

11. Right to Health

Tika ki te Whai Oranga



“Everyone has the right to enjoy the highest attainable standard of physical and mental health.”

Everyone has the right to enjoy the highest attainable standard of physical and mental health.

Convention on the Elimination of Racial Discrimination, Preamble (edited)

Introduction

Tīmatatanga

The right to health encompasses not just the absence of disease or infirmity but “complete physical, mental and social well being”.¹ It includes access to both timely and appropriate healthcare as well as the underlying social and economic determinants of health, such as conditions of work and adequate food and shelter.²

Since the Commission’s review of human rights in New Zealand in 2004,³ there has been improvement in some areas, but little or none in others. Poor health outcomes for Māori and Pacific people are still unacceptably high compared with the rest of the population,⁴ and rates of youth suicide and disease and death from smoking (particularly among Māori and Pacific people) remain a problem. There have also been cuts in public health initiatives developed over the past decade to promote and protect the health of communities (despite their acknowledged success), and more cuts are possible in the interests of economic efficiency.⁵

On the positive side, there has been an increase in overall life expectancy.⁶ Māori-led health initiatives (including the introduction of the Whānau Ora programme) have been strengthened to improve health outcomes for Māori, and there is greater recognition of, and willingness to address, the difficulties facing trans people in accessing health services.

Internationally there is increasing acceptance of a human-rights-based approach to health. The World Health Organisation (WHO) has committed to promoting the integration of human rights norms and principles in the design, implementation, monitoring and evaluation of health-related policies and programmes. The principles of equality and freedom from discrimination – including on the basis of sex and gender roles – are considered fundamental to the development of health policy, along with recognition of the rights of vulnerable groups and universally accessible health systems.⁷ For example, the United Nations Population Fund (UNPF) has developed a training package based on a human rights approach, with a particular focus on gender equality and reproductive rights.⁸

There have also been some significant additions to the international instruments. The new Convention on the Rights of Persons with Disabilities (CRPD) – designed to ensure that people with disabilities can enjoy the same human rights as everyone else – has helped to reinforce a

- 1 Preamble to the Constitution of the World Health Organisation. Accessible online at <http://www.who.int/about/definition/en/print.html>
- 2 UN Commission on Human Rights (2003), *Economic, social and cultural rights: The right of everyone to the enjoyment of the highest attainable standards of physical and mental health: Report of the Special Rapporteur, Paul Hunt*, (E/CN.4/2003/58, 13 February). Accessible online at [http://www.unhcr.ch/Huridocda/Huridoca.nsf/0/9854302995c2c86fc1256cec005a18d7/\\$FILE/G0310979.pdf](http://www.unhcr.ch/Huridocda/Huridoca.nsf/0/9854302995c2c86fc1256cec005a18d7/$FILE/G0310979.pdf)
- 3 It should be read in conjunction with other chapters in this review, such those on the rights of disabled people, rights of women, rights of sexual and gender minorities, rights of children and young people, right to housing and right to social security.
- 4 Ministry of Foreign Affairs and Trade (2009), *New Zealand National Universal Periodic Review Report* (April) (Wellington: MFAT), p 3. Accessible online at <http://www.mfat.govt.nz/Foreign-Relations/1-Global-Issues/Human-rights/Universal-Periodic-Review/Final-Report/index.php>
- 5 Ministerial Review Group (2009), *Meeting the Challenge: Enhancing Sustainability and the Patient and Consumer Experience within the Current Legislative Framework for Health and Disability Services in New Zealand*, Report of the Ministerial Review Group (Wellington: MRG), 31 July. Accessible online at <http://www.beehive.govt.nz/sites/all/files/MRG%20Report%20Meeting%20the%20Challenge.pdf>
- 6 Ministry of Health (2008), *Health and Independence Report 2008* (Wellington: MoH), para.2.2.1. Life expectancy in New Zealand is still lower than in a number of OECD countries such as Japan, Switzerland, Australia and Italy, according to OECD Health Data 2010, accessible online at <http://www.oecd.org/health/healthdata>
- 7 World Health Organisation (2010), *World Health Report – Health systems financing: the path to universal coverage*. Accessible online at <http://www.who.int/whr/2010/en/index.html>
- 8 Human Rights Council (2007), *Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Paul Hunt*, (A/HRC/4/28, 17 January), para 10. Accessible online at <http://daccess-dds-ny.un.org/doc/UNDOC/GEN/G07102/97/PDF/G0710297.pdf/OpenElement>

paradigm shift to a social model of disability, emphasising the effects of a disabling environment rather than the more traditional medical model, which focusses on disease or illness. An Optional Protocol to the International Covenant on Economic Social and Cultural Rights (ICESCR), which will allow individuals to complain to the relevant international treaty body about breaches of the rights in the Covenant, has been agreed to by the United Nations. There is increasing acceptance that the courts have a role to play in relation to the delivery of social and economic rights – that is, that such rights are justiciable.⁹ Very recently, the International Labour Organisation (ILO) adopted a standard aimed at preventing discrimination against people with HIV in the workplace, emphasising the importance of work and income-generating activities for workers living with HIV, particularly in terms of continuing treatment.¹⁰

International context

Kaupapa ā taiao

The right to health is fundamental to human rights and is expressly referred to in a number of core international treaties. The most significant is the ICESCR, which refers to the right to the “enjoyment of the highest attainable standard of physical and mental health”.¹¹ Other international treaties also refer to the right to health. In some it applies generally; others address the rights of particular groups such as women or children. There is also a body of international standards and declarations relating directly or indirectly to the right to health. These are not binding in the same way as the treaties, but have a significant impact, particularly if they achieve the status of customary international law.

Numerous conferences and declarations, such as the International Conference on Primary Health Care in 1978

(which resulted in the Declaration of Alma-Ata), and the United Nations Millennium Development Goals, have also helped clarify aspects of public health and reaffirmed commitment to the realisation of the right to health generally.¹²

INTERNATIONAL HUMAN RIGHTS TREATIES RECOGNISING THE RIGHT TO HEALTH

- **Convention on the Elimination of all Forms of Racial Discrimination (CERD): Article 5(e)(iv), (1965)**
- **International Covenant on Economic, Social and Cultural Rights (ICESCR): Article 12 (1966)**
- **Convention on the Elimination of All Forms of Discrimination against Women (CEDAW): Articles 11(1)(f), 12 and 14 (2)(b) (1979)**
- **Convention on the Rights of the Child (UNCROC): Article 24 (1989)**
- **Convention on the Protection of the Rights of all Migrant Workers and Members of their Families (Migrant Workers Convention): Articles 28, 43(e) and 45(c) (1990)**
- **Convention on the Rights of Persons with Disabilities (CRPD): Article 25 (2006)**

By ratifying the ICESCR, a state agrees to protect the health of its citizens and provide the services, policies and budgetary means to promote good health and ensure the elimination of health-based discrimination.¹³ This is qualified by recognition of finite resources and the concept of progressive realisation: given the cost of

9 New Zealand remains ambivalent on the direct enforceability of social and economic rights through the courts. See *Implementation of the International Covenant on Economic, Social and Cultural Rights, Third Periodic Report by New Zealand* (2009), paras 20–21. Accessible online at <http://www2.ohchr.org/english/bodies/cescr/docs/AdvanceVersions/E.C.12.NZL.3AUV.pdf>

10 ILO (2010), *HIV and AIDS and the World of Work* (Geneva: ILO). Accessible online at http://www.ilo.org/lang--en/docName--WCMS_141898/index.htm

11 ICESCR, article 12

12 OHCHR/WHO (2008), *The Right to Health: Fact Sheet No.31*. Accessible online at www.ohchr.org/Documents/Publications/Factsheet31.pdf

13 Glazebrook S, Baird N and Holden S (2009), *New Zealand: Country Report on Human Rights*, *Victoria University of Wellington Law Review* 40, pp 57–102, p 89

health services, compliance is contemplated as happening incrementally, or progressively, depending on available resources and the competing claims and priorities on those resources.¹⁴

To avoid resource constraints being used as a reason for non-compliance, states must demonstrate that they have made every effort to use what resources they have to satisfy at least the minimum obligations in the covenant. States therefore need to establish some form of monitoring mechanisms, including a system of benchmarks and indicators; collection of health data that is disaggregated on certain grounds such as sex, age and rural/urban; and the ability to demonstrate progressive implementation of the rights in the ICESCR.¹⁵ Although the right to health is recognised in a variety of international treaties, each instrument is reported on individually. This can make it difficult to determine how well the right is realised overall by particular states.

As with other rights, the right to health imposes three types of obligations on a state¹⁶, including:

- to respect the right which requires states to refrain from interfering with it directly or indirectly – for example, denying access to healthcare services or discriminating in how the services are provided
- to protect the right which requires states to prevent third parties from interfering with the right to health, which may require states to enact legislation to ensure that individuals comply with the appropriate standards or prohibit doing acts harmful to the health of others – for example, prohibiting female genital mutilation
- to fulfill the right which requires states to adopt progressive legislative, administrative, budgetary and other measures to fully realise the right to health – for example, adopting national immunisation policies.

The committee responsible for monitoring implementation of the ICECSR also stresses the need for inter-sectoral action – that is, working across all levels of government (not just in the health sector) to address the social, political, economic and environmental factors that influence health and inequities in health.¹⁷

How the right to health is delivered is considered in relation to the availability, accessibility, acceptability and quality of health services.

FIGURE 1: A HUMAN RIGHTS-BASED APPROACH TO HEALTH

The Right to Health

Underlying healthcare determinants

Availability:

functioning public health and healthcare facilities, goods, services and programmes in sufficient quantity

Accessibility:

non-discrimination, physical accessibility, economic accessibility (affordability), information accessibility

Acceptability:

respectful of medical ethics and culturally appropriate, sensitive to age and gender

Quality:

scientifically and medically appropriate

Source: OHCHR/WHO (2009), A Human Rights-Based Approach to Health, www.who.int/hhr/en

14 Alston P and Quinn G (1987), The Nature and Scope of States' Parties Obligations under the International Covenant on Economic, Social and Cultural Rights, *Human Rights Quarterly* 9(2), pp156–184

15 For an example of how indicators have been addressed domestically, see Advisory Committee on Official Statistics (2009), *Good Practice Guidelines for the Development and Reporting of Indicators* (Wellington: StatsNZ); Ministry of Health (2008), *Health and Independence Report 2008* (Wellington: MoH)

16 United Nations Committee on Economic Social and Cultural Rights, *General Comment No. 14: The right to the highest attainable standard of health* (Article 12) (2000) E/C.12/2000/4, p 27

17 New Zealand is described as having done a particularly good job in monitoring inequalities and reporting on those inequalities in ways that best facilitate action, in WHO and Public Health Agency of Canada (2008), *Health Equity Through Intersectoral Action: An Analysis of 18 Country Case Studies*, p 34. Accessible online at http://www.who.int/pmnch/topics/health_systems/healththequity_who/en/index.html

New Zealand context Kaupapa o Aotearoa

LEGISLATIVE FRAMEWORK

While there is no express right to health in New Zealand law, by ratifying the ICESCR the Government has accepted an undertaking to comply with the standards in the Convention. This is achieved by a range of laws, including legislation directly linked to the delivery of health services:

- New Zealand Public Health and Disability Act 2000
- Health and Disability Services (Safety) Act 2001
- Health Practitioners Competence Assurance Act 2003 and the Health Act 1956.

Other legislation deals with specific issues, including the:

- Mental Health (Compulsory Assessment and Treatment) Act 1992 (MH(CAT) Act)
- Intellectual Disability (Compulsory Care and Rehabilitation) Act 2003 (IDCCR Act)
- Alcoholism and Drug Addiction Act 1966 (ADA Act).

Employment-related legislation, such as the Health and Safety in Employment Act 1992 and the Smoke-Free Environments Act 1990, deals with health in the workplace. The Injury Prevention, Rehabilitation and Compensation Act 2001 provides no-fault personal insurance cover for injury through the Accident Compensation Corporation scheme. The National Administration Guidelines (NAGs) for school administration set out statements of desirable principles of conduct, requiring boards of trustees to provide a safe environment and promote healthy food and nutrition for all students.¹⁸

The right to health is also protected by the New Zealand Bill of Rights Act 1990 (BoRA) through the right to

freedom from discrimination,¹⁹ the right not to be subjected to medical or scientific experimentation,²⁰ and the right to refuse medical treatment;²¹ the Human Rights Act 1993 (HRA), which deals with discrimination and human rights generally; the Health and Disability Services Act 1994 (together with the accompanying Code of Consumer Rights); and the Privacy Act 1993 (which, together with the Health Information Privacy Code 1994, protects individual privacy).

The future of some of this legislation is uncertain. The ADA Act, considered out of date for many years, is under review, with proposals for reform expected to be considered by Cabinet before the end of 2010. The MH (CAT) Act was considered to comply with existing human rights standards when it was introduced, but must now be seen in light of the increasing international recognition that committal does not mean a person automatically loses their capacity to consent to treatment.²² The IDCCR Act is currently the subject of litigation concerning the adequacy of statutory direction about which criteria will justify extending an order under the act.²³

New Zealand today Aotearoa i tēnei rā

New Zealand has a publicly funded health system which functions well for the most part. Although the proportion of GDP spent on health falls short of a number of other OECD countries, the funds allocated to the health vote amount to the second largest area of expenditure of public monies.²⁴ There is a strong legislative framework, and numerous strategies and policies are designed to ensure the provision of healthcare and the underlying determinants of the right to health. The Health and Disability Commissioner Act 1994 (HDC) establishes

18 CERD/C/NZL/CO/66 10 August 2007, para 24

19 CAT/C/NZL/CO/5 14 May 2009, para 6

20 CCPR/C/NZL/CO/5 25 March 2010, para 16

21 Detention is possible only if the person is liable for deportation under section 164(3) IA 2009, because Articles 32.1 or 33 of the Refugee Convention apply, or where a protected person can be sent to a country where they are not in danger of torture or death. Even this has led to criticism by the UN Human Rights Committee (CCPR/C/NZL/CO/5 25 March 2010).

22 See also the case of Chief Executive of the Department of Labour v Hossein Yadegary and Anor [2008] NZCA 295 for exceptional circumstances that would permit continued detention.

23 Supra fn 20, para 13

24 Supra fn16, para 6

a complaints system to deal with issues of informed consent, consumer rights and the duties and obligations of healthcare providers, while also providing a strong accountability mechanism via a human rights-based Code of Health and Disability Services Consumers' Rights.

Over the past decade, greater emphasis has been placed on the delivery of primary healthcare. Primary healthcare that focusses on the underlying determinants of health is regarded as the most effective way to address health needs. While it is recognised that improved life expectancy, delayed onset of disability associated with chronic disease and the reduction of inequalities can be attributed to the relatively strong commitment to public health programmes, not everyone can afford to access services such as doctors (with the result that people often rely on emergency departments in public hospitals for conditions that can be easily prevented or treated in primary healthcare settings). This suggests that further spending in this area, at the expense of more immediate health needs, might be necessary to reduce future health costs.

In the coming years, New Zealand will need to address the effects of an ageing population. This, coupled with increased longevity, will impose growing demands on the health system, exacerbated by the impact of diabetes, smoking and obesity and the long-term effects of child abuse.

It is beyond the scope of this chapter to address the entire range of health issues confronting New Zealanders. Rather, the chapter highlights certain key issues and focusses on community or population groups proven to have the poorest health outcomes – people on low incomes, Māori and Pacific people, people with experience of mental illness, refugees and asylum seekers, and trans people. The chapter also looks at some of the health issues facing men, sexual and reproductive rights,

and the possible implications of recent developments in the area of genetics.

HEALTH INEQUALITIES – AVAILABILITY AND ACCEPTABILITY

Although health outcomes have generally improved in recent years, inequalities still persist – particularly for people with disabilities,²⁵ those on low incomes, Māori and Pacific people, and other minority sections of the population. The entrenched inequalities play a significant role in poor health outcomes for these particular groups. This in turn affects children and young people, highlighting the importance of underlying determinants such as adequate housing and nutrition in ensuring good health generally. New Zealand's child-health and safety statistics are among the worst in the OECD.²⁶ The number of children living in poverty has increased exponentially since the mid 1990s as a result of economic policies that impact adversely on children to the point that today 22 per cent of New Zealand children live in poverty.²⁷

Given the link between health status and underlying social and economic conditions, it is probably inevitable that poor health is correlated with income disparity. Health and social problems are almost invariably worse in countries where there are greater inequalities in income.²⁸ While socially disadvantaged groups may be expected to have poorer health, to be more likely to be exposed to greater health hazards and to find it more difficult to access adequate health services,²⁹ the overall population also suffers where there are wide income gaps. For example, a higher level of mental illness across all groups is found in countries (such as the United States and New Zealand) where there are greater disparities in income.

Health inequalities cannot be explained simply by economic factors. Māori and Pacific people continue to have

25 For further on the difficulties experienced by people with disabilities, see the chapter on the rights of disabled people.

26 UNICEF (2007), *Child Poverty in perspective: An overview of child well-being in rich countries*, Innocenti Report Card 7 (Florence: UNICEF Innocenti Research centre). Accessible online at http://www.unicef-irc.org/publications/pdf/rc7_eng.pdf

27 Asher I (2008), *Improving our poor child-health outcomes – what more can New Zealand do?* Keynote address to Paediatric Society of New Zealand Annual Scientific Meeting. Accessible online at <http://www.paediatrics.org.nz/files/PSNZ%20Asher%20Child%20Health%20Oct%202008%20formatted.pdf>

28 Wilkinson R and Pickett K (2009), *The Spirit Level: Why More Equal Societies Almost Always Do Better* (London: Allen Lane)

29 *Implementation of the International Covenant on Economic, Social and Cultural Rights, Third Periodic Report by New Zealand* (2009), para 438. Accessible online at <http://www2.ohchr.org/english/bodies/cescr/docs/AdvanceVersions/E.C.12.NZL.3AUV.pdf>

poorer health outcomes generally, and this cannot be attributed solely to economic and social circumstances. Disparities in mortality between Māori and non-Māori persist within income groups.³⁰ The Government has acknowledged that the situation is “unacceptable”.³¹ In 2003 the ICESCR Committee recommended that New Zealand “adopt effective measures to improve the health situation of the indigenous Māori people”.³²

Overall, New Zealand is considered to do a good job of monitoring inequalities and reporting on them in ways that facilitate action. For example, the New Zealand Deprivation Index is used to evaluate data from the Census in order to “boost intersectoral interest in inequities, facilitated discussion ... about the root causes of inequities and provided social agencies with evidence on which they could plan programmes and policies to address health inequities”.³³ Improving the effectiveness of mainstream services to ensure better health outcomes for Māori and Pacific people is recognised as an important priority.³⁴ This has led to a shift from increasing the number of Māori providers to strengthening existing services to ensure that they serve Māori better in terms of accessibility and quality. The Government also recently announced the introduction of the Whānau Ora programme. This is an innovative approach to the provision of services, designed to empower families rather than focus on individuals. The programme will require government agencies to work together and with families, to provide advice on employment and welfare matters as well as health services, and has the potential to address the entire range of health determinants.

Despite this, finite resources mean that prioritising which services get funded is inevitable. The criteria which determine the allocation of health funding can be contentious. At present, decisions about which services and interventions are funded are made by district health boards, taking into account nationally determined priorities tempered by local needs and requirements. The decision-making, which is based on need, has been criticised as lacking objectivity and transparency, and being overly responsive to lobby groups with vested interests, with the result that those least able to promote themselves and their healthcare needs are the most likely to miss out.³⁵

One area where this is likely to come to a head is age. As New Zealand has an ageing population, there will be increasing demand for health services by older people and corresponding costs to the health system.³⁶ The committee responsible for the implementation of the ICESCR (CESCR) has indicated that in realising the right to health for older people, it is necessary to bear in mind not simply access to treatment but investment through the whole of life, including encouraging the adoption of healthy lifestyles.³⁷ This is provided to a large extent through the Ministry of Health’s strategy for the health of older people. The strategy aims to encourage older people to participate to the fullest in decisions about their health, and to provide “support that will ensure access to flexible, timely and co-ordinated services and living options”, including any community-based care and support they may require.³⁸

30 Ministry of Health (2004), *Tracking Disparity: Trends in Ethnic and Socioeconomic inequalities in mortality, 1981–2004* (Wellington: MoH). Accessible online at <http://www.moh.govt.nz/moh.nsf/indexmh/tracking-disparity-inequalities-mortality-1981-2004?Open>

31 Ministry of Foreign Affairs and Trade (2009)

32 UN Committee on Economic, Social and Cultural Rights (2003), Concluding Observations/Comments (30th Sessions: E/C.12/1 Add.88) at para 33

33 WHO and Public Health Agency of Canada (2008), p 19

34 Ministry of Health (2006), *Whakatataka Tuarua: Māori Health Action Plan 2006–2011* (Wellington: Ministry of Health). Accessible online at <http://www.moh.govt.nz/moh.nsf/by+unid/2860946B115F26EACC25723B00032ADD?Open#information>

35 Morgan G and Simmons G (2009), *Health cheque: The truth we should all know about New Zealand’s public health system* (Auckland: Public Interest Publishing), p 144

36 By 2028 it is expected that 50% of health spending will be on people over 65: Ministry of Health, *Briefing for the Incoming Minister* (2008).

37 CESCR (1995), *General Comment 6: The economic, social and cultural rights of older persons*: (08/12/1995), para 35. Accessible online at [http://www.unhcr.ch/tbs/doc.nsf/\(Symbol\)/482a0aced8049067c12563ed005acf9e?Opendocument](http://www.unhcr.ch/tbs/doc.nsf/(Symbol)/482a0aced8049067c12563ed005acf9e?Opendocument)

38 Ministry of Health (2002), *Health of Older People Strategy*. Accessible online at www.moh.govt.nz/publications/hops

The Ministerial Review Group tasked with ensuring the continuation of affordable access to a strong public health and disability system in New Zealand recognised the benefits of a productive and longer-living workforce.³⁹ However, encouraging people to live healthier lives does not necessarily translate into corresponding savings in health and disability costs. As people age, their need for health and support services increases, and a significant amount of health funding is spent on the last year of life.⁴⁰ The elderly are also likely to suffer from multiple conditions related to ageing, and longer life expectancy means that people will live longer with chronic conditions.⁴¹

ICESCR requires rights to be provided on a non-discriminatory basis, but where resources are limited they should be targeted at the most vulnerable. A human rights approach which promotes an understanding of the right to health and the shared nature of obligations would allow a more equitable and transparent means of distributing health resources. There is some way to go before the needs of the most vulnerable groups are adequately addressed in New Zealand. For example, people with intellectual disabilities encounter persistent and enduring barriers to exercising and enjoying their human rights in most spheres of daily life.

MENTAL HEALTH SERVICES – QUALITY AND AVAILABILITY

Between 2005 and 2009 the Commission received 773 complaints and inquiries relating to mental health matters.⁴² A significant number (131) related to the way in which mental illness impacted on the ability to participate in society (and therefore on the right to

health in its wider sense). They included being refused insurance or offered it on different terms and conditions; experiencing difficulty in obtaining custody of children; and being turned down for employment, prevented from performing certain tasks or not being promoted as a result of mental illness.

The quality of mental health services improved in New Zealand with the introduction of the concept of community care in the Mental Health (Compulsory Assessment and Treatment) Act 1992 (MH(CAT) Act).⁴³ While a range of services is provided in the community, ensuring safe, recovery-oriented environments remains a challenge, particularly for Māori and Pacific people and young people.⁴⁴ There is some concern among community groups that the recession and recent changes in policy could impact adversely on the funding available for community mental-health initiatives.⁴⁵

The gaps in mental services for children and young people include:

- a lack of forensic, residential placements⁴⁶
- a shortage of mental-health professionals who specialise in working with children and young people (although there have been attempts to address this and the workforce more than doubled over the last decade)⁴⁷
- a shortage of addiction services for young people and those with parenting responsibilities
- inadequate co-ordination among the multiple agencies involved in the care and treatment of young people with very high needs (although this is being addressed through a variety of programmes with other government agencies).⁴⁸

39 Ministerial Review Group (2009), para 115

40 Data from the Ministry of Health suggests that this amounts to 10–15 per cent.

41 Ministerial Review Group (2009), para 114

42 The Commission interprets mental health as including conditions such as depression, anxiety, alcohol misuse and addictions generally.

43 Ministry of Foreign Affairs and Trade (2009), para 3.2.9

44 *ibid*

45 Budget papers released at the beginning of July indicate that more than \$20 million has been cut from mental health programmes: *New Zealand Herald*, 15 July 2010

46 The ministry has prepared a youth forensic guidance document for DHBs in preparation for further development when funding is available.

47 The shortage of trained professionals in this area is not limited to New Zealand but presents as an international problem.

48 For example, the Ministry of Health is working with the Ministries of Social Development and Education on health and education assessments for children coming into the care of CYFs and improving information-sharing mechanisms between agencies working with children and their families.

The Deaf community is also poorly served by mental health services. Research suggests that 10 per cent of the Deaf population is at the chronic/severe end of the mental health spectrum, compared with 3 per cent in the mainstream population. Yet services are frequently inaccessible for Deaf people,⁴⁹ and there is little awareness of the special needs of Deaf mental-health consumers, signalling a need for a nationally co-ordinated Deaf mental health service.⁵⁰

In relation to the act itself, people have complained to the Commission about repeat hospitalisation, the use of seclusion and Electroconvulsive Therapy (ECT) and the need for greater oversight of the Act, particularly the implications of compulsory treatment (see the chapter on the Rights of people who are detained).

The priorities in the Commission's first action plan included ensuring that any practice involving confinement, isolation and reduction of sensory input was acknowledged as seclusion in guideline documents, clarifying the human rights issues around the use of seclusion and requiring district health boards to report on the use of seclusion in service profiles. In 2008, the Human Rights Commission and the Mental Health Commission published *Human Rights and Seclusion in Mental Health Services* to clarify the human rights matters that can arise in the practice of seclusion.⁵¹ Instances of seclusion are now routinely reported on by DHBs, a new reporting template on the use of seclusion for DHBs was introduced in 2006, and the Health and the Restraint Minimisation and Safe Practice Standards (2008) include a broader definition of seclusion. The Ministry of Health also published guidelines on the use of seclusion in 2010 as part of its ongoing commitment to promote a decrease in its use. The use of seclusion is now monitored but,

although there has been a decrease in the incidence of seclusion, for a small number of patients the duration of seclusion has increased.

The use of ECT was the subject of examination by a parliamentary committee in response to petitions presented in 1999⁵² and 2007.⁵³ One result of the 1999 petition was that reports on the use of ECT are now published annually. It also recommended that there be an independent review of the use of ECT in New Zealand.⁵⁴ Following the 2002 petition, the second opinion required that, where a patient refuses consent to the administration of ECT, this must now be obtained from a specialist who practices independently of the clinical team providing the treatment.

The issue of capacity and the tension between compulsory treatment⁵⁵ and the right to refuse mental health treatment, to make an informed choice and give informed consent were also priorities in the original action plan and have been raised by mental-health service users on many occasions (and constitute the most common complaint received by the Commission in relation to mental health issues). There is now a series of cases in like-minded jurisdictions on this topic which have changed the way in which capacity is viewed internationally,⁵⁶ and which indicate that simply because a person is defined as mentally disordered, it does not necessarily follow that they have lost the ability to consent to treatment. The CRPD, with its emphasis on individual capacity, has also shaped thinking in this area. While the Director of Mental Health has acknowledged that the discussion on capacity is in its infancy in New Zealand, he has also noted that "future revisions of mental health law will need to be consistent with recent international and domestic human rights developments".⁵⁷

49 Bridgman G (2000), *Deaf Mental Health Research Project: Reducing Risk in Deaf Mental Health*, paper presented at Challenges Choices and Strategies, Mental Health Conference 2000, Parkroyal Wellington, November

50 Report to be published by the HRC in 2010

51 Human Rights Commission (2008), *Human Rights and Seclusion in Mental Health Services* (Wellington: HRC)

52 Petition 1999/30 of Anna De Jonge and others

53 Petition 2007/162 of Helen Smith

54 Ministry of Health (2004), *Use of Electroconvulsive Therapy (ECT) in New Zealand: A Review of the Efficacy, Safety and Regulatory Controls* (Wellington: MoH). The review found that ECT is an effective treatment for some seriously ill patients.

55 A clinician should still try to obtain the consent of the patient even if there is a compulsory treatment order in place.

56 *Starson v Swayze* 1 SCC 32 (2003)

57 Chaplow D (2010)

Article 12 of the ICESCR refers to the right to the highest attainable standard of both physical and mental health. Yet all too often mental health comes a poor second to physical health, principally because it has traditionally been viewed as simply a health issue. A human rights-based approach which acknowledges the social, economic and political forces that shape the way in which people with mental illness are treated may be more appropriate, provided it ensures the participation and leadership of people with mental illness in addressing the inequalities and discrimination they encounter.⁵⁸

PROVISION OF SERVICES – ACCESSIBILITY, ACCEPTABILITY AND QUALITY

Access to health services remains a concern for some people. At various times over the past five years this has been raised in relation to treatment for certain types of cancer (where patients were funded to go to Australia because of the time they would have had to wait to access radiotherapy locally),⁵⁹ the availability of elective surgery⁶⁰ and, more recently, cutbacks to home-based residential care for elderly people. Refusal of, or difficulty in accessing, treatment is also the subject of individual complaints to the Commission.⁶¹

Access to medicines has also been contentious. New Zealand spends less on medicines per capita than other comparable countries, largely as result of the way in which PHARMAC (the Crown entity responsible for purchasing pharmaceuticals for the Government)

prioritises and procures medicines. It is PHARMAC's ability to negotiate deals with the drug companies that has made viable the supply of drugs at an affordable price for ordinary New Zealanders.

In 2008, PHARMAC was judicially reviewed over its decision not to fund certain types of early breast-cancer treatment. The court accepted that PHARMAC had failed to consult the public and other interested parties adequately before reaching its decision.⁶² However, the authors of a recent report on access to high-cost, highly specialised medicines,⁶³ while acknowledging the importance of participation and transparency and involvement of the community in medicine assessment and prioritisation processes, noted that "increased transparency needed to be balanced against PHARMAC's continuing ability to perform its purchasing activities".

WORKFORCE ISSUES – AVAILABILITY AND QUALITY

Resources in the health sector generally remain a problem. New Zealand has far below the OECD average number of doctors per head of population, although slightly above the average number of nurses. In 2008, New Zealand had 2.5 practising physicians per 1000 of the population. This is well below the OECD average of 3.2.⁶⁴ The ratio of specialists to population is also lower.⁶⁵ Māori are under-represented in all regulated health occupations, and Pacific peoples are under-

58 Burns J (2009), *Mental Health and inequality: A human rights approach to inequality, discrimination and mental disability*, *Journal of Health and Human Rights*, 11(2)

59 MOH figures suggest that 2007 was a low point and the situation has improved subsequently but also that delays may still arise as a result of workforce, equipment or other facility-based constraints: Ministry of Health (2008), *Health and Independence Report 2008* (Wellington: MOH) at para 3.5

60 The number of elective surgery procedures has been increasing steadily over the past 10 years, with the current Government claiming a 10% increase since taking office.

61 Over the five years from 2004 to 2009, there were 122 complaints about inequalities in healthcare.

62 *Walsch and Ors v Pharmaceutical Management Agency HC WN CIV 2007-485-1386* [2008]. In 2009 the National Government decided to fund 12 month courses of Herceptin to fulfill a promise it had made during the election campaign.

63 McCormack P, Quigley J and Hansen P (2010), *Review of Access to High-Cost, Highly-Specialised Medicines in New Zealand: Report to Minister of Health, Hon. Tony Ryall*, 31 March 2010. Available online at http://img.scoop.co.nz/media/pdfs/1005/Review_of_Access_to_High_Cost_Highly_Specialised_Medicines_31_April_2010.pdf

64 Organisation for Economic Co-operation and Development (2010), *OECD Health Data 2010 – Country Notes*, p 2. Accessible online at <http://www.oecd.org/dataoecd/43/22/40905041.pdf>

65 Commission on Competitive and Sustainable Terms and Conditions of Employment for Senior Medical and Dental Officers Employed by the District Health Boards (2009), 'Senior Doctors in New Zealand: Securing the Future', Report of the Director-General of Healths (Wellington: MoH)

represented in the health workforce generally.⁶⁶ There is a growing need for the nursing workforce to better reflect the ethnic diversity of the population, in order to meet diverse cultural needs.

In 2006 the number of doctors who had been trained in other countries reached 39.9 per cent.⁶⁷ The reliance on overseas-trained doctors suggests that New Zealand is not training enough practitioners for its increasing population. It is also difficult to retain foreign doctors once they are here (with 75 per cent of foreign-trained doctors leaving New Zealand within six years).⁶⁸ Yet refugee and some migrant doctors can find it difficult to obtain work, because of what some claim to be overly stringent entry criteria and the absence of programmes enabling them to be accredited in the New Zealand health system. New Zealand also has a high proportion of foreign-born and overseas-trained nurses. In some hospitals, up to 80 per cent of the nursing workforce on any given ward may hold internationally obtained qualifications.

Conversely, New Zealand nurses are leaving New Zealand to enter the global market, resulting in a substantial number of locally trained nurses being lost to other countries each year. Nurses will be the primary providers of healthcare for people experiencing the effects of long-term conditions in the future. The lack of trained practitioners – both doctors and nurses – coupled with an ageing population with chronic long-term conditions and greater expectations of the health system as a result of developing technology constitutes a significant workforce challenge for the New Zealand health system.

ACCESS TO ACCIDENT COMPENSATION – AVAILABILITY AND ACCEPTABILITY

The Commission receives a steady stream of complaints and enquiries relating to accident compensation and the Accident Compensation Corporation (ACC). Over the past two years, the nature of complaints has changed. Complaints about the level of assistance and ability to access adequate compensation have become more

common and there are fewer complaints about service delivery. This may reflect in part the development of the Code of Claimants' Rights in 2002, designed to ensure a high standard of service and fairness. The code is based on a claimant's right to be treated with dignity and respect; to be treated fairly and have their views considered; to have their culture, values and beliefs respected; to have a support person present; to expect effective communication; to be fully informed; and to have their privacy respected.

Recent complaints received by the Commission have included concerns at the manner in which eligibility for sensitive claims – that is, claims arising out of mental injury resulting from sexual abuse – is decided, the imposition of a threshold for hearing loss, and limitations on claims by seasonal workers. Although the issue of sensitive claims remains contentious, recent changes have ameliorated the situation to some extent.

There have been questions about the differences in treatment and level of resources provided to people disabled as a result of an accident and to those requiring similar services because of illness. In 2008 the High Court dismissed a claim that the provision of healthcare under the ACC scheme discriminated against those whose care did not arise from an accident.⁶⁹ Earlier, however, the Human Rights Review Tribunal had observed that it had considerable sympathy for the plaintiff's argument that there was "substantial social inequity arising out the fact that similarly circumstanced people are treated differently depending on the cause of their disability" and it was "far from clear ... how that state of affairs might be justified", conceding that the plaintiff had a legitimate political point to make.⁷⁰ Similar sentiments can be found in *Atkinson and Ors v Ministry of Health*,⁷¹ in which the tribunal commented (in relation to services funded by ACC and those funded by the Ministry of Health) that it seemed "artificial to make a distinction as to payment options to family members for home care, purely on the basis of the cause of the disability".

66 Ministry of Health (2008), *Health and Independence Report 2008* (Wellington: MoH), para 2.6.4

67 *ibid*

68 Black J, 'The public health system: this is going to hurt', *NZ Listener*, November 2009

70 *Trevethick v Ministry of Health* [2008] NZAR 454

71 *Trevethick v Ministry of Health* [2007] NZHRR 13 (24 October 2007), para 3

REFUGEES AND ASYLUM SEEKERS – ACCESSIBILITY AND AVAILABILITY

In addition to the difficulties that face the wider population, refugees experience difficulties in accessing interpreters and health professionals trained to respect customary practices.

Asylum seekers not formally recognised as refugees can encounter extra difficulties in accessing health services. While they have access to public health doctors, they are unable to access specialist services, such as dentistry, mental health care or optometry.⁷² Refugee spokespeople say that beyond the main centres, mental health services are often ill-equipped and lack trained professionals to deal with experiences unique to refugees, such as trauma resulting from torture or anxiety over family reunification.

Refugee groups have welcomed the introduction of the Whānau Ora programme, which they consider to have many elements appropriate to refugee families, and hope it will be developed further to apply to refugee communities.⁷³

TRANS PEOPLE – ACCESSIBILITY

In submissions to the Commission's Transgender Inquiry, trans people⁷⁴ and health professionals consistently raised the difficulties trans people have in accessing general health services and being treated with dignity and respect when they did use them.

Trans people also require a range of specific health services if they wish to physically transition. The Commission's report identified major gaps in the availability, accessibility, acceptability and quality of these services. Many of the health services required by trans people are available within the public health system for other

medical conditions (e.g. access to hormone specialists, assessments by mental health professionals and some surgical procedures, including mastectomies and orchidectomies), but trans people and their clinicians face significant barriers accessing these procedures.⁷⁵

Positive developments since the inquiry include the ongoing development of quality-of-life measures for prioritising access to elective surgeries which have the potential to ensure more equitable access to these procedures, including for trans people. Counties Manukau District Health Board has received a small amount of funding to co-ordinate a national project on gender-reassignment health services for trans people in New Zealand. In 2010–11 it will work with clinicians and trans health consumers to develop a multimedia training package based on current best practice and a database of health professionals working with trans people as a first step to implementing the inquiry's recommendation that standards of care and treatment pathways are developed for gender-reassignment services.

SEXUAL AND REPRODUCTIVE HEALTH RIGHTS – ACCEPTABILITY, ACCESSIBILITY

Sexual and reproductive health and rights are an integral part of the right to health. As such they have gained increasing prominence internationally over the past decade. The Beijing Platform for Action was adopted at the Fourth World Conference on Women, and the Millennium Development Goals include goals aimed at reduced maternal mortality, empowerment of women and universal access to reproductive health by 2015. In 2009, the Human Rights Council adopted a resolution on preventable maternal mortality and morbidity and human rights which paves the way for more substantive discussion on women's rights generally, and emphasises

72 This is in contrast to many countries – even less affluent EU countries – which guarantee full access to both asylum seekers and refugees. See Liebaut P (2000), *Legal and social conditions for asylum seekers and refugees in Western European countries* (Danish Refugee Council & European Commission: Brussels).

73 Awad A, Speech to the National Refugee Health and Wellbeing Conference (2009)

74 The Commission's inquiry – Human Rights Commission (2007), *To Be Who I Am: Report of the Inquiry into Discrimination Experienced by Transgender People* (Wellington: HRC) – raised, but did not deal with, the issue of discrimination and related human rights issues affecting intersex people. The Commission has now initiated further work, including treatment of intersex infants and children. For further comment on intersex issues, see the chapter on the rights of sexual and gender minorities.

75 Human Rights Commission (2007), *To Be Who I Am: Report of the Inquiry into Discrimination Experienced by Transgender People* (Wellington: HRC), p 96, paras 9.19 and 9.20

the human rights implications of the relevant Millennium Development Goals.⁷⁶ Although New Zealand played a prominent part in the negotiations which preceded the resolution, concern has been expressed domestically at the absence of explicit reference to sexual and reproductive rights in New Zealand's reports to international bodies such as CEDAW.

In 2008, the Human Rights Commission and Family Planning International brought together community leaders for a dialogue on sexuality and human rights in New Zealand.⁷⁷ Among other issues, participants noted that matters relating to sexuality, gender and human rights remain politically contentious, and that nuanced discussions of gender have been overtaken by simplified debates about relationships between the sexes. Participants considered that a rights-based approach or reference to a human rights framework would provide an opportunity to progress these issues.

NGOs have also raised concerns about the high level of unintended teenage pregnancies; the gendering of responsibility for sexually transmitted infections (for example, targeting the HPV vaccine at young women); uneven access to effective sexuality and relationship education and information; HIV testing of pregnant women; and the refusal of some doctors to refer patients to abortion services on the grounds of 'conscientious objection'.

The provision of abortion services and the role of the Abortion Supervisory Committee (the Committee) was scrutinised in judicial review proceedings in 2008 and 2009. The High Court noted that while the law does not establish a legal right to life for an unborn child, the circumstances in which abortions may be performed are limited by the Contraception, Sterilisation and Abortion Act 1977. It held that the Committee had failed to fulfil its

statutory duty by adopting an overly liberal interpretation of the act by not reviewing or scrutinising the decisions of consultants.⁷⁸ The outcome could be to further limit access to abortion.

Access to sexuality education and information for disabled people is proving controversial, as it challenges historical or stereotypical notions that disabled people do not have sexual feelings or are capable only of behaving inappropriately. Disability advocates are also concerned that entrenched stereotypes about disabled people and fears of prospective parents about having a disabled child, coupled with prejudice and stigmatisation of disabled people generally, could result in uninformed choices by families about termination of pregnancies.⁷⁹ More generally there are issues for some groups of disabled people who want to manage their own health beyond their disabled condition and need to be able to access information about cervical-smear testing, mammograms and kits for pregnancy testing. Lack of accessible information may mean that some disabled people do not receive the healthcare they need.

MEN'S HEALTH ISSUES – AVAILABILITY, ACCESSIBILITY

As in most modern societies, women in New Zealand generally live longer than men.⁸⁰ Men tend to have higher mortality rates and are more likely to engage in high-risk activities, resulting in increased rates of injury and hospitalisation, as well as ACC claims. They are also over-represented in suicide statistics.⁸¹ Women, on the other hand, tend to have higher morbidity rates, especially as they age.

Men also appear to have difficulty in accessing services. Research demonstrates that men – particularly those aged between 15 and 74 – are less likely to seek professional

76 United Nations Human Rights Council (2009), *Promotion and protection of all human rights, civil, political, economic, social and cultural rights, including the right to development A/HRC/11/L.16/Rev.1* (16 June 2009).

77 Family Planning International and New Zealand Human Rights Commission (2008), *Voices: Talking about sexuality, gender and human rights in Aotearoa New Zealand* (Wellington: FPI & HRC)

78 *Right to Life New Zealand Inc v The Abortion Supervisory Committee* HC WN CIV-2005-485-999 (9 June 2008); *Right to Life New Zealand Inc v The Abortion Supervisory Committee (Relief Decision)* (HC WN CIV- 2005-485-999 (3 August 2009)

79 The UN Convention on the Rights of Persons with Disabilities includes protection for sexual and reproductive health and rights.

80 Johnson L, Huggard P and Goodyear-Smith F (2008), 'Men's health and the health of the nation', *Journal of the New Zealand Medical Association*, vol 121 no. 1287. In New Zealand, life expectancy for Maori men is almost nine years less than for non-Maori: Ministry of Health (2010), *Tatau Kahukura: Māori Health Chart Book 2010* (2nd ed, Wellington: MoH).

81 Men are three times as likely to commit suicide but half as likely to intentionally harm themselves requiring hospital admission: Ministry of Health (2007), *Suicide Facts*. Accessible online at www.moh.govt.nz/suicideprevention

help,⁸² even though almost 70 per cent of deaths (including from heart disease, lung cancer and suicide) in this age group are preventable through early detection and treatment.⁸³ Approaches to the Commission on men's health issues are consistent with this pattern. Only 10 complaints were received between 2005 and 2009, six of which related to inequalities between men and women in the health sector. Some related to a perceived emphasis towards women's health at the expense of men's, while others related to the perception that men are the primary perpetrators of domestic violence and consequently experience unequal access to services and a reluctance from health professionals to treat them. Much of the behaviour and resistance to seeking help is attributed to traditional stereotypes and the "psyche of the New Zealand male".⁸⁴ A study of Britain's National Health Service found that men could find it difficult to engage with health services, whether because of lack of knowledge about what is available or because of inappropriate times when services are available.⁸⁵

New Zealand has been slow in developing a national men's health policy.⁸⁶ The Ministry of Health recently announced an intention to develop programmes and initiatives to encourage men to be more aware of their health and access healthcare, including tailoring existing health services so they are more accessible by providing targeted health checks at times and locations convenient for men; supporting workplace-based health initiatives; community-based health initiatives; and developing a men's social-marketing strategy.⁸⁷

GENETIC TESTING – ACCESSIBILITY

In its 2004 review of human rights in New Zealand (and the subsequent action plan), the Commission identified

the need to ensure that the HRA and the BoRA prevent genetic discrimination in certain areas, monitor the implications of the new technology for disabled people and consider whether further legislative change is necessary.

Insurance is relevant to the underlying determinants of health, since it can dictate whether people are able to obtain income-protection insurance and hence a mortgage (in order to access housing). In 2004, the Law Commission's report on life insurance in New Zealand⁸⁸ recognised that the existing situation relating to genetic information (a voluntary moratorium whereby the industry can require an individual to disclose the results of a test but cannot require them to submit to one) might be unsatisfactory, because it depended on the goodwill of the participants and could not be enforced. The Law Commission questioned whether the HRA process was adequate for deciding the actuarial relevance of the genetic information provided, and whether it was appropriate to rely on it, given that complaints are addressed on a case-by-case basis. It suggested that there may be some merit in establishing an independent regulatory body to provide advice on the scientific reliability and actuarial relevance of genetic tests (as has been proposed in other countries).⁸⁹ Although this suggestion was not progressed, the Law Commission recommended that the Government monitor the situation and make amendments if necessary.

In 2006, the Commission itself undertook a review of the Insurance Guidelines it had produced in 1997.⁹⁰ The initial discussion document noted that developments in the field of genetics – including increasing access to genetic testing – had the potential to raise significant,

82 Ministry of Health (2004), 'A Portrait of Health: Key results of the 2002/03 New Zealand Health Survey' (Wellington: MoH)

83 *ibid*

84 Kirkpatrick J and Driver E (2009), 'The State of Men's Health in Canterbury and New Zealand 2009: Identifying Trends and Opportunities'. Accessible online at <http://nzmenshealth.org.nz/wp-content/uploads/2009/12/the-state-of-mens-health-in-canty1.pdf>

85 Banks I (2001), 'No man's land: men, illness and the NHS', *British Medical Journal* 323, p 1058. See also Johnson L, Huggard P and Goodyear-Smith F, Men's health and the health of the nation, *Journal of the New Zealand Medical Association* (2008).

86 Jones R and McCreanor T (2009), 'Men's health in New Zealand', in Wilkins D and Savoye E (eds), *A review of policy and progress across 11 countries* (European Men's Health Forum: Brussels). Accessible online at www.emhf.org/resource_images/11countries.pdf

87 Ministry of Health (2009), Men's Health. Accessed 17 November 2010 from <http://www.moh.govt.nz/menshealth>

88 New Zealand Law Commission (2004), *Report 87: Life Insurance* (Wellington: Law Commission).

89 *ibid*

90 Human Rights Commission (2006), Discussion Paper: Review of the Guidelines on Insurance and the Human Rights Act 1993 (Wellington: HRC), para 5.2

contentious human rights issues for the industry. Highlighting the significance of the human rights approach set out in the relevant international instruments⁹¹ and the requirement to balance the public good with the need for confidentiality, the Commission sought feedback on whether the moratorium was satisfactory, or whether other options (including legislative amendment) were necessary. Most of those who responded considered that the situation was adequate. Although no substantive change to the HRA was recommended, the Commission considered that retaining the moratorium provided an opportunity to monitor overseas developments and best practice internationally, and promote debate within New Zealand.⁹²

In 2009, the multi-disciplinary Human Genome Research Project published its final report on the human genome.⁹³ The research project covered a variety of areas. In relation to insurance, the team concluded that legislative change was not necessary, and recommended either that an independent body assess the relevance of genetic information, or that a concordat be established between the Government and the industry to assess the fair and reasonable use of genetic information in the underwriting process.⁹⁴

Over the years, disabled persons have made it clear to the Commission that they have concerns about the way in which genetic testing may devalue disabled people. The genome project addressed the issue of prenatal testing and the possibility of a child being born with a congenital disability. The researchers noted the resistance by some disability advocates to prenatal testing, on the grounds that even permitting such testing devalued those already born with impairments, and that it was discriminatory as a result. While recognising the social model of disability, the researchers commented that:

...not all the difficulties with disability are socially constructed; and parents may legitimately seek to avoid having their children experience significant functional limitations. Nor is it incompatible to wish on the one hand to avoid transmitting a genetic mutation, but on the other hand to support attempts to minimise discrimination towards the disabled and to support policies which assist the disabled to achieve their potential... for parents to wish to avoid the harms of impairment that are accentuated by lack of social support is not necessarily to collude in discriminatory practices...⁹⁵

The current policy relating to such testing is that prospective parents can access it only if they are at risk of transmitting a serious genetic disorder. In deciding whether to abort a foetus because of the presence of such a disorder, there should not be an assumption that parents are likely to make certain choices, but rather that they should be supported by non-directive counselling and information about the relevant disorder.⁹⁶ The Commission's contribution to the development of policy was that counselling should include factual information about the value and potential of disabled people's lives, rather than simply describing the disability.

Conclusion Whakamutunga

Overall, the health system in New Zealand performs fairly well in terms of international standards on a comparatively low budget. Human rights principles are increasingly obvious in shaping the debate and there is recognition of the importance of open participation. The

91 Universal Declaration on the Human Genome and Human Rights (1997), Universal Declaration on Human Genetic Data and Universal Declaration on Bioethics and Human Rights (2005)

92 Human Rights Commission (2007), *Guidelines: Insurance and the Human Rights Act 1993* (Auckland: HRC). Accessible online at <http://www.hrc.co.nz/home/hrc/humanrightsenvironment/guidelinesoninsuranceandthehumanrightsact1993/guidelinesoninsuranceandthehumanrightsact1993.php>

93 Law Foundation Human Genome Research Project (2009), *Genes, Society and the Future, Vol. III: Using Genetic Knowledge for the Public Good* (Wellington: Brookers)

94 *ibid*

95 Law Foundation Human Genome Research Project (2007), *Genes, Society and the Future: Vol. 1*, p 42

96 Law Foundation Human Genome Research Project (2007), p 43. The writer also observes (p 51) that individual choices may not be universally endorsed, but this does not mean that certain activities should necessarily be prohibited.

right to health itself, while not reflected as a free standing right, is protected by a strong legal framework, and there are a large number of strategies and policies designed to address specific health issues.

Since the Commission's 2004 review, there have been some significant international developments. New Zealand was active in some of these, including the adoption of the CRPD and the recent UN resolution on preventable maternal mortality and morbidity and human rights. More generally, there is a greater emphasis on the reduction of maternal mortality, access to reproductive health and empowerment of women. Increased mechanisms for holding States accountable for their performance under the ICESCR include the UN's adoption of an Optional Protocol to ICESCR, and increasing recognition that economic and social rights are justiciable. There is also greater acceptance of the importance of adopting a human rights approach to the provision of health services.

Domestically, there is a clear willingness to acknowledge problems or omissions and an openness to work constructively to address them. Health service funders generally recognise the need for, and fund, services that are accessible and acceptable and provided on a non-discriminatory basis. There is also greater recognition of the importance of an intersectoral approach to delivering the right to health, and new mechanisms (such as the Whānau Ora programme) for delivering it.

Nevertheless, challenges remain. These include inadequate mechanisms for assessing New Zealand's performance in realising the right to health overall, the continuing disproportionately poor health outcomes for Māori and Pacific people and children in low income families, and recognition of capacity in non-consensual mental health treatment.

The Commission consulted with interested stakeholders and members of the public on a draft of this chapter. The Commission has identified the following areas for action to advance the right to health:

Monitoring

Ensuring the right to health is monitored across the treaty body reporting framework.

Social, economic and cultural rights

Extending the Bill of Rights Act to include social, economic and cultural rights to provide a more complete, substantive set of rights to better address the needs of all New Zealanders.

Inequalities

Tackling entrenched inequalities via a systematic, comprehensive, long term, whole of government approach with explicit targets and timelines and clear indicators to monitor the impact.

Capacity

Encouraging debate about the redrafting of the Mental Health (Compulsory Assessment and Treatment) Act 1992 to better reflect the concept of capacity in line with international developments and the UN Convention on the Rights of Persons with Disabilities.