



PAPER 05.6

POLICY PAPER

NON-COMMUNICABLE DISEASES AND THE
RIGHT TO HEALTH

I. Introduction

1. Accounting for almost 70% of global mortality in 2012 (38 million deaths),¹ four major non-communicable diseases (NCDs), namely cardiovascular diseases, diabetes, cancer and chronic respiratory disease, continue to be leading causes of preventable morbidity and associated disability.² According to the Global Status Report on Non-communicable Diseases, more than 40% of deaths due to NCDs were premature, occurring at below 70 years of age, and nearly three quarters of them occur in low and middle-income countries.
2. The increasing gravity of the situation has prompted international responses in a number of forums. In May 2000, the World Health Assembly endorsed the Global Strategy for the Prevention and Control of Noncommunicable Diseases.³ The Action Plan for the Global Strategy for the Prevention and Control of Non-communicable Diseases (2008–2013) and the Global Action Plan for the Prevention and Control of NCDs (2013–2020) were subsequently developed under the aegis of the World Health Organization (WHO).⁴ The WHO Framework Convention on Tobacco Control (WHO FCTC) entered into force in 2005 and is one of the most widely endorsed treaties in United Nations history. The WHO FCTC is an evidence-based treaty that reaffirms the right of all people to the highest attainable standard of health and it empowers Parties to accord priority to their duty to protect public health.
3. The work of the United Nations system in the area is now coordinated by the United Nations Inter-agency Task Force on Non-communicable Diseases, established in 2013.⁵ Although its terms of reference did not initially include mental health, a recent resolution of ECOSOC has formally expanded its mandate. The Task Force will now support Member States “in reflecting the new non-communicable disease-related targets included in the 2030 Agenda for Sustainable Development in their national development plans and policies, in order to enable them to accelerate progress on specific non-communicable disease-related targets”.⁶ Consequently, mental health has been firmly placed within the scope of the Task Force’s mandate.⁷
4. The United Nations General Assembly recognised the urgent need to tackle NCDs as a means of ensuring the full realisation of the right to health.⁸ Acknowledging the role of human rights in addressing NCDs, the WHO Global Action Plan for the Prevention and Control of Noncommunicable Diseases identifies human rights as one of its overarching principles. This paper examines how human rights are relevant to the NCD response; it outlines the human rights framework applicable to the prevention and treatment of NCDs and proposes several measures for inclusion in health policy. The primary addressees are the policy makers in the health and health-impacting sectors such as the finance, labour, education, water, food and

¹ WHO, Global Status Report on Non-communicable Diseases, 2014, p.xi.

² Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Treatment of NCDs (January 2012), para. 15.

³ The Global Strategy was mandated by Resolution WHA51.18 on Noncommunicable disease prevention and control.

⁴ In addition to other mandates given by the World Health Assembly, action at the international level to address NCDs includes the Global Strategy on Diet, Physical Activity and Health (2004) and the Global Strategy to Reduce the Harmful Use of Alcohol (2010).

⁵ See Economic and Social Council resolution 2013/12.

⁶ Economic and Social Council, United Nations Inter-Agency Task Force on the Prevention and Control of Non-communicable Diseases, E/RES/2016/5 (May 2016), para. 3.

⁷ Given the particular human rights dimensions of mental health promotion, which merit separate and detailed attention, this policy paper focuses on the four major NCDs falling within the terms of the Task Force’s initial mandate.

⁸ Political Declaration on the Prevention and Treatment of NCDs (January 2012), para. 6.

social security sectors but there is an important role for the United Nations agencies, intergovernmental organizations, civil society organisations and other stakeholders who play a part in policy development, implementation, review and monitoring.

II. The human rights framework applicable to NCDs

5. The right of everyone to the highest attainable standard of physical and mental health is recognised by numerous human rights instruments,⁹ including the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights¹⁰ and the Convention on the Rights of the Child.¹¹ It is also acknowledged by the Constitution of the World Health Organization¹² and the WHO FCTC.¹³
6. A human rights framework for realising the right to health calls for national governments to ensure that health facilities, goods and services are available in sufficient quantity, and are physically accessible and affordable on the basis of non-discrimination. Health facilities, goods and services must to be gender-sensitive and culturally appropriate, scientifically and medically appropriate, of good quality, and respectful of medical ethics.
7. A human rights-based approach requires that health authorities and other duty bearers be held accountable for meeting human rights obligations in public health, including through the possibility of seeking effective remedies via complaints mechanisms or other avenues for redress. It calls for attention to the many factors which affect the enjoyment of the right to health – the underlying determinants of health - such as exposure to risk factors for NCDs, poverty, early childhood health and development and healthy occupational and environmental conditions.¹⁴
8. While the right to health may be realised progressively, States are still required to ensure the satisfaction of the minimum essential levels of the right to health. These “core obligations” include, for the right to health: (a) ensuring the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups; (b) ensuring access to adequate food and nutrition; (c) ensuring access to basic shelter, housing and sanitation; providing access to essential drugs; (d) ensuring an equitable distribution of all health facilities, goods and services; and (d) adopting and implementing a national public health strategy and plan of action which address the health concerns of the whole population.¹⁵ Among obligations of comparable import are the obligations to ensure child health care, to provide education and access to health information and to provide appropriate training for health personnel, including education on health and human rights.¹⁶
9. The normative framework has benefited from the authoritative interpretations of experts in the field, most notably the human rights treaty bodies charged with monitoring implementation and the Special Procedures of the United Nations Human Rights Council (such as the Special

⁹ See articles 10(h), 11(f), 11(2), 12 and 14(2) (b) of the Convention on the Elimination of All Forms of Discrimination against Women, article 28 of the International Convention on the Protection of Migrant Workers and their Families, article 5(e) (iv) of the Convention on the Elimination of All forms of Racial Discrimination and article 25 of the Convention on the Rights of Persons with Disabilities.

¹⁰ Article 12.

¹¹ Article 24.

¹² Preamble, para. 2.

¹³ Preamble, para. 19.

¹⁴ See Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14, para. 11.

¹⁵ See CESCR, general comment No. 14, para. 43.

¹⁶ Ibid., para. 44.

Rapporteur on the right to health).¹⁷ These experts work to ensure that the right to health is given meaning and that its interpretation continues to reflect the reality of new health challenges in all their human rights dimensions as they arise.

10. Finally, the political commitments in the 2030 Agenda for Sustainable Development have complemented the framework. Goal 3 aims to “ensure healthy lives and promote well-being for all at all ages”, and sets out several objectives relevant to the response to NCDs. Target 3.4 addresses the reduction of premature mortality from non-communicable diseases as well as the promotion of mental health and well-being. The prevention and treatment of substance abuse, including narcotic drug abuse and the harmful use of alcohol, fall under target 3.5, while target 3.a aims to strengthen the implementation of the WHO FCTC in all countries. Target 3.b covers, among other objectives, support for research into, and the development of vaccines and medicines for, the communicable and non-communicable diseases that primarily affect developing countries.

III. Why human rights are crucial to the NCD response

11. Numerous programmes and plans of actions have been developed at global, national and regional level to tackle NCDs, and there is a significant, evidence-based body of standard-setting work on health. Why, then, should human rights be an integral part of the response to NCDs?

A. A legal standard

12. Member States of the United Nations affirmed their “faith in fundamental human rights, in the dignity and worth of the human person” and “in the equal rights of men and women” in the Charter of the United Nations. The normative content of these fundamental rights has been elaborated on in the treaties mentioned above, among many others, and their universality consistently affirmed. They are, therefore, binding standards rather than mere policy options, and governments and other duty bearers are under a legal duty to respect, protect and fulfil the rights to which they refer.
13. All human rights are interdependent and interrelated. The right to health, particularly, is dependent on the rights to food, housing, work, education, human dignity, life, non-discrimination, participation, equality, access to information and other rights, all of which “address integral components of the right to health”.¹⁸ As such, health policy which focuses on bio-medical interventions to the exclusion of the human rights context in which they are delivered, cannot register its best impact.

B. Special protection for vulnerable and marginalised groups

14. Human rights are especially concerned with people in situations of vulnerability and marginalisation, such as those who are most likely to be affected by NCDs - and least likely to benefit from measures to address them. With its emphasis on universal and equal access to quality health care, goods and facilities and the protection of groups in these situations, a human rights-based approach is essential for expanding access to preventative, curative and palliative care for those living with or at risk of developing an NCD. It is axiomatic that

¹⁷ Examples include the General comments of the Committee on Economic, Social and Cultural Rights, which monitors the implementation of the International Covenant on Economic, Social and Cultural Rights and those of the Committee on the Rights of the Child, interpreting the provisions of the Convention on the Rights of the Child.

¹⁸ See CESCR, General comment No. 14, para. 3.

extending good quality health care, goods and services to marginalised and vulnerable populations, and to those who cannot afford them, will improve coverage and, together with other measures, health outcomes.

C. Underlying determinants of health

15. The right to health requires that attention be paid by policy makers to the underlying determinants of health which may, for instance, be socio-economic, environmental or structural. NCDs are uniquely linked to four major risk factors - unhealthy lifestyle, physical inactivity, the use of tobacco and the harmful use of alcohol. These risk factors derive mainly from social and economic determinants, such as access to education (particularly health-related education), adequate housing and nutrition, inequality and discrimination, harmful societal norms, and poverty.
16. In the case of women, for instance, societal norms and practices that consign them to lower positions in the family, in broader society and in the work place often operate to restrict access to good quality health care by limiting the financial means at their disposal and denying them agency and autonomy over their own health.¹⁹ Women also tend to “disproportionately lack access to adequate food and are more vulnerable to malnutrition” although they are largely responsible for food cultivation and meal preparation in the home.²⁰
17. For children, the mother’s right to health and the health and health-related behaviours of parents and other significant adults are key determinants of their health, nutrition and development. A human rights-based approach requires the systematic identification of the protective factors that underlie the life, survival, growth and development of the child identified in order to design and implement appropriate policies.²¹
18. The over-representation of NCDs in middle and low-income countries and among socially and economically disadvantaged populations points to a clear association between the legal and policy choices made by governments and the burden of NCDs. As such, to the extent that public health policy fails to incorporate a focus on the underlying determinants of health, sustained improvement in health outcomes will remain unattainable.

D. Participation

19. One key pillar of a human rights-based approach to health is the meaningful participation of affected communities in the development, implementation and monitoring of policy. Participation facilitates public health responses that are relevant to the context and ensures that interventions reach the most affected communities.²² This involves effective community action in setting priorities, making decisions, planning and implementing and evaluating strategies to achieve better health.²³ This is particularly the case for civil and political rights and NCDs, where the participation of civil society in decisions around health policy is essential.

¹⁹ Jyoti Sanghera *et al*, “Human rights in the new Global Strategy”, *BMJ* (September 2015).pp.42-45, p.42.

²⁰ Interim report of the Special Rapporteur on the right to food, A/71/282 (August 2016), para. 20.

²¹ Committee on the Rights of the Child (CRC), General comment No. 15, paras. 16 and 18.

²² UNAIDS. “Ensuring Non-discrimination on Responses to HIV”, 2010, paras. 18-22.

²³ CESCR, General comment No. 14, para. 54.

E. The imperative of the SDGs

20. The number of NCD-related deaths has risen steadily in every region over the last few years.²⁴ It is estimated that, during 2011–2025, cumulative economic losses attributable to NCDs in low and middle-income countries, if current trends continue, will total US\$ 7 trillion. As the participation of the working age population in the economy declines, compromising income and standard of living as well as access to health care, services and education, NCDs remain a threat to individuals, families and communities. The 2030 Agenda for Sustainable Development commits to leaving no one behind and to reaching first those who are furthest behind – a clear expression of the human rights principles of equality and non-discrimination. Meeting the NCD-related goals will depend on the successful implementation of policies which include the many millions who experience exclusion and discrimination, address the underlying determinants of health and, ultimately, lead to the realisation of the right to health.

IV. Human rights in health policy

21. The existing consensus on human rights standards and on the need for effective measures to control the epidemic of NCDs offers an opportunity to develop common guidelines on important interventions. Many elements in the global health responses to NCDs already resonate with human rights standards applicable to health: the multiple calls for effective cross-sectoral coordination and the engagement of all sectors of society²⁵ recall the need to pay attention to the underlying determinants of health and to ensure the participation of stakeholders; health sector reform underpins the delivery of quality health care; and universal health coverage (despite divergent views as to its meaning) evokes the principle that health care should be available and accessible to all on an equal footing.
22. Even as these areas of consensus are acknowledged, however, the response to NCD prevention and treatment must remain firmly anchored in the human rights framework if it is to be effective. As emphasised by the Special Rapporteur on extreme poverty and human rights, “[h]uman rights provides a context and a detailed and balanced framework; it invokes the specific legal obligations that States have agreed upon in the various human rights treaties; it emphasizes that certain values are non-negotiable; it brings a degree of normative certainty; and it brings into the discussion the carefully negotiated elaborations of the meaning of specific rights that have emerged from decades of reflection, discussion and adjudication”.²⁶ The Special Rapporteur noted in the same report that “[e]ven more importantly, the language of rights recognizes the dignity and agency of all individuals (regardless of race, gender, social status, age, disability or any other distinguishing factor) and it is intentionally empowering”.²⁷ This is particularly true for the right to health.
23. This section proposes several measures, identified by the human rights treaty monitoring bodies as part of a human rights-based approach to health, for integration into planning and programming to address NCDs. The list of proposed measures is not intended to be exhaustive

²⁴ WHO, Global Status Report on Non-communicable Diseases, 2014, p.9.

²⁵ Multi-sectoral action is an overarching principle of the Global Action for the Prevention and Control of NCDs (2013-2020). Resolution WHA53.17 on Prevention and control of noncommunicable diseases (May 2000), para. (1)(2)(c). In the Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Treatment of NCDs (January 2012), the United Nations General Assembly recognises “...need for the efforts and engagement of all sectors of society to generate effective responses for the prevention and control of non-communicable diseases” (para. 3).

²⁶ Report of the Special Rapporteur on extreme poverty and human rights, A/70/274, August 2015, para. 65.

²⁷ See note 26 above.

- nor can it be - and the intention is to demonstrate how human rights principles could be operationalised in the context of NCDs.

A. Data collection

24. The collection of comprehensive, disaggregated data is part of a human rights-based approach to health.²⁸ Data should be disaggregated by age, gender, geographic region, education, wealth quintile and other distinctions as locally relevant.²⁹ Besides providing information on prevalence and incidence, disaggregated data will assist in identifying disparities in and barriers to access to health care, patterns of discrimination, the availability of relevant services and under-served areas, priority health problems, exposure to risk factors, underlying determinants and vulnerable populations or groups.

25. Measures could include:

- (a) the allocation of adequate resources for the expansion and institutionalisation of data collection capacity;
- (b) the analysis, dissemination and use of disaggregated data for policy formulation, impact evaluation, programming and information sharing on cost-saving strategies;
- (c) the inclusion of data collection on NCDs as part of the population census; and
- (d) the use of disaggregated data to identify accountability gaps and to monitor and review health system performance, including the extent to which health systems are successfully implementing health-related human rights norms and standards in the prevention and treatment of NCDs.

B. Prevention

26. Exposure to the risk factors for NCDs has a strong influence on the likelihood of developing an NCD. In addition to poverty, discrimination, access to education and adequate housing, food and nutrition, other determinants of health in the context of NCDs include early childhood development and health in adolescence. Given that NCDs are largely preventable, policy measures should be aimed at addressing both the determinants applicable to and known risk factors for NCDs, including tobacco use, the harmful use of alcohol, physical inactivity and unhealthy diets. As all health-impacting sectors, such as trade, agriculture, food production, education, housing and taxation are implicated, coordinated action is essential.³⁰

²⁸ CESCR General comment No. 14, paras. 16, 20 and 57.

²⁹ See also CESCR General comment No. 14, para. 20.

³⁰ The Global Action Plan states: "It should be recognized that effective noncommunicable disease prevention and control require leadership, coordinated multistakeholder engagement for health both at government level and at the level of a wide range of actors, with such engagement and action including, as appropriate, health-in-all policies and whole-of-government approaches across sectors such as health, agriculture, communication, education, employment, energy, environment, finance, food, foreign affairs, housing, justice and security, legislature, social welfare, social and economic development, sports, tax and revenue, trade and industry, transport, urban planning and youth affairs and partnership with relevant civil society and private sector entities." (p.12).

27. In addition to measures proposed in section C, interventions could include:

- (a) an in-depth assessment, at the national and sub-national levels, of the structural, social and other determinants of health (such as administrative, policy and legislative barriers to accessing treatment and care), including their differential effect on various population groups; and
- (b) an in-depth assessment of the presence of risk factors for NCDs, including overweight and obesity, tobacco use, alcohol abuse, physical inactivity and unhealthy diets across population groups.

C. Law and policy framework

28. Laws and policies determine, to a great extent, the realisation of health and health-related rights, and a detailed assessment of the legal and policy framework to establish the extent to which it complies with human rights standards is a crucial first step. Measures to ensure an enabling legal and policy environment should have as a primary objective the repeal, rescission or amendment of laws and policies that restrict the realisation of these rights, and the enactment of positive laws and policies to support them.³¹ The following measures, which should be taken by health and other relevant sectors in a coordinated manner, are proposed in a number of key areas for NCDs:

i Risk factors

- (a) developing or strengthening comprehensive national and subnational strategies, plans of action and activities to reduce the harmful use of alcohol, such as pricing policies, the prohibition or comprehensive restriction of alcohol advertising, particularly with regard to children and adolescents, and restrictions on the availability of alcoholic beverages;³²
- (b) adopting and implementing effective legislative, policy and other measures for preventing and reducing tobacco demand, supply and consumption, nicotine addiction and exposure to tobacco smoke, including through regulation of private sector activity in the area of marketing, particularly with regard to children and adolescents;³³
- (c) promoting physical activity as a part of daily life through: programmes to create safe infrastructure conducive to walking and cycling; appropriate road safety legislation and enforcement; giving priority to regular physical education classes in schools; urban planning and re-engineering for active transport; the provision of incentives for work-site healthy-lifestyle programmes; and ensuring the availability of safe environments in public parks and recreational spaces;³⁴
- (d) promoting healthy diets through food and nutrition policies which support healthy eating in line with evidence-based dietary recommendations and which address obesity and all forms of malnutrition;

³¹ See Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality (A/HRC/21/22), para. 30.

³² See Global strategy to reduce the harmful use of alcohol (2010), para. 19(a).

³³ See article 5, WHO Framework Convention on Tobacco Control.

³⁴ Global Action Plan, pp. 59 and 96 (para (d)).

- (e) laws, policies and programmes to support and promote early childhood development, in accordance with the right of the child to survival and development,³⁵ including through measures to ensure maternal, newborn and child health and to ensure safe households and other nurturing environments for children and adolescents;
- (f) ensuring an enabling environment to encourage appropriate health-seeking behaviour by parents and children, of which access to appropriate information on health issues is an important element;³⁶
- (g) mandating health education and information relevant to the prevention and treatment of NCDs, including on the health rights of users, as a priority for the health work force and the general population.

ii. Private sector regulation

- (a) the enactment and enforcement of laws aimed at requiring business enterprises, including those involved in the production, marketing and sale of tobacco, alcohol, food and beverages, to respect human rights, and the periodic assessment of such laws with a view to addressing any gaps;³⁷
- (b) ensuring that governmental departments, agencies and other State institutions that shape and regulate business practices are aware of and observe the State's human rights obligations when fulfilling their respective mandates, including by providing them with relevant information, training and support;³⁸
- (c) adopting and implementing effective legislative, executive, administrative and/or other measures, and cooperating with other States in developing appropriate policies for preventing and reducing tobacco consumption, nicotine addiction and exposure to tobacco smoke;³⁹
- (d) the regulation of commercial and private sector activity in line with the measures outlined in section C (i) and particularly with a view to reducing the harmful use of alcohol, preventing and reducing the use of tobacco and promoting healthy diets and lifestyles.

iii. Equality and non-discrimination

- (a) the formulation and implementation, with stakeholder participation at all appropriate levels, of a national strategy to promote equality and non-discrimination, underpinned by an adequately funded plan of action;
- (b) information and public education measures to combat discrimination and to raise awareness, among the general population and among health personnel, of the societal and other norms that encourage it, and its effect on health rights; and

³⁵ Article 6(2), Convention on the Rights of the Child.

³⁶ CRC, General comment No. No. 15 (2013), paras.15 and 30.

³⁷ See Report of the Special Representative of the Secretary-General on the issue of human rights and transnational corporations and other business enterprises, Guiding Principles on Business and Human Rights: Implementing the United Nations "Protect, Respect and Remedy" Framework (A/HRC/17/38), para. 3(a).

³⁸ Ibid, para. 8.

³⁹ See article 5 (a), WHO FCTC.

- (c) prohibiting discrimination in access to health care and services and providing for public education and information programmes aimed at combating discrimination both in health care settings and in broader society.

iv. Participation

- (a) building the capacity of rights holders to participate and to claim their rights, through education and awareness-raising, and ensuring that transparent and accessible mechanisms for engaging stakeholder participation and facilitating regular communication between rights-holders and health service providers are established and/or strengthened at community, subnational and national levels.
- (b) ensuring stakeholder participation in priority-setting, policy and programme design, implementation, monitoring and evaluation, and in accountability mechanisms by:
 - (i) establishing and/or strengthening transparent participation, social dialogue or multi-stakeholder mechanisms at community, subnational and national levels; and
 - (ii) ensuring that participation outcomes inform subnational, national and global policies and programmes to respond to NCDs.⁴⁰

D. Planning and budgeting

29. Although, in recognition of resource constraints, the right to health is subject to progressive realisation, States are, nevertheless, required to deploy the maximum resources available for its full realisation.⁴¹ This implies the proportionate and rational allocation of resources for the NCD response, which includes the deployment of sufficient resources to health supporting sectors such as education, food, social protection, water and sanitation and housing.

30. Measures could include:

- (a) an assessment of the human rights measures required as part of the NCD response in the health and health-supporting sectors, using disaggregated data to identify priorities;
- (b) the development of comprehensive and time-bound plans of action providing for explicit action to ensure that these measures are implemented;
- (c) the identification, through the sharing of good practices and the provision of technical support, of cost-efficient interventions for the prevention and treatment of NCDs, adapted to the national context;
- (d) the establishment of participatory budget formulation and review processes involving the representation of all stakeholders; and
- (e) the allocation of resources adequate to implement the action recommended in (a) to (d).

⁴⁰ See Technical Guidance on the application of a human rights based approach to the implementation of policies and programmes to reduce and eliminate preventable mortality and morbidity of children under 5 years of age (A/HRC/27/31), paras. 28 and 29. See also Jyoti Sanghera *et al*, "Human rights in the new Global Strategy", *BMJ* (September 2015), p43.

⁴¹ See article 2(1), ICESCR.

E. Availability, accessibility, acceptability and quality of health care

31. The International Labour Organisation (ILO) estimates that in excess of 90 per cent of the population living in low-income countries has no legal right to health coverage and that, globally, about 39 per cent of the population lacks coverage.⁴² Even where legal entitlements to health coverage are provided for, these are often inadequate or not implemented, with the result that they fail to meet the requirements of availability and affordability. Large parts of the population – particularly in rural areas – are also excluded from access to health services due, for instance, to insufficient numbers of skilled health workers and to poor infrastructure, limited benefit packages and high co-payments.⁴³
32. From a human rights perspective, States (as principal duty bearers) are under an obligation to ensure the creation of conditions which would assure to every person all appropriate medical service and medical attention in the event of need.⁴⁴ Thus, measures should be taken to expand coverage for good quality preventative, curative and rehabilitative health services for NCDs and to ensure access to acceptable health services, goods and facilities, for every person on an equal footing.⁴⁵
33. Measures aimed at broadening health coverage for NCDs could include:
 - (a) the identification of gaps in health coverage and access, including the identification of populations in situations where health care costs are likely to expose them to financial hardship;
 - (b) integrating health coverage for all into the legislative and policy framework in order to ensure the formal recognition and protection of the right to health, and incorporating the following components:⁴⁶
 - (i) The cost of the service should be met collectively by regular periodical payments which may take the form of social insurance contributions or of taxes, or of both.
 - (ii) Health care services should cover all members of the community, whether or not they are gainfully occupied.
 - (iii) Complete preventive and curative care should be constantly available, rationally organised, provided by sufficient numbers of skilled health workers, and, so far as possible, coordinated with general health services.
 - (iv) Complete preventive and curative care should be available at any time and place to all members of the community covered by the service, on the same conditions, without any hindrance or barrier of an administrative, financial or political nature, or otherwise unrelated to their health.

⁴² World Social Protection Report 2014-2015, ILO, p. 99.

⁴³ Scheil-Adlung, X., Global evidence on inequities in rural health protection – New data on rural deficits in health coverage for 174 countries, ILO, Geneva, 2015.

⁴⁴ Article 12.2(d), ICESCR.

⁴⁵ The Global Action Plan states that “[a]ll people should have access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative and rehabilitative basic health services and essential, safe, affordable, effective and quality medicines. At the same time it must be ensured that the use of these services does not expose the users to financial hardship, with a special emphasis on the poor and populations living in vulnerable situations”.

⁴⁶ ILO Medical Care Recommendation, 1944 (No. 69), paras. 4, 8, 19 and 20.

- (v) The expeditious establishment or strengthening of social protection floors comprising basic social security guarantees. The guarantees should ensure at a minimum that, over the life cycle, all in need have access to essential health care and to basic income security which together secure effective access to goods and services defined as necessary at the national level.⁴⁷ The social protection floors should include access to a nationally defined set of goods and services appropriate for NCDs, constituting essential health care, including maternity care, that meets the criteria of availability, accessibility, acceptability and quality.⁴⁸

F. Accountability

- 34. Accountability is a complex, multi-dimensional concept, and this holds true in health care. It entails the procedures and processes by which one party justifies and takes responsibility for its activities.⁴⁹ It has three essential components, namely: (a) the different parties that can either be held accountable or hold others accountable; (b) the domains of accountability (such as professional competence and adequacy of access to comprehensive, good quality health services); and (c) the procedures for ensuring accountability (such as formal and informal procedures for evaluating compliance within domains and for disseminating the evaluation and responses by the accountable parties).
- 35. A human rights-based approach integrates all the key domains involved in the response to NCDs and calls for promoting the accountability of multiple actors at various levels, within and beyond the health sector, including, professional, health system, institutional, private actor and donor accountability.⁵⁰ It requires many forms of review and oversight, such as administrative, social, political, legal and international accountability.⁵¹
- 36. Interventions in this area could include:
 - (a) regular reviews, conducted in a fully participatory and inclusive manner, of whether, and the extent to which, health systems are delivering services consistent with human rights norms;
 - (b) the establishment and/or strengthening of transparent, inclusive and participatory processes and mechanisms, with jurisdiction to recommend remedial action, for accountability, particularly at the national level, both within the health and the justice systems;⁵²
 - (c) ensuring that redress for violations of the right to health and health-related rights, including compensation, where appropriate, is, in fact, available, including through

⁴⁷ ILO Social Protection Floors Recommendation, 2012 (No. 202), para. 4.

⁴⁸ ILO Social Protection Floors Recommendation, 2012 (No. 202), para. 5.

⁴⁹ Ezekiel J. Emanuel, MD, PhD; and Linda L. Emanuel, MD, PhD, *Annals of Internal Medicine*, Vol. 124, No. 2, 15 January 1996, p. 229.

⁵⁰ Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality (A/HRC/21/22), para. 75.

⁵¹ Technical guidance on the application of a human rights-based approach to the implementation of policies and programmes to reduce preventable maternal morbidity and mortality, (A/HRC/21/22), para. 74.

⁵² See Commission on Information and Accountability, *Keeping Promises, Measuring Results*, 2012, recommendation 7.

legislative measures to address criminal and civil liability, and to ensure effective access to justice.⁵³

V. Conclusion

37. This policy paper urges a stronger effort to integrate human rights into health as an essential element of the response to NCDs, with national governments maintaining their primary role and responsibility. The role of United Nations agencies and other actors could be to support the implementation of the measures called for in the context of mandates arising from the 2030 Agenda for Sustainable Development, the Global Action Plan for the Prevention and Control of NCDs and the WHO FCTC, among others.
38. The incorporation of a human rights-based approach empowers rights-holders to claim their health-related rights, to participate in policy decisions which affect them and to hold policy makers to account. It also prioritises the protection of vulnerable and marginalised population groups and emphasises equality and non-discrimination. A human rights-based approach avoids a fragmented public health strategy where elements of the right to health are merely appended and, instead, encompasses its incorporation into all areas of policy and programming. Its full implementation allows health authorities to meet their duty to respect, protect and fulfil the right to health and other health rights for all people affected by NCDs and is essential to the achievement of the health-related SDGs.

⁵³ Article 19 of the WHO FCTC covers liability and providing Parties options for taking legislative action or promoting their existing laws, where necessary, to deal with criminal and civil liability, including compensation where appropriate.