

A Right to Participation in Public Health Strategy Development

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Abstract

United Nations human rights documentation frequently reiterates the importance of the human right to participation in policy development, but infrequently describes the process. This right is part of the normative content of Article 12 (the right to health) of the International Covenant on Economic, Social and Cultural Rights, to which Australia is a party.

General Comment No. 14 *The Right to the Highest Attainable Standard of Health*, which issued from the United Nations Committee on Economic, Social and Cultural Rights in 2000 states that "...participation of the population in all health-related decision-making at the community, national and international levels" is an important aspect of the right to health. Paragraph 43(f) of General Comment No. 14, directs states to adopt and implement a national public health strategy and plan of action, which is developed and reviewed via a *participatory* process.

The paper addresses what is required for a human rights approach to participation. It is considered that paragraph 43(f) is concerned with development of a human rights framework for public health and that participation in the context of the paragraph has close affinity with an empowerment frame of reference and can be interpreted as a right to a process. The paper identifies that current arrangements in Australia can, with modification, be employed to adopt and implement a right to participation in the national public health strategy. In view of incomplete knowledge and understanding of the human right to health consideration is given to legislative protection of the right.

Keywords

Human rights, right to health, public health, participation, empowerment frame of reference, legislative protection

Part One

I. Introduction

Health as a human right is mentioned in a wide variety of international instruments, which address different dimensions of the right to health. See for example, the preamble to the WHO Constitution (1946), the Universal Declaration of Human Rights (UDHR) (UDHR 1948, Article 25), the Convention on the Rights of the Child (CRC) (CRC 1990, Article 24) and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) (CEDAW 1981, Article 12). Its most authoritative statement is located in Article 12 of the International Covenant on Economic, Social and Cultural

Rights (the Covenant or ICESCR), which came into force generally in January 1976 and for Australia, March of that same year. Despite the fact that the international community has frequently reaffirmed the importance of full respect for the right to health, there remains a large gap between the standards set in Article 12 and the situation prevailing in most countries of the world.

The ICESCR entered into force at a time when there was increasing acceptance by the World Health Organisation (WHO) and members of the World Health Assembly (WHA) that improvement in population health required an approach that placed the activities of the health sector within overall social and economic development (Djukanovic and Mach 1975; WHO 1978; Walt 1982; Werner and Sanders 1997) and culminated in the historic International Conference on Primary Health Care held at Alma Ata in September 1978 (WHO 1978). It appears that the Covenant did not influence the activity within the international health sector as Article 12 remained largely unnoticed until the advent of the HIV/AIDS pandemic during the 1990s. Leary (1994) noted that with two exceptions, the Hague Academy of International Law workshop (Dupuy 1979) and the Pan American Health Organisation study (Fuenzalida-Puelma and Scholle Connor 1989), there had been few serious efforts by international organisations or scholars to consider the scope of the right to health. Activity surrounding conceptualisation of the right has since gained increased attention in academic literature (see for example Hunt 1996; Chapman 2000; Gruskin and Tarantola 2002), in case law (Treatment Action Campaign vs. Minister of Health 2002) and formation of health and human rights centres (see for example François Bagnoud Health and Human Rights Center, Johns Hopkins School of Public Health). Activity within the United Nations has also increased with respect to the right. Examples include publications by the WHO on health and human rights (WHO 2002), round-table discussions on economic, social and cultural rights (Harvard Law School 1993; Office of the High Commissioner for Human Rights 1998) and appointment of a Special Rapporteur on Health (United Nations High Commissioner for Human Rights 2002).

Though a substantial amount of work has been done to clarify the content of the right to health, the relationship between health and human rights is incompletely understood, particularly in the area of public health. A significant contribution to conceptualisation of the right to health came from the Committee on Economic, Social and Cultural Rights (the Committee or CESCR) in 2000 when the Committee provided a detailed interpretation of Article 12 in General Comment No. 14 *The Right to the Highest Attainable Standard of Health* (CESCR 2000). Translation of the content of the General Comment into implementable health policy together with a mechanism for national monitoring of governmental obligations is in its infancy (Gruskin and Tarantola 2002, p. 319). To facilitate this translation, it is essential that the General Comment have sufficient clarity to be useful in a legal and policy context, be easily defended and stand alone as an authoritative statement on the right to health. Several articles have appeared on the General Comment that primarily describe the content of the document (Human Rights Internet 2000; Chapman 2002; Gostin 2001). Little has been done to provide for the explicit accommodation of the right to health in public health strategy. Of particular relevance to this translation is General Comment No. 14 minimum core obligation paragraph 43(f),

which directs states' parties to develop and adopt via a *participatory* process a national public health strategy and plan of action.

Acknowledging that it is not clear how to achieve this, the aim of this paper is modest and is part of a larger study to expand upon the content of paragraph 43(f) of General Comment No. 14 to develop a human rights approach to public health strategy development. The paper seeks to link current public health practice with an interpretation of paragraph 43(f) in an effort to progress this discussion. Implicit in paragraph 43(f) is that it will be a national coordination body that develops and adopts the national public health strategy. Here I present arguments in favour of the view that in Australia there currently exists a national coordination body that, although not formed with the intention to fulfil paragraph 43(f), could with modification lead the process to implementation of this paragraph. Further, I argue that a human right to participation in public health strategy development has a close affinity with an empowerment frame of reference and can be interpreted as a 'right to a process'. As such, consideration is given to legislative protection of this process.

The paper is divided into two parts. Part I, containing sections two to four deals with identification of a human right to participation. Section two of this part deals with a definition of health and considers whether a definition of health and its boundaries is required before there can be identification of components essential to a human rights framework for public health generally. This paper is concerned with one of the elements of paragraph 43(f) of General Comment No. 14: incorporation of participation at the national level in public health strategy development. Paragraph 43(f) is a general statement and requires further elaboration. Prior to considering how a right to participation can be understood, it is necessary to develop an interpretation of the paragraph itself: this is the topic of the third section. The fourth section completes Part I and is concerned with a conceptual understanding of a right to participation. Having identified a right to participation, Part II, containing sections five to seven, considers development of a framework for participation in public health strategy development at the national level and the conditions necessary for adoption of the framework. Consideration of a framework is the topic of section five. Implicit in the interpretation of paragraph 43(f) is the presence of a national public health coordination body. Accordingly, the topic of section six is the national coordination body for public health in Australia, the National Public Health Partnership (NPHP). As the right to participation is underpinned by international human rights law, section six also considers the requirements for adoption of the framework and future possibilities of legislative protection.

II. Defining the right to health

The well known definition of health in the WHO constitution " ... a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO Constitution 1948, Preamble) has been considered as all encompassing and difficult to employ as a basis for development of health policy (Evans and Stoddart 1994, p. 28). 'Health' is a product of complex interactions between the environment and social systems as well as an everyday concept that is utilised and developed overtime within varying cultural contexts, reflects particular philosophical

positions and contains subjective as well as objective elements (Baum 2002, pp. 3-15). Definitions extend across a continuum from well-being on the broadest sense at one end to absence of some undesirable condition at the other (Evans and Stoddart 1994, p. 28).

The central formulation of the right to health located in article 12 of the ICESCR states:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
 - (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child
 - (b) The improvement of all aspects of environmental and industrial hygiene
 - (c) The *prevention*, treatment and control of epidemic, endemic, occupational and other diseases (emphasis added)
 - (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.

The article complements and adds detail to the nature and enjoyment of provisions in the UDHR: life, liberty and security of person (1948, Article 3), not to be subject to torture or to cruel, inhuman or degrading treatment or punishment (UDHR 1948, Article 5), to marry and to found a family (UDHR 1948, Article 16.1), to freedom of thought, conscience and religion (UDHR 1948, Article 18), to work (UDHR 1948, Article 23.1), to rest and leisure (UDHR 1948, Article 24), to a standard of living adequate for the health and wellbeing of people and their families and to the right to medical care and to security in the event of sickness (UDHR 1948, Article 25.1), to participate in the cultural life of the community (UDHR 1948, Article 27.1).

Implementation of economic, social and cultural rights is subject to 'progressive realisation' (ICESCR 1976, Article 2.1). An inexact obligation, it has rendered implementation of these rights difficult to monitor by the Committee (Chapman 1996, p. 23). The Committee has responded to this challenge in a number of ways including adopting the practice of developing General Comments to expand upon the nature, content and obligations contained within the various articles of the Covenant and has developed 16 general comments to date.¹ These general comments contribute to concrete

¹ General Comment No. 1 Reporting by States parties, General Comment No. 2 International technical assistance measures (Art. 22), General Comment No. 3 The nature of States parties obligations (Art. 2.1), General Comment No. 4 The right to adequate housing (Art. 11.1), General Comment No. 5 Persons with disabilities, General Comment No. 6 The economic, social and cultural rights of older persons, General Comment No. 7 the right to adequate housing (Art. 11.1), General Comment No. 8 The relationship between economic sanctions and respect for economic, social and cultural rights, General Comment No. 9 The domestic application of the Covenant, General Comment No. 10 The role of national human rights institutions in the protection of economic, social and cultural rights, General Comment No. 11 Plans of action for primary education (Art. 14), General Comment No. 12 The right to adequate food (Art. 11), General Comment No. 13 The right to education (Art 13), General Comment No. 14 The right to the highest attainable standard of health (Art. 12), General

implementation of economic, social and cultural rights by providing a degree of clarity on how obligations under the Covenant are to be interpreted as well as guidelines for legislative and policy action by States parties (Coomans 1995, p. 17). These documents have legal weight, as they are subsequently included in annual reports of the Committee and in the report of Economic and Social Council (ECOSOC), which is subsequently endorsed by the General Assembly.² Those members of the General Assembly who are also signatories to the Covenant, by implication therefore endorse the content of general comments unless otherwise indicated (Craven 1995, p. 92). Adding to their legal weight is consideration given to these documents by domestic courts as an aid to interpreting human rights provisions in domestic constitutions.³ The role of general comments should not be underestimated as in the absence of a complaint procedure to enable development of the content of an economic, social and cultural rights through Committee developed case law, they provide the most definitive interpretation of the procedural and substantive articles of the Covenant (Coomans 1995, p. 17).

General Comment No. 14 is a significant contribution to conceptualising the normative content and obligations contained in Article 12. In accordance with current knowledge, the Committee described the content of the right to health rather than attempting to define it. The right to health as interpreted by the Committee contains freedoms to control one's health and an entitlement to a system of health protection (General Comment No. 14, paragraph 8). Broad in content, the right to health extends well beyond health care to include a wide range of socio-economic determinants including the underlying determinants of health: food, nutrition, housing, water and sanitation, healthy working and environmental conditions (General Comment No. 14, paragraph 11). Participation of the population at the national level in all health-related decision-making is an important aspect of the right (General Comment No. 14, paragraph 11). Not to be interpreted as a right to be healthy, this broad conception

Comment No. 15 The right to water (Arts. 11 and 12). A compilation of General Comments is available at <<http://www1.umn.edu/humanrts/gencomm/epintro.htm>>.

² For example, General Comment No. 14 *The right to the highest attainable standard of health* was included in the Economic and Social Council, *Official Records of the Economic and Social Council*, 2000, Supplement No. 2, UN Doc. E/2000/22-E/C.12/1999/11, <<http://www.ods-dds-ny.un.org/doc/UNDOC/GEN/G01/411/87/PDF/GO141187.pdf?OpenElement>> at 1 November 2004, and included in the *Report of the Economic and Social Council for 2001*, General Assembly Official Records, Fifty-sixth Session, Supplement No. 3. UN Doc. A/56/3Rev.1 <<http://www.un.org/ga/56/document.htm>> at 1 November 2004.

³ The Constitutional Court of the Republic of Latvia, *Case 2000-08-0109* (2001) Riga, 13 March 2001. Determining compliance of Item 1 of the Transitional Provisions of the Law "On Social Insurance" with articles 1 and 109 of the Staversme (Constitution) of the Republic of Latvia and Articles 9 and 11 of the International Covenant on Economic, Social and Cultural Rights reference was made to General Comments No. 3 *The Nature of States Parties Obligations* and General Comment No. 9 *The domestic application of the Covenant* when discussing the nature of the obligation of 'progressive realisation' contained in Article 2 of the Covenant and the binding force of this obligation at the domestic level. The content of both General Comments was not disputed by the Court; *Republic of South Africa v. Grootboom* (2000) Case No. CCT11/00.2000 (11) BCLR 1169. Constitutional Court of South Africa, 4 October 2000 and *Minister of Health v. Treatment Action Campaign* (2002) Case No. CCT 8/02. Constitutional Court of South Africa, 5 July 2002, <<http://www.concourt.gov.za>>. In both of the South African cases, the Court carefully considered the relevant work of the CESCR. General Comment No. 3 *The nature of State parties obligations* and the concept of minimum core obligations were discussed for the purposes of interpreting articles 26 and 27 respectively of the South African Constitution.

of health encompasses an extensive amount of human activity and its boundaries are not clearly defined. As it includes elements, which are the subject of other human rights there is the potential for it to encounter similar difficulties as that of the WHO definition: the use of it as a basis for health policy.

The extent of the normative content of the right to health confirms that there is much more to health than access to health care and absence of some undesirable condition. The content exhibits the general perception that the surrounding socioeconomic environment has an impact on the health we have. There is also a desire to move away from narrow definitions of health that ignore external factors and avoid asking the questions that are relevant to address the external factors which influence health. The Committee recognises that for people to have increased control over their health, their participation in health-related decision-making is required not only at the community level, but also at the national level (General Comment No. 14, paragraph. 11). Further emphasis is placed on participation at the national level through its incorporation into one of the minimum core obligations of the right to health. Paragraph 43(f) of General Comment No. 14 directs states to adopt and implement a national public health strategy and plan of action which is developed and reviewed via a participatory process (General Comment No. 14, paragraph.43(f)). General Comment No 14, through the direct reference to participation in paragraph 11 and through indirect reference via incorporation of the Alma Ata Declaration into the minimum core obligations in paragraph 43, makes it clear that participation is an essential component of the right to health.

To implement human rights and identify violations, it could be argued that it is necessary to fully determine the normative content of the various rights, which would imply a need for a specific definition of health rather than a description of its content. However, Toebes (1999, p. 24) questioned whether we need to define health specifically to understand the meaning of a right to health. She argued that the right to life and the right to privacy, both of which proclaim subjective and objective values and have been difficult to define *in abstracto*, are nevertheless justiciable. Jurisprudence at the domestic and international levels has helped to determine the content of these rights. She goes on to argue that frequent application of the right to health before judicial and quasi-judicial tribunals may do the same for the right to health. Supporting this approach, it is argued that a specific definition of health and its boundaries need not be developed prior to identification of essential components. While a definition of health and defined boundaries remain obscure, people's participation in health decisions has been recognised as an essential component since at least 1948 (WHO 1946, Preamble). Developed as a 'right to participate' and subsequently legislatively protected would provide an opportunity for consideration of the extent of this right before judicial or quasi-judicial tribunals and would be a method to progress eventual full determination of the content of the right to health.

III. The National Public Health Strategy

Paragraph 43(f) of General Comment No. 14 directs States parties to the ICESCR to:

“... adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable and marginalized groups” (General Comment No. 14, paragraph 43(f)).

Considered to be a key obligation of the right to health (Chapman 2002, p. 205), the paragraph is essentially concerned with two main issues: a national coordination body and development of a human rights framework for public health. The paragraph has been designed as a general statement and requires further elaboration to have sufficient clarity to be useful in a legal and policy context. Discussion of the full elaboration of the paragraph is beyond the scope of this paper. However, as the paper is concerned with the essential component of participation in public health at the national level, it is necessary to address possible interpretations of the paragraph prior to an elaboration of a right to participation.

Paragraph 43(f) provides a broad outline and there are several alternative interpretations of the paragraph. For example, it could refer to a national public health strategy, which encompasses all public health issues and new issues as they arise; or to one which is directed as development of a multitude of strategies; or to one overarching national public health strategy, not focussed upon a particular health issue, group or setting but which directs a process to be followed when developing public health strategies. If the first interpretation was adopted: one public health strategy meant to deal with all public health issues and new issues as they arise, it assumes homogeneity of public health issues. Public health is concerned with almost every activity we do and the ground is always shifting. Minimum current issues include safe and potable water, nutrition, transport, school and work environment, adequate housing built to safety specifications, healthier exercise patterns, water safety, preventative services, health education, research and development. These activities are all part of public health. To view paragraph 43(f) as a direction for development of one public health strategy, which dealt with the various components of each of these public health issues and ‘addressed the health concerns of the whole of the population’, is not feasible. It is not logically and conceptually possible to develop one public health strategy, which is flexible and responsive enough to deal with all of these issues and new issues as they arise.

Public health strategies have historically been vertical in nature with little communication and coordination between them (Lin 2003, p.123). The danger of interpreting paragraph 43(f) as referring to a multitude of public health strategies is that there is the potential for a continuation of the situation

wherein there is development of a multitude of public health strategies, which are vertical in operation and lack coordination between them. People's lives don't necessarily respect the boundaries of vertical public health strategies and there is a need to develop a method of ensuring that vertical public health programmes are sufficiently coordinated to meet the real needs of people (Lin 2003, p. 123).

A third interpretation of paragraph 43(f) is that of an overarching framework which directs a process to be followed when developing sub-public health strategies aimed at settings, groups or issues. Paragraph 43(f) contains four elements (based upon epidemiology and addressing the health concerns of the whole of the population; focus on vulnerable and marginalised, developed and reviewed via a transparent and participatory process; to include right to health indicators and benchmarks). The paragraph is essentially concerned with the presence of a structure to ensure that the four elements, all of which are concerned with the process of participation, are included in sub-public health strategies.

Obtaining the views of the population requires their participation to obtain those views. Given the breadth of the normative content of the right, the epidemiological basis for the national public health strategy needs to extend beyond the most common classical form that focuses upon a disease or a health problem in the population to include social epidemiology. As social epidemiology focuses upon the social group rather than a disease or health problem and establishes the group's broad health experiences (Morgan 2001, p. 228), it follows that this would involve participation of the particular social group in establishing those health experiences. Participation is clearly involved in devising and reviewing the national public health strategy, as these tasks are to be undertaken via a participatory and transparent process. The national public health strategy is to focus upon the vulnerable and marginalised within an overarching human rights approach. Discrimination in development of public health strategies is prohibited (General Comment No. 14, paragraphs 12(b) and 18). This recognises inequalities in health between population sub-groups and a need to address those inequalities within a framework of a right to health for all. It is meant to turn attention away from disease and toward people incorporating what they consider their issues to be. By implication, it would be necessary to involve the vulnerable and marginalised in this process. The national public health strategy is to include right to health indicators and benchmarks. When viewed as an overarching framework, this reference is not only a reference to indicators understood as measures of outcome, such as life expectancy or numbers with a specific health issue, but also to indicators of process: indicators of participation. As indicators of participation are underdeveloped and therefore either not applied or unevenly applied, benchmarks would relate to progressively working towards improved development and application of indicators of participation and the overarching framework itself.

Paragraph 43(f) is implicitly aimed at developing a coordinated approach to public health strategy and the presence of a structure to ensure participation in public health strategy development. It therefore makes better sense to consider the paragraph to be referring to one overarching framework directed

to ensure that common and essential characteristics of public health strategies are included in sub-public health strategies. A framework, which directs that all sub-strategies must include mechanisms for inclusion of all understandings of health, be based on a broad understanding of epidemiology, ensure participation and accountability, identify all relevant groups and include processes of monitoring and evaluation through development of indicators and benchmarks relevant to the particular strategy.

This interpretation is supported by the idea of legislative protection of the right to health strategy (General Comment No. 14, paragraph 56). It may be possible to develop legislative protection of an overarching framework. The Special Rapporteur on Health speaks of the need to have a human rights approach introduced into policy (Hunt 2003 paragraph 8; Hunt 2004, paragraph 47) and paragraph 1 of General Comment No. 14 recognises that the right to health can be implemented via policy. But introduction into policy can be insufficient as there is no guarantee that the policy approach would not be changed every time there was a change in government or government priorities. Consideration needs to be given to legislative protection. Having determined that paragraph 43(f) is an overarching framework for development of sub-public health strategies and as participation at the national level is an essential component of the national public health strategy, it is necessary to now turn to consideration of what form a human right to participation takes.

IV. Human rights and participation

Although participation is emphasised in General Comment No. 14 as an essential component of health there no elaboration of its meaning or content. Accordingly, to expand upon its meaning and work towards consideration of a framework for its adoption at the national level this section discusses participation initially from human rights documentation and then moves on to the health and development discourse on the subject.

There are significant practical and ethical grounds for inclusion of people's participation in health decisions (Croft and Beresford 1996, p.190; Palmer and Short 2000 p. 332; Commers 2002, p. 25; Baum 2002, pp. 342 ff.). Practically, it is argued that participation is necessary to secure sustainability and effectiveness of interventions by gaining trust, support and internalisation of goals of public health initiatives. Ethically, it is argued that participation minimises paternalism associated with public health strategies. It is also argued that the necessity of participation is implied from the growing evidence of the important influence upon our health of our physiological and psychological predispositions (Commers 2002, pp. 34-5). Under-participation in public life generally and in public health strategy development particularly causes substantial disadvantage for under-represented groups whose interests are often marginalised and ignored (Joseph et al. 2003, p. 515; National Resource Centre for Consumer Participation in Health 2000, p. 3). Its importance is well established and is not the issue. The issue is the meaning of participation adopted (is it an individual right or a group right?), its content and the extent to which it is guaranteed.

(a) Human rights documentation

It is recognised that the right to health is reliant upon realisation of other rights contained in the International Bill of Human Rights. The importance of participation is emphasised in other United Nations treaty documentation such as General Comment No. 25 on Article 25 of the International Covenant on Civil and Political Rights (ICCPR) (Human Rights Committee (HRC) 1996) and General Recommendation No. 23 developed by the CEDAW Committee addressing discrimination against women in 'political and public life' (CEDAW 1997). General Comment No. 25 expands upon the content of Article 25 of the ICCPR: the right to participate in public affairs, voting rights and the right of equal access to public service. Of particular relevance for present purposes is article 25(a) which deals with the right of individuals to participate in processes which constitute the conduct of public affairs and which can give rise to claims under the first Optional Protocol (1976) to the ICCPR. The HRC interprets 'public affairs' broadly relating to the exercise of legislative, executive and administrative powers. It covers all aspects of public administration including formulation and implementation of policy at the national level. The HRC considers that the means by which the right to participate is implemented should be established by law (General Comment No. 25, paragraph 5). While this interpretation appears broad at first glance, its application by the HRC is quite narrow.

Case law on Article 25 (Human Rights Committee, 1986) reveals that the HRC has primarily been concerned with the manner of participation and has concluded that it is the legal and constitutional system of a state party that provides for the manner of participation. Prior *consultations* such as public hearings, public consultations with the most interested groups may be envisaged or may have evolved, but Article 25(a) can not be understood to mean 'that any directly affected group, large or small, has the unconditional right to choose the modalities of participation in the conduct of public affairs' (Marshall v. Canada 1986, paragraph 5.5). Though human rights are considered to be rights of individuals, the HRC has interpreted participation to be a group right, thereby implying representation. However, there was no consideration of issues relevant to representation (for example authorisation and quality of representation). This interpretation of participation has implications for the meaning of participation for the purposes of paragraph 43(f) as the HRC's interpretation, if adopted to determine participation for paragraph 43(f), would mean that state parties could limit participation to consultation only. However, given the breadth of the content of the right to health and the ethical and practical reasons for participation in public health planning, to limit participation for of the right to health to consultation would seem to largely defeat the freedoms and entitlements contained in the right.

CEDAW General Recommendation No. 23 addresses Article 7 of the Convention on the Elimination of All Forms of Discrimination Against Women. Of particular relevance is Article 7(b): participation in the formulation and implementation of government policy. Acknowledging that participation by women at this level continues to be low in general, states parties have an obligation "to ensure that women have the right to participate fully and be represented in public policy formulation in all sectors and *at all levels*" (General Recommendation No. 23, paragraph 25) [emphasis added]. Barriers to this participation, which include complacency and traditional attitudes that discourage women's

participation, are to be identified and overcome (General Recommendation No. 23, paragraph 27). Though emphasis is placed on participation by the CEDAW Committee further elaboration of participation has not taken place. The usefulness of General Recommendation No. 23 for present purposes is therefore limited to recognition of the importance of participation within the United Nations treaty system beyond the Committee on Economic, Social and Cultural Rights.

Public health strategies have a population rather than an individual focus, though it is true that public health strategies can be directed at specific groups, for example indigenous health strategies and women's health strategies. Human rights on the other hand usually operate at the individual level rather than the population level and General Comment No. 14 does refer to the right of individuals, for example, to "control one's health and body" (paragraph 8) and an obligation on the state to enable and assist "individuals ... to enjoy the right to health ..." (paragraph 37). However, the General Comment also implies that some components of the right to health relate to groups, in particular in paragraph 43(f), "...reflecting the health concerns of the whole population ..." and "...vulnerable and marginalized groups" (paragraph 43(f)). In support of the idea that some components of the right to health operate at the group level, is the reality that it is not possible for each and every person to participate in development of the national public health strategy (assuming they wanted to). While participation of the population at the national level must be more than consultation, the right to participation for the purposes of development of the national public health strategy can only ever be a group right. In this sense it is similar to that contained in the interpretation of participation by the HRC for the purposes of Article 25. However, none of the treaty bodies referred to have considered the content of participation when a group right and there is a need to turn elsewhere to determine this.

The various UN treaty committees rely heavily on relevant external information sources when developing general comments and general recommendations. This is entirely appropriate given they are supervisory bodies at the international level and not implementing agencies at the domestic level. For example, when developing General Comment No. 14, information was sought from UN Specialised Agencies such as the WHO and the International Labour Organisation, health and development academics and non-government organisations (CESCR 2000, SR.25). Given the reliance on external sources by UN treaty committees, it is not unreasonable to turn to mainstream health and development discourse on participation to expand upon the content of participation for the purposes of a human rights approach to public health.

(b) Health and development discourse

The rhetoric of participation has been appearing in mainstream health and development discourse for at least 50 years. Although not a new concept, it is a contentious term that can mean everything and nothing (Croft and Beresford 1996, p. 175). Morgan (2001, p. 222) notes that participation encapsulates a range of meanings which enables it to be simultaneously employed by a variety of actors for a variety of purposes simply because the term means different things to different people. The meanings can vary from allowing community representatives a seat at the table where policy

decisions are made; to a process of democratization whereby governments become more accountable and responsive to the needs of the disenfranchised; to a cost-sharing exercise contributing toward sustainable programmes; to its cosmetic value that can “make whatever is proposed look good” (Chambers 1995, p. 30 cited in Morgan 2001, p. 222).

It is present in the WHO Constitution Preamble which asserts that “informed opinion and active cooperation on the part of the public are of the utmost importance in the improvement of the health of the people” (WHO Constitution 1946, Preamble). Since that time, the notion of peoples participation as a requisite to achievement of the highest attainable standard of health has received widespread acceptance, was formally endorsed by the member states of the WHO in the Alma-Ata Declaration (1978) and was reiterated in the Ottawa Charter (1986) and the Jakarta Declaration (1997). While participation remains a disputed concept (Croft and Beresford 1996; Rifkin 1996; Morgan 2001; Oakley and Kahssay 1999) a greater understanding of what participation is as well as the factors that facilitate and create barriers to its implementation has evolved. Space does not allow a full review of the literature and this section relies heavily on the work of Susan Rifkin and Lynn Morgan, both credible exponents on the topic and to the work of the WHO and the United Nations Development Programme (UNDP).

Rifkin (1996, p. 81) noted in a review of participation in health during the previous decade, that there were two distinct and diametrically opposed frames of reference for participation which gave rise to different expectations: the targeted framework or ‘top-down’ approach and the empowerment framework or ‘bottom-up’ approach. These two approaches have been referred to by Morgan (2001, p. 221) as a ‘utilitarian effort’ or an ‘empowerment tool’. In the utilitarian effort or target-oriented framework, participation is seen as way for governments, planners and/or health professionals to mobilise community resources (land, labour, money, time and so on) to supplement or offset the costs of health programs. Though consultation may be undertaken to attempt to ensure acceptability and sustainability, decision-making in this frame of reference is firmly in the hands of the ‘experts’ as objectives of the program are developed by the ‘experts’. ‘Participants’ are to be passive recipients responding to professional direction. Outcomes of this form of participation are a product where participation is a means to an end: achieving the outcomes of a programme more efficiently, effectively and/or cheaply. As a means to an end, participation is a component of the program. As a component, its evaluation is quantitative: how many participated (Rifkin 1996, p. 81; Oakley et al. 1999, p. 122; Morgan 2001, p. 221). Described by Oakley and Kahssay (1999, p. 5) as “participation as collaboration”, people “voluntarily, or as a result of some persuasion or incentive, agree to collaborate with an externally determined development project, often by contributing their labour and other resources in return for some expected benefit”.

When participation is viewed through the second frame of reference, the empowerment frame, participation becomes a tool whereby people identify their priorities and work with government, planners and professionals to address them. Participation is viewed as a means and an end to enable

people to have power over decisions that affect their lives. Decisions are made with the active involvement of people. It is a dynamic process that cannot be measured in numbers of people but rather monitoring and evaluation describe how people perceive the process of participation and social changes that occur. Accordingly, qualitative methods are best to monitor and evaluate the process as it enables interactive information gathering that reflects people's lives rather than the priorities and concerns of health professionals (Rifkin 1996, p. 83; Oakley and Kahssay 1999, p. 5; Oakley et al. 1999, p. 122; Morgan 2001, p. 222).

The two frames of reference referred to view participation from diametrically opposed positions (Rifkin 1996, p. 86). Rifkin considered that both frames of reference share a common paradigm that has influenced expectations of the value of participation. This common paradigm views participation as an intervention to achieve identified objectives which are assumed to be controllable and predictable rather than as a result of a dynamic process among all those involved in which the outcome is neither controllable nor predictable (Rifkin 1996, p. 87). According to Rifkin, there is evidence that this paradigm is shifting. Drawing upon Uphoff's (1992) analysis which examines this paradigm and explores an alternative paradigm: a combination of both frames of reference, Rifkin considers that the alternative 'both/and' paradigm enables accommodation of different views of participation as it avoids the dichotomy between the two existing frameworks and allows both to be used (Rifkin 1996, p. 88; Oakley et al. 1999, p. 122). While Rifkin's suggestions are yet to be tested, it is clear from the literature and practice of the 1990s that there was a desire to move away from technocratic 'top-down' approaches to participation and to involve people at various stages of the programme development and implementation (UNDP 1997). Experience showed that for this to occur people's participation could not simply be proclaimed but needed to be systematically developed on the basis of a clearly defined methodology (Oakley et al. 1999, p. 114).

(c) A right to participation

By drawing upon the work of the United Nations treaty bodies and General Comment No. 14, the right to participation for the purposes of paragraph 43(f) is considered to be a group right rather than an individual right. This is based on the content of paragraph 43(f) itself and the conceptual and logistical difficulties of ensuring a right of each and every individual to participate in development of the national public health strategy. Drawing upon the health and development discourse and applying this to General Comment No. 14, it would seem that the right to participation contained within paragraph 43(f) has close affinity with an 'empowerment' frame. This interpretation accords with the efforts in the past decade, which have been directed at moving away from 'top-down' frames of reference for participation (UNDP 1997, Chapter 1). The extent of the right to participation extends beyond consultation to a partnership where all relevant groups are involved in a process of decision-making. Should it be restricted to consultation, although the views of groups may be heard, they would lack the power to ensure those views were heeded (Arnstein 1969, p. 217). To enjoy the freedoms and entitlements contained in the right to health, the partnership reflected in the right to participation means that participating groups have decision-making clout (Arnstein 1969, p. 217). There have

always been resource constraints in public health and therefore there will be trade-offs. Participating groups need to have the power to negotiate and engage in those trade-offs (Arnstein 1969, p. 217). Viewed as a partnership, can the right to participation be developed into a national framework capable of legislative protection?

Part Two

V. A national framework?

“The key issue is the notion of *process* and the fact that community participation is not merely an input to the project but the basis upon which it will operate. Furthermore, participation cannot be assumed but has to be systematically encouraged, and means have to be created to make it effective” (Oakley et al. 1999, p. 117).

The right to participation at the national level will need to be systematically encouraged. However, there are difficulties in operationalising the right as participation itself does not necessarily follow structural and predetermined directions. There is no guarantee that what works in one situation will work in another or will work in the future (Morgan 2001, p. 225). As it is a process that must be adaptable, ‘blueprint’ models will rarely work (Krishna et al. 1997 cited in Morgan 2001, p. 223). These are significant reasons why we should question whether a national framework could be developed.

There are also significant reasons why we should be concerned with development of a commitment to the right to participation at the national level. Discussions on participation frequently ignore or underplay the role of the state and are confined to participation in services or individual projects at the local level. Quite apart from the practical and ethical reasons for participation and human rights obligations on the part of states, the reality is that a substantial number of health priorities are identified at the national level for which national strategies are developed. Without input from population groups at the national level, it is inevitable that ‘participation’ can never be operating within an ‘empowerment’ framework at implementation level. While people may well be encouraged to participate and be involved in developing local responses for implementation of the national strategy, they have been presented with a particular issue/strategy, identified from ‘outside’ that is to be addressed.

Further, participatory projects are frequently focussed upon the people and groups experiencing exclusion and there are valid reasons why they should be the special subject of participatory initiatives: challenging and overcoming the discrimination and exclusion they experience (Croft and Beresford 1996, p. 189). However, these initiatives can serve other intentional or unintentional functions. Croft and Beresford observe that it is with these people and groups that the state can most readily intervene and shape the nature of participatory initiatives. As these people and groups face additional difficulties, or are in a position of particular susceptibility (Kottow 2003, p. 462), they are

also sensitive to state intervention, which depending on its frame of reference may result in failure to look closely at the nature of our overall political structures and address the structural causes of their susceptibility. It can be a short step from this failure to considering that existing institutions and structures are adequate and the difficulties faced by these people and groups as well as their non-participation is something peculiar to them (Croft and Beresford 1996, p. 189).

There are substantial barriers to adoption of an 'empowerment' frame of reference for the right to participation at the national level that include the following:

- Rigid professional health sector adherence to established practices with implementation directed from above
- Traditions within the formal health sector that decisions are made by professional health staff
- A belief that health professionals have a monopoly on health knowledge and where lay health knowledge is considered inappropriate and unscientific
- The challenge to existing practice posed by a right to participation. It will require contemplation of different ways of doing things. Its implementation may be thwarted by bureaucratic control (Oakley et al. 1999, p. 117).

Lack of knowledge and lack of political will can be added to this list. Structural blindness on the part of health professionals of economic, social and cultural rights generally and the right to health specifically will hamper implementation. Participation does not occur spontaneously and institutions or professionals who have no experience of human rights and therefore the right to participation will not be able to integrate a mechanisms to protect and fulfil this right without appropriate backup (adapted from UNDP 1997). Lack of political will was identified as a barrier at the Alma Ata Conference (WHO 1978a). Participation is sustainable only as long as there is commitment from the social, economic and political environment to support the process. A commitment to participation at all levels requires action to be taken at the national level to promote the resources (knowledge, funding, time and so on) needed for participatory processes to function. Given these substantial barriers and the fact that 'blueprint' models rarely work, development of a framework may be more to do with initial development of a formal political and health professional commitment to the right to participation at the national level that goes beyond rhetorical flourish rather than development of a step-by-step framework.

VI. The National Public Health Partnership

It is implicit in the adopted interpretation of paragraph 43(f) that it would be a national public health body that devised and adopted the national public health strategy. As the national public health strategy is to be developed via a participatory and transparent process, it follows that group representation of the population in this national public health body would be included and be actively involved in development and adoption of the national strategy. There currently exists in Australia a national coordination body for public health, which although not formed with the intention to fulfil

paragraph 43(f), could with modification lead the process to implementation of this paragraph and therefore a right to participation in public health strategy development.

The National Public Health Partnership (the Partnership or NPHP) developed between 1995 and 1997 was formalised by a Memorandum of Understanding (MOU) in February 1997. It is currently underpinned by a second MOU, signed February 2003 covers the period 2003–2008 (NPHP 2003). It has no guaranteed existence beyond 2008. Created to plan and coordinate national public health activities, the NPHP is a significant step forward over previous national efforts in Australia in development and enhancement of capacity of all jurisdictions to address public health (NPHP 1998). The partnership operates through the National Public Health Partnership Group (NPHPG) whose members are from the commonwealth, states and territories and include senior representatives from the Australian Institute of Health and Welfare (AIHW) and the National Health and Medical Research Council (NH&MRC), reporting to health ministers through the Australian Health Ministers' Advisory Council (AHMAC) (NPHP 1998). Health ministers, meeting as AHMAC, report to the Council of Australian Governments (COAG). The work program of the NPHP is progressed through standing committees or working groups in most instances and through purpose-specific project steering groups.

The NPHP provides a feature that is new to governance in public health in Australia: inclusion of an Advisory Group (recently renamed the NPHP Non-Government Reference Panel) (NPHP 2005) in the NPHPG. The establishment of an Advisory Group of health related non-government organisations (NGOs) within the NPHP to act as a link between the community, government and non-government organisations (NGOs) was an innovative step as it was the first time such a forum had been established in public health in Australia (Lin 2002, p. 125). The Advisory Group's objectives include ensuring that the NPHP is aware of important community issues in public health and that these are included in the work of the NPHP. Its membership, consists of peak professional bodies and health related NGOs.⁴

The role of the NPHPG is specified in Schedule 2 of the second MOU and includes consulting and negotiating with relevant agencies including the Advisory Group, on development of national public health priorities and strategies (NPHP 2003a, Schedule 2). The Advisory Group, subject to the direction of the NPHPG is to contribute to the work of the NPHP by participation on Partnership working groups (NPHP 2003a, Schedule 2). Given the existence of the NPHP and its role to coordinate public health activities and the presence of the Advisory Group within the decision-making body of the NPHP, it would seem that the NPHP while not formed with the intention to fulfil paragraph

⁴ Current Advisory Group members are: Australian Faculty of Public Health Medicine/Royal Australasian College of Physicians; Australian Chronic Disease Prevention Alliance; Australian Health Promotion Association; Australian Institute of Environmental Health; Australian Network of Academic Public Health Institutions; Australian Nursing Federation; National Aboriginal Community Controlled Health Organisations; National Rural Health Alliance; Public Health Association of Australia; The

43(f) of General Comment No. 14, would be the appropriate body to lead the process of implementation of paragraph 43(f) and hence of a right to participation. However, closer inspection reveals that some modification would be required to evince a formal political and health professional commitment to the right to participation at the national level.

(a) The make-up of the national decision-making body

The interpretation of the right to participation adopted is that the parties to the decision-making body will be in equal partnership. As participation is to be via group representation, that representation would need to have a broad constituency. The Advisory Group, pursuant to the MOU is subject to the direction and approvals of the NPHPG, which implies that it is not an equal partnership arrangement (NPHP 2003a). It is also apparent that the contribution of the Advisory Group via participation on working groups is observer status only (NPHP 2003b). Indeed on two of the working groups there is no Advisory Group representation. Both the Legislative Reform Sub-Group and the Healthy Ageing Sub-Group have no Advisory Group representation and it appears from the Advisory Group Communiqué on 11 November 2002 that the decision that Advisory Group representation was not required was made by NPHPG and not by the Advisory Group (NPHP 2003b)

While the Advisory Group is an innovative mechanism to bring an NGO perspective to the NPHP and to public health strategy development, its current make-up is of peak professional health bodies and health related NGOs, principally the Consumers Health Forum of Australia (CHF). This organisation has a wide variety of constituents whose voting members represent community opinions and do not act primarily as representing professional, provider or commercial interests (CHF 2002, p. 43). Its aims and objects are directed at representation of the opinions of people and groups. While this NGO can and does provide community input into the NPHP, due to the description of the content of the right to health contained in General Comment No. 14 (paragraphs 8 and 11) a broader scope for community input is required.

The NPHP is considered to reflect the WHO Health for All agenda (NPHP, 1998) which explicitly acknowledges health as a human right. Inclusion of a national human rights organisation into the Advisory Group would be a step towards addressing possible structural blindness towards the right to health present in the health sector and would accord with NPHP reflection of the WHO Health for All agenda. Given the breadth of the content of the right to health and incorporation of factors external to the health sector, the make-up of the Advisory Group should also be extended to non-health related groups and academic centres researching the influence of external factors on public health. Organisations such as the Human Rights and Equal Opportunities Commission, the Australian Council of Social Services and the National Collaboration Centre for Inequalities in Health could be included, and would bring a constituency that would promote a broader understanding of health in line with content of the right to health described in General Comment No. 14.

While the NPHP is an obvious national body to develop and adopt the national public health strategy and advance a right to participation, a formal political and health professional commitment to the right to participation would require modification of current arrangements: an equal partnership between the NPHPG and the Advisory Group and a broader constituency base for the Advisory Group. Legislative protection of the NPHP could also be considered to provide a deliberate and systematic commitment to the right and also to guarantee the existence of the NPHP beyond 2008.

(b) Legislative protection of the NPHP and the right to participation

The importance of participation in health-related decision-making has been recognised in the WHO Constitution, the Alma-Ata Declaration, the Ottawa Charter, the Jakarta Declaration and in General Comment No. 14. It is acknowledged in health and development discourse that participatory thinking needs to be institutionalised in national ministries of health as efforts of the 1980s and 1990s tended to bypass this level of health planning and policymaking. Originally introduced as an international mandate and part of the primary healthcare strategy to be implemented at the national level, it was often implemented only at the local level. While local level commitment to participation is important, it is insufficient to ensure sustainability of the concept and must extend beyond the local level (Kahassy and Oakley 1999). There are substantial barriers to participation and to adoption of a right to participation and there is no guarantee that the right to participation will be implemented. While General Comment No. 14 acknowledges that the right to health can be implemented via policy, consideration should also be given to legislative protection of the national public health strategy (General Comment No. 14, paragraph 56).

The ICESCR came into force for Australia in March 1976. However, there is no legally enshrined right to health in Australia. As with other economic, social and cultural rights such as housing, education and social security, successive Australian governments have relied upon an indirect method via policy to ensure enjoyment of economic, social and cultural rights. This method is considered to be consistent with the idea of responsible government within a democracy (Otto 2002, p. 2). Participation in public health strategy development, therefore, is not a 'legal' right in the sense that there is a correlative and enforceable legal duty that it be respected or fulfilled. More aptly described as a 'privilege' in the Hohfeldian sense there is no express legal obligation for the state to honour this 'privilege' to participate (Hohfeld 1919, pp. 36-9).

There is no doubt that the commonwealth parliament could act to legislatively protect the NPHP and the national public health strategy and therefore the right to participation pursuant to the external affairs power: section 51 (xxix). Reynolds (2004, pp. 81-2) comments that this power enables the commonwealth to legislate in areas traditionally the responsibility of the states. It enables the commonwealth to make whatever laws necessary to implement Australia's international treaty obligations, provided the laws keep within the terms and scope of the treaty and is appropriate and proportional to the nature of its international obligations.

The possibility of legislative protection for the NPHP was briefly explored in a 1997 (and therefore prior to release of General Comment No. 14) in a report of the current state and future directions of public health law in Australia (Bidmeade and Reynolds 1997, p. 85). With subsequent release of General Comment No. 14, this possibility should be revisited. The authors of the 1997 report considered an NPHP Act could set out the partnership agreement and provide an opportunity to schedule relevant international declarations relating to public health: the Alma-Ata Declaration 1978 and the Ottawa Charter on Health Promotion 1986 (Bidmeade and Reynolds 1997, p. 86). Both the ICESCR and General Comment No. 14 could also be included. An alternative would be to develop a broader National Public Health Act that included the arrangements for the NPHP and also covered other national public health initiatives warranting a legislative base (Bidmeade and Reynolds 1997, p. 86). This could include the national public health strategy, which would entrench the strategy in legislation and therefore include an express legal obligation on the part of the state to honour the right to participation. It could be used to raise the profile of public health within government (and also health professionals and wider society) through creation of a Ministerial Council on Public Health (Bidmeade and Reynolds 1997, p. 86; Reynolds 2002, p. 84). Either Act would provide the opportunity to include a philosophical foundation for public health that is based on human rights. As rights imply redress for violations it would also provide an opportunity to include a review mechanism such as a Public Health Ombudsman or Public Health Commission with a mandate to receive, hear and determine complaints. This would provide a confidential, flexible and informal quasi-judicial method, almost invariably will be free of charge (Gomez 1995, p. 156), whose determinations would assist in expanding upon the content of the right to health and the right to participation.

VII. Conclusion

The right to participation within a human rights approach to public health strategy development is a right to be included in the process of decision-making that has close affinity with an 'empowerment' frame of reference. However, there is no inevitable inclusion of the right to participation in public health strategy development without a deliberate and systematic commitment to it and the values that attach to it. Modification in the NPHP decision-making group together with guaranteed existence for the NPHP beyond 2008 would be evidence of the beginnings of a commitment to this right. Development of legislative protection of the NPHP and the national public health strategy are well within the power of the commonwealth parliament, and would provide a deliberate and systematic commitment to the right to health and the right to participation. However, this would require political will coupled with acceptance that international human rights law supports the right. The approach taken by successive Australian governments to economic, social and cultural rights does not favour the presence of the required political will to adopt domestic legislation to incorporate the right to health into Australian law. This paper is part of a larger project to expand upon the content of paragraph 43(f) of General Comment No. 14 and develop a human rights framework for public health. The ideas and suggestions made here are done so for the purposes of consideration and discussion.

References

- Baum F 2002, *The New Public Health*, 2 edn, Oxford University Press, Melbourne.
- Bidmeade I & Reynolds C 1997, *Public Health Law in Australia: Its current state and future directions*, Commonwealth of Australia, Canberra.
- Chapman A 1996, 'A 'Violations Approach' for Monitoring the International Covenant on Economic, Social and Cultural Rights', *Human Rights Quarterly*, vol. 18, pp. 23-66.
- Chapman A 2002, 'Core Obligations Related to the Right to Health', in eds A R Chapman & S Russell, *Core Obligations: Building a Framework for Economic, Social and Cultural Rights*, Intersentia, Antwerp, pp. 185-215.
- Commers M 2002, *Determinants of Health: Theory, Understanding, Portrayal, Policy*, Kluwer, Dordrecht.
- Committee on Economic, Social and Cultural Rights 2000, 'Summary record of the 25th meeting: 11/05/2000', UNHCHR, viewed 14 January 2004, <<http://www.un.org/cescr/>>.
- Committee on Economic, Social and Cultural Rights 2000, 'General Comment No. 14, The right of everyone to the enjoyment of the highest attainable standard of physical and mental health', (UNHCHR), viewed 6 June 2005, <<http://www.ohchr.org/english/bodies/cescr/comments.htm>>.
- Committee on the Elimination of Discrimination against Women 1997, 'General Recommendation No. 23: Political and public life', (UNHCHR), viewed 6 June 2005, <<http://www.un.org/womenwatch/daw/cedaw/recommendations/index.html>>.
- Convention on the Elimination of All Forms of Discrimination against Women, Adopted and opened for signature, ratification and accession by General Assembly resolution 34/180 of 18 December 1979, entry into force 3 September 1981, in accordance with article 27(1).*
- Convention on the Rights of the Child, Adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20 November 1989, entry into force 2 September 1990, in accordance with article 49.*
- Coomans F 1995–2004, 'Economic, Social & Cultural Rights', *SIM Special No. 16*, Netherlands Institute of Human Rights, pp. 3-52, viewed 6 June 2005, <<http://www.uu.nl/uupublish/homerechtsgeleer/onderzoek/onderzoekscholen/sim/english/publications/simspecials/no/23072main.html>>.
- Craven M 1995, *The International Covenant on Economic, Social and Cultural Rights: A Perspective on its Development*, Clarendon Press, Oxford.
- Croft S & Beresford B 1996, 'The Politics of Participation', in ed. D Taylor, *Critical Social Policy: A Reader*, Sage, London.
- Djukanovic V & Mach E (eds) 1975, *Alternative Approaches to Meeting Basic Health Needs in Developing Countries*, World Health Organisation, Geneva.

Dupuy R (ed) 1979, *The Right to Health as a Human Right Workshop*, The Hague Academy of International Law and the United Nations University, Sijthoff & Noordhoff, The Netherlands.

Evans R G & Stoddart G L 1994, 'Producing Health, Consuming Health Care', in eds R G Evans, M L Barer & T R Marmor, *Why are some people healthy and others not?*, A de Gruyter, New York.

Fuenzalida-Puelma H L & Scholle Connor S (eds) 1989, *The Right to Health in the Americas*, Pan-American Health Organization, Washington DC.

Gostin L 2001, 'The Human Right to Health: A Right to the "Highest Attainable Standard of Health"', *The Hastings Center Report*, vol. 29.

Gruskin S & Tarantola D 2002, 'Health and Human Rights', in eds R Detels, J McEwen, R Beaglehole, & H Tanaka, *Oxford Textbook of Public Health*, 4 edn, Oxford University Press, Oxford.

Harvard Law School and François-Xavier Bagnoud Center for Health and Human Rights 1993, 'Economic and Social Rights and the Right to Health', Harvard Law School, viewed 6 June 2005, <<http://www.law.harvard.edu/programs/hrp/projects.html>>.

Human Rights Committee 1986, 'Communication No. 205/1986: Canada 03/12/91', UNHCRH, viewed 5 May 2003, <<http://www.ohchr.org>>.

Human Rights Committee 1996, 'General Comment No. 25: The right to participate in public affairs, voting rights and the right of equal access to public service', UNHCHR, viewed 6 June 2005, <<http://www.ohchr.org/english/bodies/hrc/comments.htm>>.

Hohfeld W 1919, *Fundamental Legal Conceptions as Applied in Judicial Reasoning*, Yale University Press, New Haven.

Human Rights Internet 2000, 'Health: Committee on Economic, Social and Cultural Rights', Human Rights Internet, viewed 6 June 2005, <<http://www.hri.ca/fortherecord2000/vol1/health.htm>>.

Hunt P 1996, *Reclaiming Social Rights: International and Comparative Perspectives*, Dartmouth, Aldershot.

Hunt P 2003, 'The right of everyone to the enjoyment of the highest attainable standard of physical and mental health', UN Doc. E/CN.2/2003/58, UNHCHR, viewed 6 June 2005, <<http://daccessdds.un.org/doc/UNDOC/GEN/G03/109/79/PDF/G0310979.pdf?OpenElement>>.

Hunt P 2004, 'The right of everyone to the enjoyment of the highest attainable standard of physical and mental health', UN Doc. A/59/422, UNHCHR, viewed 6 June 2005, <<http://daccessdds.un.org/doc/UNDOC/GEN/G03/109/79/PDF/G0310979.pdf?OpenElement>>.

International Covenant on Civil and Political Rights, Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966, entry into force 23 March 1976, in accordance with Article 49.

International Covenant on Economic, Social and Cultural Rights, Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966, entry into force 3 January 1976, in accordance with Article 27.

Joseph S, Schultz J & Castan M 2003, *The International Covenant on Civil and Political Rights: Cases, Materials, and Commentary*, 2 edn, Oxford University Press, Oxford.

Kottow M 2003, 'The Vulnerable and the Susceptible', *Bioethics*, vol. 17, no. 5-6, pp. 460-71.

Leary V 1994, 'The Right to Health in International Human Rights Law', *Health & Human Rights: An International Journal*, vol. 1, no. 1, p. 1.

Lin V 2002, 'Structural Reform and Cultural Transition: Reflections on the National Public Health Partnership', in eds H Gardner & S Barraclough, *Health Policy in Australia*, 2 ed, Oxford University Press, Melbourne, pp. 122-38.

Minister of Health v. Treatment Action Campaign 2002, Case No. CCT 8/02, Constitutional Court of South Africa, 5 July 2002.

Morgan L 2001, 'Community participation in health: perpetual allure, persistent challenge', *Health Policy and Planning*, vol. 16, no. 3, pp. 221-30.

National Public Health Partnership 1998, 'Public Health in Australia', NPHP, viewed 12 November 2003, <<http://hna.ffh.vic.gov.au/nphp/publications/broch/contents.htm>>.

National Public Health Partnership 2003a, 'Memorandum of Understanding', NPHP, viewed 6 June 2005, <<http://www.dhs.vic.gov.au/nphp/about/mou.htm>>.

National Public Health Partnership 2003b, 'About the NPHP Advisory Group', NPHP, viewed 6 May 2003, <<http://www.nphp.gov.au>>.

National Public Health Partnership 2005, 'NPHP Non-Government Reference Panel', NPHP, viewed 6 June 2005, <<http://www.nphp.gov.au>>.

Oakley P, Bichmann W & Rifkin S 1999, 'CIH: developing a methodology', in eds H Kahssay & P Oakley, *Community involvement in health development: a review of the concept and practice*, WHO, Geneva.

Oakley P & Kahssay H 1999, 'Community involvement in health development: an overview', in eds H Kahssay & P Oakley, *Community involvement in health development: a review of the concept and practice*, WHO, Geneva.

Optional Protocol to the International Covenant on Civil and Political Rights, Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966, entry into force 23 March 1976, in accordance with Article 9.

Otto D 2002, 'Homelessness and Human Rights: Engaging Human Rights Discourse in the Australian Context', *Public Law and Legal Theory Research Paper No. 34*, (Social Science Research Network Electronic Library), viewed 27 May 2004, <http://ssrn.Committee/abstract_id364840>.

- Reynolds C 2004, *Public Health Law and Regulation*, The Federation Press, Sydney.
- Rifkin S 1996, 'Paradigms Lost: Toward a new understanding of community participation in health programmes', *Acta Tropica*, vol. 61, no. 79, pp. 79-92.
- Toebes B 1999, *The Right to Health as a Human Right in International Law*, Intersentia-Hart, Antwerp.
- United Nations Development Programme 1997, *UNDP Guidebook on Participation*, UNDP, New York.
- United Nations High Commissioner for Human Rights 1998, Benchmarks for the Realization of Economic, Social and Cultural Rights, unpublished report, Geneva, 25 March.
- United Nations High Commissioner for Human Rights 2002, 'The right of everyone to the enjoyment of the highest attainable standard of physical and mental health', Commission on Human Rights resolution 2002/31, UNHCHR, viewed 6 June 2005, <<http://www.unhchr.ch/Huridocda/Huridoca.nsf/0/5f07e25ce34edd01c1256ba60056deff?Opendocument>>.
- Universal Declaration on Human Rights*, Adopted 19 December 1948, General Assembly Resolution 217A (III), U.N. Doc. A/810.
- Walt G 1982, 'Primary health care approach: how did it evolve?', *Tropical Doctor*, vol. 12, p. 145.
- Werner D & Sanders D 1997, *Questioning the Solution: The Politics of Primary Health Care and Child Survival*, Health Wrights, Palo Alto, CA.
- World Health Organisation Act 1947* (Cth).
- World Health Organisation 1946, *Constitution*, WHO, Geneva.
- World Health Organisation 1978a, 'Primary Health Care', Report of the *International Conference on Primary Health Care*, Alma-Ata, USSR, 6-12 September, WHO, Geneva.
- World Health Organisation 1978b, *Declaration of Alma-Ata*, WHO, Geneva.
- World Health Organisation 1986, *Ottawa Charter for Health Promotion*, WHO, Geneva.
- World Health Organisation 1997, *The Jakarta Declaration on Leading Health Promotion into the 21st Century*, WHO, Geneva.
- World Health Organisation 2002, *25 Questions & Answers on Health and Human Rights*, Iss. 1, WHO, Geneva.