

GENERAL ASSEMBLY, THIRD COMMITTEE
STATEMENT BY PAUL HUNT, SPECIAL RAPPOREUR ON THE RIGHT OF
EVERYONE TO THE ENJOYMENT OF THE HIGHEST ATTAINABLE
STANDARD OF PHYSICAL AND MENTAL HEALTH
FRIDAY 28 OCTOBER 2005

Mr Chairperson,
Distinguished Delegates,
Ladies and Gentlemen,

Mr. Chairperson, with your permission I use today the label ‘the right to the highest attainable standard of health’ or ‘the right to health’ as convenient shorthand for the longer formulation of the right.

The right to health can be understood as 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 other words, the health system must encompass both health care *and* the underlying determinants of health, such as adequate sanitation and safe drinking water.

It must be accessible to all. Not just the wealthy, but also those living in poverty. Not just majority ethnic groups, but minorities and indigenous peoples, too. Not just those living in the urban areas, but also remote villagers. The health system has to be accessible to all disadvantaged individuals and communities.

It must be responsive to both national *and* local priorities. Properly trained community health workers, village health teams and so on, know their communities’ health priorities. Community participation is a vital element of the right to health.

The health system must also be effective and integrated: it cannot consist of little more than a bundle of loosely coordinated vertical interventions for different diseases.

This is fundamentally what the right to health is all about: an effective, integrated health system accessible to all.

One of the most striking features of the Millennium Development Goals (MDGs) is the prominence they give to health: reducing child and maternal mortality; controlling HIV/AIDS, malaria and tuberculosis; providing access to sanitation and safe drinking water; and so on.¹

Moreover, the first MDG - to reduce by half the proportion of the population living in extreme poverty – cannot conceivably be accomplished if the health Goals are not

¹ My last report to the General Assembly emphasised the prominence of health in the Millennium Development Goals and explained how the right to health reinforces the Goals and could contribute to their achievement (A/59/422, 8 October 2004).

achieved. Societies burdened by large numbers of sick and dying individuals cannot escape from poverty.

In short, the Goals cannot be achieved without effective health systems that are accessible to all.

It was for this reason that, at last month's World Summit, 170 Heads of State and Government committed themselves:

“to improve health systems in developing countries and those with economies in transition with the aim of providing sufficient health workers, infrastructure, management system and supplies to achieve the health-related Millennium Development Goals by 2015”.²

Both the Millennium Declaration and 2005 World Summit are crystal clear that developing *and* developed countries have a crucial role to play in establishing effective, inclusive health systems in North and South. Goal 8 - a global partnership for development – is vitally important.

World leaders at last month's Summit also agreed to:

“adopt, by 2006, and implement comprehensive national development strategies to achieve the internationally agreed development goals and objectives, including the Millennium Development Goals”.³

In the light of this commitment, I strongly urge Ministers of Health in low-income and middle-income countries to prepare health sector programmes that are bold enough to achieve the health Goals. Carefully prepared and costed, national programmes should reflect what is actually needed to develop effective, integrated health systems accessible to all. The programmes should not reflect what donors say can be paid for – they should say what is really financially required to achieve the health Goals.

These national health programmes should then form a central part of the development strategies mandated by last month's World Summit for adoption in 2006.

I am asking no more than that the world honours what it signed up to in 2000 and re-affirmed last month. This is extremely important because, over the last two decades, many health systems have been seriously neglected. Many have suffered from chronic under investment. Far from being improved and strengthened, many health systems have been undermined and weakened.

² See 2005 World Summit Outcome para 57(a), also 68(i). Also see the UN Millennium Project's *Investing in Development: A Practical Plan to Achieve the Millennium Development Goals* and the Project's Task Force report *Who's Got the Power? Transforming Health Systems for Women and Children*.

³ Para 22(a). Also see para 22(c).

As I have argued elsewhere, an effective health system depends upon health professionals. In many countries, health workers are in a precarious condition. HIV/AIDS increases the work burden, sickening and killing health workers. And the skills drain is hitting many developing countries hard, especially in sub-Saharan Africa.

The skills drain is the main focus of my present report to the General Assembly.

The report also includes a chapter on the crucial role of human rights education for health professionals. Additionally, it highlights the important WHO Commission on Social Determinants of Health.

Today, however, I make a few brief remarks about the skills drain.

The skills drain - or brain drain – comes in many forms. My report examines one of them: the migration of health professionals from developing to developed countries.

The skills drain raises numerous human rights issues, such as the freedom of movement and labour rights of health professionals. Any policy response to the skills drain must respect these human rights.

However, my report focuses on a human rights aspect of the problem that is frequently overlooked: the impact of the skills drain on the enjoyment of the right to health in the countries where the health professionals come from – their countries of origin.

While the skills drain phenomenon is experienced differently in different countries, for some countries the scale of the problem is huge. Some 30%-50% of health graduates leave South Africa for the USA or UK each year. In 1999, Ghana lost more nurses than it trained. During the 1990s, two thirds of Jamaica's nurses left the country permanently.

Migration of this sort is like a haemorrhage on a health system, making it more difficult for developing countries of origin to deliver the right to health to those within their jurisdiction. It imposes substantial economic and social costs on developing countries of origin, while saving developed countries significant training costs. The economic name for this process is a 'subsidy'. The subsidy is perverse because it flows from poor to rich countries.

The skills drain may have some positive effects, including for developing countries. In some cases, for example, migrants' remittances make a major contribution to the economies of countries of origin. But even when this occurs, it does not mean that the remitted funds are invested in those countries' health systems.

In my report, I explore some of the reasons for, and possible policy responses to, the skills drain. Here, I have time to make only the following additional remarks.

One, developed countries have an obligation to respect the right to health in developing countries. They should ensure that their human resources policies do not jeopardise the right to health in developing countries.

It is disingenuous for developed countries to provide overseas development assistance, debt relief and so on for developing countries, while simultaneously hiring health professionals who have been trained at the expense of, and are desperately needed in, developing countries of origin. What is the point of giving with one hand and taking with the other? Isn't this inconsistent with the Millennium Declaration, the MDGs, and last month's World Summit?

Two, when the skills drain amounts to a perverse subsidy from poor to rich, the policy response of compensation - into a ring-fenced restitution fund - should be given serious and sympathetic consideration.

Three, health systems in developing countries of origin must be strengthened.

Four, destination countries should strengthen their own domestically trained human resource base.

Five, each developed country should establish an independent national office - along the lines of an Ombudsman - to monitor the impact of the Government's policies on the right to health in developing countries. One of the health issues that the office should monitor is the skills drain.

Six, in today's world, there is a shocking inequality in levels of health care and protection. In rich countries, life expectancy approaches 80 years; in some of the poorest it is below 40 years. In Sweden, the death rate of children under five years is .3%; in Sierra Leone it is 28%. In Germany, 100% of the population have access to safe drinking water; in Cambodia, only 34%. In UK, 99% of babies are delivered by health professionals; in Yemen, only 22%. A woman in sub-Saharan Africa faces a 1 in 16 risk of dying during pregnancy or childbirth, as compared to a 1 in almost 3000 risk in the developed world.

The skills drain deepens this global health inequality. Policies that are intended to tackle the skills drain must address, in a systematic and coordinated manner, global health inequality.

Crucially, last month's World Summit - to the credit of all those who participated - signals a path for vigorously addressing global health inequality: the concerted development of effective, integrated health systems that are accessible to all.

In conclusion, it is time to grasp 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 effective health systems accessible to all.