

**Castan Centre for Human Rights Law,  
Monash University, Melbourne, Australia**

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***The right to the highest attainable standard of health: opportunities and challenges***

**by Professor Paul Hunt, UN Special Rapporteur on the right to the highest attainable standard of physical and mental health**

The human right to the highest attainable standard of physical and mental health (or the ‘right to health’) is codified in numerous legally binding international and regional human rights treaties. These binding treaties are beginning to generate case law and other jurisprudence that shed light on the content of the right to health. The right to health is also enshrined in numerous national constitutions: over 100 constitutional provisions include the right to health or health-related rights. Moreover, in some jurisdictions constitutional provisions on the right to health have generated significant jurisprudence.<sup>1</sup>

But what does the right to health mean?<sup>2</sup>

It includes the right to health care, but it goes beyond health care to encompass the underlying determinants of health, such as safe drinking water, adequate sanitation and access to health-related information. The right includes freedoms, such as the right to be free from discrimination and involuntary medical treatment. It also includes entitlements, such as the right to a system of health protection. The right has numerous elements, including child health, maternal health, and access to essential drugs. Like other human rights, it has a particular concern for the disadvantaged, the vulnerable, and those living in poverty. The right requires an effective, inclusive health system of good quality.

International human rights law is realistic and recognises that the right to health for all cannot be realised overnight. Thus, the right is expressly subject to both progressive realisation and resource availability. Although qualified in this way, nonetheless the right to health imposes some obligations of immediate effect, such as non-discrimination, and the requirement that a state at least prepares a national plan for health care and protection. The right demands indicators and benchmarks to monitor the progressive realization of the right. It also encompasses the active and informed participation of individuals and communities in health decision-making that affects them. Under international human rights law, developed States have some responsibilities towards the realization of the right to health in poor countries. Crucially, because the right to health gives rise to entitlements and obligations, it demands effective mechanisms of accountability.

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<sup>1</sup> Eg the Argentinian court case of *Viceconti v. Ministry of Health and Social Welfare*, Poder Judicial de la Nación, Causa no. 31.777/96, 2 June 1998.

<sup>2</sup> Generally, see my UN reports, press statements etc that can be accessed at the website of the Right to Health Unit, Human Rights Centre, Essex University, UK  
[http://www2.essex.ac.uk/human\\_rights\\_centre/rth/](http://www2.essex.ac.uk/human_rights_centre/rth/)

Our understanding of the right to health is not yet as deep as our understanding of some of the classic civil and political rights – there are historical reasons for this that I will not explore today. Nonetheless, our knowledge of the right to health is deepening. Of course, there are grey areas - and there are also good-faith disputes and disagreements, just as there are in relation to the classic civil and political rights, and all fields of inquiry.

When everything else is stripped away, at root the right to health consists of globally legitimised standards; out of these standards derive legal obligations; and these obligations demand effective mechanisms of accountability. The combined effect of these three dimensions -- standards, obligations and accountability -- is the empowerment of vulnerable individuals and disadvantaged communities.

In other words, the human right to health is not just a slogan – it is not just a bumper sticker. Of course, the right is a powerful campaigning and advocacy tool and it can and should be used in this way. But, in addition, it has normative depth and something constructive and concise to say to policy makers.

But what is it that the right to health brings to policy making?

In general, abstract terms it brings a set of fundamental principles, such as dignity, well-being, autonomy, and equality.

It places the interests of individuals and communities – their dignity and well-being – at the heart of policy making.

It brings a keen preoccupation with the vulnerable and disadvantaged, including those living in poverty.

The right to health emphasises primary health and it demands effective health systems that are responsive to local priorities.

It places obligations – moral and legal – on states and requires that they be held to account for their conduct.

It insists that rich states have a responsibility to help developing states realise the right to health – in this way responding to the shocking inequality in global health that shames our contemporary world.

One of my responsibilities as UN Special Rapporteur on the right to health is to clarify what, in more *practical* terms, the right to health brings to a particular health problem.

In a report of 2004 to the UN General Assembly, I briefly consider the right to health for indigenous peoples.<sup>3</sup> My remarks were not made in relation to a specific country or specific indigenous people, they were of a general nature.

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<sup>3</sup> 8 October 2004, A/59/422.

After signalling the profound health disparities between indigenous and non-indigenous in many countries around the world, the report observes that, according to international human rights law, indigenous people have the right to specific measures to improve their access to health services and care as well as the underlying determinants of health. These services should be culturally appropriate, taking into account traditional preventive care, healing practices and medicines. In particular, I urge Governments and others to make every effort to ensure:

- (a) The disaggregation of health data by ethnicity, gender, socio-economic status, cultural or tribal affiliation and language;
- (b) The active and informed participation of indigenous people in the formulation, implementation and monitoring of health policies and programmes;
- (c) As far as possible, the availability of health facilities, programmes and projects, and health-related information, in languages spoken by indigenous peoples;
- (d) The strengthening of health programmes in indigenous communities, including training of indigenous health workers to conduct outreach services to and home care in indigenous communities;
- (e) Training of health professionals to ensure that they are aware of, and sensitive to, issues of ethnicity and indigenous culture;
- (f) The development and implementation of strategies that encourage indigenous people to become health professionals. These strategies should include measures to increase the ethnic diversity of the student body attending existing training programmes, as well as the recognition of indigenous health practitioners, including traditional birth attendants, by State health care systems. Also, new training courses should be devised by — and for — indigenous and other nondominant ethnic groups, including training in the medical traditions and practices of indigenous peoples;
- (g) The establishment of monitoring and accountability mechanisms in indigenous communities in relation to abuses and neglect in the health system.

This begins to give a sense of the practical application of the right to health, in general terms, to indigenous communities that are among the most disadvantaged in the world.

There is a cliché – ‘the devil is in the detail’ – the idea being that something becomes more problematic the more closely you look at it.

I have come to the view that, at least in some important senses, this is the reverse of the truth in relation to economic, social and cultural rights, such as the right to the highest attainable standard of health.

In recent years, the international human rights community has collectively made some significant progress towards understanding the broad contours and content of

economic, social and cultural rights, but I suggest that we have come just about as far as we can while addressing these rights at an abstract, general level.

If we are to take the next steps in the evolution of these rights, we have to build upon the intellectual progress collectively made in recent years and apply those insights to specific issues in specific countries and specific contexts.

Of course, this will be very challenging – but, if we wish to advance economic, social and cultural rights, it will be easier to do this than if we confine our discussions to sweeping generalisations of a large and abstract nature.

With this in mind, I secured an invitation from the Government of Uganda to visit and prepare a report on neglected diseases. By neglected diseases I mean those that are mainly suffered by poor people in poor countries. In Uganda these diseases include river blindness, sleeping sickness and lymphatic filariasis. These terrible diseases attract little health research and development because those afflicted invariably have negligible purchasing power. The market fails them.

Examining Uganda's neglected diseases through the lens of the right to health underlined the importance of a number of policy responses. It underscored the imperative of developing an *integrated* health system responsive to local priorities. Vertical interventions that focus on one particular disease can actually weaken the broader health system - an integrated system is needed. Village health teams are urgently needed to identify the local health priorities. They know which neglected diseases their village is afflicted with much better than a health official in the regional or national capital. Of course more health professionals are essential, but also incentives are needed to ensure that the health workers are willing to serve these remote neglected communities. There are myths and misconceptions about the causes of neglected diseases – these can be dispelled by accessible public information campaigns. Some of those suffering from neglected diseases are stigmatised and discriminated against – this too can be tackled by evidence-based information and education. The international community and pharmaceutical companies also have responsibilities to provide needs-based research and development on neglected diseases, as well as other assistance. Effective monitoring and accountability devices must be established – existing parliamentary and judicial accountability mechanisms are not enough in relation to those diseases mainly affecting the most disadvantaged and in my Ugandan report I will be suggesting a way to enhance accountability.

Neglected diseases mainly afflict neglected communities. It was the right to health analysis – and its preoccupation with disadvantage – that led, in the first place, to the identification of this neglected issue as a serious right to health problem demanding much greater attention.

My point is that the right to health has something precise, practical and constructive to contribute to serious, complex health issues, such as neglected diseases. Of course, it does not bring a magic solution. Also, you could identify these policy responses for neglected diseases without reference to the right to health. But the right to health can help to identify these responses and, where they already exist, the right can reinforce them.

Because of its evolution in recent years, the right to health – as never before - is in a position to shape national and international policy-making. The traditional human rights techniques – ‘naming and shaming’, letter writing campaigns, taking test cases, and so on – are still needed. But, in addition, there are new possibilities for the right to health to influence and animate policy-making processes.

In my view, we are at the threshold of a new era for the right to health. Whether we manage to take those crucial steps across the threshold remains to be seen. But the threshold lies right in front of us.

I want to close with some remarks – and a challenge – about maternal mortality. The challenge is not so much for health professionals, as for the human rights community. It is a challenge that health professionals might vigorously put to traditional human rights organisations and activists.

The scale of maternal mortality is catastrophic. Every minute a woman dies in childbirth or from complications of pregnancy. That means well over 500,000 women a year. 95% are in Africa and Asia. 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. This is global health inequality on a shocking scale. For every woman who dies as many as 30 others suffer chronic illness or disability.

Also, as you know, there are alarming disparities in maternal mortality among different groups within some rich countries. Maternal mortality is not just a developing country problem.

Crucially, nearly all maternal mortality is avoidable. Most fatal obstetric complications could be treated with a few well-known technologies, namely emergency obstetric care. Of course, having the technical answers is not enough. Other forces can - and do - prevent widespread access to appropriate care.

In the 1990s, domestic violence was identified as a violation of human rights and this helped the global campaign against domestic violence gather momentum. By the same token, I suggest that the human rights community should be challenged to mount a global human rights campaign against maternal mortality. The human rights community must be urged to remonstrate and demonstrate about maternal mortality just as loudly as it complains about extra-judicial executions, arbitrary detention, unfair trials, and prisoners of conscience.

We have to get across the message that avoidable maternal mortality is a violation of the woman’s right to health and life.

In some respects, this task might be more complex than it was in relation to domestic violence. After all, domestic violence is *always* a breach of human rights, whereas a few cases of maternal mortality are unavoidable.

Also, the lawyers will rightly ask: if avoidable mortality is a violation of the right to health, who is the violator? This is an important question raising important issues.

It seems to me that in some cases there might be many with some responsibility for avoidable maternal mortality. Perhaps the family or community who discouraged the woman from seeking timely and appropriate medical help. Perhaps the health facility for not having the necessary care package, because of its own mismanagement, even corruption. Perhaps the government for providing insufficient funds. Perhaps the international community for providing a developing country with inadequate technical or financial assistance. And so on.

I think the answer to the lawyers is to insist – here is an extremely serious violation of the right to health. Who is responsible? We do not know - but that does not stop it from being a human rights violation – and this violation must be investigated *precisely to determine where responsibility lies*, and so as to better ensure that the appropriate policy changes are introduced as a matter of urgency.

We must not be distracted from insisting: avoidable maternal mortality is a serious violation of the right to health. It must stop.

Earlier I argued for a policy approach to the right to health. The right must shape policy. If it does, the policy is likely to be more equitable and meaningful to disadvantaged individuals and communities. Equally, however, advocates of the right to health can use the traditional human rights techniques of ‘naming and shaming’, letter writing campaigns, and so on.

A global human rights campaign against avoidable maternal mortality should use both – the traditional well-tried human rights campaigning techniques, as well as the more nuanced policy analysis.

One reason why I suggest the time has come for a human rights campaign against avoidable maternal mortality is because such an initiative can draw upon the inspiring work already done by many who are active in this field, including tireless grassroots health workers and activists in every region of the world.

A human rights campaign against avoidable maternal mortality would inevitably lead to other crucial issues, not least the vital importance of constructing effective health systems that are accessible to all.

And this in turn leads to a far-reaching insight: 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 our demand for effective health systems accessible to all.

**Paul Hunt**