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LEADING ARTICLE

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

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Summary The health and human rights communities have much in common. Recently, the international community has begun to devote more attention to the right to the highest attainable standard of health ('the right to health'). Today, this human right presents health and human rights professionals with a range of new opportunities and challenges. The right to health is enshrined in binding international treaties and constitutions. It has numerous elements, including the right to health care and the underlying determinants of health, such as adequate sanitation and safe water. It empowers disadvantaged individuals and communities. If integrated into national and international policies, it can help to establish policies that are meaningful to those living in poverty. The author introduces his work as the UN Special Rapporteur on the right to health. By way of illustration, he briefly considers his interventions on Niger's Poverty Reduction Strategy, Uganda's neglected (or tropical or poverty-related) diseases, and the recent US—Peru trade negotiations. With the maturing of human rights, health professionals have become an indispensable part of the global human rights movement. While human rights do not provide magic solutions, they have a constructive contribution to make. The failure to use them is a missed opportunity of major proportions.

1. Introduction

The health and human rights communities have much in common. Both are animated by the well-being of individuals and populations. In both communities, many have a particular preoccupation with discrimination and disadvantage. While human rights violations often lead to higher morbidity and mortality, health programmes have a crucial contribution to make towards the realization of human rights. Increasingly, health and human rights professionals are recognizing their common interests and mutually reinforcing goals.

The last few years have seen some remarkable developments in the field of international human rights. For some decades, the international community focused on classic civil and political rights — the prohibition against torture, the right to a fair trial, freedom of speech and so on. But, since the late 1990s, the international community has begun to devote more attention to economic, social and cultural rights — the rights to education, food and shelter, as well as the right to the highest attainable standard of physical and mental health (Yamin, 2005).

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As the right to the highest attainable standard of health migrates from the margins to the human rights mainstream, it presents human rights and health professionals with a range of new opportunities and challenges (Gruskin et al., 2005; UNDP, 2000; WHO, 2002).

2. What is the right to the highest attainable standard of health?

The right to the highest attainable standard of health is codified in numerous legally binding international and regional human rights treaties (E/CN.4/2003/58). (The full name of the right is 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. For convenience, this is often shortened to the 'right to the highest attainable standard of health' or the 'right to health'.) These binding treaties are beginning to generate case law and other jurisprudence that shed light on the scope of the right to health. The right 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 the highest attainable standard of health have generated significant jurisprudence (for example, the Ecuadorian case of *Mendoza and others v Ministry of Public Health and the Director of the HIV-AIDS National Programme*, Resolucion No. 0749-2003-RA, 28 January 2004).

While the right to health includes the right to health care, 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 essential primary health care. 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 recognizes that the right to the highest attainable standard of health for all cannot be realized overnight. Thus, the right is expressly subject to both progressive realization 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 the 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 the 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.

At root, the right to the highest attainable standard of health consists of globally legitimized 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.

While the right to the highest attainable standard of health is a powerful campaigning and advocacy tool, it is more than just a slogan. Additionally, it has normative depth and something constructive and concise to say to policymakers. The right can help to ensure that health policies devote special attention to the vulnerable and disadvantaged, enhance community participation, ensure that health interventions strengthen health systems, and so on. If integrated into national and international health policy-making, the right to health can help to establish policies that are robust, sustainable, equitable and meaningful to those living in poverty.

3. The UN Special Rapporteur on the right to the highest attainable standard of health

A UN Special Rapporteur is an independent expert appointed to promote and protect human rights. Some Special Rapporteurs are appointed to focus on human rights in a particular country, such as Myanmar. Some are appointed to focus on a particular human rights theme, such as violence against women. And some are appointed to promote and protect a specific human right, such as the right to the highest attainable standard of health.

Special Rapporteurs are neither employed nor paid by the UN. Nor do they represent any country. They are independent experts reporting to the UN Commission on Human Rights (at the time of writing, it is anticipated that the UN Human Rights Council will shortly replace the UN Commission on Human Rights). Some also report to the UN General Assembly. With scant resources, their only sanction is to place their findings, concerns and recommendations in the public domain.

For many years, the UN appointed Special Rapporteurs to focus on the classic civil and political rights, such as freedom of religion and the prohibition against torture. Only more recently has it appointed experts to focus on economic, social and cultural rights, the first being the Special Rapporteur on the right to education, who was appointed in 1998. Two others soon followed — on the right to food and the right to adequate housing. In 2002, the UN decided to appoint a Special Rapporteur on the right to the highest attainable standard of health. Supported by civil society organizations, Brazil led the campaign to establish this position. Two countries voted against it: the United States and Australia. Following the UN's decision, I was nominated to the position by New Zealand and appointed in 2002 by the Chairperson of the UN Commission on Human Rights for a term of three years, now renewed until 2008.

In brief, the Special Rapporteur is asked to help states, and others, better promote and protect the right to the highest attainable standard of health (UNHCHR, 2003). To give some shape to the mandate, my first report identifies three key objectives: to promote — and encourage others to promote — the right to health as a fundamental human right; to clarify the scope of the right to health; and to identify good practices for the operationalization of the right

to health at community, national and international levels (E/CN.4/2003/58). I pursue these three objectives by focusing on two inter-related themes: poverty and discrimination.

Each year I submit written and oral annual reports to the UN General Assembly and another to the UN Commission on Human Rights. In each report I select one or more issues that I then examine through the prism of the right to health. To date, these annual reports have looked at a range of issues, including the health-related Millennium Development Goals (A/59/422), the skills drain of health professionals (A/60/348), sexual and reproductive health rights (E/CN.4/2004/49), indigenous peoples (A/59/422), mental disability (E/CN.4/2005/51), and others.

I also undertake two country missions each year. Hitherto, country missions have been undertaken to — and reports have been completed on — Mozambique (E/CN.4/2005/51/Add.2), Peru (E/CN.4/2005/51/Add.3), Romania (E/CN.4/2005/51/Add.4) and Uganda (E/CN.4/2006/48/Add.2). One mission was not to a country but to the World Trade Organization to examine important global issues — trade liberalization, patents — that impact on the right to health in all states (E/CN.4/2004/49/Add.1). Another distinctive report is on Guantánamo Bay (E/CN.4/2006/120). A mission to Sweden in January 2006 has not yet generated a report.

During a country mission, my practice is to visit poor rural areas and meet with civil society organizations, including health professional associations, as well as ministers and senior public officials. I try to get a balanced view by visiting fine health facilities as well as those that are less impressive. At the end of each mission I hold a press conference to raise the profile of some of the key health issues in the jurisdiction.

Although a mission takes months of work — research, preparation, the mission itself and writing the report — the report is only some 25 pages. No country mission report is comprehensive. Usually, I select a small handful of strategic health issues and focus on them, identifying recommendations for the Government and other actors, including (in appropriate cases) the donor community. After my oral presentation of the written country report to the UN Commission on Human Rights, the State concerned has a right of reply.

Special Rapporteurs frequently receive information alleging human rights abuses falling within their mandate. The information comes from victims, their families and civil society organizations. Unfortunately, I do not have the resources to respond to all the complaints I receive. To date, I have taken up about 75 cases with about 40 states. These complaints have included: the persecution of health workers on account of their professional activities; discrimination on the basis of health status, including HIV/AIDS; the abusive treatment of mental health patients; the denial of health services to migrant workers; and non-consensual medical treatment. At the end of each year, a report summarizes the cases taken up with states and any replies received (E/CN.4/2005/51/Add.1 and E/CN.4/2006/48/Add.1). Occasionally, I will publicize an especially serious health situation without waiting for the end of year report. In March 2004, for example, in collaboration with seven other UN human rights experts, I drew attention to the deepening humanitarian and health crisis in Darfur.

By way of illustration, the following paragraphs briefly signal three issues that are addressed more fully in my UN reports.

3.1. Niger's poverty reduction strategy

One of my reports to the UN Commission on Human Rights briefly considers Niger's Poverty Reduction Strategy (PRS) through the prism of the right to health (E/CN.4/2004/49, paras 57—75).

The report commends a number of the public health features of the PRS, such as the objective of ensuring that essential, high-quality medicines are available at affordable prices, a goal that reflects Niger's international right to health obligations.

Additionally, however, the report draws attention to some issues in the PRS that, had the right to health been taken into account when the PRS was prepared, would have been addressed somewhat differently. From a right to health perspective, for example, a pro-poor health policy should include education and information campaigns concerning the main health problems in local communities, including methods of prevention and control. Also, explicit attention should be given to the health situation of all marginal groups in the jurisdiction, including racial and ethnic minorities. Further, the right to health requires that transparent, accessible and effective monitoring and accountability mechanisms be established, providing rights-holders (for example, individuals) with an opportunity to understand how duty-bearers (for example, ministers and officials) have discharged their obligations in relation to the PRS.

Although a commendable poverty reduction strategy, from the right to health perspective, Niger's PRS did not give sufficient attention to these (and some other) issues.

3.2. Uganda's neglected diseases

In 2004, I was invited by the Government of Uganda to visit and prepare a report on neglected diseases and the right to the highest attainable standard of health (E/CN.4/2006/48/Add.2). 'Neglected diseases' was the term used during the mission to refer to tropical or poverty-related diseases that are mainly suffered by poor people in poor countries. As is well known, in Uganda these diseases include onchocerciasis, African trypanosomiasis and lymphatic filariasis.

Examining Uganda's neglected diseases through the lens of the right to health underlines the importance of a number of policy responses. First, it underscores 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. While there might be a place for some vertical interventions, they must be designed to strengthen, not undermine, an integrated health system. Second, village health teams are urgently needed to identify local health priorities. Their local knowledge about the prevalence of disease in the community will enhance the perspectives provided by a health official from the regional or national capital. Third, 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. Fourth, there are myths and misconceptions about the causes of neglected diseases: these can be dispelled by accessible public information campaigns. Fifth, some of those suffering from neglected diseases are stigmatized and discriminated against: this, too, can be tackled by evidence-based information and education. Sixth, the international community and pharmaceutical companies also have responsibilities to provide needs-based research and development on neglected diseases, as well as other assistance. Seventh, 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. In my report I suggest a way of enhancing accountability in relation to neglected diseases in Uganda.

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.

The UNICEF/UNDP/World Bank/WHO Special Programme for Research and Training in Tropical Diseases has commissioned research on neglected diseases and human rights; it is anticipated that this study will be available later this year (Hunt et al., 2006).

3.3. US—Peru trade agreement

My country report on Peru covers a range of health issues, including sexual and reproductive health, mental health, environmental health, ethnicity and culture, and the US—Peru trade agreement (E/CN.4/2005/51/Add.3). At the time of the mission in June 2004, Peru was engaged in negotiations towards a bilateral trade agreement with the United States. While the prospective agreement covered a number of issues, the mission report focuses on the potential impact of the trade agreement on access to essential medicines in Peru.

Crucially, the Constitution of Peru protects the right to health. Also, Peru has ratified a number of binding international human rights treaties that enshrine the right to health and encompass access to affordable essential medicines, including for those living in poverty. The primary aim of the report was to try to ensure that these constitutional and international provisions were given proper attention in the negotiating process.

The report expresses concern that the bilateral trade agreement may result in 'WTO-plus' restrictions, including new patent and registration regulations that impede access to essential medicines, such as antiretrovirals for people living with HIV/AIDS. The report also stresses the human rights responsibility of countries to make use of the safeguards available under the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) and the Doha Declaration on the TRIPS Agreement and Public Health — such as compulsory licences — to protect public health and promote access to medicines. After all, TRIPS and the Doha Declaration allow countries to protect public health. Thus, the conclusion of a bilateral trade agreement should not restrict Peru's ability to use the public health safeguards enshrined in TRIPS and the Doha Declaration.

The mission report urges Peru to take its human rights obligations into account when negotiating the bilateral trade agreement. Before any agreement is finalized, assessments should identify the likely impact of the agreement on the enjoyment of the right to health, including access to essential medicines and health care, especially of those living in poverty. From the human rights perspective, all the negotiations must be open, transparent and subject to public scrutiny.

Also, in accordance with its human rights responsibility of international cooperation, the United States should not apply pressure on Peru to enter into commitments that either are inconsistent with Peru's constitutional and international human rights obligations, or by their nature are 'WTO-plus'.

These — and other arguments in the mission report — were reinforced by press releases in July 2004 and July 2005 as the negotiations continued (see 5 July 2004 and 13 July 2005 at http://www2.essex.ac.uk/human_rights_centre/rth/pressreleases.shtm).

In June 2005, the Peruvian Ministry of Health released a study on the potential effects of an eventual US—Peru trade agreement on access to medicines. The study revealed that between 700 000 and 900 000 people would be left excluded from accessing medicines without an increase in the budget of the Ministry of Health or an increase in household income for the poor. The first year of the agreement would require an additional increase in spending of US$34.4 million, of which US$29 million would fall on families and the rest on the Ministry of Health.

In the press release of July 2005, I welcomed the Ministry of Health's impact assessment, again warned all parties of the effects of the bilateral trade agreement on the right to health, and urged the Government to introduce complementary measures to protect the poor from bearing the costs of the agreement. The Ministry of Health study proposes the creation of a fund for medicines, the fund being drawn from sectors benefiting from the agreement.

Although my country report and press releases on the bilateral trade agreement certainly generated considerable media interest in Peru, I leave others to judge the effect, if any, of human rights arguments on the actual negotiations. In any event, it was important that the governments of Peru and the United States, as well as civil society, were fully aware that the bilateral trade negotiations would have a vital bearing upon the enjoyment of the fundamental human rights of many individuals and families, including those living in poverty.

With the text recently completed, Peru's legislature now has an opportunity to consider the human rights dimensions of the agreement. It remains to be seen whether or not the agreement will also be challenged in the Peruvian courts on human rights grounds.

4. Conclusion

A right to health approach — whether to poverty reduction (Niger), neglected diseases (Uganda) or trade (Peru) — does not imply a radically new departure. Rather, it is

likely to reinforce and enhance elements already existing in many policies, programmes and projects. The Government of Uganda, for example, already has a number of policies that will help to tackle neglected diseases. Nonetheless, an examination of the problem through the right to health lens can provide insights, and signal measures, that sharpen and deepen existing initiatives.

Increasingly, the right to the highest attainable standard of health presents health and human rights professionals with new opportunities and challenges.

The traditional techniques and skills that have served the human rights community so well for many years — 'naming and shaming', letter-writing campaigns, taking test cases to court, and so on — will not be sufficient to ensure that the right to health is integrated into national and international health policy-making. Quite apart from expertise in the field of health, additional techniques and skills are needed. For example, selecting priorities and making trade-offs are part of the inescapable reality of policy-making. So human rights proponents will have to clarify how to select priorities in a way that is respectful of the right to health. They will have to clarify how to identify which trade-offs are permissible and which are not from the human rights point of view. They will also have to develop and use new tools, such as human rights impact assessments and human rights indicators and benchmarks (Humanist Committee on Human Rights, 2006; E/CN.4/2006/48). Of course, the traditional human rights techniques remain vitally important. But they are no longer enough. Additional skills are needed.

Crucially, these new techniques and skills will have to be developed in close cooperation with health professionals. The right to the highest attainable standard of health cannot be realized without their active engagement. In short, with the maturing of human rights, health professionals have become an integral and indispensable element in the global human rights movement.

As never before, national and international human rights are at the disposal of health professionals. While human rights do not provide magic solutions, they have a constructive contribution to make. The failure to use them is a missed opportunity of major proportions.

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The following Reports to the UN General Assembly (A/59/422 and A/60/348) and to the UN Commission on Human Rights (E/CN.4 etc) are available through the following websites:

http://www.ohchr.org/english/issues/health/right/annual.htm
http://www2.essex.ac.uk/human_rights_centre/rth/rapporteur.shtm

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