UN HUMAN RIGHTS COUNCIL

SECOND SESSION

STATEMENT BY PAUL HUNT

SPECIAL RAPPORTEUR ON THE RIGHT OF EVERYONE TO THE ENJOYMENT OF THE HIGHEST ATTAINABLE STANDARD OF HEALTH ('right to health' or 'right to the highest attainable standard of health')

21 SEPTEMBER 2006

Mr Chairperson, distinguished delegates, ladies and gentlemen:

Today provides me with an opportunity to briefly review progress since I presented my first report to the Commission three years ago.

In 2003, I identified three key objectives for my mandate, all demanding close cooperation with a wide range of actors.[1]

The first objective was to raise the profile of the right to health as a fundamental human right.

What progress has been made towards this objective?

In some respects there has been steady progress, especially in countries of the South, and especially among civil society. In some countries I have been very impressed - even inspired - by civil society's commitment to, and familiarity with, the right to health. Numerous civil society groups are actively organising on the right to health. They explicitly use human rights language. They run right to health information campaigns. They call for grassroots participation in health policy-making. They take test cases on the right to health.

Of course, progress is uneven. In some countries, few NGOs have even heard of the right to health. Nonetheless, overall I have the impression that in civil society there is a rising tide of support for the right to health, thanks to the work of innumerable individuals and organisations.

At the highest levels of government, however, the situation is different and much more discouraging. To be frank, I find very little familiarity with the right to health within most governments. And if the right is known, it is seldom taken seriously. Of course, there are honourable exceptions, including in some of those governments that I have visited on mission.

Last December saw the launch of a high-level initiative that is designed to address this major problem.

[1] E.CN.4/2003/58.

The Leaders' Call to Action on the right to health has been endorsed by Jimmy Carter and Bill Clinton (former Presidents of USA), Fernando Henrique Cardosa (former President of Brazil), Hong Koo Lee (former Prime Minister of Korea), Desmond Tutu (Anglican Archbishop Emeritus of Cape Town), His Royal Highness Prince El Hassan bin Talal of Jordan, Gro Harlem Brundtland (former Prime Minister of Norway and former Director-General of WHO), Mary Robinson (former President of Ireland and former High Commissioner for Human Rights), Vaclav Havel (former President of Czechoslovakia and the Czech Republic), and many more too numerous to mention.

In their Call to Action, these eminent leaders urge governments, international organisations, private companies, communities and individuals, to fulfil their responsibilities in ensuring the realisation of the fundamental human right to health for all. The leaders call for systemic changes to build strong health systems.

By their initiative, they remind all governments that the human right to health is real, binding, and literally a matter of life or death. Copies of the Leaders' Call to Action are being distributed in the room today. I strongly commend it to you.

In 2003, my second objective was to clarify what the right to health means: what obligations does it give rise to?

The right to health is one of the most extensive and complex human rights in the international code. However, it is generating an increasing number of national and international cases that shed light on its content. WHO has recently produced an analysis of over 70 cases relating to just one element of the right to health, access to essential medicines.

For my part, I have developed a way of 'unpacking' the right to health so it is more manageable, easier to grasp. This approach draws from the work of WHO, UN treaty bodies, NGOs and academics. In numerous reports, I have applied this approach to specific elements of the right to health. The most detailed application of this approach is in my report on mental disabilities.[2] Here you will find a 'map' to the right to health that is not confined to mental disabilities. It has general application.

In 2003, my third objective was to identify how to operationalise the right to health, how to make it real.

Of course, this is a lifetime's work, but some progress has been made.

Today, you have before you a report on my mission to Uganda.[3] The report focuses on just one issue – the problem of neglected diseases, that is those diseases mainly affecting the poorest people in the poorest communities. These diseases are sometimes known as 'poverty-related' or 'tropical' diseases. They include sleeping sickness, river blindness, and lymphatic filariasis. They inflict severe and permanent disabilities and deformities on almost 1 billion people around the world.

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[2] E.CN.4/2005/51.
[3] E.CN.4/2006/48/Add.2.

In one sense, my Ugandan report is not about Uganda, it is about all countries that suffer from neglected diseases. The report examines neglected diseases through the prism of the right to health. It identifies what needs to be done, at both the national and international levels, if these terrible diseases are to be tackled in a way that reflects the right to the highest attainable standard of health.

In another sense, my Ugandan report is about neither Uganda nor neglected diseases. It is about how to operationalise the right to health, how to make it real and practical. The report has relevance beyond Uganda and beyond neglected diseases. It is really about my third objective of 2003.

I would like to thank the Government of Uganda for inviting me to visit last year. In 2003, the Commission on Human Rights passed a resolution requesting me to look at the problem of neglected diseases.[4] Kampala invited me to undertake a mission to look specifically at this issue in Uganda. I undertook the mission in close cooperation with WHO. This, it seems to me, is a model of how the system should work. I am very grateful to all concerned.

As well as my Ugandan report, you also have before you today my general report that is mainly devoted to the technical issue of indicators and benchmarks.[5] This issue is highly relevant to objectives two and three. The right to health is subject to progressive realisation. So, inescapably, we need a way of measuring and monitoring how the enjoyment of the right to health varies over time. The primary way of doing this is by using indicators and benchmarks. Building on numerous consultations and the work of many experts, my report sets out a human rights-based approach to health indicators. This is designed to help a State recognise which health policies are working and which are not.

So far my right to health reports have focussed on particular countries (eg Uganda), particular groups (eg those with mental disabilities), particular rights (eg sexual and reproductive health rights), and particular issues (eg indicators and benchmarks, the Millennium Development Goals, and the skills drain).

All, however, are united by one message. The right to health is a right to an effective and integrated health system, encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all.

In September 2005, five years after the Millennium Declaration, 170 Heads of State and Government committed themselves to improving health systems in developing countries and economies in transition. The Millennium Declaration and 2005 World Summit are clear that developing *and* developed countries have a crucial role to play in establishing effective, inclusive health systems in North and South.

I urge health ministers in low-income and middle-income countries to prepare national health programmes that reflect what is actually needed to establish effective, integrated health systems accessible to all. The programmes should not reflect what

[4] CHR 2003/28 para 16.
[5] E.CN.4/2006/48.

donors say can be paid for – they should say what is really financially required. Otherwise, how can the world honour what it signed up to in 2000 and re-affirmed at the World Summit last year?

We have to understand that an effective health system is a core social institution, no less than a court system or a political system. The right to a fair trial underpins a good court system. The right to vote underpins a democratic political system. And the right to health underpins the call for an effective health system accessible to all.

Next year, working in close collaboration with others, I hope to have sufficient resources to identify and examine some of the key features of a health system that is reflective of the right to the highest attainable standard of health.

In the meantime, I take this opportunity to thank OHCHR, WHO and many others for their indispensable support.

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