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The World Health Organisation recently commissioned a survey of the right to health provisions of national constitutions. According to the preliminary findings of this study, over 60 constitutional provisions include the right to health or the right to health care. In addition, over 40 constitutional provisions include health-related rights, such as the right to reproductive health care. Moreover, in some jurisdictions these provisions have generated significant jurisprudence, such as the recent decision of the Constitutional Court of South Africa in *Minister of Health v Treatment Action Campaign.*

Regional human rights mechanisms - European, Inter-American and African - also adjudicate cases involving the right to health.

These domestic and international laws and cases confirm the justiciability of the right to health - or elements of the right to health.

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.

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 court-based approach and 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.

Three objectives; two themes

The right to health extends across a wide and diverse range of issues. So, with a view to making the mandate more manageable, I propose to focus on three objectives and two themes in my forthcoming work.

The three objectives are:

First, to promote - and encourage others to promote - the right to health as enshrined in numerous legally binding international treaties, the Constitution of the WHO, and resolutions of this Commission.

Second, to clarify the legal scope of the right to health.

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

I propose to address these three objectives via two themes: poverty and the right to health and, second, discrimination, stigma and the right to health.

These twin themes enable me to examine crucial issues that derive from my mandate, such as gender, children, racism, HIV/AIDS and mental health.

Here, time does not permit me to comment on both twin themes so I will confine myself to a few general remarks about the first – poverty and the right to health - and may I encourage you to look at my preliminary report for discussion about the equally important theme of discrimination, stigma and health.

Poverty is a global phenomenon experienced in varying degrees by all states. By examining poverty and the right to health, I will be able to make a contribution to one of the key policy imperatives of modern times: poverty eradication. The poverty theme will enable me to examine the Millennium Development Goals through the prism of the right to health -- I note in passing that no less than four of the eight Millennium Development Goals are health-related. This theme will enable me to consider the various dimensions of health and poverty in a balanced and rigorous manner.

Thanks in part to the work of this Commission, in recent years we have become clearer about the *general* contribution of human rights to poverty reduction.

Now, building on those insights, the challenge is to identify the *specific* contribution of the *right to health* to poverty reduction.

Let us assume a government wants to formulate a new national health policy for its poor, and that it wants this new pro-poor health policy to be animated by its binding international right to health obligations - what would such a policy look like?

I will be frank: to the best of my knowledge, nobody has a complete answer to this question. I hope that, working closely with others, I can help states, and other actors, identify the main features of a pro-poor health policy based upon the right to health. Of course, this is an ambitious and complex undertaking. It will take time.

Consultations and cooperation

In my view, the right to health mandate is impossible unless I work very closely with a wide range of actors.

To date, I have had fruitful meetings with a number of states, WHO, UNICEF, UNFPA, UNAIDS, World Bank, IMF and a large number of health professional and civil society organisations. These discussions have shaped my selection of objectives and themes. I look forward to extending and deepening these consultations. For example, I have not yet met with the ILO to discuss issues of occupational health, with a view to identifying what my role might be in this area. To take another example, some of the work of the World Trade Organisation is health-related and I am keen to consider these issues, in cooperation with the WTO and its Secretariat, in a constructive spirit.

Perhaps it is invidious to draw attention to one particular partner because all of them are crucial - but I would like to mention the WHO. I have been greatly encouraged by the WHO's

support for my mandate. I understand that WHO's distinctive mandate is very different from mine and I will not replicate their work. In the context of the right to health, there are many actors, many roles. But, as the Director-General's compelling speech to this Commission confirms, the WHO and the Special Rapporteur have a common concern: the promotion and protection of the right to health. So, during my mandate, I hope to work closely and cooperatively with the WHO while remaining respectful of our different approaches and responsibilities.

Conclusion

My report is only a preliminary report and this overview is not comprehensive. This morning I have omitted to mention important right to health issues that are signalled in my report, such as corruption, health impact assessments, 'very neglected diseases', indicators and benchmarks, international assistance and cooperation, and so on.

One omission, however, cannot stand: health professionals. Just as the right to a fair trial depends upon the independence and integrity of lawyers, so the right to health depends upon the independence and integrity of health workers. In some countries, on account of their professional activities, health workers have been victims of discrimination, arbitrary detention, arbitrary killings and torture, and have had their freedoms of opinion, speech and movement curtailed. In these circumstances, I propose to monitor and explore the indispensable role played by health professionals in relation to the right to health.

I look forward to answering your questions - and also discussing informally with delegations, civil society organisations and others outside today's inter-active dialogue.

Thank you.

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