



General Assembly

Distr.: General
16 July 2019

Original: English

Seventy-fourth session

Item 72 (b) of the preliminary list*

Promotion and protection of human rights: human rights questions, including alternative approaches for improving the effective enjoyment of human rights and fundamental freedoms

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

Note by the Secretary-General

The Secretary-General has the honour to transmit to the General Assembly the report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Dainius Pūras, submitted in accordance with Human Rights Council resolutions [6/29](#) and [33/9](#).

* [A/74/50](#).



Summary

The Special Rapporteur promotes the uptake of health-care worker education based on human rights principles. From the selection of students, to the curricula taught, the location of training and subsequent employment within health systems, he promotes the impact that human rights-based approaches to medical education can have on the health-care workforce. Integration of human rights into health education can help health-care workers overcome their own inherent discriminatory behaviours and attitudes.

The Special Rapporteur does not intend to replicate the global effort to, and volume of literature on, the health-care workforce crisis, but to show the impact that human rights-based approaches to medical and other health education can make. He identifies features of current health education that limit the capacity of the health-care workforce to function effectively and to play its crucial role in promoting, respecting and fulfilling the right to physical and mental health. He presents some structural elements that shape the capacity of the health-care workforce to fulfil States' right-to-health obligations to make health care available, accessible, acceptable and of good quality, while also applying a right-to-health framework to health-care workers themselves in order to identify issues that can enhance or restrict their ability to perform well.

Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health

Contents

	<i>Page</i>
I. Introduction	4
II. Context	7
A. Building primary care as the basis of the health-care system	8
B. Biomedical paradigm	9
C. Power asymmetries	9
D. Medical education	10
E. Aligning medical education curricula with national health strategies	11
III. Strong health systems are needed for an effective workforce	12
A. Health services and facilities	13
B. Medical products, essential medicines, vaccines and technologies	13
C. Health information systems	13
D. Health financing	14
E. Leadership and governance	14
F. Corruption in the health sector	14
IV. A rights-based approach to health-care workforce strengthening	15
A. Equality and non-discrimination	15
B. Participation	16
C. Ongoing support and training for the remote and powerless	16
D. Governance of health-care workers	16
E. International assistance and cooperation	17
F. Accountability	17
V. Issues in focus	17
A. International assistance for health-care workforce strengthening	17
B. Mental health workforce training	18
C. Mental health conditions as biologically determined diseases rather than consequences of social and environmental risk factors	18
D. Mental health-care standards defined by one professional group	19
E. Power asymmetry reflected in definitions	19
F. Changes needed for mental health education	20
VI. Recommendations and conclusions	22

I. Introduction

1. Health-care workers are a vital component of healthy societies and functioning health systems without whom the right to the highest attainable standard of physical and mental health cannot be realized. All health-care workers, whether located in villages or tertiary teaching hospitals, contribute to the population's health, and they require care, protection and support. The roles, support and often precarious state of the health-care workforce has been raised under the mandate of the Special Rapporteur previously (see [A/60/348](#)), including in the context of mental health (see [A/HRC/35/21](#) and [A/HRC/35/21/Add.1](#)), in the effects of corruption ([A/72/137](#)), and in the achievement of the Sustainable Development Goals ([A/71/304](#)).

2. Throughout the world, health-care workers are employed in challenging, underresourced, and at times dangerous, contexts, where human rights, including their own, are violated. Extremes are experienced in places where impartial health care is criminalized,¹ when health facilities come under fire, or when health-care workers are targeted for providing care, such as with Ebola.² When medical and health education is grounded in human rights, health-care workers are equipped to see challenges as human rights issues, and themselves as change agents and human rights advocates. Such an approach to education instils in health-care workers the fundamental human rights principles of equality, non-discrimination and dignity for all people, including the persons with whom they interact in their medical practice.

3. The present report is based on inputs from a wide range of stakeholders, including representatives of relevant United Nations entities, civil society and academic experts. The Special Rapporteur also received a number of written submissions from across all continents and is grateful to all for their valuable contributions.

4. The social and underlying determinants of health, the conditions in which people are born, grow, live and work, are shaped by the distribution of money, power and resources. Those determinants are mostly responsible for health inequities and avoidable differences in health status.³ Many of the current problems in health-care systems arise from insufficient attention to determinants, and population needs, during health-care workforce training. Health education (which includes medical education and mid-level training) must emphasize that the realization of the right to health should not be conflated with learning how to diagnose and treat disorders/diseases. It depends on more than just providing quality health care to all, as the determinants of health, including inequality, discrimination, violence and environmental conditions, must also be addressed.

5. In the present report, the Special Rapporteur promotes the uptake of health-care worker education based on human rights principles. From the selection of students, the curricula taught, the location of training and subsequent employment within health systems, he promotes the impact that human rights-based approaches to medical education can have on the health-care workforce. The integration of human rights into

¹ Open statement by the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on the occasion of the second anniversary of Security Council resolution [2286 \(2016\)](#). Available at www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23225&LangID=E.

² J. Fairhead, "Understanding social resistance to the Ebola response in the Forest Region of the Republic of Guinea: an anthropological perspective", *African Studies Review*, vol. 59, No. 3 (December 2016), pp. 7–31.

³ World Health Organization (WHO), Commission on Social Determinants of Health, *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health* (Geneva, 2008).

health education can help health-care workers overcome their own inherent discriminatory behaviours and attitudes.

6. A conventional approach to medical education (i.e., training of doctors) is based on traditional medical hierarchy and a biomedical paradigm which is focused excessively on the diagnosis and cure of diseases and biomedical pathologies, rather than considering health determinants and their known impact on health outputs. This can create imbalances and exacerbate serious problems in the performance of health systems, including excessive medicalization, fragmentation in the provision of health care, undermining the principle of “first do no harm”, and power asymmetries between doctors and users of services, as well as between doctors and other health-care workers.

7. Health-care workers who have been trained to employ human rights-based approaches to health can help reshape health systems to become more participatory, equitable, inclusive, non-discriminatory and responsive. To gain that understanding, health-care workers must experience their training in a rights-based environment, with a curriculum based on such principles and in settings as close as possible to the environments in which people live. Single lectures or courses on human rights in patient care, as stand-alone vertical subjects, cannot bring about the culture change in health care needed to address the systemic problems mentioned above.

8. The Special Rapporteur recognizes and commends numerous initiatives to modernize health education, through integrating human rights-based approaches, public health and the social and underlying determinants of health. However, those remain the exception rather than the rule. He urges changes to health education to reshape the workforce in ways that will overcome workforce shortages and make health services more available, accessible, acceptable and of good quality. He cautions all countries, and, in particular, low- or middle-income countries, against emulating conventional hierarchical education systems.

9. The global health-care workforce is underresourced in both numbers of workers, and financing for them. In its *Global Strategy on Human Resources for Health: Workforce 2030*,⁴ the World Health Organization (WHO) estimated that there was a global health-care workforce shortage of 17.4 million in 2013, including 2.6 million doctors and over 9 million nurses and midwives. It was predicted that, by 2030, the global shortage would reach 14.5 million, with the largest needs-based shortages of health-care workers in South-East Asia and Africa.

10. The Special Rapporteur welcomes the *Global Strategy*, in which WHO acknowledges the focus of the Sustainable Development Goals, on the need to substantially increase health financing, and the recruitment, development and training and retention of the health workforce in developing countries, especially in least developed countries and small island developing States and its renewed focus on equity and universal health coverage which can only be attained through substantive and strategic investment in the global health-care workforce. In the *Global Strategy*, WHO identifies the health-care workforce as critical to the functionality of health systems and the realization of the right to health.

11. In the light of the global effort to address, and the volume of literature on, the health-care workforce crisis, the Special Rapporteur will not replicate that work, but will endeavour to show the impact that human rights-based approaches to health education can make. He identifies features of current health education that limit the capacity of the health-care workforce to function effectively and to play its crucial role in promoting, respecting and fulfilling the right to health.

⁴ WHO, *Global Strategy on Human Resources for Health: Workforce 2030* (Geneva, 2016).

12. Those features include broadening physicians' understanding of ill health to embrace the social and underlying determinants of health. With this understanding, health education must move beyond biomedical constructs of ill health and an overreliance on the health sector to fix all ill health. The Special Rapporteur promotes a more participatory, less hierarchical approach to the workforce so that the experience and views of all workers in health-care are valued. The current system values health-care workers differently, depending mainly on the length of their training. Most health-care systems give physicians decision-making power at all levels, including in patient care, health-care facilities management and municipal and national health policies, because the hierarchical system prioritizes clinical knowledge based predominantly on biomedical evidence. A human rights-based approach to health systems would promote more participatory and inclusive processes that recognize everyone involved in the system and give them a voice, including users of services. That would enable the workforce to perform optimally, using their training and experience more fully, ultimately making health services more available. The Special Rapporteur appreciates the large and important role of physicians in health care and their clinical leadership over diagnostic and therapeutic decisions. In addition, there are many decisions made within health-care services, including on policy, managerial, diagnostic, preventive and therapeutic issues, which can be effectively led by nurses and non-medical workers.

13. Medicine is not an exact science and there is nearly always some uncertainty about the most appropriate way to manage any condition. However, the training of physicians builds the expectation in themselves and users of services that they have the knowledge and power to make all decisions, including non-clinical ones, with certainty and confidence. This places physicians under constant stress and may lead to burnout.

14. Within the hierarchy, there are disparities between physicians who hold the highest positions and the rest of the health-care workforce and most other physicians, including vast salary differences and opportunities to wield power and potentially engage in corrupt practices by the minority at the top. Power imbalances ingrained from medical training enable systems of corruption to emerge, and these have a damaging impact on the right to health, with money being directed away from health care and promotion (see [A/72/137](#)).

15. Users of health services have been empowered throughout the world over the past few decades, with patients' charters and established rights in many countries. This has been accompanied by an impressive movement of health-care policies and services from a culture and practice of paternalism to a culture and practice of partnership. This emphasis on medical ethics and addressing power asymmetries is in line with a human rights-based approach and should be strengthened. This movement, however, has been more about empowering users, and less about empowering health-care workers who are not physicians. Furthermore, there are instances of patient advocates supported by the pharmaceutical industry, which is not about users' empowerment and rights, but commercial interests.⁵ Many health-care workers remain subservient to doctors; this power imbalance has negative impacts professionally and personally and contributes to workforce attrition. A human rights-based health system would reduce the power imbalances between doctors and other cadres of health-care workers, contributing to a more resilient and sustainable workforce.

16. The present report has special relevance to middle- and low-income countries where there are insufficient numbers of health-care workers to achieve universal

⁵ S. Rose, "Patient advocacy organizations: institutional conflicts of interest, trust, and trustworthiness", *Journal of Law, Medicine and Ethics*, vol. 41, No. 3 (2013), pp. 680–687.

health coverage. Most of the world's population live in these countries, where health needs are greatest. The Special Rapporteur encourages low- or middle-income countries to reconsider the replication of health education systems, often inherited from their colonial histories, that have inappropriate biomedical models and hierarchical systems.

II. Context

17. In 2013, there were 9.8 million physicians, 20.7 million nurses/midwives and 13 million “other” health-care workers globally.⁶ The “other” classification includes dentistry, pharmacy, laboratory, environment and public health, community and traditional health, health management and support and all other health-care workforce categories. This means that, for every physician working, there were only 2.1 nurses and 1.3 “others”.

18. WHO estimates that, by 2030, when universal health coverage should have been achieved as part of the Sustainable Development Goals, there will be a shortage of 14.5 million health-care workers, made up of 2.3 million physicians, 7.6 million nurses and 4.6 million others.⁷

19. The Global Health Workforce Alliance in 2013 defined mid-level health-care workers as cadres who are trained for 2–5 years to acquire basic skills in diagnosing, managing common conditions and preventing disease.⁸ The Alliance found that mid-level workers deliver care as effectively as physicians and are often more responsive to users' expectations. Its report suggested that better use of mid-level workers could contribute to a more efficient human resources skills mix, which can mitigate the effects of health-care workforce shortages and better enable countries to meet or make considerable progress towards universal health coverage. It noted that policy, governance and management challenges limit the contribution that mid-level workers could make. The Special Rapporteur agrees with these observations and considers mid-level workers to be undervalued and under-used, a reflection of structural problems, including regulations that permit doctors only to perform minor procedures that others could be trained to do, and of power asymmetries that often start with medical education.

20. The cost of training and employing physicians is much higher than training and employing nurses and other “mid-level” health-care workers. The average cost per graduate is estimated at \$113,000 for medical students and \$46,000 for nurses, with unit costs highest in North America and lowest in China.⁹ Having a high ratio of physicians to mid-level health-care workers therefore has a significant impact on budgets for health care, and the equitable distribution of health-care workers, which is an essential element in making health services available and accessible to all.¹⁰

⁶ P. Mahon and G. McPherson, “Explaining why nurses remain in or leave bedside nursing: a critical ethnography”, *Nurse Researcher*, vol. 22, No. 1 (2014), p. 41.

⁷ WHO, *Global strategy on Human resources for health: Workforce 2030*, p. 44.

⁸ WHO, Global Health Workforce Alliance, “Mid-level health workers for delivery of essential health services: a global systematic review and country experiences”. Available at www.who.int/workforcealliance/knowledge/resources/mlp2013/en/.

⁹ Julio Frenk and others, “Health professionals for a new century: transforming education to strengthen health systems in an interdependent world”, *The Lancet*, vol. 376, No. 9756 (2010), pp. 1923–1958.

¹⁰ Gordon McCord, Anne Liu and Prabhjot Singh, “Deployment of community health workers across rural sub-Saharan Africa: financial considerations and operational assumptions”, *WHO Bulletin*, vol. 91, No. 4 (2012) pp. 244–253.

A. Building primary care as the basis of the health-care system

21. Efficient use of mid-level health-care workers occurs in health systems that are not overly dependent on specialist physicians and which recognize that ill health does not always require a medical response involving physicians exclusively. Primary health care is the cornerstone and the means of sustainability of all health-care systems, which function more effectively and rationally when up to 80 per cent of users can receive care at the primary level. Efficient use of primary health care prevents over-diagnosis and over-treatment. Primary care and general practitioners are of enormous value to public health and to the realization of the right to health. Efficient use of primary health care allows for resources to be directed to expensive treatments for severe and complex medical cases. The Special Rapporteur has previously noted how health systems can improve equity, efficiency, effectiveness and responsiveness by strengthening primary care while decreasing the unnecessary use of specialists and hospital care (see [A/HRC/35/21/Add.2](#), para. 36). He welcomes initiatives such as “Choosing Wisely”,¹¹ which encourage users of services to have discussions with physicians over selection of evidence-based screening tools and diagnostic tests and prevent excessive diagnostic and therapeutic interventions.

22. Where there is greater equality and power shared between primary and secondary care and workers, it becomes easier to attract, train, fund and retain primary health-care workers, if they are adequately supported. When these conditions are met, the attainment of universal health coverage and primary health care is more achievable. Low- and middle-income countries, experiencing vast workforce shortages, should value primary health care.

23. Despite evidence that primary care physicians not only improve individual and population outcomes, but also limit costs, they are usually undervalued by society. That perception is exacerbated by the pay discrepancy between generalists and specialists.¹²

24. It is critical that health-care workers are available and accessible to all, which requires their equitable distribution to match the demographics of a country and may require incentives to encourage health-care workers into rural and underserved areas.

25. The Special Rapporteur encourages WHO to return to and revitalize its global strategy for changing medical education and practice for health for all, adopted in 1995. The strategy advocated for “five-star doctors” with competencies in five areas: care provision, decision-making, communication, community leadership and management. This mix of skills was described as a necessary enabler for health systems to deliver quality, cost-effective and equitable health care.

26. The Lancet commission on the education of health professionals for the twenty-first century similarly concluded that “leadership, management, policy analysis, and communication skills – are not only essential but also neglected elements of the health curriculum to deliver such value for money”.¹³ WHO, in its five-star doctor strategy stated that, where physicians were not available, other health-care workers could fill those roles. In promoting that model, it recognized that there was fragmentation in health care, including between generalists and specialists. WHO is currently working towards developing a global competency framework for universal health coverage in which it seeks to identify the skills needed at all levels of health care. The Special

¹¹ See www.choosingwisely.org/.

¹² Kathleen Klink, “Incentives for Physicians to Pursue Primary Care in the ACA Era”, *American Medical Association Journal of Ethics*, vol. 17, No. 7 (2015), pp. 637–646.

¹³ Richard Horton, “A new epoch for health professionals’ education”, *The Lancet*, vol. 376, No. 9756 (2010), pp. 1875–1877.

Rapporteur welcomes the framework, which will apply to all health-care workers with 12–48 months of training, irrespective of occupation, title or role.¹⁴ WHO has also encouraged medical schools to demonstrate social accountability regarding the appropriate training of physicians who can respond to priority health concerns.¹⁵

B. Biomedical paradigm

27. Medical care is estimated to account for only 10–20 per cent of the modifiable contributors to healthy outcomes for a population.¹⁶ But there is resistance within traditional medical education to training a workforce to focus less on medical and surgical care and more on the determinants of health, or more broadly, to train fewer physicians and more mid-level workers. The Lancet commission identified: mismatch of competencies to individual and population needs; poor teamwork; persistent gender stratification of professional status; narrow technical focus without broader contextual understanding; predominant hospital orientation at the expense of primary care; quantitative and qualitative imbalances in the professional labour market; and weak leadership to improve health-system performance.⁹

28. Nearly 10 years later, the Special Rapporteur notes that, while there is little evidence to suggest that those problems have been addressed on a global scale, he has received many submissions citing successful approaches to overcoming some of them. In submissions, it was stressed that the training of medical students should not be concentrated in “ivory towers” remote from the communities in which many of them will be, or should be encouraged to be, working. Good health care looks beyond whether a disease is curable or not, to consider how, for each person, quality of health can be improved, using human rights and evidence-based approaches. Evaluations have found those types of approaches good for health-care students and the community.¹⁷

C. Power asymmetries

29. The power imbalance accompanying the medical hierarchy is linked to the biomedical paradigm. Physicians have been educated to focus on biomedical inputs, and those who have spent the most time being educated, achieving specialist status, are the most powerful in the health system. Leaders of specialized medicine also often receive political appointments to guide health policy. The Special Rapporteur has previously highlighted how power asymmetries have given rise to the widespread prioritizing of specialized medicine over primary care and public health (see [A/HRC/35/21](#) and [A/72/137](#)). Such asymmetries generate preferences for biomedical interventions over non-biomedical interventions; the prioritization of certain disciplines that promote expensive biomedical technologies over social sciences in public health research; the excessive use of diagnostic and curative interventions and limited space for civil society participation in health policymaking. They also combine to give greater power and prestige to physical health care over mental health care. If doctors use methods to address ill health without considering patients’ rights, including their participation in decisions, the power imbalance can result in harm to

¹⁴ WHO, global competency framework for universal health coverage, forthcoming in 2019.

¹⁵ Charles Boelen, “The five-star doctor: an asset to health care reform?” (WHO, Geneva, 1995). Available at www.who.int/hrh/en/HRDJ_1_1_02.pdf.

¹⁶ Hood, C. M., K. P. Gennuso, G. R. Swain and B. B. Catlin, “County health rankings: relationships between determinant factors and health outcomes”, *American Journal of Preventive Medicine*, vol. 50, No. 2 (2016), pp. 129–135.

¹⁷ See www.aamc.org/download/479898/data/sdohwebinarslides.pdf.

the users of services and to the health system.¹⁸ Associated with the power asymmetry are bullying and high rates of attrition,¹⁹ which threaten users' safety.²⁰

D. Medical education

30. Medical schools influence students' attitudes towards their colleagues (including all health-care workers), users of services and others in the community, as well as towards community medicine and primary health care. There is great opportunity for medical schools to promote human rights principles of equality, non-discrimination and dignity, as well as seeing the role of health-care workers as health rights advocates with five-star-doctor competencies. If medical education promoted the concept of human rights in patient care, it could set an ambitious frame for thinking about the transformative potential of human rights education in health, because it is so expansive in its scope. The concept includes the interpersonal relationship between user of services and provider in the delivery of health care, but also reaches systemic factors and State responsibilities that shape the health care encounter itself.²¹

31. The Special Rapporteur welcomes the significant shift in medical training over the past 20 years, now emphasizing competency in practice rather than simply knowledge accrual. Accreditation bodies in Canada, the United States of America and many European and other countries have moved to an outcomes-based education model.²² In addition to technical competence, such models promote the idea that physicians need to have good communication skills and must be able to consider the context in which the user lives and the way that care is provided.

32. Medical schools do not sufficiently address human rights issues, the corrupting influence of industry interests on medicine, critical evaluation of the biomedical research literature for commercial bias or the effects of discrimination and stigmatization on patient care. Over 100 years ago, in response to concerns about the quality of medical education in the United States and Canada, Abraham Flexner, in his report on the subject, made recommendations that changed the education of physicians and the practice of medicine.¹³ It is again time for a paradigm shift, to overhaul the many failings of medical education and its impacts on health systems, resulting in the right to health failings identified throughout the present report. National medical associations and universities should accept responsibility for anchoring medical education in a human rights framework.

33. Medical education curricula should also promote and value social medicine (primary health and community medicine) to encourage its uptake. Medical schools

¹⁸ Dainius Pūras, "Human Rights and the Practice of Medicine", *Public Health Reviews*, vol. 38, No. 9 (2017), p. 3.

¹⁹ K. Scott and others, "'Teaching by humiliation' and mistreatment of medical students in clinical rotations: a pilot study", *The Medical Journal of Australia*, vol. 203, No. 4 (2015), p. 185; Young-Ran Yeun and Jeong-Won Han, "Effect of nurses' organizational culture, workplace bullying and work burnout on turnover intention", *International Journal of Bio-Science and Bio-Technology*, vol. 8, No. 1 (2016), pp. 372–380.

²⁰ B. Green and others, "Challenging hierarchy in healthcare teams – ways to flatten gradients to improve teamwork and patient care", *British Journal of Oral and Maxillofacial Surgery*, vol. 55, No. 5 (2017), pp. 449–453.

²¹ Joanna N. Erdman, "Human rights education in patient care", *Public Health Reviews*, vol. 38, No. 14 (2017), p. 2, citing Jonathan Cohen and Tamar Ezer, "Human rights in patient care: a theoretical and practical framework", *Health and Human Rights Journal*, vol. 15, No. 2 (2013), pp. 7–19.

²² R. M. Harden, "Outcome-based education: the future is today", *Medical Teacher*, vol. 29, No. 7, pp. 625–629; and Olle ten Cate, "Competency-based postgraduate medical education: past, present and future", *GMS Journal for Medical Education*, vol. 34, No. 5, document 69.

in high resource settings, often too strongly influenced by specialized university hospitals, have emphasized and glorified medical specialties and subspecialties, which has promoted their position and power in an imbalanced way. This gives specialists too much control at all levels of the health system and undervalues public health approaches, primary care doctors and other health-care workers.

E. Aligning medical education curricula with national health strategies

34. Medical schools should align their curricula with national health plans and health-care workforce strategies in their countries; this is outlined by the Committee on Economic, Social and Cultural Rights in its general comment No. 14 on the right to the highest attainable standard of health and also in the *Global Strategy*. In particular, the focus needs to be on primary health care in those countries that are not yet achieving universal health coverage. There is a need to encourage health-care workers into rural areas to make health care available to all: with the domination of specialized medicine, rural health has been left behind. Recommendations to move away from training strategies dominated by transfer of clinical competencies, and towards a transformative education agenda enhancing the role of health-care workers as change agents in society, remain important.

35. Some groups in society are overlooked in medical education. During his country visits, the Special Rapporteur has gathered testimonies about the reluctance of some doctors to work with groups in vulnerable situations, such as people in extreme poverty or using drugs, or the homeless. He urges people who are responsible for shaping the knowledge, skills and values of future doctors to encourage them to engage with those groups and to prevent the tendency to ignore suffering, which conflicts with the essence and purpose of the medical profession. The Special Rapporteur notes that the power and prestige associated with medical specialization reinforce such biases, away from caring for the groups in the most vulnerable situations. The selection of students from communities in marginalized and disadvantaged situations can help address those problems.

36. Two other groups in vulnerable situation are persons with disabilities and those requiring palliative care. Both are often overlooked in medical curricula, and they require holistic, quality, rights-based care. Examples of successes follow.

37. **Palliative care.** In Uganda, the Palliative Care Association worked with lawyers to train over 300 health-care workers, including doctors, nurses, clinical officers and allied health professionals on palliative care as a human right. Law students also chose palliative care sites for their clinical law site placements internships. Costa Rica recognizes the ageing population in its workforce planning and in 2009 started a palliative medicine residency programme, with its graduates teaching medical students throughout their training. They plan to adopt palliative care as a fundamental principal of primary health care.

38. **Persons with disabilities.** Although they represent 15 per cent of the global population, persons with disabilities are twice as likely to find health-care workers' skills and health facilities inadequate, three times more likely to be denied health care and four times more likely to be treated badly in the health-care system.²³ Training health-care workers on human rights and service provision for persons with disabilities is therefore essential. Inclusive health training requires modules on the Convention on the Rights of Persons with Disabilities, human rights and the right to health and a disability inclusion approach with specific interventions to address the needs of persons with disabilities in every sector of health care. Providing powerful

²³ WHO and World Bank, *World Report on Disability* (Geneva, 2011).

and visually accessible communication through the use of sign language, the implementation of important communication technologies and cultural awareness training for health-care workers, including doctors, have been found to be effective in promoting access to health care in persons with disabilities.²⁴ The Council of Europe has recommended that higher education institutions, in particular, medical schools, should review their curricula to ensure that they adequately reflect the provisions of the Convention.²⁵

39. The Special Rapporteur cautions that, even if greater emphasis were to be placed on training more mid-level workers to achieve a more equitable distribution of primary health care, and universal health coverage, this might not in itself address the emphasis placed on biomedical models. There is a risk that all health-care workers will continue the emphasis of looking for, and treating, biomedical “causes” of all health conditions. The Special Rapporteur urges mid-level worker training to be grounded in public health principles, acknowledging the contribution that environmental, social and economic factors have on individual and community health.

40. The concept of syndemics may offer medical educators new frameworks for teaching, moving away from the conventional “vertical” framing of diseases. Syndemics examines the biosocial complex, which consists of interacting, co-present or sequential diseases and the social and environmental factors that promote and enhance the negative effects of disease interaction.²⁶ Accordingly, health-care worker education should embrace methodologies that teach the disease clusters arising from biosocial conditions, emphasizing the social and underlying determinants that give rise to them. The alternative of teaching about each disease as a vertical condition contributes to fragmentation.

41. There is also an urgent need for medical education to address and prioritize today’s emerging global and public health issues. These include climate change, mental health, an ageing population, palliative care, the risk factors and effects of non-communicable diseases, opioid and other drug use challenges, and others depending on context. Use of evidence-based education on addiction is also necessary so that physicians are better informed and comfortable prescribing dignity-affirming opioids when needed. In many submissions, reference was made to participatory and community-embedded educational approaches to those public health issues.

III. Strong health systems are needed for an effective workforce

42. A human rights-approach provides a transformative set of provisions with profound implications. The equality and dignity of all people, including health-care workers, lie at the heart of human rights. In this section, the Special Rapporteur examines how the fulfilment of the health-care workers’ rights would contribute meaningfully to improved health systems. He also looks at the components of health systems to illustrate its impact on the capacity of health-care workers to make health care available, accessible, acceptable and of good quality for all. Universal health coverage cannot be achieved without strong health systems.

²⁴ Alexa Kuenburg, Paul Fellingner and Johannes Fellingner, “Health care access among deaf people”, *Journal of Deaf Studies and Deaf Education*, vol. 21, No. 1 (January 2016), pp. 1–10. Available at <https://doi.org/10.1093/deafed/env042>.

²⁵ Parliamentary Assembly, Council of Europe, “Ending coercion in mental health: the need for a human rights-based approach”, document No. 14895, 22 May 2019. Available at <http://assembly.coe.int/nw/xml/XRef/Xref-DocDetails-EN.asp?fileid=27701&lang=2>.

²⁶ M. Singer, N. Bulled, B. Ostrach and E. Mendenhall, “Syndemics and the biosocial conception of health”, *Lancet*, vol. 389, No. 10072 (2017), pp. 941–950.

43. The health-care workforce is an essential part of the health system and it cannot function effectively to provide quality health care without the support of all other elements of the health system.

44. The right to health requires States to address barriers arising from inequality and discrimination that impede appropriate access to health care and to the underlying and social determinants of health. Groups in vulnerable situations must be prioritized. Health-care workers themselves should be protected against inequality and discrimination, which can take various forms within health systems. Community health-care workers, and the communities they work with, often suffer poor health as a result of being placed at the bottom of the medical hierarchy, where they experience powerlessness, discrimination, inequality and poverty. States must improve working conditions and address pay inequities for health-care workers most directly serving population and social needs, as well as developing education campaigns to enhance the image and reputation of all health-care workers.

45. Each part of the health system must function in a way that supports health-care workers, respects their human rights and promotes fair employment conditions. In the following paragraphs, the Special Rapporteur identifies some features that are needed to strengthen the health-care workforce so that it can deliver available, accessible, acceptable and good quality services, for all people.

A. Health services and facilities

46. In order to retain the health-care workforce, and to ensure the presence of health-care workers in locations that are accessible even to remote, rural or marginalized communities, appropriate facilities, including ad hoc facilities, should be located in such settings, and they must be of an adequate standard to enable quality care for all. The Special Rapporteur has observed the substandard quality of many rural and remote health centres, often in stark contrast to the urban and specialist facilities. Furthermore, accommodation should be provided for health-care workers and their families as an incentive to work in remote locations. Submissions for the present report provided evidence of success when housing was provided for rural health-care workers.

B. Medical products, essential medicines, vaccines and technologies

47. Health-care workers cannot function adequately without a reliable, consistent supply of appropriate, quality medicines, vaccines and technology, including communications technology. Essential health interventions and technologies should not be limited to biomedical products and should include effective psychosocial and population-based public health interventions.

C. Health information systems

48. Health-care workers need to access and add to the records of the people that they are treating, and this information must accompany users of services as they are referred throughout the system. Health-care workers need to be trained in those methods so that data is available about the health of the communities, while still securing users' confidentiality. Information about the number of health-care workers by category must be current and available for human rights accountability purposes.

D. Health financing

49. Health-care workers are entitled to all the rights held by employees: the right to decent work is supported by the Universal Declaration of Human Rights, and the decent work Agenda of the International Labour Organization. The Committee on Economic, Social and Cultural Rights, in its general comment 14, has also acknowledged that health-care workers are entitled to domestically competitive salaries and appropriate training. The aim of the right to decent work is to ensure that everyone – without discrimination – enjoys just and favourable conditions and the rights to organize and bargain collectively. The Special Rapporteur supports a fair distribution of finances for all health-care workers, so that community health-care workers are paid and the practice of using unpaid volunteers for important primary health-care work is discontinued.²⁷ The medical hierarchy, and the dominance of the biomedical paradigm, can result in unacceptable income inequities between medical specialists and other health-care workers.

E. Leadership and governance

50. A health-care workforce cannot function effectively without good leadership, management and governance. When health-care workers are rendered inefficient through poor or absent management, their ability to provide accessible, quality health care diminishes. Good governance can ensure the right-to-health requirement for a comprehensive national health plan which encompasses human resources, has been developed in a participatory way, is implemented and reported against. The plan for health-care workers should include preventive, curative and rehabilitative health, covering physical and mental health, and it should also include mid-level workers.

F. Corruption in the health sector

51. Corruption is an issue that the Special Rapporteur has addressed in other reports (see [A/72/137](#)). Types of corruption that have a particularly demoralizing impact on health-care workers include long-term absenteeism, financial mismanagement, nepotism and other unfair treatment of health-care workers. A rights-based approach to leadership and governance includes the active participation of health-care workers in decision-making and transparency around decisions made, including financial decisions.

52. The medical hierarchy has a strong impact on leadership and governance, which can lead to institutional corruption. Those at the top of the hierarchy have far greater access to managers and those responsible for governance and overall decisions on health policy, including resource allocations. Their influence can be wielded over spending decisions, so that funding is more likely to go to specialist services than to health promotion measures or less prestigious but important services such as child mental health, geriatrics, palliative care or primary health-care facilities in settings which are remote and without advocacy power.

²⁷ WHO, *Guideline on Health Policy and System Support to Optimize Community Health Worker Programmes* (Geneva, 2019). Available at www.who.int/hrh/community/en/.

IV. A rights-based approach to health-care workforce strengthening

53. The present report illustrates some structural elements that shape the capacity of the health-care workforce to fulfil States' right-to-health obligations to make health care available, accessible, acceptable and of good quality. In this section the Special Rapporteur applies the right to health to health-care workers, to identify issues that can enhance or restrict their ability to perform well.

54. The right to health is recognized in the Constitution of the World Health Organization and protected by the Universal Declaration of Human Rights and international human rights treaties which are binding on States parties, including the International Covenant on Economic, Social and Cultural Rights, the Convention on the Elimination of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination against Women, the Convention on the Rights of the Child, the Convention on the Rights of Persons with Disabilities and the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families. Additionally, regional human rights treaties and many domestic constitutions protect the right to health. The international treaties and domestic laws obligate States to take action to respect, protect and fulfil the right to health and to promote education of health-care workers so that they can help States meet their right-to-health obligations.

55. The right to health gives rise to obligations that provide a framework for action for duty bearers, as well as a framework of reference for accountability. The right to health is subject to progressive realization. This means that many aspects of the right to health do not have to be realized immediately; rather, States must take effective and targeted measures towards the progressive realization of the right to health. However, States also have some immediate obligations, such as: the equitable distribution of health facilities and services; the provision of essential medicines; access to basic shelter, potable water and safe sanitation; and the adoption of a national health strategy on the basis of epidemiological information which should inform national health-care workforce planning and education.

A. Equality and non-discrimination

56. The human rights principles of equality and non-discrimination apply to health-care workers in their workplaces and to the selection of health-care workers. Therefore, it may be necessary to have outreach programmes for the recruitment of health-care workers from communities and groups in vulnerable situations, such as indigenous peoples, to reduce discrimination and promote respect for cultural difference. Such selection programmes have been shown to have a positive impact in many different settings, including the Open Society Foundations Roma Health Scholarship Programme, which has supported over 500 Roma medical students in the past 10 years in Bulgaria, North Macedonia, Romania and Serbia.²⁸

57. Effective measures must be in place to achieve a gender balance among health-care workers in all fields to ensure equality and non-discrimination on the basis of gender. These and other measures, such as inclusion of minority groups and persons with disabilities, is necessary to ensure respect for cultural difference for these communities and for the workers providing their health care.

²⁸ Merziha Idrizi, "Celebrating 10 Years of Investing in Roma Health", Open Society Foundations (8 April 2019). Available at www.opensocietyfoundations.org/voices/celebrating-10-years-investing-roma-health.

58. Human rights, including respect for cultural diversity and neurodiversity, as well as the importance of treating patients and others with respect, should be a compulsory part of training for all health-care workers.²⁹ In many reports of previous Special Rapporteurs, States have been urged to include human rights training for health-care workers. In several submissions for the present report, the ways in which human rights had been included in training were described, and the World Medical Association states that medical education should include compulsory human rights courses at all stages.

B. Participation

59. A key human rights principle is that entitlement to participate in decisions or policy development that affect them. Accordingly, it is incumbent upon States to include health-care workers and civil society when developing national health and health-care workforce plans. Health education institutions and representatives from all health-care worker cadres should participate in the design and monitoring of workforce plans. Care needs to be taken to ensure that the medical hierarchy is not replicated in planning consultations. Community health-care workers from rural settings will likely have greater understanding of the health needs of the population than medical specialists working in tertiary hospitals.

C. Ongoing support and training for the remote and powerless

60. The Special Rapporteur has observed, notably during his country visits, that health-care workers located far from the hubs of medical education and secondary or tertiary level facilities receive less mentoring, supervision and ongoing training than their urban counterparts. Yet, perversely, especially in lower resource countries with a high percentage of the population living rurally, such health-care workers are critically important for the achievement of universal health coverage, or fulfilment of the State core obligation to provide essential primary health care on a non-discriminatory basis. Therefore, in addition to the requirements to select an appropriate range of people to train as health-care workers, and incentivizing workers to live and work in rural and remote areas, it is necessary to provide meaningful oversight, mentorship and continuing training. Health-care workers without such support have been shown to lose clinical skills and enthusiasm for their roles.³⁰ The Global Workforce Alliance found that, despite the great successes achieved in various contexts through the use of mid-level health-care workers, in contexts where they receive little supervision and insufficient training, the quality of their care can be suboptimal and negatively impact retention.³¹

D. Governance of health-care workers

61. Health-care workers should be self-governed. The independence of health professions from the State prevents subordination to the State. Subordination can result in dual loyalty of health-care workers, which is in contradiction of their duty to respect and protect users' human rights and the right to health at all times. If the State

²⁹ G. Backman and others, "Health systems and the right to health: an assessment of 194 countries", *The Lancet*, vol. 372, No. 9655 (2008), pp. 2047–2085.

³⁰ A. Palagyi, G. Brian and J. Ramke, "Training and using mid-level eye care workers: early lessons from Timor-Leste", *Clinical and Experimental Ophthalmology*, vol. 38, No. 8 (2010), pp. 805–811.

³¹ WHO, Global Health Workforce Alliance, "Mid-level health workers for delivery of essential health services" (2013), p. 32.

comes between a health-care worker and users, problems of dual loyalty and impartial health care arise, creating serious problems with confidentiality and trust. Dual loyalty is a human rights issue in prisons,³² in psychiatry,³³ when working with migrants and refugees³⁴ and also in sexual and reproductive health and rights.³⁵

E. International assistance and cooperation

62. States are obligated to provide technical and financial assistance to other States when requested, to assist them to meet right-to-health obligations. Health-care worker education in low- and middle-income countries receives only a small percentage of overall support for health through official development assistance. Donor support is further expounded below.

F. Accountability

63. States must be held to account for their obligations to ensure full enjoyment of the right to health and other stakeholders, including professional organizations and universities, for their responsibility in terms of the right to health. All should promote a health-care workforce that can provide quality health-care services to all. Accountability mechanisms should reflect the principles of transparency and participation and be based on quality data and information.

V. Issues in focus

A. International assistance for health-care workforce strengthening

64. In 2016, about \$21.3 billion was allocated to health from total overseas development assistance.³⁶ The total spent on health and medical training amounted to \$446 million, or just 2 per cent of the total expenditure on health aid. WHO has called for additional official development assistance funding for health-care workforce training, especially in the light of the many health-care workers trained in low- and middle-income countries leaving to work in high-income countries.³⁷

65. The Special Rapporteur expresses two concerns about health assistance allocated to training. First, relative to the need for additional health-care workers in low- and middle-income countries, such financial support is small, and unlikely to significantly help countries meet their training needs. Second, the outcomes of health training cannot be sustained if inputs are ad hoc, and not part of an overall national plan of strengthening the workforce and the health system. As referred to above,

³² S. Glowa-Kollisch and others, “Data-driven human rights: using dual loyalty trainings to promote the care of vulnerable patients in jail”, *Health and Human Rights Journal*, vol. 17, No. 1 (2015), pp. 124–135.

³³ M.D. Robertson and G. Walter, “Many faces of the dual-role dilemma in psychiatric ethics”, *Australian and New Zealand Journal of Psychiatry*, vol. 42, No. 3 (2008), pp. 228–235.

³⁴ Linda Briskman and Deborah Zion, “Dual loyalties and impossible dilemmas: health care in immigration detention”, *Public Health Ethics*, vol. 7, No. 3 (2014), pp. 277–286.

³⁵ J. Jaime Miranda and Alicia E. Yamin, “Frameworks for understanding dilemmas of health care in a globalized world: a case study of reproductive health policies in Peru”, *Politics and Ethics Review*, vol. 1, No. 2 (2005), 177–187.

³⁶ Organisation for Economic Co-operation and Development statistics, available at: www.oecd.org/dac/stats/aidtohealth.htm.

³⁷ A Micah, et al, “Donor financing of human resources for health, 1990–2016: an examination of trends, sources of funds, and recipients”, *Globalization and Health*, vol. 14, No. 98. Available at <https://globalizationandhealth.biomedcentral.com/articles/10.1186/s12992-018-0416-z>.

health training and education is of little use if the trainees are not subsequently integrated into functional health systems and provided with ongoing supervision and mentoring.

66. Furthermore, the Special Rapporteur has expressed concerns about the reductive nature of indicators used to monitor Sustainable Development Goals and universal health coverage goals that do not promote rights-based responses (see [A/71/304](#)). Indicators that capture the number of people trained, but do not convey their ability to translate the training into health outcomes for their communities, can be misleading. Yet many donors continue to report their overseas development expenditure and activities in health training in such terms.

67. Ad hoc training of health-care workers in low resource settings can lead to distortions in the allocation of health-care workers within the health system.³⁸ Training provided to help strengthen the workforce must cover the whole health system, including: the regulatory environment; financial considerations; trainees' needs for a reliable supply of medicines or devices; information systems to monitor post-training services; and supervision of newly trained health-care workers. Such consideration of the whole health system promotes sustainability of outcomes and the right to health.

B. Mental health workforce training

68. Mental health workforce training requires special mention. As outlined in the 2017 report of the Special Rapporteur, on mental health, obstacles exist that impair the provision of mental health care and hinder the realization of the right to health (see [A/HRC/35/21](#)). Such obstacles include the overuse of the biomedical model to define emotional distress and a medical hierarchy that can result in coercion that is detrimental and dehumanizing to patients, as well as providers of mental health. Power asymmetries between medical specialties, between doctors and other health-care workers, and between doctors and users of services, create additional barriers to the realization of the right to health.

C. Mental health conditions as biologically determined diseases rather than consequences of social and environmental risk factors

69. Too often, decisions in psychiatry result from paternalism (not consistently taking seriously the views of the users of psychiatric services) and by an overzealous commitment to biomedical interventions and psychotropic medications. However, social psychiatry and proponents of the structural competency movement in psychiatry take to heart what Rudolf Virchow observed 150 years ago, that medicine is a social science, physicians are the natural attorneys of persons in situation of poverty and social problems are issues that fall to a large extent within their jurisdiction.

70. The prevailing approach to mental health is based on a biomedical model of disease in which mental health conditions are too often seen as a biologically defined abnormalities irrespective of context. However, mental health differs from other types of health in that the biological markers for mental health conditions do not exist and the demarcation between health and illness are in large part defined by culture and

³⁸ Carmel Williams and Garry Brian, "Using a rights-based approach to avoid harming health systems: a case study from Papua New Guinea", *Journal of Human Rights Practice*, vol. 5, No. 1 (2013), pp. 177–194.

context.³⁹ As a result, mental distress in one context might be considered part of normal human experience whereas in another culture the same constellation of behaviours could signify illness.

71. Mental health is heavily influenced by social factors (see [A/HRC/41/34](#)). However, overreliance on the biomedical model to explain emotional distress favours pharmacological treatment over addressing the core underlying and social determinants of health, such as poverty, inequality, discrimination and violence, which result in chronic stressors that lead to distress. Institutional corruption, which occurs when the mental health care orthodoxy is no longer sufficiently independent from other institutions, namely the pharmaceutical industry, leads to compromising truth-seeking. This results in perverse incentive structures that reinforce and reward the over-use of psychotropic medicines, diverting resources that could be used to address and understand the role of health determinants and to allow access to cost-effective psychosocial interventions.

D. Mental health-care standards defined by one professional group

72. Most mental health care is provided by primary care physicians, health-care workers, psychologists, clinical social workers, therapists, pastoral counsellors and peer specialists. However, one professional group – psychiatrists – controls the definition of mental health and mental illness. This control occurs globally through the *Diagnostic and Statistical Manual of Mental Disorders*,⁴⁰ the manual of psychiatric diagnoses that has become the de facto standard for categorizing mental distress through such uses as the International Classification of Diseases. It has been criticized for medicalizing normal aspects of the human experience (e.g., the medicalization of grief; pathologizing normal age-related cognitive decline as “mild neurocognitive disorder”), while also using a diagnosis-by-checklist approach that facilitates the use of pharmacology as the primary treatment option.

73. The codification of emotional distress as discrete disorders in the *Diagnostic and Statistical Manual*, together with the dominance of the biomedical model in organized psychiatry, can result in the coercion of both users and health-care workers, limiting their right to health or their provision of health care. This paternalistic approach has not kept pace with other areas of health care that have evolved to include users of services, through shared decision-making, to arrive at an approach to mental distress that could be based on partnership and mutual trust between providers and users of services.

E. Power asymmetry reflected in definitions

74. The power asymmetry that results from control of mental health definitions, ascribing causation (via the biomedical model) and defining appropriate and inappropriate treatment does not emphasize the role of communication skills, relationships between mental health-care workers and users of services and the role of context to identify the cause of mental distress and appropriate, often non-pharmacological, solutions. In some contexts, the power asymmetry results in the delegitimization of treatment approaches other than medication and leads to overuse of psychotropic medication. The field of mental health continues to be over-medicalized, with support from academic psychiatry and the pharmaceutical industry

³⁹ A. Kleinman, “Culture, bereavement, and psychiatry”, *The Lancet*, vol. 379, No. 9816 (2012), pp. 608–609.

⁴⁰ *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (Washington, D.C., American Psychiatric Association, 2013).

(see [A/HRC/35/21](#) and [A/HRC/41/34](#)) and from health insurers which will reimburse costs of medicines but not necessarily psychosocial interventions.

75. Psychiatry as a profession has a near monopoly of power over most decisions, which may be harmful not only for users of services and other mental health professionals, but also psychiatrists. With such concentration of power within one professional group comes enormous pressure in the process of decision-making, especially in cases involving decisions to use biomedical interventions or to promote voluntary or even involuntary placement (hospitalization) and treatment. Psychiatrists and users of services both become the hostages of an ineffective system in which decisions to override human rights are based on unsound arguments about danger and medical necessity. It is well accepted in the profession that psychiatrists will often make decisions to deprive persons with certain mental health conditions of liberty to avoid legal action against them “if something happens”, and this leads to misuse and overuse of coercion. Changes in medical education that significantly reduced those power asymmetries and incentives to use coercion would be beneficial for users of services and psychiatrists.

F. Changes needed for mental health education

76. There must be changes in mental health workforce training to address the issues of context and its effect on mental health, the narrowness of mental health and mental distress definitions and the power asymmetry between health-care workers and users of services. Mental health should have benefited from changes in medical training mentioned earlier that emphasize competency in practice. However, mental health training models, especially in medical education, have lagged behind other areas of medical care. Training of other health-care workers should also change to embrace the role of context in causing mental health distress, the role of health determinants on mental health and the role of communication and relationships in improving mental health.

77. Psychiatrists and other mental health professionals must be willing to see the ways in which institutional thinking and practice, and guild interests, may impede their ability to genuinely make room for models of care that fall outside the medical model.⁴¹ The dominance of the biomedical model in mental health education is an epistemic injustice that impedes the progress required to promote and protect the right to mental health.

78. In some countries, medical education is expected to create physicians who have interpersonal and communication skills “that result in effective information exchange and teaming with patients, their families and other health professionals.”⁴² The Canadian CanMEDS framework of outcomes-based education, used in many countries, defines one role of a physician as “communicator”, described as the ability to “form relationships with patients and their families that facilitate the gathering and sharing of essential information for effective health care”.⁴³ This framework emphasizes an understanding of the user’s perspective, context and socioeconomic status as relevant psychological and sociological issues. It is only through such understanding that physicians and users can come to a shared understanding on which

⁴¹ R. Mezzina and others, “The practice of freedom: human rights and the global mental health agenda”, *Advances in Psychiatry* (Springer, 2018); Robert Whitaker and Lisa Cosgrove, *Psychiatry under the Influence: Institutional Corruption, Social Injury, and Prescriptions for Reform* (Springer, 2015).

⁴² M. S. Kavic, “Competency and the six core competencies”, *Journal of the Society of Laparoendoscopic Surgeons*, vol. 6, No. 2 (2002), pp. 95–97.

⁴³ See www.royalcollege.ca/rcsite/canmeds/framework/canmeds-role-communicator-e.

to make shared decisions as to best courses of action. Informed consent needs to be reconfigured as a relational process. It is an ongoing exercise, not something that can be achieved once and for all by disclosing currently known risks, benefits, and alternatives to treatment.⁴⁴

79. These frameworks require teaching that leads to understanding and practice that considers the context in which the patient lives. CanMEDS describes the need for physicians to be health advocates to “contribute their expertise and influence as they work with communities or patient populations to improve health. They work with those they serve to determine and understand needs, speak on behalf of others when required, and support the mobilization of resources to effect change.”⁴³

80. Mental health workforce training needs to be adapted to emphasize the underlying and social determinants of health, redefine mental illness in the context of culture and context, and equip health-care workers with the attitudes, knowledge and skills necessary to build relationships to avoid the inherent paternalism of the system.

81. It is also important, in this climate of global corporatization and commoditization of health care, to train the health-care workforce to think critically about the use of research findings to guide decisions. Such training should include critical appraisal of the medical literature, but also an understanding of cognitive biases to improve confidence to make better decisions.

82. Some medical schools have rebuilt their curricula to use social justice⁴⁵ and socially accountable education as cornerstones. Such models move medical student training away from academic medical centres to areas where the underlying and social determinants that impact health, including mental health, can be directly witnessed by those in training. In addition to developing clinical competence, these models develop “structural competency” by directing attention to the social factors that are among the root causes of health disparities.⁴⁶

83. The workforce must have the skills and willingness to forge relationships with users of services that will lead to a shared understanding of emotional distress within the context of the user’s culture and life. In so doing, they begin to address many of the health-care workforce problems already identified by WHO.

84. Health-care workforce training also needs to move away from a strict emphasis on the biomedical model to explain mental distress and illness to incorporate other sociological and psychological models of explanation. It is only through widening the lens that solutions can be implemented in such a way that they address users’ needs within their context and culture.

85. Finally, mental health research needs to embrace participatory research and its emancipatory traditions to identify underlying causes of mental distress and find ways to address them. Participatory research allows for genuine stakeholder involvement and will have the combined effect of delivering mental health care to groups in most vulnerable situations while also teaching a re-envisioned model of providing care and support to persons with mental health conditions. It was observed in a recent meta-analysis of 35 years of intervention research that “burnout is prevalent among mental health providers and is associated with significant employee, consumer and

⁴⁴ R. Blum, “When patient and physician disagree on patient’s ‘best interest’”, *American Medical Association Journal of Ethics* (previously known as *Virtual Mentor*), vol. 11, No. 3 (2009), pp. 223–227.

⁴⁵ See for example, <https://medicine.tufts.edu/education/health-justice-scholars>.

⁴⁶ L.J. Kirmayer, R. Kronick and C. Rousseau, “Advocacy as key to structural competency in psychiatry”; *JAMA Psychiatry*, vol. 75, No. 2 (2018), pp. 119–120.

organizational costs;” and that “the field has made limited progress in ameliorating mental health provider burnout.”⁴⁷

VI. Recommendations and conclusions

86. The role of the health-care workforce in the realization of the right to physical and mental health is crucial. While investing in the health sector, States should ensure that the education of all health-care workers, as well as the implementation of national health workforce strategies, fully embrace all the elements of a human-rights based approach, the right-to-health analytical framework and a modern public health approach. The global community needs to learn lessons from the past, when science and the practice of medicine was exercised without a human rights imperative, resulting in more harm than good. Empowering all health-care workers with rights-based competencies and skills not only prevents violations of human rights in the care of patients: it also promotes and protects the rights of health-care workers, as it reduces power asymmetries within the health workforce, prevents corruption in the health sector and contributes to decent working conditions and a climate of mutual trust and respect within and beyond health-care systems.

The Special Rapporteur urges States to:

87. Develop national health-care workforce plans in a participatory way, with representation from all cadres of health-care workers and other stakeholders, including representatives of civil society and users of health services.

88. Undertake measures to reduce power asymmetries within the existing medical hierarchy through a rights-based approach in health education.

89. Ensure that schools of medicine and public health and all colleges that train health-care workers have their curricula firmly grounded in a human rights framework, aligned with national health sector strategies and health workforce plans, in order to prepare future health-care workers in all competencies (not just clinical skills).

90. Ensure that all health education facilities design their curricula to reflect global health priorities and the needs of the country, paying particular attention to groups that are in vulnerable situations, including, inter alia, people with disabilities and people needing palliative care.

91. Ensure that there is coherence across government agencies with priority given to population health needs and the right to health.

92. Ensure that medical and health training curricula provide a balance between different competencies, including public health, preventive health, community and social medicine, mental health promotion and care, palliative care, medical ethics, medical law, managerial skills, communication skills and human rights.

93. Ensure that medical and nursing schools select their candidates without discrimination and to reflect the needs of the country.

94. Ensure that nurses’ and community health-care worker training is professionally recognized and developed by nurses and community health-care workers.

⁴⁷ K. C. Dreison and others, “Job burnout in mental health providers: a meta-analysis of 35 years of intervention research”, *Journal of Occupational Health Psychology*, vol. 23, No. 1 (2018), pp. 18–30.

95. **Recognize the crucial importance of nurses and mid-level health-care workers and budget for their decent work conditions.**
96. **Ensure that all health-care workers are paid adequate and appropriate salaries.**
97. **Invest adequately in health systems so that health-care workers can provide health care that is available, accessible and acceptable to all and of good quality.**
98. **Allow oversight of medical curricula by independent experts to determine whether curricula are promoting public health and human rights-based approaches to health.**

The Special Rapporteur urges national health professional organizations to:

99. **Accept responsibility to ensure that schools of medicine and public health, and all colleges that train health-care workers, have curricula firmly grounded in human rights and right-to-health frameworks.**
100. **Promote incentives that attract people to primary health care.**
101. **Promote incentives that attract people to work in rural or remote settings including by, inter alia, providing housing for them.**
102. **Be accountable for the medical profession and use self-governance mechanisms so that their members have the knowledge, skills and spirit of human rights-based approaches to the delivery of health care and public health.**

The Special Rapporteur urges leadership of universities and other health education institutes to:

103. **Ensure that their curricula reflect national health-care workforce strategies.**
104. **Keep curricula evolving to meet the needs of society and reflective of new knowledge and emerging public health priorities, including climate change.**
105. **Have all curricula firmly grounded in human rights and right-to-health frameworks which promote an understanding that health-care workers should engage with groups in vulnerable situations, including persons with disabilities.**
106. **Select candidates for training that come from areas of deprivation and rural areas and reflect all of society.**
107. **Address the knowledge gap in rights-based and evidence-based mental health within medical education, and eliminate bias in knowledge, related to the overreliance of medical education on the biomedical paradigm.**
108. **Recalibrate mental health research priorities to promote independent, qualitative and participatory social science research, and explore alternative service models that are non-coercive and prevent over-medicalization and institutionalization.**