

# 10th CANADIAN CONFERENCE ON INTERNATIONAL HEALTH

26-29 OCTOBER 2003, OTTAWA

Plenary Session, 28 October 2003

*Paul Hunt (UN Special Rapporteur on the Right to Health)*  
*Maude Barlow (National Chairperson of the Council of Canadians)*  
*Maria del Carmen Ledo Garcia ( San Simón University)*

## **Panel presentation of Paul Hunt “The Right to Health: New Opportunities and Challenges”**

After years of neglect, the international human right to health is beginning to attract the attention it deserves.

The right emerged at the international level immediately after the Second World War, most notably in the constitution of the WHO. But, like all economic, social and cultural rights (ESCR), the right to health was a victim of the Cold War. During the Cold War, ESCR were marginal and neglected. For some forty years, the international right to health received relatively little serious attention.

That changed in the 1990s. When the Berlin Wall fell, it not only liberated people, it liberated ideas. The holistic conception of human rights - that all human rights have equal status - re-emerged and was re-affirmed at the human rights world conference in Vienna during 1993. Civil society organisations - especially those in the South - insisted that the historic neglect of ESCR should be redressed.

We should never forget that progress in the field of international human rights is invariably driven - or inspired - by national civil society organisations. The frontline of the human rights struggle does not run through the UN corridors of Geneva or New York. It runs through Lagos, Sao Paulo, Mumbai - and Ottawa - as well as smaller communities that do not show up on the world atlas.

In any event, the re-emergence of the holistic conception of human rights in the 1990s coincided with another important international development. In 1997, Kofi Annan's UN's reforms were endorsed by the General Assembly. According to these reforms, human rights are a cross-cutting issue and they are to be mainstreamed across the United Nations.

So, remarkably, in just a few years, the position of ESCR was transformed. They were no longer marginal within human rights. And human rights were no longer marginal within the UN. Suddenly, ESCR were catapulted from the edges of marginal human rights, to the middle of the UN mainstream.

These dramatic developments present ESCR, including the right to health, with exceptional opportunities -- but also exceptional challenges.

How has the international human rights system responded to this new focus on ESCR? Briefly, a couple of points.

In 2000, the UN Committee on Economic, Social and Cultural Rights adopted General Comment 14 on the right to health. General Comments are not binding documents. But, based on the Committee's long experience, they are intended to shed light on the contours and content of the right in question. Many economic, social and cultural rights are worded vaguely. How can one reasonably expect a state to honour its obligations in relation to economic, social and cultural rights when the rights are so imprecise that it is not clear what they mean? So the Committee's General Comments are designed to help states, and other actors, by clarifying the Committee's understanding of what the rights means.

This is what General Comment 14 does in relation to the right to health. When preparing General Comment 14, the Committee received invaluable assistance from WHO and numerous other experts. The Committee interpreted the right to health provisions in the context of developments in other parts of the UN human rights system, such as the provisions of the Convention on the Rights of the Child, as well as the outcomes of UN world conferences, such as Cairo and Beijing. General Comment 14 also develops new analytical frameworks to help states, and others, better grasp the meaning of the right to health - I will briefly mention one of these frameworks later. And the General Comment takes the first steps towards developing tools by which to monitor the progressive realisation of the right to health, in particular right to health indicators and benchmarks.

At the same time, WHO has been developing its understanding of a rights-based approach to health. It is endeavouring to integrate human rights into health and into its work. It has produced valuable publications, such as '25 Questions and Answers on Health and Human Rights'. WHO's Health and Human Rights Focal Point, Helena Nygren-Krug, is attending this conference, and has a session this afternoon, so it is best if she speaks for herself. I would just emphasise that, in recent years, WHO's engagement on human rights issues has dramatically increased and improved. Its role in relation to human rights, and the right to health, is absolutely critical.

Other right to health developments within the UN include recent resolutions of the Commission on Human Rights. In the last couple of years a number of Commission resolutions explicitly re-affirm the right to health - see, for example, the resolutions on access to medication and also disabilities - and several other Commission resolutions contain provisions that bear closely upon the right to health.

### **UN Special Rapporteur on the right to health**

Last year, the Commission on Human rights passed a resolution establishing a UN Special Rapporteur on the right to health. Nominated by New Zealand, I was appointed in September 2002. In my preliminary report to the Commission, I set out my main three broad objectives. Each reflects what I see as a key challenge confronting the right to health.

*First objective*, to promote - and to encourage others to promote - the right to health as a fundamental human right. The right to health is unquestionably part of international human rights law, but still - in my experience - many people do not grasp that it is a fundamental human right. They feel intuitively that the right to a fair trial and freedom of expression are human rights, but they do not instinctively regard the right to health as a human right. In other words, the right to health has not yet gained the same human rights currency as more established rights. So my first objective is to work with others to enhance recognition of the right to health as a fundamental human right.

*Second objective*, to clarify the contours and content of the right to health. There is a growing national and international jurisprudence on the right to health, but still the legal content of the right is not yet well established. This is unsurprising given the historic neglect of the international right to health. So I would like to clarify the contours and content of the right to health by drawing upon the evolving national jurisprudence - over 60 constitutional provisions include the right to health or the right to health care; and also by drawing upon the evolving international jurisprudence on the right to health, such as General Comment 14; and also by going back to the basic principles that animate all human rights, such as equality, non-discrimination and the dignity of the individual.

*Third objective*, to identify good practices for the operationalisation of the right to health at the community, national and international levels. Let's assume that between us we make progress with the first objective and the right to health is more widely understood as a human right. And let's assume we also make progress with the second objective and clarify the legal content of the right to health. Then the real challenge remains: to operationalise the right to health. We have to move from fine-sounding norms to effective policies, programmes and projects in relation to various actors including Governments, the courts, national human rights institutions, health professionals, civil society organizations and international organizations.

To make these challenging objectives somewhat more manageable, I propose to focus on two main themes. *One*, poverty and the right to health. And *two*, discrimination, stigma and the right to health. These themes will enable me to give particular attention to those living in poverty, gender issues, racial and ethnic minorities, indigenous peoples, people living with HIV/AIDS, and other vulnerable groups.

I have also chosen these twin themes of poverty and discrimination because I want the mandate to be relevant. Today, at the international level, whether we like it or not, the main shows in town are poverty reduction and realisation of the Millennium Declaration via the eight Millennium Development Goals, at least four of which are health-related. So I think it is important that attempts are made to constructively examine poverty reduction strategies and the MDGs through the prism of the right to health. If we do not engage with poverty and the MDGs it seems to me that we are missing an important opportunity - it would be like walking off the playing field and joining the spectators in the stand.

Time permits me only to mention six specific projects or interventions that I would like to make as Special Rapporteur if my resources permit. Again, in my view they reflect some of the key opportunities and challenges facing the right to health. *First*, as

already discussed, we have to integrate the right to health in poverty reduction strategies with a view to making those strategies more meaningful to those living in poverty. *Second*, we must focus on neglected diseases - those diseases that are mainly suffered by the poorest people living in the poorest countries. *Third*, we need to develop a methodology for using health impact assessments - if we understood them better, impact assessments could be a useful tool for the better promotion of the right to health. *Fourth*, I suggest we need to look at how trade liberalisation impacts on enjoyment of the right to health. *Fifth*, we must give due attention to the right to mental health - too often the human rights community neglects mental health issues. *Sixth*, I want to explore the indispensable role of health professionals in relation to the right to health, as well as the difficulties impeding their practice which, as we know, sometimes includes the violation of their human rights.

This is by no means an exhaustive list of right to health opportunities and challenges. For instance, it does not include the challenge of devising practical right to health indicators without which it is impossible to monitor the progressive realisation of the right to health - an issue that I begin to explore in my latest report to the UN General Assembly.

I appreciate that many of you in this room are already working precisely on these issues. I offer this incomplete list for discussion and critical comment.

Time is short, so I will make a few remarks about my second objective - the clarification of the contours and content of the right to health. What does the right to health mean? Here I draw upon General Comment 14.

The right to health includes the right to health care - but it goes beyond health care to encompass adequate sanitation, healthy conditions at work, and access to health-related information, including on sexual and reproductive health. It includes freedom, such as the right to be free from non-consensual medical treatment, and entitlements, such as the right to a system of health protection. The right to health has numerous elements, including access to essential drugs. Like other human rights, it has a particular preoccupation with the disadvantaged, vulnerable, and those living in poverty. Although subject to progressive realisation, the right to health imposes some obligations of immediate effect, such as the obligations of equal treatment and non-discrimination. It demands indicators and benchmarks to monitor the progressive realisation of the right. Developed states have some responsibilities towards the realisation of the right to health in poor countries - we learn this from the Millennium Declaration, including MDG8, as well as the provisions on international assistance and cooperation in international human rights law.

In short, we know quite a bit about what the right to health means. Of course, there are grey areas - some of them extensive. And there are good faith disputes and disagreements, just as there are in all worthwhile fields of human endeavour. But the important point is that the right to health is not just a slogan - it is not just a bumper sticker - it has normative depth and something constructive and concise to say to national and international policy-making processes.

The right to health brings something else, too. It brings an analytical framework which policy makers might find useful.

Take one established element of the right to health - essential medicines - and consider it in relation to a Least Developed Country (LDC).

Under the right to health, the LDC has to do it all reasonably can to make an essential drug *available* to its people. For example, it might have to pass and use compulsory licence legislation - in other words to use the TRIPS flexibilities that are quite properly available to it. This analytical concept of *availability* is found in the literature on the right to health.

But the availability of the essential medicine is not enough. According to the right to health, the LDC has to do all it reasonably can to ensure that the essential drug is *accessible* to all, especially those living in poverty. The drug cannot just be accessible in the urban areas or to the rich or to some ethnic groups and not others. This right to health requirement of accessibility means one has to think creatively about delivery mechanisms: mobile clinics, mopeds for nurses, para-medics and so on.

The right to health requirement of *accessibility* might also mean that the LDC has to revisit any import duties it imposes on the essential drug, because import duties could make the drug inaccessible to people living in poverty.

But the right to health notions of availability and accessibility are not enough either - the essential drug has to be of *good quality*. Sometimes drugs have passed their expiry date and so have been rejected in the North - and only then are they made available in the South. Sometimes the drugs have been interfered with. So the right to health requirement of *good quality* essential drugs means the LDC must have in place a basic system for the monitoring and checking of essential drug quality.

In summary, the right to health analysis of *availability*, *accessibility* and *good quality* can, in relation to essential drugs, help to identify practical and precise policy interventions that will help to ensure all in the LDC enjoy this element of the right to health.<sup>1</sup>

This sketch underscores two other crucial elements of the right to health: *international assistance and cooperation* (IAC) and *accountability*.

Regarding IAC, rich states - and other powerful actors - have some responsibilities to help LDCs realise the right to health for their people - something LDCs cannot do alone.

I suggest that the rich states should not discourage a developing country from using the TRIPS flexibilities. On the contrary, they should actively facilitate the use of the flexibilities. They should help the LDC deliver the essential drug to all at affordable

---

<sup>1</sup> For completeness I note that the analytical framework mentioned here includes a fourth component - *acceptability* - which I have omitted in these remarks in the interests of brevity. Acceptability is identified in CESCR's General Comment 14.

prices. They should help the LDC develop a sound health infrastructure. Health-related ODA deserves the most sympathetic consideration, especially given that at least four of the eight MDGs are health-related.

It is also crucial that rich states tackle the problem of neglected diseases. Today, only 10% of the world's health research and development goes to the health problems of 90% of the world's population. This is unconscionable and a human rights issue of non-discrimination, equality and enjoyment of the right to health.

As for accountability - the right to health brings with it the crucial requirement of accessible, transparent and effective mechanisms of accountability. Those with human rights responsibilities must be held to account in relation to the discharge of their duties, with a view to identifying difficulties and making the necessary policy adjustments.

This net of accountability extends to all actors with human rights responsibilities. So, in the example of an essential drug in an LDC, the LDC should be held to account - and so should rich states in relation to their responsibilities to assist the LDC, with a view to enhancing the effectiveness of the relevant policies.

## **Conclusion**

I would like to close with a few brief remarks.

*First*, what does the right to health bring to the table? At root, what is the value-added of the right to health? I suggest that the right to health - like all human rights - brings a set of globally agreed norms or standards, and out of these norms arise governmental obligations, and in relation to these obligations there has to be mechanisms of accountability. Rights are about obligations - not charity. This combination of globally legitimized norms, obligations and accountability empowers the disadvantaged and powerless.

*Second*, 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.

*Third*, 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.

*Fourth*, 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 a commitment to listen to the powerless, plus effective mechanisms of human rights accountability.

*Fifth*, this challenge demands that the human rights community learns from health professionals and other experts. It demands that human rights practitioners develop

new approaches and new skills. We should approach this challenge with some humility because human rights do not provide all the answers.

*Finally*, I encourage health practitioners to use human rights - to use the framework of norms, obligations and accountability - as a way of fortifying your work, reaching your goals and empowering people. In this way, the distinction between human rights practitioners and health professionals collapses. Health practitioners become human rights practitioners. This, I suggest, is the way forward.

Professor Paul Hunt  
Human Rights Centre  
Law Department  
Essex University  
England

\*\*\*\*\*