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COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS

Ninth session

SUMMARY RECORD OF THE FORTY-SECOND MEETING

Held at the Palais des Nations, Geneva,
on Monday, 6 December 1993, at 3 p.m.

Chairperson: Mr. ALSTON

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GE.93-19806 (E)

The meeting was called to order at 3.15 p.m.

ORGANIZATION OF WORK (agenda item 2) (continued)

1. The CHAIRPERSON pointed out that the draft general comment on persons with disabilities (E/C.12/1993/WP.26) had been revised in the light of observations made by members and non-governmental organizations, and invited members of the Committee to study it with a view to being able to discuss it shortly and adopt it.

2. The Committee had also been called on to consider the question of the right to education at its current session. Members would recall that the Vienna Declaration and Programme of Action contained a number of proposals relating to the right to education, and that the General Assembly of the United Nations had before it a proposal to declare a decade for education. The Human Rights Committee had also been instructed to consider the question, and it was probable that the Committee on Economic, Social and Cultural Rights would serve as the coordinating body. He had therefore informed the secretariat, on a provisional basis, that the Committee would devote one hour to the question before the end of the session.

3. He then informed the Committee that Ms. Bonoan-Dandan, in her capacity as Rapporteur, and he himself would be studying, along with the Under-Secretary-General for Human Rights, ways of improving the Committee's working methods.

4. He pointed out finally that the draft general comment on the economic, social and cultural rights of the elderly prepared by Mrs. Jimenez Butragueño (E/C.12/1993/WP.21) had been distributed and that the Committee should be able to begin its consideration of it before the end of the session.

GENERAL DISCUSSION ON THE RIGHT TO HEALTH (MINIMUM CORE CONTENT AND NON-DISCRIMINATION DIMENSIONS) AS RECOGNIZED IN ARTICLE 12 OF THE COVENANT (agenda item 5) (continued) (E/C.12/1993/WP.17-20 and 22-25)

Importance of the recognition of health as a human right (continued)

5. Ms. PINET (World Health Organization - Vice-Chairman of the Working Group on Human Rights) said that the right to health was a fundamental right, just as the right to liberty and the right to life, and that physical and mental integrity was an integral part of human dignity. The right to health was not, however, an absolute right; it was the resultant of a number of individual and collective rights to which it imparted dynamism and put the finishing touches, and whose scope it was able to modify. There was a very close link between a person's right to health and freedom, and just as no one was ever definitively free, so no one was ever definitively in good health, a fact which nevertheless should not be adduced to deny recognition and realization of a right to health. The right to health was not simply a right to health care because it had a socio-economic, behavioural and environmental dimension which was decisive in human rights terms. In fact, if the effects on health of social and economic inequalities could be attenuated by health action, the reduction of inequalities in regard to health could be secured in the final analysis only by an improvement in social and economic conditions. None of

the fundamental aims of public health could be achieved without greater social justice, which demanded a sustained participation by the State in all economic and social areas. The right to health was a social right with an individual focus, and society should commit itself to using all means at its disposal to guarantee the exercise of that right.

6. Furthermore, that obligation was of global significance, as was underlined in the Constitution of the World Health Organization and in the Global Strategy of Health for All, prompted by the same concern that motivated the Committee on Economic, Social and Cultural Rights, namely, securing recognition of a collective and individual responsibility for health and achieving a universal consensus on the content of "Health for All" and of the essential minimum which it represented for all individuals and all peoples.

7. Full consideration should also be given to the progressive recognition in international law of flexible standards and guidelines such as the resolutions of the World Health Assembly which, although not legally binding, engaged the collective will of the Member States of WHO and played a leading part in the promotion and dynamic definition of the right to health, especially in respect of equity and non-discrimination.

8. However, the right to health demanded more than guidelines and programmes. It had to be guaranteed by texts and to be invocable immediately. That was one of the continuing concerns of the Committee on Economic, Social and Cultural Rights in its dialogue with States parties which were submitting reports. In that respect, WHO was fully aware that its mandate and those of the human rights treaty monitoring bodies were complementary.

9. Finally, she said it should not be forgotten that there were individual and collective obligations in the area of health. Each one had a responsibility in the management of his or her own state of health, in the rational utilization of health services and in the preservation of a healthy environment, and there was a duty of human, scientific and financial solidarity with regard to the most vulnerable, as well as between peoples and generations.

10. She proposed, in conclusion, that the Human Rights Committee of WHO and the Committee on Economic, Social and Cultural Rights establish links for cooperation in a number of areas. For example, they could develop an exchange of information and give thought, jointly, to the right to health when next revising the general guidelines for submitting reports. It would, for instance, be useful to specify the obligations of States regarding public access to information, which lay at the basis of choice in matters of health, and community participation in the field of health. Finally, the Centre for Human Rights might give consideration, at the international level, to innovative forms which the reporting obligation might take.

11. Ms. SKOLD (Christian Medical Commission of the World Council of Churches) reminded the Committee that the World Council of Churches was present in more than 100 countries, and that its Medical Commission helped member churches and local communities in their efforts to make health and health care accessible to all.

12. She said it should not be forgotten that the preamble to the Constitution of WHO declared that "enjoyment of the highest attainable standard of health" was one of the fundamental rights of every human being without distinction of any kind. That right had been reaffirmed at the 1978 WHO Conference on Primary Health Care. Of course, there remained the difficult question of defining health as a human right. The World Council of Churches was concerned by the fact that the Declaration of the WHO Conference in Alma Ata on Primary Health Care had only been partially implemented, and by the fact that very often health was regarded as the absence of disease, while the Declaration defined health as a state of physical, mental and social well-being. The conditions necessary for the enjoyment of good health were of a social and economic nature; they included access to land, economic productivity, food, housing, clean water, proper sanitation, education, public works and communications, recreation and people's participation.

13. The World Council of Churches had long recognized the social, economic and political dimensions of the right to health. The concept of health was inextricably linked to cultural and religious traditions, and the conditions essential to the enjoyment of holistic health depended on political and economic will and the means deployed. People's conscious effort to analyse their health situation and to improve their quality of life was an important indicator of one's right to health. Every effort should be made to enable communities and individuals to recognize that health was a fundamental right and a dynamic process which required the participation of all at every level. Individuals and the community also had the right and duty to participate jointly in ensuring that in agriculture, education, employment, housing and public health, priority was given to policies designed to create the conditions necessary for the enjoyment of health for all. Yet, in some regions and countries, health workers and community organizers were thwarted by government measures that invoked national security. That was where international bodies and Governments had a role to play. Today, as a result of structural adjustment policies, most third world countries, crushed under the burden of foreign debt and subject to the diktat of the International Monetary Fund and World Bank, were taking measures which were particularly prejudicial to the well-being of their populations. Those measures - the privatization of services, the freezing of wages, the laying off of workers, reductions in public spending in the areas of health and education, etc. - had the effect of making large sectors of the population both impoverished and marginalized, with dramatic consequences for vulnerable groups, such as women, the elderly and the unemployed, who no longer had access to satisfactory health care. Structural adjustment policies must therefore be rethought and humanized.

14. The minimum core content of the right to health was therefore nothing else but the full implementation of the Alma Ata Declaration on Primary Health Care, without which large sectors of the population would be the victims of serious discrimination. The unjust distribution of health resources within and between nations could be corrected only by promoting primary health care.

15. The World Council of Churches recommended that the United Nations - through the Committee on Economic, Social and Cultural Rights and in cooperation with Governments and the World Health Organization - should launch a study programme with the object of achieving the full realization of the

right to health, with, as a prerequisite, the right to non-discrimination. The programme should take as its starting point article 25 of the Universal Declaration of Human Rights which stated the right of everyone to a standard of living adequate for his health, and medical care and the necessary social services in the event of lack of livelihood in circumstances beyond his control.

16. Mrs. AHODIKPE stated that the right to health could take the form of traditional medicine, particularly in the developing countries where modern therapies were not available to the majority of the population. The promotion of traditional medicine was therefore an important element in the right to health.

17. Mr. SIMMA said that the speakers he had heard had taught him a great deal by highlighting the sociological aspects of the right to health. However, he would still like to hear more specific proposals which might be of use to the pre-sessional working group. The working papers and statements had been of a general nature and some concepts had still not been defined. For example, there was a difference between laying claim to health and having a genuine right to health. The Committee should address itself to the minimum core content of the right to health and to non-discrimination, and he urged participants to focus their statements on those two points so as to give the Committee the precise focus it needed.

18. Mr. GRISSA said it was easy to pay lip service to the right to development, which no one would dream of denying. But it should not be forgotten that health had a cost and that the whole problem lay in having the means to realize that right. In many countries there was a lack of food, proper sanitation and drinking water. In Africa the main problem was water, which was the cause of a large number of diseases, and providing the necessary sanitation would require amounts of money roughly equivalent to the Gross National Product of the entire continent. In Latin America, less than 20 per cent of the population had running water. In such conditions of penury, it was obvious that one could not speak of realizing the right to health.

19. The CHAIRPERSON acknowledged that the difficulties Mr. Grissa had referred to certainly existed. However, he recalled what Ms. Leary had said on that subject in the morning, namely, that it was not the resources that were most lacking, but the will of Governments to make the right to health the focus of their priorities, and to do everything in their power to ensure that it was realized.

20. Mr. KOUZNETSOV said he wanted the question of international cooperation in the field of health to be discussed. It might take the guise of providing technical assistance or medicines. WHO, for example, was undertaking activities in that area on a large scale.

21. It might also involve drawing up international instruments and agreements to make Governments and public opinion aware that the right to physical and mental health was a priority, as laid down in article 12 of the Covenant. States had already drawn up a number of instruments on the subject, and the Committee should encourage them to do more in that direction.

22. It was worth noting that many experts, especially members of the International Law Association, considered that international medical law should be codified. WHO, a special committee of the General Assembly or even a working group of the Economic and Social Council might be given the task of drawing up a declaration on the principles of international medical law which could play a similar role in the area of health to that which was played in another area by the Declaration on Principles of International Law concerning Friendly Relations and Cooperation among States in accordance with the Charter of the United Nations. By acceding to such a declaration, States would be undertaking new obligations in respect of health.

23. As long as they pursued their nuclear, chemical or bacteriological weapons tests, States could not claim that they were doing everything to protect the health of populations. There should also be an investigation of the health problems posed by environmental pollution, drugs trafficking and prostitution.

24. Finally, as the Chairperson had underlined, the Committee should seek to persuade Governments to make the right to health the focus of their concerns, especially by allocating to health the sums it deserved to receive from national budgets.

25. Mr. GRISSA said it was difficult to establish priorities when resources were lacking.

26. He considered that education was essential to exercise of the right to health. Other rights like the right to sufficient food and the right to housing also had an influence on realization of the right to health.

27. He said he wanted to know who should be fixing the priorities - whether individuals or authorities - and how.

28. The CHAIRPERSON recalled that States parties had undertaken, by ratifying the Covenant, to give priority to fundamental economic, social and cultural rights.

29. Mrs. JIMÉNEZ BUTRAGUEÑO said it was very important to study the discrimination experienced by women in the field of health.

30. Furthermore, priority should be given to preventive medicine, both for health reasons and for reasons of cost-effectiveness, especially in respect of people of retirement age.

31. The relationship that existed between the right to health and other rights such as the right to sufficient food and the right to housing should also be studied.

32. Governments should be asked what they were doing to encourage individuals to keep themselves in good health, in particular by protecting themselves against the damage caused by tobacco and alcohol.

33. As Ms. Pinet had rightly emphasized, it was important at a time of economic crisis to call on the help of civilian volunteers to complement the action taken by Governments in the health field.

34. Finally, she said she considered that what Mr. Fluss had said about health indicators had been very important.

35. Mr. MUTERAHEJURU felt, like Mr. Simma, that the content of the right to health should be defined.

36. It was also important to explore the question of the compatibility between structural adjustment programmes and respect for economic, social and cultural rights.

37. Finally, he was at pains to underline that in certain exceptional situations, notably the situation in which people living in the refugee camps in Africa and other parts of the world found themselves, it was virtually impossible to make a distinction between the right to life and the right to health. In fact, the very survival of such people was at stake. He had been able to see for himself that many of them had died of starvation or disease. The Committee should therefore take account of such extreme situations when it took up the question of the right to health.

The principle of non-discrimination

38. Mr. HENDRIKS (Chairman of the Dutch section of the International Commission of Jurists) said that the right to health imposed upon States an obligation to protect individual and public health by guaranteeing access by all to appropriate health services and by taking preventive measures which were both comprehensive and targeted.

39. The new medical techniques which had been developed had made possible a considerable improvement in the health situation of the population, in accordance with the objectives laid down in article 12 of the Covenant, but their unrestricted use, notably outside the traditional patient-doctor relationships, posed a grave threat to the rights and dignity of human beings. Mandatory medical examinations in the context of employment and medical experiments carried out on human subjects were examples of that. The health status of the individual was increasingly used to determine access to all kinds of goods and services, such as employment, social security, housing, etc. The providers of goods and services were free to require applicants to furnish them with detailed health information, and might even subject them to a physical and psychological examination.

40. Such a development gave cause for serious concern, for it could lead to systematic violation of the right to privacy and physical integrity. The rights and dignity of all persons should be protected. It was not acceptable for an individual to be excluded from social life, employment, housing or social security by virtue of his or her state of health. Furthermore, the absence of adequate legal protection for the confidentiality of personal information regarding health might deter those who needed to do so from contacting the medical services. In such situations, the right to health itself was at stake.

41. A question that urgently needed to be answered was the issue of at what point differentiation on the grounds of health status constituted discrimination. It was particularly important in view of the rapid progress being made in the field of genetics which in the near future would mean that certain anomalies could be detected, or their appearance predicted.

42. All discrimination based on health status should therefore be expressly prohibited. In that context, it was worth recalling that in its resolution 1989/11 the Commission on Human Rights of the United Nations had stated that "all men and women are equal before the law and entitled to equal protection of the law from all discrimination and all incitement to discrimination related to their state of health". Even today there were very few jurisdictions which provided legal safeguards against such discrimination.

43. Further, international minimum standards needed to be formulated to regulate the extent to which providers of goods and services were justified in requiring applicants to provide them with information on their state of health. That seemed all the more urgent now that access to a large number of economic, social and cultural rights depended on the ability of individuals to meet the health criteria unilaterally set by the providers of goods and services.

44. In conclusion, he expressed the hope that the Committee would take account of those suggestions when it monitored the compliance of States parties with their obligations.

45. Mr. GRISSA wondered whether, by preventing the disclosure of information in order to protect the privacy of some, the right of others to the protection of their physical integrity might not be infringed. He gave the example of two persons who were infected, one of them by a relative and the other by a companion, who were HIV positive but were not known to be carriers of the HIV virus.

46. Mr. HENDRIKS (Chairman of the Dutch section of the International Commission of Jurists) observed that extreme prudence should be exercised in restricting the rights of the individual in the supposed interest of the community. It had been shown, for example, that mandatory AIDS tests on large groups of the population had led to discriminatory attitudes rather than to a change in behaviour. Instead, everyone should be given adequate education so as to be able to protect one another.

47. The CHAIRPERSON, speaking in his capacity as an expert, said that persons who ran a risk of being infected needed to be informed about others in order to protect themselves.

48. Ms. HAUSERMANN (Rights and Humanity) said that the non-governmental organization she chaired, Rights and Humanity, had as its objective in the area concerned the promotion of respect for the human rights of persons who were HIV positive or who had AIDS, and to protect the health of women. She said that most discussions on the right to health were centred on the substance of the policies and measures which the public authorities should adopt in order to ensure that everyone had the opportunity to enjoy the highest attainable standard of physical and mental health. Rights and

Humanity was instead concerned to investigate the extent to which States fulfilled in specific terms their duty to respect human rights in the context of health care and to protect individuals from any discrimination in that respect. The problems that were encountered showed that one of the State's prime duties was to educate public health officials - from those who decided policy to those who carried it out - who were often ignorant of the legal obligations undertaken by the State by means of international instruments and were even less aware of the measures to be implemented in order to ensure respect for human rights in the context of health policies and services. It was a question which the Committee on Economic, Social and Cultural Rights might study. WHO, she said, was working on the development of a framework for promoting policies at the international and national levels, and Rights and Humanity was collaborating in that endeavour.

49. Rights and Humanity was also participating in the work being done by a WHO Global Commission on women's health, which had decided to consider the subject in the context of respect for human rights. It had in fact been noted that the discrimination suffered by women and their unenviable socio-economic conditions made them particularly vulnerable in health terms: illiteracy or lack of information deprived them of any means for acting, and many of them were obliged to live and work in conditions that were dangerous to their health. The inequities suffered by women were well known: some of them, such as the lack of investment in research on diseases affecting women or the lack of appropriate health care facilities, and even the unequal access to existing resources, were directly attributable to Governments; others resulted from particular social attitudes, such as boy child preference which, among other things, led to female infant malnutrition and mortality. Governments nevertheless had an obligation to combat such prejudices and discrimination against women and girls through education and corrective measures on their behalf.

50. In promoting a human rights approach to the consideration of women's health issues, Rights and Humanity had chosen to focus on two key principles: that of equity - and therefore of non-discrimination and equality of access - and that of human dignity, which assumed respect for autonomy, freedom of choice and participation. Respect for those values at the international and national levels, and at the level of health professionals, could have a significant impact on the enjoyment of the right to health, which was an objective that all States Members of the United Nations must strive to achieve, separately and jointly. That was an idea which the Committee on Economic, Social and Cultural Rights might stress when examining the difficulties encountered by some countries due to their structural adjustment policies. More generally, there should be an evaluation of the impact of the policies and projects of international financial institutions on the enjoyment of human rights, especially the right to health, and steps should be taken to ensure that national policies and budgets took account of the particular needs of women in the health field. Governments should also redouble their efforts to eliminate the obstacles of an economic, social and legal nature which prevented women from enjoying the right to health.

51. More generally, adopting a human rights approach to health amounted to confirming that health was a right which should not be sacrificed to economic or other interests, and that any international or national policy on health

should be based on respect for human rights and dignity and on the participation of women and vulnerable groups, as it was only through such participation that the causes of their particular problems could be effectively tackled. The AIDS pandemic, for example, had demonstrated the validity of the provisions of article 1 of the Universal Declaration of Human Rights, and had confirmed that the most effective measures in the struggle against the spread of HIV were those that were founded on respect for the person, the participation of individuals and personal responsibility, whereas coercion and discrimination merely impeded the efforts made to that end.

52. Since the most odious violations of the right to health were often due to cultural traditions or social pressures, the question arose of the extent to which the State should intervene against irresponsible behaviour by individuals and groups. It was clear that the State was obliged to act, by taking legislative or other measures, when it was a matter of protecting individuals against the risks of illness or disability as a result of the behaviour of others, particularly companies producing toxic waste and negligent employers. In that connection, a number of speakers had raised the question of how one could know where respect for the rights of the person stopped and the State's obligation to protect the health of the population began. It had sometimes been stated that in order to control the AIDS epidemic it was necessary to limit the rights and freedoms of those who were HIV-positive, but all too often the measures taken by the public health authorities had gone well beyond what was strictly necessary and had served as a pretext for human rights violations - such as arbitrary detention, restrictions on freedom of movement, invasions of privacy and denial of the right to work, housing, education and even health care. It was perhaps worth recalling that measures restricting individual rights and freedoms were justifiable only to the extent that they were provided for by law, were absolutely necessary for the protection of public health, were proportionate to the anticipated benefit, represented the least intrusive method of achieving the desired end and were not arbitrarily directed against a particular individual, group or section of society. Those were arguments that militated in favour of education, rather than isolation. The AIDS pandemic showed that the legislation operating in many countries gave the health authorities Draconian powers which sometimes went as far as detaining a person who was HIV-positive and considered likely to infect others and denying the right of appeal, which was in breach of the principles guaranteeing due process.

53. There were also grounds for concern regarding the manner in which health services were delivered. In a number of countries, those services were often provided in a form which infringed privacy, physical integrity or freedom of movement. Traditionally, medical ethics had not been a matter for the public authorities, but it was not permissible for those authorities to refrain from intervening when there was a flagrant breach of medical ethics, as was frequently the case with the treatment of people who were HIV-positive or suffered from AIDS. There was also the question of discrimination on grounds of ill health, a problem whose full extent had been revealed by the AIDS pandemic. Various United Nations bodies had devoted themselves to combating discrimination related to AIDS, but none had yet declared officially that discrimination based on health status amounted to a violation of human rights. The Committee on Economic, Social and Cultural Rights might consider making

such a statement in its general comment on discrimination, perhaps by referring to the declaration and charter on HIV and AIDS which the organization Rights and Humanity had drawn up with the assistance of human rights advocates and public health experts from around the world. Finally, the Committee might perhaps turn its attention to the relationship between the right to health and the freedom to die in dignity.

54. Mr. GRISSA, returning to the sensitive issue of the respect for privacy and the disclosure of HIV-positive status, emphasized the fact that the policy of not declaring cases of HIV-positive status to the authorities could only contribute to the spread of AIDS, which was, after all a fatal disease. It was a risk which must not be ignored. In those circumstances, he maintained that society had the right to know which individuals in its midst were HIV-positive.

55. Mrs. BONOAN-DANDAN regretted the fact that no representative from the major international financial institutions had taken part in the discussion, because it was undeniable that the structural adjustment policies imposed on developing countries by those institutions in order to absorb their foreign debt had an impact on the right to health, and even to life. In the countries of Asia, where she came from, it had been ascertained by a non-governmental organization that every hour a child died because 66 per cent of the national budget was devoted to servicing foreign debt rather than to public health, education, housing and other programmes. In short, it was the so-called disadvantaged groups which paid the costs of structural adjustment policies. It was a point which the Committee could not over-emphasize.

56. It had been stated during the discussion that those responsible for drawing up and implementing public health policies were in the majority of cases unaware of the obligations undertaken by the State under the International Covenant on Economic, Social and Cultural Rights. She was convinced that most of those officials did not know that access to drinking water, decent housing and an adequate standard of living were human rights like any other, and that States did not see their contractual obligations in human rights terms. In fact, what was lacking was a theoretical framework which would demarcate and provide guidance for national and international policies in the areas covered by economic, social and cultural rights.

57. Mr. VANEY (International League of Societies for Persons with Mental Handicap) said that his organization represented 140 national societies from 88 countries, accounting for some 40 million mentally handicapped persons or, more specifically, people suffering from mental retardation or intellectual deficiency. The League had long been involved in defending the rights of handicapped people, especially in matters of health. Although the United Nations General Assembly had adopted a Declaration in 1971 in which, inter alia, it had stipulated that mentally handicapped people enjoyed the same rights as any other citizens, and had underlined in 1975 that handicapped persons had a right to the same respect and dignity as any other human beings, it nevertheless remained the case in practice that such people were often not even considered as full human beings or even as individuals who were useful to themselves and to society.

58. In its efforts to combat such discrimination, the League took as its starting point the principle that no matter what degree of deficiency the mentally handicapped person suffered from, he or she had the same needs as any other human being regarding security, membership of society, love, dignity and fulfilment, as well as physiological needs. The organization also placed emphasis on the necessity of satisfying all those needs so that the mentally handicapped person could enjoy the best health status he or she was capable of achieving. In specific terms, that meant that irrespective of the cultural and social context in which the mentally handicapped child lived, he or she must be able to live within the family, which should be guaranteed the necessary support for that purpose, and must receive an education or at least stimulation in order to avoid the risk of any additional handicap which would affect his or her state of health, just as the mentally handicapped adult needed an occupation or a job that was socially useful. Above all, the mentally handicapped person needed to belong to a community from which he or she was still all too often excluded. In the area of health, that exclusion manifested itself by the fact that he or she was taken into care by special services and refused any possibility of choosing his or her own doctor and course of treatment. Exclusion from the community also took the form of being placed in special institutions where the mentally handicapped person was cut off from the stimulus of a family and social environment and where his or her deficiency could only get worse, for lack of care. Some handicapped people were even attacked physically in the sense that they were castrated or made the subject of medical research. Some people went as far as to contemplate depriving the profoundly handicapped of the right to life - and there was no need to point out the dangers of that idea.

59. The inappropriate application of bioethics was also extremely worrying since it could lead to the arbitrary elimination of handicapped persons, whose right to life would thereby be violated.

60. The problem of health should be tackled in a comprehensive manner by taking account of the rights of the human person and by following the approach adopted by WHO and certain specialist institutions. The activity to be undertaken in terms of the right to health should relate not only to handicapped persons and prevention but also to the community and the environment, in order to limit the social effects of handicap. Efforts should also be made to reduce handicaps, even in countries which lacked resources; to develop information regarding handicapped persons and make society more responsible in that respect; to enable everyone to have access without discrimination to health care services, even if that might mean positive discrimination on behalf of handicapped people; to undertake large-scale and small-scale studies in order to assess the quality of life and health in institutions that provided care; to re-establish support networks so that everyone could assume responsibility for health; to appoint someone at the international level who would be responsible for receiving complaints relating to health and for taking the necessary sanctions; and, finally, to encourage handicapped persons, including the mentally handicapped, to group themselves together within associations that were oriented towards meeting their needs.

Minimum core content of the right to health

61. The CHAIRPERSON invited participants to speak about the concept of the minimum core content of the right to health.

62. Ms. CHAPMAN (Director, Science and Human Rights Programme, American Association for the Advancement of Science) said that the "minimum core content of the right to health" was often understood to refer to a "floor" below which health conditions must not in any circumstances fall. But in her view the expression should really describe the minimum conditions which a Government must meet in order to be in conformity with the obligations incumbent upon it under the International Covenant on Economic, Social and Cultural Rights. Consistent with that understanding, the core content would refer to the minimum duties all States parties set for themselves regardless of the resources available. That latter formulation had the benefit of focusing on public policy priorities and implementation, both of which were under the control of States parties, rather than on health development status, which reflected a confluence of many factors, including levels of economic development.

63. She considered that a primary obligation of States parties to the Covenant regarding the right to health was to establish an institutional framework and set of policies which enabled them to assure minimum health conditions and thereafter progressively to realize the best possible conditions of physical and mental health. The appropriate health sector paradigm for minimum core standards should have the following objectives: the potential to provide basic standards of health to all citizens and residents, assurance of respect for the equality of all persons, priority efforts to rectify existing inequities and imbalances in the distribution of resources available for health so as to bring currently under-served and disadvantaged groups up to mainstream levels, designation and treatment of health protection and health services as a public good and not a profit-making commodity, recognition of some form of legally enforceable entitlement to health protection and health services to individuals, provision of inexpensive and accessible mechanisms through which individuals and groups could pursue recourse for the violations of health sector rights, procedures for individuals or groups to participate in the setting of priorities for the health sector and monitoring the activities of major health institutions, and public responsibility for financing health care utilizing the least costly and most affordable approaches possible.

64. With some rewording and reorganizing of article 12 of the Covenant, and differences in emphasis, the four essential objectives of the right to health might be considered to be the following: (i) undertaking public health measures that safeguarded and improved environmental standards, including the quality of water and air; significantly reducing or eliminating exposure to toxic substances through reducing emissions and cleaning up toxic waste sites; discouraging use of alcohol, tobacco and other harmful substances; and improving work place safety; (ii) providing preventive health services, especially through inoculations, check-ups and screening tests; (iii) preventing, treating and controlling epidemic, endemic and occupational diseases; and (iv) establishing curative medical services.

65. A minimum core content of the right to health could include the following elements: (i) according priority to investments in public health measures, particularly those which seemed most effective when widely used, particularly in providing safe and clean drinking water to all communities: that approach would also mean that the Committee would need to develop indicators for achieving public health goals, and to consider the overall and relative adequacy of States parties' investments in public health initiatives; (ii) providing essential preventive health services, including a minimum provision of all major childhood inoculations; (iii) identifying and treating major epidemic and endemic diseases, including (most particularly) AIDS, and developing and operating health policy strategies to prevent and control their transmission and to treat those affected while respecting patients' rights; and (iv) in view of the cost of curative medical services, placing the emphasis on preventive health services and prevention of epidemic and endemic diseases, and giving priority to primary or community health care centres as compared with high technology and capital-intensive establishments. Furthermore, each State party should develop a detailed plan with specific goals for the progressive realization of all aspects of the right to health care.

66. In conclusion, she underlined that emphasis should be placed on the broader issues of health protection, preventive health services and the promotion of more favourable health conditions; standards of equity and non-discrimination should be developed which included corrective measures and recognized the special needs of the most disadvantaged and vulnerable groups and communities; the legal basis of an enforceable right to care, as well as the monitoring and compliance mechanisms to make that right meaningful, should be recognized; procedures should be made available that provided for broader participation by the public and affected communities in the policy-making process and in health delivery operations without any increase in expenditure; and sufficient investment should be made in the health services.

67. Mr. KUNNEMANN (International Human Rights Organization for the Right to Feed Oneself (FIAN)) was of the opinion that the Committee should define the minimum core content of the right to health. That right imposed on States three types of obligation. Firstly, States must respect the right to health of persons within their jurisdiction by refraining from harming their physical or mental health by action or omission. Secondly, they must protect the right to health by adopting the appropriate criminal legislation. Thirdly, they must assist all people to enjoy access to adequate health services and attain the best possible state of health by providing them with curative and preventive health services, including inoculation.

68. In order to fulfil those obligations, States must allocate financial means in accordance with the principles set out in the 1991 UNDP report which advocated that at least 5 per cent of GNP should be devoted to basic education and primary health care. In that connection, the Committee should invite Governments to indicate the minimum sum they were proposing to spend on health, among their overall priorities.

69. In implementing article 2, paragraph 1, of the Covenant, according to which States undertook to take steps, individually and through international assistance and cooperation, to achieve progressively the realization of the

rights recognized in the Covenant, the Committee should invite the countries of the Group of 7 and the international financial institutions to contribute to the realization of economic, social and cultural programmes by countries which were required to take structural adjustment measures. One could therefore create a fund for economic, social and cultural rights which would be supplied by contributions paid by all States in proportion to their GNP and which would assist the third world countries to finance their health expenditure. Furthermore, the international financial institutions should be restructured so that they fulfilled their obligations under international humanitarian law.

70. He said he was astonished by the tendency, which seemed paradoxical, to justify measures to protect human rights by their positive effects on economic growth, since, in his view, the starting point should be human rights, which were non-negotiable and represented legal obligations for States and not merely ethical demands.

71. Mr. AL-ATTAR (Arab Organization for Human Rights) said that the right to health was one of the basic human rights set out in the International Covenant on Economic, Social and Cultural Rights, article 12 of which declared that States parties recognized the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. But while the Constitutions of many countries recognized people's right to acceptable health standards and care, there were great disparities in health standards between the countries of the North and those of the South, and even within individual countries. For example, infant mortality ranged from 10 to 300 per thousand, and life expectancy at birth ranged from 45 to 75 years, a shocking difference that clearly indicated that application of the right to health left much to be desired in the developing countries and even among certain levels of the population in the developed countries.

72. He thought that agreement should be reached on a definition of the word "health" and the minimum core content of the right to health should be determined, namely, the floor below which health conditions were unacceptable in any State. In that connection, it would be useful to refer to the Constitution of WHO which had been signed by 187 States.

73. He read out extracts from the Constitution of WHO relating to health and recalled that health encouraged socio-economic development and therefore represented not only an individual right but also a social and economic goal in itself. Achievement of that goal required a clearly expressed commitment translated into deeds through policies, strategies and programmes to enhance the health status of individuals and communities.

74. The CHAIRPERSON invited the speaker, should he so desire, to continue his statement at the next meeting.

The meeting rose at 6.05 p.m.