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The right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Note by the Secretary-General**

The Secretary-General has the honour to transmit to the members of the General Assembly the report of the Special Rapporteur of the Commission on Human Rights on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt, submitted in accordance with Commission resolution 2005/24.

* A/60/150.
** This report is submitted late in order to reflect as much updated information as possible.

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Summary

The right of everyone to the highest attainable standard of physical and mental health ("the right to health") requires access not only to timely and appropriate health care, but also to the underlying determinants of health, such as adequate sanitation, safe drinking water, food, nutrition and housing. The World Health Assembly recently established, for a three-year period, an important commission to study the social dimensions of health: the Commission on Social Determinants of Health. Section II of the present report notes the congruity between the Commission's mandate and the dimension of the right to health of the underlying determinants. The Special Rapporteur looks forward to interacting with the Commission and learning how it proposes to integrate the right to health into its work.

Health professionals have an indispensable role to play in the promotion and protection of human rights, including the right to health. Section III of the report considers the importance of health professionals' education in human rights and notes that inadequate attention is given to the right to health and other human rights in the curricula of medical and nursing schools around the world. In his country missions, the Special Rapporteur will continue to examine the degree to which health professionals receive human rights education, as well as the human rights support they are provided by States and national health professional associations.

The report's most substantive section is on the migration of health professionals, sometimes known as the "skills drain" or "brain drain". As the Special Rapporteur highlighted in his last report to the General Assembly (A/59/422), health is strikingly prominent in the Millennium Development Goals. If the international community is serious about achieving the Goals, it has to be serious about strengthening health systems, addressing the "precarious condition" of health professionals, and the skills drain. In today's world, there is a shocking inequality in levels of health care and protection. The skills drain has to be seen in the context of this alarming global health inequality.

The report sketches the scale of health professionals' migration from developing to developed countries, as well as the "push" and "pull" factors that contribute to the skills drain. Three clusters of human rights are especially relevant to the skills drain: freedom of movement; labour rights; and the right to health, which encompasses a right to an effective and inclusive health system of good quality. The report focuses on the right to health, including participation, international assistance and cooperation, and accountability. It particularly considers the right to health in relation to those countries from which health professionals migrate.

After reproducing some guiding principles, the section concludes by emphasizing that if human rights are integrated into national and international policies bearing upon the skills drain, this is likely to make the policies more effective, robust, equitable, inclusive and meaningful to those living in poverty. The conclusion briefly considers three possible policy responses to the skills drain: strengthening health systems in countries of origin; ethical recruitment by destination countries; and compensation or restitution. It suggests that developed countries establish independent national offices to monitor their international cooperation on health, including those polices relating to the skills drain.

Contents

I. Introduction

1. The Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health ("right to health") submitted his annual report (E/CN.4/2005/51 and Add.1-4) to the Commission on Human Rights at its sixty-first session, in accordance with the mandate set out in Commission resolution 2004/27. In its resolution 2005/24, the Commission welcomed the report and again requested the Special Rapporteur to submit annually a report to the Commission and an interim report to the General Assembly on the activities performed under his mandate. The present report is submitted in accordance with Commission resolution 2005/24.

2. Since he submitted his annual report to the Commission in February 2005, the Special Rapporteur has undertaken a country mission to Uganda (15-25 March), at the invitation of the Government and with the support of the World Health Organization (WHO), to address the issue of neglected diseases and the right to health. A report on his mission will be submitted to the Commission at its sixty-second session. The Special Rapporteur also has issued a number of urgent appeals and other communications to various Governments, as well as statements and press releases on issues ranging from the rights to sexual and reproductive health to the impact of trade agreements on access to medication. He will report on these communications in his forthcoming annual report to the Commission.

3. The Special Rapporteur also has participated in meetings including the annual meeting of special procedures organized by the Office of the United Nations High Commissioner for Human Rights; various consultations with WHO, including with WHO regional directors; a meeting in Berlin, sponsored by WHO and GTZ, on intensified control of tropical diseases; and a panel discussion on neglected diseases, which was held during the World Health Assembly. In February he attended a meeting in New York, organized by the Ethical Globalization Initiative, to discuss the role of pharmaceutical companies in relation to the right to health. In April the Special Rapporteur delivered a keynote address at a conference on "Lessons learned from human rights-based approaches to health", which was organized by the Institute of Human Rights of Emory University, Atlanta, United States of America, in collaboration with WHO, CARE USA, the Carter Center human rights office, the United States Centers for Disease Control and Prevention (CDC), and Doctors for Global Health. In July, the Special Rapporteur met with developing country delegates to the World Trade Organization and others to discuss issues related to General Agreement on Trade in Services (GATS) mode 4 and the migration of health professionals. He also chaired a meeting at the Human Rights Centre, University of Essex, United Kingdom, which was sponsored by the International Federation of Health and Human Rights Organizations, to discuss future strategies and priorities for the right to health mandate.

4. For ease of reference, all the Special Rapporteur's reports to the General Assembly and the Commission on Human Rights, in addition to his press statements and a collection of his speeches and interventions on the right to health, can be found on the website of the Human Rights Centre, University of Essex, http://www2.essex.ac.uk/human_rights_centre/rth.shtm. All United Nations documents related to the work of the Special Rapporteur, including press statements and reports to the General Assembly and the Commission on Human Rights, are

available on the website of the Office of the High Commissioner for Human Rights at http://www.ohchr.org/english/issues/health/right/.

II. Commission on Social Determinants of Health

5. In accordance with international human rights law, realizing the right to health requires access not only to timely and appropriate health care, but also to the crucial "underlying determinants" of health.[1] These include factors that influence health such as safe drinking water and food, adequate sanitation and housing, healthy work and environmental conditions, and so on. From the outset, the Special Rapporteur has addressed these issues throughout his mandate, including in the course of his country missions.[2]

6. Recognizing the vital importance of the underlying determinants of health, the World Health Assembly recently established, for a three-year period, an important commission composed of leading policymakers and practitioners, in order to study the social dimensions of health. The Commission on Social Determinants of Health seeks to translate public health knowledge into actionable global and national policy agendas, in order to improve health and access to health care. Information about the Commission can be found on the WHO website at www.who.int/social_determinants/en/. In brief, the Commission's work includes compiling and analysing scientific evidence on social mechanisms that shape health and health inequities, developing policy recommendations to strengthen health and advance health equity through action on social determinants, and advocating for implementation of recommendations in countries.

7. There is considerable congruity between the Commission's mandate and the "underlying determinants of health" dimension of the right to health, as well as other interconnected human rights such as adequate housing, food and water. In other words, national and international human rights law informs and reinforces the Commission's mandate. At a preliminary informal meeting with members of the Commission secretariat, the Special Rapporteur expressed his firm support for the Commission's important and far-reaching mandate. He looks forward to further interaction and to learning how the Commission proposes to integrate the right to health into its work. If the Commission wishes, the Special Rapporteur will be pleased to provide whatever support his very limited resources permit.

III. Health professionals and human rights education

8. The practice of health professionals has a significant bearing on the promotion and protection of human rights, in particular the right to health. As providers of health-care services, health professionals play an indispensable role in the realization of the right to health. They have also often played an important role in helping document and redress violations of human rights, such as violence and torture.

9. While the vast majority of health professionals have made valuable contributions towards human rights, some have, wittingly or unwittingly, been complicit in human rights violations. Political, legal, economic, social or cultural pressures that may conflict with human rights mean that they sometimes have to

make decisions in their daily practice which have profound human rights implications. Personal views of health professionals may also influence their practice: at times, their views may be inconsistent with the rights of patients. For example, in some countries, health professionals are subjected to institutional or societal pressures, or make decisions based on their own views and conscience, to deny treatment to marginalized groups, such as immigrants; disclose confidential medical records; or deny sexual and reproductive health information to women or adolescents. Health professionals have also, at times, been subject to pressures to participate in human rights violations including torture, forced sterilizations, and female genital cutting/mutilation. Decisions made by health professionals can mean the difference between the protection or violation of human rights.

10. In his preliminary report to the Commission on Human Rights, the Special Rapporteur indicated his intention to examine the roles and responsibilities of health professionals towards the right to health, as well as to the difficulties that they face in this regard (E/CN.4/2003/58, paras. 95-98). This chapter makes some introductory remarks about just one issue concerning health professionals, namely the importance of their education in human rights.

11. Inadequate compliance by health professionals with human rights standards is often the result of complex and interrelated circumstances, including political pressures and societal influences. However, it is often partly attributable to inadequate or non-existent training in human rights.[3] Human rights education is an essential starting point for equipping health professionals with the knowledge and tools to empower them to promote and protect human rights. As well as enabling them to defend the rights of their patients, human rights education also has an important role to play in assisting health professionals defend their own human rights.

12. The value of educating health professionals in human rights has been widely endorsed by States and the health and human rights communities worldwide. In the Vienna Declaration and Programme of Action, adopted in June 1993 by the World Conference on Human Rights, States recognized the importance of special education in human rights and humanitarian law for health professionals. The World Medical Association (WMA) strongly recommends that medical schools include medical ethics and human rights as an obligatory course in their curricula.[4] The International Council of Nurses, in its position on nurses and human rights adopted in 1998, advocates inclusion of human rights issues and the nurses' role in all levels of nursing education programmes.[5] The Committee on the Elimination of Discrimination against Women recommends that Governments "[e]nsure that the training curricula of health workers includes comprehensive, mandatory, gender-sensitive courses on women's health and human rights, in particular gender-based violence".[6]

13. Recent years have witnessed the development of many excellent human rights training manuals and courses for health professionals. These range from general ones to those addressing health-related human rights in specific circumstances where human rights are most at risk, such as in prisons and reproductive health-care services, or the health-related human rights of vulnerable groups, such as refugees.[7] Recent research by the British Medical Association and WMA also shows that there is demand among medical students worldwide to learn more about human rights and ethics during their education.[8] The Special Rapporteur is greatly encouraged by

these developments. However, he is also very concerned at the inadequate attention given to the right to health and other human rights in curricula of medical and nursing schools and textbooks around the world. Many health professionals simply do not receive education in human rights.

14. While the subject of human rights is regrettably normally absent from medical and nursing education, many medical and nursing schools and textbooks do integrate teaching on bioethics. Bioethics and human rights derive from similar core values. Bioethical frameworks provide valuable, and often human rights-compatible moral guidance to health professionals relating to their professional conduct. The importance of training in bioethics cannot be overemphasized. However, human rights education is also of importance if health professionals are to be fully equipped to defend human rights as an important component of their professional practice. Human rights are grounded firmly in international legal instruments and are subject to a number of monitoring mechanisms. They have a particular preoccupation with accountability and non-discrimination, as well as the protection of the most vulnerable members of society. Human rights therefore provide health professionals with extremely useful tools for promoting and protecting the rights and well-being of patients, as well as their own human rights.

15. To some extent, what health professionals need to know will depend on the country in which they work, as well as their professional specialization. At a minimum, all health professionals should receive education on the human rights of patients, including their right to health; the health-related human rights of vulnerable groups, such as women, children and people with disabilities; and their own human rights relating to their professional practice. Human rights education should also always include practical instruction in how to implement a human rights approach in clinical practice, including how to maintain respect for the inherent dignity of all patients, resist institutional or societal pressure to commit violations, identify violations, empower patients or colleagues to defend their human rights, and promote accountability in relation to known or suspected abuses, as well as minimizing risks of reprisals. More specialized human rights education should be provided to health professionals working in those situations most likely to generate human rights violations, or bring them into contact with evidence of abuses, including in forensic medicine, prisons, mental health services, family planning services, situations of armed conflict, or working with vulnerable communities.

16. Under international human rights law, States have the primary obligation to ensure the right to the enjoyment of the highest attainable standard of health. The Special Rapporteur therefore emphasizes the central importance of States building an environment that supports the adoption of rights-based approaches by the health professional community. It is particularly important that States do not place health professionals in a position where they may be called on to use their skills to further violations of human rights of the people they serve, and that States provide accountability mechanisms to redress or prevent human rights violations in the context of clinical practice. However, other actors also have an important role to play. Medical and nursing schools and other bodies training health professionals should integrate human rights education and training at all professional levels. Building on existing examples of good practice, national health professional associations should raise awareness about human rights and stimulate demand for human rights education among their members, and they should also assist health professionals involved in defending human rights through providing specialist

advice and institutional support. Although the focus of this particular chapter is the human rights education of health professionals, the Special Rapporteur notes in passing that law schools and other human rights training institutions should include the right to health and other health-related human rights in their curricula.

17. In his country missions, the Special Rapporteur seeks — and will continue to seek — information on whether health professionals receive human rights education, and how far States and national health professional associations support health professionals to promote and protect human rights.

IV. The skills drain: the migration of health professionals

18. The migration of health professionals, in particular doctors and nurses but also midwives, pharmacists, dentists, technicians and others, raises serious right to health issues.

19. The movement of health professionals is not in one direction, but many. Overall, however, net migration occurs away from rural to urban areas, from the public to the private sector, from poorer to wealthier developing countries, from fragile to more stable States, from developing to developed countries, and from developed countries with poorer health sector terms and conditions to developed countries with better health sector terms and conditions. This phenomenon is often referred to as the "skills drain" or the "brain drain".

20. This chapter focuses on the international dimension of the skills drain, in particular the migration of health professionals from developing to developed countries.[9] The Special Rapporteur recognizes, however, the interlinked crises in many countries of rural-urban, and public-private migration that deprive poor and rural populations of much needed health care.

21. While it is well known that the skills drain raises human rights issues such as the freedom of movement and labour rights of health workers, the impact of the skills drain on the enjoyment of the right to health in developing countries of origin is frequently neglected. This aspect of the skills drain is the primary focus of this chapter.

22. In today's world, there is a shocking inequality in levels of health care and protection. The skills drain — developed countries employing health professionals trained at the expense of, and desperately needed in, developing countries — deepens this global health inequality. Policies that are intended to tackle the skills drain must address, in a systematic and coordinated manner, global health inequality.[10]

A. Increasing recognition of the skills drain as a global problem

23. The need to address the skills drain is now widely recognized. In 2004 and 2005, for example, the World Health Assembly adopted resolutions recognizing that migration and recruitment of health personnel from developing to developed countries is a major challenge for health systems in developing countries.[11] Additionally, there is now an extensive and expanding literature on the causes and consequences of the skills drain in the health sector.[12]

24. Moreover, the skills drain is beginning to generate media interest and public concern. Prior to the Group of Eight (G-8) Summit in Gleneagles, Scotland, in July 2005, for example, London's *Financial Times* carried a large advertisement under the banner headline "How Long Will the Poorest Countries Train Health Workers for the Richest?".[13] At the Summit, leaders committed to invest in improved health systems in partnership with African Governments, including by helping Africa to train and retain health professionals.[14] Such commitments must be actioned, extended and monitored — an issue that is revisited in the conclusion to this chapter.

B. The Millennium Development Goals, health systems and health professionals

25. In his report to the General Assembly last year (A/59/422), the Special Rapporteur emphasized the prominence of health in the Millennium Development Goals. The report set out how the right to health reinforced the health-related Goals and could contribute to their achievement.

26. The right to health requires the development of effective, inclusive health systems of good quality — precisely what is needed for the achievement of the Goals. For its part, the United Nations Millennium Project consistently emphasizes the importance of building health systems that provide universal access to essential health services — consider, for example, *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals*, as well as the compelling Task Force report *Who's Got the Power? Transforming Health Systems for Women and Children*.

27. Critically, an effective health system depends upon health professionals. Yet human resources are in crisis in many health systems. In many countries, health workers are in "a precarious condition".[15] The HIV/AIDS epidemic increases the work burden, sickening and killing health workers, and stigmatizing those who care for patients. Many health-care systems have been neglected and suffer from more than two decades of underinvestment. The skills drain is hitting many developing countries hard, especially in sub-Saharan Africa.

28. For these and other reasons, there is "a massive global shortage of health workers", equivalent to about 4 million health professionals.[16] Experts estimate that if sub-Saharan countries are to come close to approaching the health-related Millennium Development Goals, they must triple their current health workforce by adding about 1 million health professionals.[17] In short, if the international community is serious about achieving the Goals, it has to be serious about health systems, health professionals, and the skills drain.

29. The dimension of the skills drain that is the focus of this report, namely the migration of health professionals from developing to developed countries, is both complex and varied. The phenomenon is experienced differently in different countries; also, it can be experienced differently within different parts of the same country. The Special Rapporteur recognizes that the migration of health professionals from developing to developed countries may have positive effects, not only for the migrants themselves but also for developing countries. If the migrants return, for example, the professional experience they have gained overseas can enhance their contribution to health systems in countries of origin. In some cases,

migrants' remittances make a major contribution to the economies of countries of origin although, significantly, that does not mean the funds are invested in those countries' health systems.

30. Numerous policy responses have been suggested, and sometimes implemented, in response to the negative impacts of the skills drain. The aim of this chapter is not to examine these policy options in detail, although some are briefly considered. Rather, the chapter's objective is more modest: to provide a brief introduction to the skills drain from the perspective of the right to health and to emphasize that the skills drain is a serious right to health issue, especially for those living in poverty in countries of origin.[18]

C. The problem

31. Health professionals tend to migrate from poorer to richer regions or countries. Source countries for international migration are mainly in Africa, the Caribbean, South-East Asia and South Asia, with their workers moving to destination countries including Australia, the United States, the United Kingdom, Canada, France and Belgium.[19]

32. The problem is most acute for source countries with low densities of health professionals, or understaffed health sectors, in particular countries in sub-Saharan Africa. In Malawi, only 1,842 of 6,620 established posts for nurses are filled.[20] Thirty-four, mainly sub-Saharan African countries have fewer than 10 doctors per 100,000 population.[21] This compares with much higher densities in high-income countries. OECD countries average around 222 doctors per 100,000 population.[22] Sub-Saharan Africa has a tenth of the nurses and doctors for its population that Europe has.[23]

33. There are also dramatic differences between rural and urban areas. In Ghana, for example, more than 85 per cent of general physicians work in urban regions, although 66 per cent of the population lives in rural areas. In Bangladesh, metropolitan centres have 15 per cent of the population, but 35 per cent of the doctors and 30 per cent of the nurses.[24]

34. Yet health professionals from developing countries, including sub-Saharan countries, are increasingly migrating to take up employment in developed countries. The South African Medical Association estimates that at least 5,000 South African doctors have moved abroad, mostly to the United States, Canada, the United Kingdom and Australia.[25] An estimated 30-50 per cent of health graduates leave South Africa for the United States and the United Kingdom each year. In 1999, Ghana lost more nurses than it trained. Between 1998/99 and 2001/02, in the United Kingdom there was a dramatic increase in registration of nurses from Zimbabwe (52 to 368) and from Malawi (1 to 75).[26] Other countries are also affected. For example, during the 1990s, two thirds of Jamaica's nurses left the country permanently.[27]

35. The loss of health professionals is particularly acute in the English-speaking world. In France (a country whose language is also widely used in medical education) only 5 per cent of practising doctors qualified overseas.[28] In Canada, the United States and Australia, over 20 per cent of doctors qualified overseas, while in the United Kingdom and New Zealand the figure is over 30 per cent.[29]

D. Reasons for the skills drain: "push" and "pull" factors

36. The complex and varied reasons causing the migration of health professionals are often framed as "push" and "pull" factors. Many of these factors are closely related to inequalities between, and within, countries.

37. Push factors often include terms and conditions at work, such as poor remuneration; inequitable salary structures; long working days; unsafe working environments; poor management of health personnel; and fragile health systems where health professionals often lack medicines, equipment and supplies that enable them to help their patients. In many countries, in particular in sub-Saharan Africa, HIV/AIDS is a particular burden on the workforce, increasing the number of patients, diminishing human resources where health personnel have died or become ill with the disease, and creating additional responsibilities for health professionals who have to care for family members. Shortages of health professionals exacerbate pressures on staff. A lack of training and career opportunities also leads to the migration of health workers. Many of these problems are experienced most severely in underresourced health systems.

38. Other push factors, largely external to the health system, include abuses of civil and political rights, lack of security, and poor educational provision and a low standard of living.

39. Pull factors include the inverse of many push factors — higher salaries; enhanced career or educational prospects; better working conditions and political and economic stability in countries of destination. Some health professionals who have migrated report that immigration restrictions make it difficult for them to circulate between their country of origin and destination. An important pull factor is demand in developed countries where there are inadequate numbers of health workers compared to health-care needs arising from poor retention rates, inadequate numbers of health professionals being trained and increasing health-care demands. It is estimated that by 2020, the United States will face a shortfall of 85,000 to 200,000 physicians, and may face a shortage of over 800,000 nurses.[30] And it is estimated that England will need 25,000 more doctors and 250,000 more nurses by 2008 than it did in 1997.[31]

40. Migration flows are also influenced by a host of other factors. International integration, and commercialization, of health services has created new opportunities for health workers to seek employment beyond their countries of origin and in the private sector.[32] Improved telecommunications have raised awareness among health professionals of opportunities overseas. Also significant are the activities of recruitment agencies, which recruit on a large scale (e.g. groups of 20, 50 or 100 nurses at a time) in developing countries, and often smooth the process of migration.[33] Loans, which ease the migration process, are also more widely available to migrants. The GATS may facilitate and lead to an increase in migration of health professionals in the future.[34]

E. The skills drain, human rights and the right to health

41. Broadly speaking, three clusters of human rights are especially relevant to the dimension of the skills drain that is the focus of this report, i.e. the migration of health professionals from developing to developed countries:

(a) The right of everyone to liberty of movement, as well as the freedom to leave any country including one's own;

(b) Labour rights — the rights to and in work;

(c) The right to the highest attainable standard of health, which encompasses a right to an effective and inclusive health system of good quality.

42. In the context of the present discussion, (a) and (b) are especially relevant to health professionals. Importantly, (c) is especially relevant to individuals and communities in countries of origin and destination.

43. There are some key features of the international code of human rights which are integral components of one or more of these clusters of rights: non-discrimination, participation, international assistance and cooperation, and accountability. Additionally, some other human rights are relevant to the skills drain, such as the rights to an adequate standard of living and to education.

44. For a number of reasons, not least the scope of the Special Rapporteur's mandate, the following discussion focuses on the right to the highest attainable standard of health (i.e. (c) above), while also encompassing the key generic human rights features of non-discrimination, participation, international assistance and cooperation, and accountability.[35]

45. As already signalled, the skills drain bears upon the right to the highest attainable standard of health in both countries of origin and destination. Here, however, the Special Rapporteur emphasizes the impact of the skills drain on the enjoyment of the right to health in developing countries of origin. In his experience, the voices of individuals and communities in these countries are least likely to be heard. It is their human rights that are most frequently overlooked. Thus, it is the right to health of individuals and communities in developing countries of origin to which he gives particular attention.

1. Freedom of movement

46. International human rights law recognizes the right of everyone to liberty of movement, as well as the freedom to leave any country, including his or her own.[36] In other words, health professionals have a right to leave their country, should they wish to do so. Many health professionals exercise this right with a view to living and working in an environment that enables them to enjoy their other economic, social, cultural, civil and political rights.

2. Labour rights

47. Poor terms and conditions of work are a primary cause of health professionals seeking to migrate. However, while migration often helps health professionals enhance their terms and conditions of work, as well as their enjoyment of other human rights, migration sometimes has negative implications for the labour rights of some migrants.

48. Recruitment agencies may exploit and reinforce unrealistic expectations among migrant health professionals about the extent and nature of working opportunities overseas.[37] Unscrupulous employers sometimes withhold or confiscate migrants' identity papers. There is evidence of discrimination against migrant health workers in relation to career opportunities.[38] Many migrant health professionals are

women who face discrimination based on their gender, as well as their national origin, race, ethnicity and migrant status.

49. Migrants' rights to, and in, work are firmly entrenched in numerous international labour conventions, the International Covenant on Economic, Social and Cultural Rights, the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families and other international instruments.

3. The right to health

50. An extensive and nuanced body of international and national law elaborates the scope of the right to health. In his various reports, the Special Rapporteur has begun to set out and examine this law and practice. He will not repeat this exercise here. Instead, for ease of reference, he provides a brief introduction to the right to health.

51. Adopted in 1946, the Constitution of the World Health Organization recognizes the fundamental human right to health. Two years later, the Universal Declaration of Human Rights laid the foundations for the international legal framework for the right to health. Since then, the right to health has been codified in numerous legally binding international and regional human rights treaties. The most extensive treaty elaboration of this right is in the Convention on the Rights of the Child, which has been ratified by all States, bar two. Further, these binding treaties are beginning to generate case law and other jurisprudence that sheds light on the content of the right to health. The right to health is also enshrined in numerous national constitutions: over 100 constitutional provisions include the right to health, the right to health care, or health-related rights such as the right to a healthy environment. Moreover, in some jurisdictions constitutional provisions on the right to health have generated significant jurisprudence, such as the South African Constitutional Court case *Minister of Health and Others v. Treatment Action Campaign and Others*.[39]

52. As already mentioned, the right to health includes the right to health care, but it goes beyond health care to encompass safe drinking water, adequate sanitation and access to health-related information, including on sexual and reproductive health. The right includes freedoms, such as the right to be free from involuntary sterilization, as well as to be free from discrimination in health programmes and services. It also includes entitlements, such as the right to a system of health protection. The right has numerous elements, including child health, maternal health and access to essential drugs. Like other human rights, it has a particular preoccupation with the disadvantaged, the vulnerable and those living in poverty. The right requires an effective, inclusive health system of good quality.

53. Although subject to progressive realization and resource availability, the right to health imposes some obligations of immediate effect, such as non-discrimination. It demands indicators and benchmarks to monitor the progressive realization of the right. The right to health also encompasses the active and informed participation of individuals and communities in health decision-making that affects them. Under international human rights law, developed States have some responsibilities towards the realization of the right to health in poor countries. Because the right to health gives rise to entitlements and obligations, it demands effective mechanisms of accountability.

54. It is self-evident that it is impossible to realize a vital dimension of the right to health — to establish an effective inclusive health system of good quality — without a minimum number of health professionals.

55. Some of the relevant facts and figures have already been mentioned and they will not be repeated. In parts of some countries, even the most rudimentary health system is barely functioning. Where they are functioning, some health systems are — in reality — inaccessible to millions of those living in poverty. Yet in some of these countries health professionals are being trained at considerable public expense, only to leave and work in countries that already enjoy among the finest health systems in the world. In other words, in some countries the skills drain is helping to turn a health crisis into a health catastrophe.

56. In his previous reports, the Special Rapporteur has been developing a common way of approaching elements of the right to health with a view to making them easier to understand. He has applied this common approach to sexual and reproductive health rights (see E/CN.4/2004/49) and to mental disability (see E/CN.4/2005/51). For example, one part of the common approach is to see the right to health as a bundle of health services, goods and facilities which must be available, accessible, acceptable and of good quality within a country. Applying this aspect of the common approach to the skills drain underlines that a State must ensure that an adequate number of health professionals are available in the country, accessible to all, including those living in poverty in the rural areas, and delivering health services of good quality in a culturally acceptable manner.

(a) Participation

57. Participation is an integral feature of the right to health. It extends to the active and informed participation of individuals and communities in decision-making that affects them, including decisions that relate to health, such as those that impact upon the skills drain. In other words, the right to health not only attaches importance to achieving health-related objectives, but also to the processes by which they are achieved.

58. In relation to policymaking which impacts upon the skills drain, efforts should be made to ensure the participation of all relevant stakeholders, including health professionals (e.g. those who have migrated, may migrate, and those that remain), as well as health system users in countries of origin. Such participation is likely to depend upon participants' representative organizations, such as health professional associations and patients' groups.

(b) International assistance and cooperation

59. In addition to obligations at the domestic level, States have a responsibility deriving from, inter alia, article 2, paragraph 1, of the International Covenant on Economic, Social and Cultural Rights and article 4 of the Convention on the Rights of the Child to take measures of international assistance and cooperation towards the realization of economic, social and cultural rights, including the right to health. This responsibility, which is particularly incumbent on developed States, also arises in the context of commitments made at recent world conferences, including the Millennium Summit, and to Millennium Development Goal 8 (see A/59/422).

60. Like other human rights and responsibilities, the parameters of international assistance and cooperation are not yet clearly drawn. However, as the next paragraphs illustrate, international assistance and cooperation is not simply a matter of developed countries making funds available to developing countries. In the context of the right to health and the skills drain, the human rights responsibility of international assistance and cooperation encompasses a number of dimensions, including the following.

61. First, developed countries should respect the right to health in developing countries. For example, developed countries should ensure that their human resource policies do not jeopardize the right to health in developing countries. If a developed country actively recruits health professionals from a developing country that is suffering from a shortage of health professionals in such a manner that the recruitment reduces the developing country's capacity to fulfil the right to health obligations that it owes its citizens, the developed country is prima facie in breach of its human rights responsibility of international assistance and cooperation in the context of the right to health. Some countries have developed policies that reflect this principle.[40]

62. Second, States should take all reasonable measures to prevent third parties from jeopardizing the enjoyment of the right to health in other countries, so far as they are able to influence such third parties by way of legal or political means.[41] For example, States should regulate private recruitment agencies that operate internationally with a view to ensuring that they do not recruit in a manner that reduces a developing country's capacity to fulfil the right to health obligations that it owes to those within its jurisdiction.

63. Third, States should ensure that the right to health is given due attention when drafting and implementing international agreements, for example, when negotiating their scheduled commitments under GATS mode 4 (which concern, inter alia, health professionals temporarily entering another country to provide a health service). In a previous report, the Special Rapporteur observes that if increased trade in services were to lead to substandard health facilities, goods and services, this would prima facie be inconsistent with the right to health (E/CN.4/2004/49/Add.1, para. 49). If a State chooses to engage in trade liberalization, including in relation to services, then it should select the form, pacing and sequencing of liberalization that is most conducive to the progressive realization of the right to health for all, including those living in poverty and other disadvantaged groups (ibid., paras. 30 and 46-56). The form, pacing and sequencing of liberalization should be selected on the basis of right to health impact assessments. In this way, a draft mode 4 commitment could be revised, if necessary, so as to ensure that it will not have a negative impact on the right to health of all. Consistent with their responsibility of international assistance and cooperation, developed States should not apply undue pressure on developing countries to make mode 4 commitments that are inconsistent with developing countries' obligations arising from the right to health.

64. Fourth, depending on resource availability, States should provide aid to developing countries so as to facilitate access to essential health facilities, goods and services, especially for those living in poverty and other disadvantaged groups. Aid policies should include support for human resources in the health sector.

65. However, the central point is that it is disingenuous for developed countries to provide overseas development assistance, debt relief and other forms of

international assistance and cooperation to developing countries, while simultaneously hiring health professionals who have been trained at the expense of, and are desperately needed in, the developing countries of origin. What is the point of giving with one hand and taking with the other?

(c) Accountability

66. International human rights empower individuals and communities by granting them entitlements and placing legal obligations on others. Critically, rights and obligations demand accountability: unless supported by a system of accountability they can become no more than window dressing. Accordingly, a human rights — or right to health — approach emphasizes obligations and requires that all duty holders be held to account for their conduct.

67. All too often, "accountability" is used to mean blame and punishment.[42] But this narrow understanding of the term is much too limited. A right to health accountability mechanism establishes which health policies and institutions are working and which are not, and why, with the objective of improving the realization of the right to health. Such an accountability device has to be effective, transparent and accessible.[43]

68. In the context of the skills drain, national and international accountability mechanisms are needed in relation to the discharge of the various human rights obligations of the various actors. For example, national mechanisms should monitor the human rights of health professionals in their countries of origin. In countries of destination, national mechanisms should monitor the human rights of health professionals, including migrants. Also, international accountability mechanisms, such as treaty bodies, should consider the human rights of health professionals in countries of origin and destination.

69. However, these national and international accountability mechanisms should not only encompass the human rights of health professionals, they should also consider the impact of the skills drain on relevant health systems. In other words, the mechanisms should consider the impact of the skills drain on the enjoyment of the right to health of individuals and communities in both countries of origin and destination. It is necessary to develop indicators and benchmarks to monitor the right to health dimensions of the skills drain, including the responsibilities of countries of origin and destination (see A/58/427 and A/59/422 for the Special Rapporteur's approach to this question).

70. Here, an important point demands emphasis. There is a long-standing perception among developing countries that accountability arrangements are imbalanced and mainly applicable to them, while developed countries escape accountability when failing to fulfil their international pledges and commitments that are of particular importance to developing countries.[44]

71. There is no doubt that national and international accountability mechanisms in relation to developed countries' responsibility of international assistance and cooperation remain weak. For example, there are few (if any) national or international mechanisms that give adequate attention to the impact of a developed country's policies on the skills drain and its effect upon the enjoyment of the right to health in countries of origin. This state of affairs is unacceptable because human

rights require effective, transparent and accessible accountability mechanisms in relation to the human rights responsibilities of all actors.

72. In the conclusion to this chapter the Special Rapporteur makes a modest proposal — a national office to monitor international cooperation in health — to address this lacuna in the promotion and protection of the right to health.

F. Some guiding principles

73. Physicians for Human Rights, a non-governmental organization, has recently published a White Paper on the skills drain, entitled *An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa*.[45] Most of the text is a detailed plan of action for addressing the African skills drain. This plan of action is guided by a set of principles that "reflect human rights law and pragmatic concerns".[46] While these guiding principles and a commentary upon them are lengthy, the authors provide a summary of the principles. This summary is reproduced in the next paragraph.

74. The guiding principles provide an interesting contribution to the discussion about the skills drain. In the opinion of the Special Rapporteur, although the principles are neither definitive nor comprehensive (for example, they would be strengthened by the inclusion of principles on monitoring and accountability, as well as the important role of community health workers), they merit careful attention.[47] The principles identified by Physicians for Human Rights are as follows:

- The primary response to the skills drain must be to redress second-class health systems that reflect widespread violations of the right to health and other rights.
- The response must include significantly increased funding to the health sector from domestic and international sources, including debt relief.
- The response to the skills drain must incorporate the broader effort of addressing the unequal distribution of health professionals within countries, including particularly severe shortages in rural areas.
- Low-income countries that are the source of health professionals who migrate to wealthy nations should be reimbursed by those nations.
- Solutions to the skills drain must be locally determined, with participation from representatives of poor and rural communities, health-care workers and civil society.
- Foreign assistance must be structured to promote and enable sound policies on human resources for health.
- The rights of health professionals and their desire to seek a better life must be respected given the constraints and demands of a global public health crisis.
- Countries must adhere to ethical recruitment principles, including not recruiting from developing countries absent an agreement with them.
- High-income countries must address their own inadequate production and retention of health professionals.

- Measures to promote macroeconomic policies must be consistent with human rights.
- Along with increasing retention of skilled health workers, more health professionals must be recruited and trained.
- Capacity-building for health sector human resource management must be a priority.
- Members of the health professional diaspora from developing countries can make an important contribution to health care in developing countries.

G. Conclusion

75. As already mentioned, there are numerous policy responses to the negative impacts of the skills drain, including strengthening health systems in countries of origin, and destination countries strengthening their own domestically trained human resource base. Unfortunately, lack of space does not permit the Special Rapporteur to examine them in detail in this chapter.

76. *Integrate human rights into all skills drain policies*. As the Special Rapporteur has consistently argued since his first report to the Commission on Human Rights, the right to health — and other human rights — should be integrated into all relevant national and international policymaking. Policies that are shaped by human rights are more likely to be effective, robust, equitable, inclusive and meaningful to those living in poverty. Accordingly, human rights should be integrated into all health sector policies, including those bearing upon the skills drain. Attention to the right to health of individuals and communities in developing countries, as well as the human rights of health professionals, will help to address the negative dimensions of the skills drain.

77. *Strengthen health systems in countries of origin*. Consistent with the right to health, one vital policy response to the skills drain is to strengthen health systems in developing countries of origin.[48] A higher priority should be given to human resources in the health sectors of countries of origin, including enhanced terms, conditions, professional development, planning, management and incentives to work in the rural areas. More health professionals are needed, requiring more training resources. Integrated district health systems must be strengthened, their infrastructure upgraded and the role of community health workers enlarged. Governance, including public participation, and effectiveness in the health sector demand serious attention. If the health systems of developing countries of origin are to be strengthened, donors and development partners have an indispensable role to play, as anticipated by numerous international commitments, including the human rights responsibility of international assistance and cooperation.

78. *Ethical recruitment by destination countries*.[49] Since 1999, the United Kingdom Department of Health has gradually strengthened a Code of Practice for the international recruitment of health-care professionals.[50] Ethical codes of practice have been promoted by several international and professional organizations.[51] So far as the Special Rapporteur is aware, the United Kingdom has gone further than any other developed country in its attempts to implement an ethical code. To the Government's credit, the Code recognizes, and attempts to address, the negative

impact of its active recruitment of professional staff trained and working in developing countries of origin.

79. Under the Code, the United Kingdom National Health Service may not actively recruit in developing countries unless there is a Government-to-Government agreement that allows targeted recruitment in that country. The Code affirms the employment rights, such as non-discrimination, of health workers from overseas. Compliance with the Code by employers of the National Health Service is not mandatory, but strongly recommended.

80. Although a welcome initiative, from the human rights perspective the Code is flawed. For example, it lacks an independent monitoring mechanism and fails to cover the private sector. Some commentators argue that the Code indirectly discriminates on the grounds of race because it mainly affects health professionals from Africa and the Caribbean.[52] Crucially, there is little evidence of the Code's sustained impact on the rate of recruitment of health professionals from countries with staff shortages.[53]

81. In the view of the Special Rapporteur, while rights-based ethical recruitment policies and codes have a role to play in relation to the skills drain, they do not provide an adequate response and must be supplemented by other measures, including those that strengthen health systems in developing countries of origin.

82. *Compensation*. The migration of health professionals from developing countries where there are staff shortages to developed countries imposes substantial economic and social costs on countries of origin, while saving developed countries' health services significant training costs. The economic name for this process is a "subsidy". The subsidy is perverse because it flows from poor to rich countries, worsening existing global inequalities in health care and protection. This process has been called, inter alia, a "perverse subsidy", an "unjust subsidy" and "reverse foreign aid".[54]

83. As well as being ethically indefensible, this flow of resources from poor to rich is inconsistent with developed countries' human rights responsibility of international assistance and cooperation, as well as other international commitments, including the Millennium Declaration and Goal 8 (a global partnership for development) (see paras. 59-65). There is a compelling case that this perverse subsidy should be redressed by the payment of compensation, restitution or reparation to those developing countries of origin where the skills drain reduces their capacity to fulfil the right to health obligations that they owe their citizens.

84. The call for compensation raises a number of objections and challenges that deserve careful attention. With genuine political commitment, however, they are unlikely to prove insurmountable. Compensation could be paid into a restitution fund that is properly managed and used for specific health purposes agreed by all the parties, such as support for health staff remaining in or returning to the country in question.

85. The Special Rapporteur strongly recommends that when the skills drain amounts to a perverse subsidy the policy response of compensation should be given serious and sympathetic consideration.

86. *A national office to monitor international cooperation on health*. Each developed country should establish an independent national office to monitor the

impact of the Government's policies on the enjoyment of the right to health in developing countries. Along the lines of an ombudsman, the office should report annually to the national legislature. It should have the power to make investigations, conduct inquiries and monitor the Government's international commitments and pledges on health matters. Responsibility for these international health commitments is often spread across various ministries — health, finance, foreign affairs, trade, international development and so on — thereby complicating both coordination and accountability.[55]

87. One of the health issues that the office should monitor is the skills drain. In many countries, there is a dearth of reliable data on the skills drain, so one of the office's tasks would be to ensure that the Government collects the necessary data. What is the extent of the skills drain in the country in question? Which national policies are impacting upon the skills drain? What is the impact of the skills drain, especially in the countries of origin? How might national policies be revised to make them consistent with the Government's human rights responsibilities, including international assistance and cooperation for health? An ombudsman-style office that asks these sorts of questions would complement and strengthen existing accountability mechanisms, such as parliamentary subcommittees.

88. The office might also serve as a watchdog for national codes of conduct on ethical recruitment, such as the one adopted by the United Kingdom National Health Service, as well as national implementation of comparable international codes, such as the Code of Practice for the International Recruitment of Health Workers adopted by the Commonwealth Secretariat in 2003.

89. *A multidimensional response*. Because of its complexity, the international migration of health professionals requires a multidimensional response, some elements of which are signalled in this chapter. The skills drain has to be understood, however, in the context of the alarming inequality in levels of health care and protection in the contemporary world.

V. Conclusion

90. **A recurrent theme throughout this report is the indispensable role of health professionals in the promotion and protection of human rights, including the right to health. Human rights education helps health professionals defend the rights of their patients, as well as their own human rights. The skills drain — developed countries employing health professionals trained at the expense of, and desperately needed in, developing countries — undermines the enjoyment of the right to health in the countries of origin and deepens global health inequality. If the Millennium Development Goals are to be achieved, and effective inclusive health systems of good quality are to be established, it is imperative that the situation of health professionals, including the skills drain, is given urgent attention.**

Notes

[1] For example, see article 12 (2) (b) of the International Covenant on Economic, Social and Cultural Rights and article 24 (2) (c) of the Convention on the Rights of the Child.

[2] See for example the reports of the Special Rapporteur on his missions to Peru (E/CN.4/2005/51/Add.3) and Romania (E/CN.4/2005/51/Add.4).

[3] See Commonwealth Medical Trust (Commat), *A Training Manual of Ethical and Human Rights Standards for Health Care Professionals*, 1999.

[4] Resolution on the Inclusion of Medical Ethics and Human Rights in the Curriculum of Medical Schools Worldwide, adopted by the 51st Annual General Assembly of the World Medical Association (October 1999).

[5] See http://www.icn.ch/pshumrights.htm.

[6] CEDAW, general recommendation 24 (1999) on women and health, para. 31 (f).

[7] See, for example, Commat, op. cit. at note 3; Johannes Wier Foundation, *Health and Human Rights: A Course for Doctors, Nurses, and Paramedics* (in Training), 1996; J. Asher, *The Right to Health: A Resource Manual for NGOs*, Commat/AAAS, 2004; Norwegian Medical Association, *Doctors working in Prisons: Human Rights and Ethical Dilemmas, A Course for Prison Doctors* (http://lupin-nma.net); Physicians for Human Rights-UK, *Medicine and Human Rights Study Module* (http://phruk.shared-inter.net/module/index.php). Note also the International Human Rights Academies, focusing on the right to health, organized by the International Federation of Health and Human Rights Organizations and others in 2004 and 2005, and the annual intensive course on health and human rights organized by the François-Xavier Bagnoud Centre for Health and Human Rights, Harvard University, and others.

[8] See British Medical Association (BMA), *The Medical Profession and Human Rights: Handbook for a Changing Agenda*, BMA/Zed Books, 2001, p. 490.

[9] In this report, the Special Rapporteur has made particular use of research carried out on the skills drain in certain countries and regions, notably sub-Saharan Africa, the United Kingdom and the United States. He emphasizes, however, that the skills drain is a global problem and not confined to these regions and countries of origin and destination.

[10] K. Mensah, M. Mackintosh and L. Henry, The "Skills Drain" of Health Professionals from the Developing World: A Framework for Policy Formulation, Medact, 2005, p. 5.

[11] Resolutions WHA57.19 and WHA58.17, International migration of health personnel: a challenge for health systems in developing countries.

[12] For example, see O. Adams and B. Stilwell, Health Professionals and Migration. *Bulletin of the World Health Organization*, vol. 8, August 2004, p. 560; L. Chen et al. Human Resources for Health: Overcoming the Crisis, *The Lancet*, vol. 364, 27 November 2004, pp. 1984-1990; EQUINET, Health Systems Trust and Medact, Health Personnel in Southern Africa: Confronting Maldistribution and Brain Drain, 2003; Joint Learning Initiative (JLI), Human Resources for Health: Overcoming the Crisis, 2004; Mensah, Mackintosh and Henry, op. cit. at note 10; Physicians for Human Rights (PHR), An Action Plan to Prevent Brain Drain: Building Equitable Health Systems in Africa, 2004; A. Willets and T. Martineau, Ethical International Recruitment of Health Professionals: Will Codes of Conduct Protect Developing Country Health Systems? 2004; J. Bueno de Mesquita and M. Gordon, The International Migration of Health Workers: A Human Rights Analysis, Medact, 2005; WHO, International Migration, Health and Human Rights, 2003.

[13] Sponsored by PHR. Also see "Medical staff quit for the West, leaving Africa's health service in crisis", The *Independent*, 27 May 2005.

[14] Group of eight (G-8) Summit, "Statement on Africa (Africa: A Historic Opportunity)", Gleneagles, Scotland, 8 July 2005.

[15] PHR, op. cit. at note 12, p. vii. A similar analysis is adopted by the Millennium Development Project Task Force on Child and Maternal Health in *Who's Got the Power?*, pp. 120-123.

[16] Chen et al., op. cit. at note 12, p. 1985.

[17] Ibid.

[18] For a more detailed human rights examination of the skills drain than is possible here, see in particular Bueno de Mesquita and Gordon, PHR and WHO, op. cit. at note 12.

[19] JLI, op. cit. at note 12.

[20] J.-M. Aitken and J. Kemp, HIV/AIDS, Equity and Health Sector Personnel in Southern Africa, EQUINET and Oxfam, 2003, p. 20.

[21] WHO Global Health Atlas, http://www.who.int/globalatlas/dataQuery/default.asp. Data from 2004.

[22] PHR, op. cit. at note 12.

[23] Chen et al., op. cit. at note 12.

[24] JLI, op. cit. at note 12.

[25] South Africa: Government wakes up to flight of health workers, IRIN, 14 May 2002.

[26] PHR, op. cit. at note 12.

[27] Bueno de Mesquita and Gordon, op. cit. at note 12.

[28] J. Eastwood et al., "Loss of health professionals from sub-Saharan Africa: the pivotal role of the UK", *The Lancet*, vol. 365, Issue 9474, 28 May 2005.

[29] JLI, op. cit. at note 12.

[30] See "Medical miscalculation creates doctor shortage", *USA Today*, 3 February 2005; United States Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Professions, National Center for Health Workforce Analysis, *Projected Supply, Demand, and Shortage of Registered Nurses: 2000-2020*, 2002.

[31] Addressing Africa's Health Workforce Crisis: An Avenue for Action, background paper presented at the second High-level Forum on the Health MDGs, Abuja, 2-3 December 2004.

[32] Mensah, Mackintosh and Henry, op. cit. at note 10.

[33] PHR, op. cit. at note 12.

[34] It should be noted that GATS mode 4 is intended to facilitate temporary migration. Eastwood et al., op. cit. at note 28.

[35] All of these key generic features are given separate consideration below except discrimination, which is integrated throughout the text.

[36] International Covenant on Civil and Political Rights, art. 12.

[37] "Abused, threatened and trapped: Britain's foreign 'slave nurses'", *The Guardian*, 29 May 2001; Foreign Doctors, BBC News Online, United Kingdom edition, 8 September 2004.

[38] K. Decker, Overseas Doctors: Past and Present, in *Racism in Medicine: An Agenda for Change*, N. Coker (ed.), King's Fund, 2001; D. Singh, "Racism rife in the medical professional, BMA report says", *British Medical Journal*, vol. 326, 28 June 2003, p. 1418.

[39] Constitutional Court of South Africa, Case CCT 8/02, decided 5 July 2002.

[40] See for example United Kingdom Department of Health, Code of Practice for the International Recruitment of Health Professionals, 2004; see paras. 78-80 below for a discussion of the Code.

[41] Committee on Economic, Social and Cultural Rights, general comment No. 14, para. 39.

[42] See L. P. Freedman, "Human rights, constructive accountability and maternal mortality in the Dominican Republic: a commentary", *International Journal of Gynaecology and Obstetrics*, vol. 82, 2003, pp. 111-114.

[43] The accountability device should clarify who has the responsibility to do what — and whether they have done it. If they have not done it, the device should explore why not, with a view to ensuring that it is properly done next time. For more on accountability, see A/59/422, para. 38.

[44] United Nations Development Programme, Bureau for Development Policy, *Is MDG 8 on track as a global deal for human development?* by J. Vandenmoortele, K. Malhotra and J. A. Lim, 2003.

[45] PHR, op. cit. at note 12.

[46] Ibid., p. 29.

[47] The Special Rapporteur has declined to revise the guidelines, save to change "brain drain" to "skills drain" and to extend the last guideline beyond Africa to all developing countries.

[48] *Who's Got the Power?*; PHR and Bueno de Mesquita and Gordon, op. cit. at note 12.

[49] Willets and Martineau, op. cit. at note 12; Mensah, Mackintosh and Henry, op. cit. at note 10; Bueno de Mesquita and Gordon, op. cit. at note 12.

[50] Department of Health, op. cit. at note 42.

[51] E.g. Commonwealth Secretariat, Commonwealth Code of Practice for International Recruitment of Health Professionals, 2002; World Organization of National Colleges, Academies and Academic Associations of General Practitioners/Family Physicians (WONCA), A Code of Practice for the International Recruitment of Health Care Professionals, 2002.

[52] Mensah, Mackintosh and Henry, op. cit. at note 10, p. 27.

[53] Ibid., p. 26; PHR, op. cit. at note 12, p. 57.

[54] Mensah, Mackintosh and Henry, ibid., pp. 30-40, Save the Children UK and Medact, *Whose Charity? Africa's Aid to the NHS*, Briefing Paper, 2005; PHR, ibid., p. 31. For discussions of the perverse subsidy see Mensah, Mackintosh and Henry; and also Bueno de Mesquita and Gordon, op. cit. at note 12, from both of which the Special Rapporteur has drawn extensively.

[55] G. Lister, A. Ingram, M. Prowle, "Country Case Study: UK Financing of International Cooperation for Health", United Nations Development Programme, Office of Development Studies, 30 September 2004.