

The Right to Health: An Interview with Professor Paul Hunt*

The mandate of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health was established through the United Nations Commission on Human Rights resolution 2002/31 of 22 April 2002. Since the establishment of the mandate, Professor Paul Hunt has been carrying out the task. Paul Hunt is Professor in the Department of Law and former Director of the Human Rights Centre at Essex University, and also Adjunct Professor at Waikato University, New Zealand. He has served as an independent expert on the United Nations Committee on Economic, Social and Cultural Rights. Duties entailed in the mandate include receiving individual complaints, carrying out country visits, and producing annual reports for the UN Commission on Human Rights and UN General Assembly. Professor Hunt recently returned from visits to Peru and Romania and he has also visited Mozambique as well as the World Trade Organization. Thus far the Special Rapporteur has produced three reports for the UN Commission on Human Rights as well as two reports for the UN General Assembly. The *Essex Human Rights Review (EHRR)* is proud to bring this interview with the Special Rapporteur.

EHRR: Since the mandate is fairly new, could you please explain to us what you consider the main tasks entailed in your mandate?

PH: In my first report to the UN Commission on Human Rights,¹ I identify my three main objectives. First, to raise the profile of the right to health as a fundamental human right. Second, to clarify what the right to health means. Third, to suggest ways in which the right to health can be made operational. I aim to pursue these objectives while focussing on the twin themes of discrimination² and poverty.

My first report also identifies a number of issues that I wish to pay particular attention to, such as mental health (which is often overlooked) and the indispensable role of health professionals in the promotion and protection of the right to health. I also highlight the right to health problem of 'neglected diseases' – those diseases mainly suffered by those living in poverty in developing countries, in relation to which there has been little or no health research and development to find cures or treatment.

The right to health can be vindicated in the courts. There are many court cases that illustrate this point. But, additionally, I argue that the right to health must be integrated into national and international policy-making processes. In this way, the right to health can *shape* laws, policies, programmes and projects. I was gratified that, in its most recent right to health resolution,³ the UN Commission on

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¹ UN Commission on Human Rights. Economic, Social and Cultural Rights. The right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Report of the Special Rapporteur, Paul Hunt, submitted in accordance with Commission resolution 2002/31, UN document E/CN.4/2003/58.

² For more information on the Special Rapporteur's views on discrimination with regards to the right to health, please see 'Intergovernmental Working Group on the Effective Implementation of the Declaration and Programme of Action of Durban. Third Session, October 2004. Racism and Health. Remarks by Paul Hunt, UN Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.' As of time of writing the paper is not available on the internet but can be obtained from the EHRR at the address ehrr@essex.ac.uk.

³ UN Human Rights Commission resolution 2004/27 'The right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.

Human Rights expressly affirms the importance of integrating the right to health into policy-making processes.

However, the integration of the right to health into policy-making means that we need to develop and refine new skills. We still need the well-practised human rights techniques – ‘naming and shaming’, letter-writing campaigns, taking test cases, and so on. Indeed, I have written over forty letters to over twenty States regarding alleged violations of the right to health. But, in addition to the classic human rights methodologies, we need new skills and techniques if we are to engage effectively in policy-making. For example, we need indicators, benchmarks and impact assessments that address the right to health. We need to be able to analyse budgets and to identify which trade-offs are permissible and impermissible in international human rights law.

So one of my objectives is to contribute to the development of these new skills and techniques. That is why I am spending a lot of time working with international organizations and civil society groups to identify a manageable approach to indicators and benchmarks. You will find my current thinking on this in my General Assembly reports (2003, 2004).⁴ This remains work in progress.

Another idea I am trying to convey in my work is that developing countries can legitimately use the right to health as a way of getting a better deal from the developed world. Developing countries have firm obligations arising from the right to health. But, additionally, the developed world has responsibilities to assist developing countries emerge from poverty and realise the right to health – of course, developed countries also have duties in relation to individuals and communities within their own borders. I try to be very even-handed on this point, insisting on the responsibilities of developing and developed countries in relation to the South. Predictably, many developed states are uneasy with this approach. But it is an approach that is demanded by international human rights law – consider the numerous references in binding treaties to international assistance and cooperation. I work from the basis that these references are not meaningless!

Over the last two years, it has become clearer to me that we – those of us committed to and working on the right to health – have to focus on Article 2 as well as Article 12 of the International Covenant on Economic, Social and Cultural Rights. What I mean is that we have to clarify the various components of the right to health as set out in Article 12 of the Covenant. That is why I devoted my Commission report this year⁵ to sexual and reproductive health, and that is why my next Commission report will examine mental health. Gradually, these and other elements of the right to health must be clarified. But, before reaching Article 12, one has to pass through Article 2 – the Covenant provision that sets out the general legal obligation of States in relation to the various Covenant rights, including the right to health in Article 12. And Article 2 includes some notoriously elliptical phrases that need careful attention. What precisely do ‘progressive realisation’, ‘maximum available resources’, and ‘international assistance and cooperation’ mean?

So, in addition to clarifying Article 12, one of my objectives is to shed some light on Article 2. This explains why my reports look at international assistance and cooperation, as well as indicators and benchmarks. Indicators and benchmarks are really just tools for getting a handle on the slippery concept of progressive realisation.

⁴ Interim report of the Special Rapporteur of the Commission on Human Rights on the right of everyone to enjoy the highest attainable standard of physical and mental health, Mr. Paul Hunt, Special Rapporteur of the Commission on Human Rights, in accordance with Economic and Social Council resolution 2003/45, UN Doc A/58/427 and Report of Paul Hunt, Special Rapporteur of the Commission on Human Rights, on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, submitted in accordance with Commission resolution 2004/27, UN Doc. A/59/422.

⁵ UN Commission on Human Rights. Economic, Social and Cultural Rights. The right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Report of the Special Rapporteur, Paul Hunt, UN document E/CN.4/2004/49.

EHR: In addressing the problem that certain groups do not have access to health care, and in order to also reach vulnerable groups in society, do you have any views as to whether a health care system should be public and open to all? Further, from your own experience are special measures such as mobile health units and in-settlement health stations needed to ensure that basic health care reaches the most marginalised groups?

PH: Of course a State's health care system must serve all, including the most disadvantaged. A health care system – whether traditional or modern – is a core social institution. It is as central to society as a dispute settlement system. That is one reason why both access to health care and access to justice are protected by rights and responsibilities.

But there is nothing in international human rights law that says a State's health care system must be public in the sense that it must be a nationalised health service, such as the United Kingdom's National Health Service. The right to health places an obligation on the State to ensure that there is a health care system delivering right to health outcomes – such as those in the Convention on the Rights of the Child and the International Covenant on Economic, Social and Cultural Rights – to all. Second, whatever system a State chooses, its operation must be consistent with other human rights and democratic principles. So a good right to health outcome (for example low or negligible HIV-prevalence) that is achieved in a way inconsistent with other human rights (for example through the incarceration of all those with HIV/AIDS) is unacceptable.

The right to health approach is evidence-based. What delivers the right to health for all, including those living in poverty? If evidence shows that a private health care system does the job in a way that is respectful of human rights and democratic principles, so be it. If a public (that is, nationalised) system delivers, that is fine, too. The right to health does not prescribe the system. It is interested in democratically achieved right to health outcomes for all.

Right to health practitioners are inspired by ideals – but we are also interested in evidence-based solutions that are proven to work. A right to health approach brings rigorous analysis – you might say discipline – to national and international health policy-making.

Then you ask whether, from my own experience, special measures such as mobile health units and in-settlement health stations are needed to ensure that basic health care reaches the most marginalised groups.

I recently returned from a country mission to Peru. Peru has a flat coastal plain, a mountainous interior (*sierra*), and a huge hinterland of Amazonian jungle (*selva*). About 50 per cent of the people live in poverty and roughly 25 per cent live in extreme poverty. There are marked regional differences, but those living in poverty are found on the coast, in the *sierra* and in the *selva*.

Clearly, some measures that deliver primary health care on the coast will not work in the mountains and jungle. For example, on the coast, you might want to train more nurses and give them bicycles or mopeds. But a nurse on a bike is not going to get far in the *sierra* – and will get nowhere in the *selva*! In the *sierra*, a better approach might be with a helicopter. In the *selva*, a small boat with an outboard motor, a can of diesel, and a two-way radio.

In short, common sense dictates that special measures are needed to ensure that basic health care reaches the most marginal throughout a jurisdiction.

EHR: Although the main goal is to ensure health care for everybody, resources may often be limited, forcing us to prioritise health care through targeted implementation. What are your thoughts upon this?

PH: This is one of the questions most frequently asked by Governments. How does a Minister of Health make policy choices in a manner consistent with his or her international human rights obligations? Given finite health budgets, how does the Minister choose between providing anti-retrovirals, an immunisation programme, or emergency contraception? The problem is broader. How does a Government choose between establishing a network of rural primary health care clinics (which will come out of the health budget) and extending access to safe drinking water (which, although

health-related, will probably come out of the budget of another Ministry)? Indeed, the problem is broader still. How does a Government choose between building more rural clinics (right to health), hiring more teachers (right to education), and improving squalid places of detention (prohibition against torture and ill-treatment)?

Earlier (see response to your first question), I explained that I encourage States to better integrate the right to health into policy-making – but I added that this demands skills and techniques that are still being developed. One of the challenges is to identify a way of addressing this difficult question of priority setting, both in the health sector itself and across sectors, in a way that is consistent with the right to health. This challenge also ties in with my earlier point about how we need to give more thought to Article 2 of the International Covenant on Economic, Social and Cultural Rights.

The human rights community has not yet formulated an adequate response to these tough issues. We know parts of the answer. For instance, the priority setting must be participatory and the outcomes non-discriminatory, as well as respectful of the minimum essential levels of the right to health. But we do not yet have a comprehensive and compelling response. I – and others – am working on this at the moment. It will take time to identify an adequate response. This is an excellent dissertation topic!

EHRH: Granted that the State has an obligation to ensure that all third parties within its jurisdiction are respectful of human rights, what exactly are the obligations of pharmaceutical companies, which fall within the category of ‘non-state actors’? According to the Special Rapporteur, what should the conduct of a pharmaceutical company be in respect of the right to health?

PH: Only this week I attended a conference organised by Novartis – a major Swiss-based pharmaceutical company – on precisely this question. The conference was called ‘The Right to Health: a Duty for Whom?’. In my view, the pharmaceutical sector has some duties in relation to the right to health – consider, for example, the UN Global Compact and the UN Sub-Commission’s UN Norms on the Responsibilities of Trans-national Corporations and other Businesses on Human Rights. By the way, both instruments have been endorsed by Novartis, to its credit. But we have a long way to go to clarify the scope of these duties and then to figure out what they mean in the real world of patents, drug pricing, health research and development, Joint Public Private Initiatives in the field of health, and so on.

At the Novartis conference I made the following suggestions: First, a small group of so-called experts from the human rights community and from the pharmaceutical sector should meet three or four times a year for two years to talk through these issues in a serious manner, supported by solid research, and without grandstanding. At the end of two years, the experts should produce a report that identifies common ground as well as differences of opinion. In a way, this will be a confidence-building exercise – presently, it seems to me, there is much misunderstanding between the human rights and pharmaceutical communities. This exercise should be followed by a three-year experimental period during which an *ad hoc* group of independent experts examines, through the prism of the right to health, the activities of some pharmaceutical companies. The *ad hoc* group should publish short, accessible, constructive, and balanced reports on what they find. In other words, here we have an embryonic form of human rights accountability being extended to some parts of the pharmaceutical sector. It is by way of measured processes such as this that we can make significant progress towards identifying the human rights responsibilities of the pharmaceuticals.

It is tempting to give facile, glib responses to these complex issues. I think it is very important to resist this temptation. These are challenging, far-reaching and important issues that demand intellectual rigour, interdisciplinary collaboration, and imagination.

EHRH: In your latest report to the UN Commission on Human Rights, you considered sexual and reproductive rights through the prism of the right to health and recommended that increased attention be devoted to a proper understanding of reproductive health, reproductive rights, sexual health and

sexual rights. During the Commission's assembly your approach was criticised by some government representatives, who found that dealing with these issues was beyond the mandate and that homosexuality is a mental disease, which should be dealt with by a psychologist – not the Special Rapporteur.

PH: For the record, more States publicly endorsed my approach than criticised it. The report examines sexual and reproductive health through the prism of the right to health. I chose this topic at this particular time because of the tenth anniversaries of the Cairo (1994) and Beijing (1995) world conferences. In my experience, most of the human rights community has little or no appreciation of the human rights content of Cairo – which is a great pity. Both conferences made important contributions to our understanding of human rights and sexual and reproductive health. One of my aims in the report was to show the synergies between, on the one hand, the Cairo and Beijing processes and, on the other hand, the international human rights law relating to health.

The issues are immensely sensitive, but it would be a dereliction of duty if I did not closely examine, in my annual reports and country missions, sexual and reproductive health. In 2003 the UN Commission on Human Rights' resolution on the right to health confirmed that 'sexual and reproductive health are integral elements' of the right to health. Looking at all the relevant law, I have no doubt that within the right to health there is a sub-set of sexual and reproductive health rights, such as access to information on sexual and reproductive health and access to safe and reliable contraception. If we take reproductive health seriously, we have to take sexual health seriously. It is misguided to think of reproductive health as the overarching issue. Obviously, it is not! The overarching issue is sexual health. Given my mandate, I am obliged to promote and protect sexual and reproductive health rights and they have to be seen in the broader human rights context. It is for this reason that, in my Commission report, I recommend that 'increased attention be devoted to a proper understanding of sexual health and sexual rights, as well as reproductive health and reproductive rights'. However, my report makes clear that my mandate is primarily concerned with sexual and reproductive *health* rights.

One reason why I examined sexual and reproductive health rights in early 2004 was because I wished to look at the health-related Millennium Development Goals in my next report to the UN General Assembly. In a way, my report of 2004 to the UN Human Rights Commission was preparing for my report to the UN General Assembly published later in the year. Although they contrive to avoid the words 'sexual' and 'reproductive', the Millennium Development Goals are replete with sexual and reproductive health rights issues – consider the Goals on maternal mortality, HIV/AIDS, child mortality, and gender equality.

As for sexual orientation, my report simply adopts the view that is now well established in international human rights law: sexual orientation is a prohibited ground for discrimination. Of course, this remains controversial in some societies – but being a Special Rapporteur is not a popularity contest. Whether controversial or not, it is my job to explain, apply, promote and protect the right to health in the context of international human rights law. We must never lose sight of the fact that millions of men and women are persecuted – and many are killed – on account of their sexual orientation.