GENERAL ASSEMBLY, THIRD COMMITTEE

STATEMENT BY PAUL HUNT, SPECIAL RAPPORTEUR ON THE RIGHT TO HEALTH

TUESDAY 11TH NOVEMBER 2003

Mr Chairperson,
Distinguished Delegates,
Ladies and Gentlemen,

I was appointed Special Rapporteur on the right to health about a year ago. In my preliminary report to the Commission on Human Rights (2003), I sketch my broad approach to the mandate. In brief, this approach includes the following features:

1. a determination to consult and cooperate as widely as possible.

2. a conviction that international human rights law, including the right to health, should be consistently and coherently applied across all relevant national and international policy making processes.

3. a recognition that numerous cases at the national and international levels confirm the justiciability of the right to health, or elements of the right to health.

4. a recognition that the right to health includes the right to health care and also the underlying determinants of health, such as access to safe and potable water and adequate sanitation, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health.

5. a focus on three particular objectives:

    * to promote - and encourage others to promote - the human right to health as enshrined in numerous legally binding international treaties, the Constitution of the WHO, and resolutions of the Commission on Human Rights.

    * to clarify the legal scope of the right to health.

    * to identify good practices for the operationalisation of the right to health at the community, national and international levels.

6. a focus on two particular inter-related themes: on the one hand, poverty, and on the other hand, discrimination and stigma. These twin themes enable me to examine crucial issues that derive from my mandate, such as gender, children, racism, HIV/AIDS and mental health. These twin themes also reinforce the congruity between my mandate and the Millennium Project. No less than four of the eight Millennium Development Goals are health-related.

My preliminary report to the Commission also discusses some specific projects or issues or interventions that, resources permitting, I would like to address as Special Rapporteur:

- the health component of poverty reduction strategies, including Poverty Reduction Strategy Papers.

- neglected diseases.
- impact assessments.
- the World Trade Organisation and the right to health.
- mental health.
- the role of health professionals.

I am gratified that, in its right to health resolution of 2003, the Commission on Human Rights broadly endorsed this general approach to my mandate.

May I emphasise one point?

The court-based approach to the right to health has an indispensable role to play - but it is only one approach to the vindication of the right to health. Another complementary approach is the policy approach - that is, bringing the right to health to bear upon local, national and international policy-making processes.

The court-based approach and the policy approach are not alternatives. One is not better than another. They are mutually reinforcing. Both are indispensable to the full realisation of the right to health. So far as my resources permit, I aim to examine and promote both.

Policies based on human rights norms, including the right to health, are more likely to be effective, robust, sustainable, inclusive, equitable and meaningful - especially for the most vulnerable and disadvantaged members of our societies.

While the policy approach does not depend upon court processes, it is not a soft-option. Far from it. It demands legal clarity, rigorous analysis, transparent policy processes, creative policy initiatives, careful monitoring, an unswerving commitment to human rights, and political will - all of this underpinned by two features: *first*, a commitment to listen to the powerless and marginal, *second*, effective mechanisms of human rights accountability.

The policy approach represents a huge challenge to the human rights community. The traditional human rights techniques – letter-writing campaigns, slogans, litigating, naming and shaming, and so on – are no longer sufficient. The policy approach demands new techniques, new skills. The traditional human rights skills are still essential – but they are no longer enough if the right to health is to be effectively integrated into national and international policy-making processes.

Chair -

Since I presented my report to the Commission on Human Rights, I have undertaken a mission to the World Trade Organisation to consider certain trade rules and policies in the context of the right to health. My report on this mission will be submitted to the Commission in 2004.

My main mission objective was to enhance understanding of the WTO within the human rights community, and to enhance understanding of the right to health among those working on trade issues. During the mission, I had a large number of meetings with the WTO secretariat, WTO member states, and many others – without exception, these meetings were constructive, informative and helpful. I am most grateful to all those who gave me their time.

Since April 2003, the Government of Mozambique has invited me to undertake a country mission during December 2003. I am very grateful to the Government of Mozambique for its invitation.

Chair –

The Third Committee has my interim report of 2003. The executive summary is self-explanatory and I will not repeat it.

The report tries to address, in a balanced and practical manner, the difficult issue of right to health indicators. Here, I confine myself to four remarks about right to health indicators.

First, the international right to health is subject to progressive realisation - and I see no way of monitoring progressive realisation without using right to health indicators and benchmarks.

Second, right to health indicators can help states, and others, recognise when national and international policy adjustments are required.

Third, as I set out in my interim report, right to health indicators are needed at both the national and international levels.

Fourth, while right to health indicators have a useful role to play, it should be recognised that they will never provide a complete picture of the enjoyment of the right to health.

Time permits me to highlight only one other issue from my interim report: neglected diseases and the 10/90 gap. For present purposes I adopt the WHO definition of neglected diseases – those diseases mainly suffered by the poorest people in the poorest countries. These diseases attract very little research and development. Only 10% of health research and development is directed to the health burden of 90% of the world's population. This is unconscionable – and a major human rights problem that I am hoping to examine in more detail with WHO next year.

Chair –

In paragraph 6 of my interim report, I have taken the liberty of indicating some of the issues in relation to which I will especially welcome comments and guidance.

However, of course, I will be pleased to enter into a discussion on any issue arising from either my interim report or the mandate generally. I will be pleased to have such a discussion either during our interactive dialogue or bilaterally on other occasions.

Thank you.

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