PUBLIC HEALTH AND HUMAN RIGHTS

CONFERENCE ORGANISED BY MONASH UNIVERSITY AND KING'S COLLEGE, LONDON

PRATO, ITALY

7-9 JUNE 2007

Public Health and Human Rights: at the Crossroads

by Paul Hunt,
UN Special Rapporteur on the right to the highest attainable standard of health

Public health and human rights have reached a major crossroads.

Clearly, the right to the highest attainable standard of health depends upon the interventions and insights of public health - obviously, the right to health cannot be realised without public health programmes.

Equally, the classic, long-established public health objectives can benefit from the newer, dynamic discipline of human rights.

At an abstract level, a few far-sighted people understood this when the WHO Constitution was drafted in 1946 – that is why the Constitution refers to the right to the highest attainable standard of health.

And, again at an abstract level, some understood this at Alma-Ata in 1978 – which is why the Alma-Ata Declaration reaffirms the right to health.

The Ottawa Charter of Health Promotion of 1986 also reflects the connections between public health and human rights.

But these connections were general and abstract. At that time, the right to health was only dimly understood and attracted limited support from civil society. For the most part, the right was little more than a slogan, a sort of bumper sticker.

Fortunately, since Alma-Ata and Ottawa, human rights have come a very long way.

Crucially, they have travelled a long way since the pioneering health and human rights work of Jonathan Mann and his colleagues in the 1990s -- to all of whom we are enormously indebted.

But Jonathan suffered from a serious limitation that does not constrain us today.

When Jonathan worked, there was a widespread and detailed understanding of many human rights -- and his brilliance was to apply them to public health.

But during his lifetime there was no widespread and detailed understanding of what must surely be a cornerstone of any consideration of public health and human rights: *the right to the highest attainable standard of health.*

For that we had to wait until 2000, when a UN committee of independent human rights experts - working in close collaboration with WHO, as well as many others – set out its detailed understanding of what the right to health means.

At last, the right to health as set out in WHO's constitution – affirmed at Alma-Ata – enshrined in numerous binding international human rights treaties – was more than a slogan!

Here was something detailed that could be wrestled with and applied.

Of course, this UN understanding of the right to health is incomplete. Of course it is flawed. Nonetheless, it is detailed and compelling. For the first time, we have an understanding of the right to health that we can work with - something we can improve in the light of practical experience.

So the UN's right to health insights of 2000 were another important milestone in the journey of public health and human rights.

Since 2000 the pace has quickened.

An increasing number of civil society organisations are campaigning around health and human rights – this is especially true in low-income and middle-income countries. Significantly, a number of well-established international human rights organisations that have traditionally focussed on civil and political rights - organisations like Amnesty International - are beginning to turn their attention to the right to health. Crucially, some groups of health professionals - Physicians for Human Rights, even the British Medical Association - are now giving much more attention to health and human rights. Moreover, other groups of health professionals that help to deliver health services to vulnerable individuals and communities in all regions of the world - like Partners in Health – are increasingly using human rights in their work.

Providing a bridge between many of these groups, the People's Health Movement has recently launched a global 'Right to Health and Healthcare Campaign'.

But there are other encouraging developments, too. The academic literature is deepening. Thanks to the work of innumerable organisations and individuals, we are learning how to operationalise the right to health. We are developing new tools, such as indicators and benchmarks, for measuring the progressive realisation of the right to health. This is enabling us to develop right to health impact assessments and to engage with health policy makers.

In short, the days when the right to health was mere rhetoric are long gone – they lie far behind us.

For the first time, most of the key pieces are in place for public health and human rights to invigorate and enrich each other in an operational, systematic and sustained way.

Since my appointment in 2002, I have produced about twenty-five UN reports on the right to the highest attainable standard of health.[1] Some of these reports are on general themes, such as maternal mortality.[2] Some of them are on the right to health in specific countries.[3]

I do not have the time to explore them here but, time and again, these reports illustrate the common ground between public health and human rights. They show how human rights can help to reinforce *existing*, good health programmes. They also show how human rights can sometimes help to identify *new*, equitable health policies.

Both public health and human rights stress the importance of the underlying determinants of health, as well as health care. Both look beyond the health sector. Both struggle against discrimination and disadvantage. Both demand cultural respect. Both attach great importance to public information and education. And so on.

Human rights strengthen public health in several ways, not least by introducing a set of rules - guidance for policy-making, as well as by demanding accountability.

Human rights and the right to health ask awkward questions.

As you devise this new health programme, how will you ensure that the voices of women and girls are heard and respected? How are you ensuring that the poor and vulnerable have access to these health services? How are you measuring the impact of that new mine on the health of neighbouring communities? How are you measuring whether or not access to health care is being progressively improved? If you are using indicators and benchmarks, are they disaggregated on the grounds of sex, ethnicity and other prohibited grounds of discrimination? Why are maternal and infant mortality rates static - or worsening - for some ethnic minorities? Are your health programmes respectful of minority cultures? Are they available in common minority languages?

But human rights not only ask awkward questions, they also require answers – that is what accountability is all about.

For example, if health outcomes are not improving, we need to know why, so that policy adjustments can be made.

[1] These various reports, as well as other presentations, press releases, interviews etc are available at the website of the Right to Health Unit, Human Rights Centre, Essex University, England: http://www2.essex.ac.uk/human_rights_centre/rth/

[2] See report dated 13 September 2006, A/61/338 at the website in footnote 1.

[3] There are country specific reports on: Mozambique, Peru, Uganda and Romania. Additionally, there is a joint report on Guantanamo Bay and another on Lebanon/Israel (regarding the conflict of July/August 2006). Additionally, there is a report on the World Trade Organisation. A report on Sweden will be available shortly. All these reports are available at the website in footnote 1.

If the evidence shows that a new industrial plant is damaging health, we need to identify what is going to be done and by whom. What is the mining company going to do about it? What is the local authority going to do? What is the State going to do?

If those living in poverty do not have access to essential health care, water and sanitation, we need to identify the obstacles so those responsible can take specific, targeted remedial action – and if they fail to take all reasonable steps, the poor need to be told why.

In short, human rights accountability asks questions and requires answers, *not* with a view to blame and punishment, but with a view to finding out what works and what does not. Accountability is a powerful human rights tool for improving the health of all.

Of course, we have not figured out all the implications of the right to health – and we probably never will. The only human right or discipline without dilemmas and disputes is one that has atrophied and died.

But, in my view, *for the first time*, the key pieces are now in place for public health and human rights, including the right to health, to invigorate and enrich each other in an operational, systematic and sustained way.

But I have to also say frankly that there is no chance of us moving forward in the right direction - there is no chance of systematically operating the right to health – without the active engagement of many more health professionals in this enterprise. That is why this conference is so important.

To be blunt, in my UN work I am often dismayed by the lack of knowledge about health and human rights. Of course, there are honourable exceptions, but most health professionals in most Ministries of Health have not even heard of the right to the highest attainable standard of health. If they have heard of it, they have no idea what it means, neither conceptually nor operationally. If they have heard of it, they are probably worried that it is something that will get them into trouble. I am not reproaching them – it is not their fault if they have never been exposed to the empowering potential of human rights. The problem is partly one of language – public health and human rights have much in common, but the language used is often different.

In my view, we have gone about as far as we can with public health and human rights unless we can generate much more support from many more health professionals. That is what I had in mind when I said, at the beginning of these remarks, that we have reached a major crossroads.

It is imperative that many more health professionals come to appreciate that the right to the highest attainable standard of health is not just a rhetorical device, but also a tool that can save lives and reduce suffering, especially among the most disadvantaged.

If we are to make progress, we have to get across the message much more clearly and widely that human rights, including the right to health, are allies and assets for health

professionals to use – to devise better policies and programmes; to raise more funds from the Treasury; to leverage more funds from developed countries to developing countries; in some countries, to improve the terms and conditions of those working in the health sector; and so on.

We have to convince many more health professionals of the new maturity and rich potential of the right to health and other human rights. Only then will be able to go forward with confidence.

I want to close my remarks with a few brief comments about health systems.

If we look at a health system - that is both health care and the underlying determinants of health – through the right to health lens, what are the key features that we would expect to see?

Put more succinctly, what are the key right-to-health features of a health system?

Of course, from a right to health perspective, a health system needs a bundle of facilities and services: accident and emergency, paediatrics, an oncology department, and so forth. The system also needs to deliver adequate water and sanitation services, and so on. The heart of these health facilities and services is integrated primary health care, with an adequate referral system to secondary and tertiary care. Moreover, these health facilities and services must be accessible to all, culturally sensitive, and of good quality.

This is all fine – as far as it goes. But I think it fails to capture some of the essential right to health features of a health system.

From the point of view of human rights, a State must formally recognise the right to health. Additionally, the State has to clarify what the right means – by way of guidelines, codes of conduct and regulations. It must have an overarching, intersectoral national plan for the organisation and development of the health system. It must have detailed strategies and policies, with timeframes, reporting procedures, indicators and benchmarks. It must have a methodology for health impact assessments, so Ministers know the likely impact of a projected policy on the right to health, especially of disadvantaged individuals and communities. There must be as much participation as possible in health policy formulation, implementation and accountability. There must be an effective system for the collection of disaggregated data. Because the health system is not the sole responsibility of the Ministry of Health, there must be an effective mechanism for intersectoral coordination. Rich States have a human rights responsibility to provide international assistance and cooperation in health to low-income countries. There must be effective monitoring and accountability mechanisms, including redress for when things go wrong.

And so on and so forth. This is not an exhaustive list of the key right to health features of a health system. There are others – and at a lunchtime workshop today we will have an opportunity to explore them with you and invite your critical comments and guidance.

For now the point I want to emphasise is that identifying something as a key right to health feature is important because such a feature is underpinned by law. A State is required to take all reasonable steps to implement the key right to health features of a health system. It is not just a matter of good management, justice or humanitarianism. It is a matter of international legal obligation.

And this takes us back to Alma-Ata.

Alma-Ata is far from perfect. If it were to be written today, it would look somewhat different. For instance it would be more gender-sensitive. Nonetheless, there is much resonance - much common ground - between Alma Ata's conception of a health system and the right to health's understanding of a health system.

Alma-Ata failed for many complex reasons - but I suggest that one reason was that, at the relevant time, the connections between public health and human rights remained general and abstract. Today, as I have tried to show, these connections are specific and practical.

So, in my view, it is time to revisit Alma-Ata. In the light of the new maturity of the right to health, we need to re-examine Alma-Ata - and human rights - as we struggle with contemporary public health and human rights challenges.

*****