integrating a right-to-health impact assessment within HIA does not therefore require a radical value shift, but instead is more a change in emphasis and language that has the potential to be revolutionary.

The integration of a right-to-health impact assessment within HIA can also be seen as offering a better solution for mainstreaming the right to health than a consideration of the right to health within HRIA, which seeks to consider a bundle of human rights. Within the human rights matrix, an assessment of the right to health will generally need to be contained in order to give meaning to the assessment of other rights. Accordingly, regardless of how interconnected or indivisible those rights may be to the right to health, from a practical perspective, health is almost inevitably conceptualised and disserted in a narrower sense.

Of course, this is not to say that the proposal for the integration of a right-to-health impact assessment within HIA is a perfect solution. Even before the right to health is plunged headlong into HIA, HIA still has much work to do in order to institutionalise itself in decision-making circles. There is also a growing trend towards integrated impact assessment methodologies, which means the present proposal runs counter to that trend (Birley 2003). Nevertheless, if the object of a right-to-health impact assessment is to mainstream the right to health in decision-making processes, then subjugating it within an all-encompassing integrated impact assessment seems unlikely to be a solution. On the other hand, embedding an impact assessment of the right to health within HIA offers the right to health the opportunity to take advantage of the work already done by HIA practitioners, both methodologically and with respect to the mainstreaming of health concerns. In this regard, HIA may be capable of incorporating right-to-health impact assessment in a way that recognises its connection with the suite of rights enshrined in international human rights law and, at the same time, sees those rights as essential preconditions to the enjoyment of the right to health. In doing so, HIA offers a practical impact

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assessment methodology that locates the right to health within the human rights matrix, without seeing it being subsumed by it. At the same time, this approach also presents the possibility of providing HIA with some solutions to the challenges that it is presently facing, so that it can ensure its long-term effectiveness in promoting healthy public policy.

Different methodologies

The methodological variation that presently exists between HRIA tools raises the further question of whether it is desirable to strive towards an agreed form of right-to-health impact assessment. The lessons of HIA suggest that, in the practical world, it will be essential for right-to-health impact assessment to establish some consistency so that it provides an easy-to-use and transparent screening tool (Cole et al 2005; Douglas et al 2001; Mindell 2001). However, methodological variation also enures right-to-health impact assessment with a degree of flexibility that enables it to adapt to different settings and uses.

For example, where impact assessment is to be undertaken by governments, its methods will need to adapt to the political and administrative reality of the decision-making environment. In particular, a key requisite will be its ability to provide decision makers with a way of navigating the right to health, such that it is properly balanced and prioritised among competing objectives. On the other hand, where the right-to-health impact assessment is intended for use by non-government organisations, its priority will be to provide conclusions that are sufficiently justifiable and robust to be worthy advocacy tools. The methodologies may also need to be varied depending on the type and stage of the intervention under consideration. The challenge for right-to-health impact assessment will therefore be to develop itself to a point of methodological maturity and consistency that gives it traction with decision makers, while still maintaining enough flexibility to adapt to the variety of circumstances in which it may be applied.

In addition to this balancing act, the experience with HRIA anticipates that a right-to-health impact assessment will need to achieve a balance between developing comprehensive tools, which tend to be complex and time consuming, and limited tools, which may be more user-friendly but which may not achieve the desired right-to-health outcomes. The three levels at which HIA has been undertaken may provide a right-to-health impact assessment with some guidance in this respect. HIA has been undertaken as a desk-based audit, an intermediate HIA and a comprehensive HIA (Simpson et al 2004, 164; Harris 2005, 108). Accordingly, consideration might be given to whether it is either feasible or desirable to develop right-to-health impact assessment methodologies that mirror some or all of these approaches. Certainly, to

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date, none of the right-to-health methodologies proposed have envisaged anything like a desk-based audit, and the dangers of reducing right-to-health impact assessment to an administrative function have already been discussed. Nevertheless, as right-to-health impact assessment seeks to find its place in the decision-making world, the experience of these various levels of HIA will be invaluable indicators of how the methodologies of a right-to-health impact assessment should best position themselves.

A further issue that arises from both a methodological and a conceptual perspective is the extent to which a right-to-health impact assessment differs from a rights-based approach to health impact assessment. In many ways, HOM's Health Rights of Women Assessment Instrument looks more like a rights-based approach to health impact assessment. This appears to be reflected in at least one experience with its practical application, which has identified HeRWAI as a useful tool for 'highlighting the links between women's rights violations and their poor health' (Nahar 2007) — that is, it begins with women's health, and then applies a rights-based lens in its analysis of the contributors to the state of women's health in a given population. This mirrors the rights-based approaches taken in the development space (Ruggie 2007, para 27; Human Rights Council of Australia 1995; Boesen and Martin 2007) and the approach proposed by the Halifax Initiative Coalition for its HRIA methodology (Halifax Initiative Coalition 2004, 17). A potential differentiator for a right-to-health impact assessment is that it begins with a series of inputs that are themselves human rights, and then considers how those inputs affect a population's enjoyment of the right to health. In this way, both the input and the outcome of the assessment process are driven by human rights norms and principles. The extent to which these conceptual differences correspond to methodological differences, and the relative merits of a rights-based approach to HIA versus a right-to-health impact assessment, will require further explication as this field of impact assessment develops and matures.

Evidence and indicators

Closely related to the methodological issues surrounding a right-to-health impact assessment are questions as to the type of evidence that should be relied upon, and the use of indicators. A right-to-health impact assessment, like other forms of impact assessment, is intended as an evidence-based tool for informing the decision-making process. Accordingly, both its methods and the evidence it relies upon must be capable of withstanding close scrutiny and challenge. Within HIA circles, the same need for robust evidence has given rise to considerable debate as to whether quantitative or qualitative evidence ought to be used, with the use of quantitative evidence being preferred by some practitioners on the basis that it provides HIA with

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a robust scientific base and is likely to be more influential on decision makers (Cole et al 2005; Mindell 2001). However, in the context of a right-to-health impact assessment, even more so than in HIA, it seems highly improbable that the multidimensional causal pathways through which an intervention may impact on a population's right to health can be properly explored and predicted through quantitative evidence.

At the same time, express recognition should be given to the inherent limitations associated with making predictions and fully elucidating causal connections. Regardless of the type of evidence used, a right-to-health impact assessment is unlikely to ever offer a mechanism by which scientifically accurate predictions can be made.[10] Accordingly, a right-to-health impact assessment should not be concerned to identify an objective truth, but rather to fully examine the range of pathways through which a proposed intervention may influence the enjoyment of the right to health of a population The essential aspect of a right-to-health impact assessment should therefore be its systematic nature and its use of a range of appropriate quantitative and qualitative evidence to create a better understanding of, and better outcomes with respect to, the right to health in the decision-making process.

Further, notwithstanding the problems associated with undertaking accurate impact analysis in relation to the right to health, it is still possible to develop better analytical tools through the development and use of appropriate indicators (Andreassen and Sano 2007). Buoyed by the success of indicators in development analysis, human rights indicators, both qualitative and quantitative, have been proposed as valuable tools in the struggle for human rights, as they can be used to monitor human rights, build accountability and capture the attention of policy makers (Chapman 2000; Raworth 2001; UNDP 2000, chapter 5). In relation to economic, social and cultural rights, in particular, human rights indicators have been perceived as being especially helpful, as they offer the possibility of measuring the somewhat elusive concepts of progressive realisation and resource availability (Hunt 1998; Chapman 2000, 4).

With respect to health, the use of indicators is also well known. For example, a number of key indicators have long been used as part of the reporting requirements under ICESCR in relation to the right to the highest attainable standard of health (CESCR 1991). These indicators are derived from health indicators developed by the WHO, which makes extensive use of indicators in its endeavour to promote global public health (WHO 2007, 7). More recently, the Millennium Development Goals

10 For a similar discussion in relation to HIA, see Parry and Stevens (2001).

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(MDGs) have also given much prominence to health indicators (Hunt 2003a, para 47).[11]

In the context of a right-to-health impact assessment, it will be important to distinguish between health indicators and right-to-health indicators. In this regard, the Special Rapporteur for Health has identified that while the substance of health indicators and right-to-health indicators may often not differ, the essential distinguishing feature of a right-to-health indicator is that it is derived from and is designed to monitor the realisation of specific right-to-health norms (Hunt 2003b). Accordingly, as the concepts and methods of right-to-health impact assessment continue to be developed, greater clarity will be required in relation to the indicators that are being used, in terms of both what is being assessed and how it will be measured. It will be also be necessary to consider how indicators with respect to the underlying determinants of the right to health can be developed and incorporated into the assessment process. This will be a complex task, given the range of factors that are preconditions to human wellbeing and the concurrent need to contain the scope of the assessment process, so that it does not become too chaotic or onerous. It will also be necessary to ensure that indicators be selected according to their appropriateness for effective monitoring of the right to health in the specific circumstances (WHO 2004).

In developing right-to-health indicators, it is also important that the limitations of indicators be expressly recognised. Indicators alone will never give a complete picture of the multiple dimensions of a government's performance with respect to the right to health (Hunt 2006, para 30; de Beco 2007, 271). This is particularly the case where indicators are being used within an assessment process that is seeking to predict a likely impact (Anderson and Sano 2006, 21). Indicators are therefore one piece of the assessment puzzle, and must be used together with benchmarks, which provide an essential means of measuring performance over time, and other forms of quantitative and qualitative evidence. It is the combination of this evidence that is best able to inform both the predictions made by a right-to-health impact assessment and the decision makers that it is seeking to influence.

Conclusion

A right-to-health impact assessment has the potential to be a powerful tool in the struggle to ensure that the right to health is embedded within the decision-making

11 Of the 48 MDG indicators, at least 17 are health indicators: <http://unstats.un.org/unsd/mdg/Host.aspx?Content=Indicators/OfficialList.htm>.

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processes that affect our wellbeing. While it is clear that, at a practical level, right-to-health impact assessment still has much work to do in resolving the methodological challenges that it presently faces, the challenges that lie ahead should not discourage efforts to further explore its potential and develop its methodologies. One of the most important lessons to be learnt from earlier forms of impact assessment is that it is possible to move beyond rhetoric and shift entrenched practices and attitudes through the use of these tools. A right-to-health impact assessment therefore holds the promise of taking the health and human rights message to the decision-making corridors, where it might ultimately be heard and heeded by the decision makers who are responsible for shaping the societies in which we live. ●

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