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*Access to Health: A Right for All?*  
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Ladies and Gentlemen,

It is always a pleasure to return to Geneva and it is a particular honor to be here for the *Geneva Forum: Towards Global Access to Health*. I would like to thank the University of Geneva and its hospitals and medical school for organizing this important event on the occasion of the 150<sup>th</sup> anniversary of the Geneva Hospital and for inviting me to help open your discussions today.

As I arrived at the airport this morning, I was reflecting on the fact that it has been nearly four years now since I left Geneva after spending five extremely challenging but rewarding years here as UN High Commissioner for Human Rights. What I recognized then, but have come to appreciate even more in the intervening years, is how central a role this city plays as a focal point for international policy and action on a diverse range of global challenges.

I see that role through the work of the project I now lead - Realizing Rights: The Ethical Globalization Initiative. Our efforts to encourage a more equitable international trade system and support countries in Africa which have been largely excluded from the potential benefits of the global economy has meant that I have spent a good deal of time here in Geneva engaging with representatives of member states of the WTO and its officials. Most recently we have been collaborating with civil society organizations, governments and inter-governmental actors around the "Aid for Trade" initiative, which - despite the disappointing lack of progress in the Doha round of negotiations - does offer promise in supporting developing countries through additional resources for building the

infrastructure and institutions they need to benefit from more open regional and global markets.

Another issue that we at Realizing Rights are addressing – international migration - brought me to Geneva numerous times during 2005 as a member of the Global Commission on International Migration. The Commission's final report, which was submitted to UN Secretary-General Kofi Annan last October, and will be one of the key inputs to the first ever UN high level dialogue on migration and development in two weeks time, sought to forge a new approach to migration based on shared responsibilities in addressing the challenges and opportunities associated with today's increased movement of people across national borders. Much of the Commission's research and policy activities centered around Geneva where we could draw on the expertise of institutions such as the International Organization for Migration, the International Labor Organization and the UN High Commissioners for Refugees and Human Rights among others.

But perhaps no other single issue has come to define Geneva as much as global health. This city is known not only as the headquarters of the World Health Organization, but also for a growing number of health institutions and initiatives like UNAIDS, the Global Fund and the GAVI Alliance, the Medicines for Malaria Venture and the Drugs and Neglected Diseases Initiative to name only some of the notable organizations and projects that call Geneva home. Added to this network is the expertise and commitment of Geneva's university and hospitals which have long traditions of international cooperation and partnerships in the field of health which serve as models for others around the world. Your efforts to bring together for this Forum Geneva's community of health activists, experts and policy makers, with counterparts from around the world, is yet another example of leadership to be commended.

We have come together because we recognize that today, more than half way through the first decade of the 21<sup>st</sup> century, inequalities in health status and access to healthcare

globally are still wide and deep. What is worse, all indications are that these divides are growing.

We should acknowledge that the state of public health in many countries improved significantly during the 20th century. We should find hope in the fact that we now have the health interventions available to prevent or treat most conditions. But we also recognize the enormous challenge still to be faced. That challenge is one of implementation - of ensuring access to health for all.

My message today is that we won't make sustainable progress toward that objective without greater attention to the links between health and the realization of fundamental human rights. Implementing international human rights standards, specifically the right to the highest attainable standard of health, should be the ultimate objective of action in the field of public health. But human rights also provide powerful moral and legal arguments and practical tools that can bolster the strategies and efforts of governments, international institutions, the private sector and civil society to make significant and sustainable progress in addressing the challenge of access to health today.

I am convinced that greater focus on the right to health and on human rights based strategies can make a practical difference. Many of you here are key actors in the emerging movement for health and human rights that has been taking shape in recent years. You are already making the case that health is more than a dream to hope for. Health is a right that must be fought for. But we are also deeply aware of the enormous challenges still to be faced and the current limitations we see in policy and action.

Realizing the right to health for all requires shared responsibility, sustained capacity and strengthened accountability at every level, from the local village to the national health ministry, from the meeting rooms of inter-governmental organizations to the board rooms of multinational corporations. Only through committed leadership and effective partnerships between the global North and South, between the public and private sectors, and between human rights advocates and health professionals, will we see real progress

towards the goal of access to health in the years to come, particularly for those who have been most marginalized and excluded.

I would like to use my remarks this evening to highlight some of the positive developments that have been made in recent years in building understanding globally about the right to health. I will then discuss briefly the work we at Realizing Rights are developing which seeks to contribute to furthering progress towards operationalizing the right to health at local, national and international levels by focusing on what is needed to strengthen health systems in the world's poorest countries.

### **Understanding the right to health**

To begin, we should ask - what does it mean, precisely, to say that health is a human right? What are the links between human rights and improved health outcomes around the world? Despite the fact that the World Health Organization declared in 1946 that the “enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being” and that over 70% of all nations have ratified the International Covenant on Economic, Social and Cultural Rights which makes the right to health an international legal obligation that must be progressively realized at the national level, the reality is that the right to health is still not universally recognized as a *fundamental* human right. Like other economic, social and cultural rights, it has been neglected and violated on a massive scale in too many parts of the world.

During my time as President of Ireland and later as High Commissioner for Human Rights, I was privileged to travel to countries around the world where again and again I witnessed how basic rights – to live free from violence and discrimination, to have access to clean water and basic sanitation and to adequate nutrition – all rights guaranteed by international law – were also fundamental requirements for improving health in rich and poor countries alike. I saw the denial of these rights in individual cases that we often speak of in broader statistics. Some of the images that remain with me are of a child dying of hunger in the arms of her mother waiting in line at a feeding station in Somalia,

one of the 30,000 or so preventable deaths of children under 5 occurring every day. I remember the mother of five in a refugee camp in Goma who died giving birth because there was no one to help her, one of the over 500,000 cases of maternal mortality each year which could be prevented.

Many of you have undoubtedly witnessed similar moments in your work and will have made the connection to human rights. But you also may have asked yourselves: “even if we are convinced that to live a life of dignity, all people deserve access to the basic requirements of health - which includes not only health care but also the underlying determinants of health such as proper nutrition, adequate sanitation, safe drinking water and education - how does affirming the right to health change the realities in communities and nations around the world?” It is a powerful question, one which we in the human rights community are still coming to grips with ourselves. But significant progress has been made in recent years. Allow me to mention briefly some of these noteworthy steps forward.

First, with the adoption in 2000 of a detailed General Comment on the right to the highest attainable standard of health by the UN Committee on Economic, Social and Cultural Rights, a body composed of independent experts which is responsible for monitoring the International Covenant, the normative content of the right to health has become more precise. The General Comments of the various human rights treaty monitoring committees provide authoritative interpretation of sometimes imprecise treaty provisions. The Committee on Economic, Social and Cultural Right has clarified that the right to health includes a right to timely and appropriate health care interventions, including access to essential medicines, which are *available, accessible, acceptable* and of adequate *quality*. Essentially, this means that health facilities, goods and services have to be available and accessible - both physically and economically - to everyone, without discrimination. Having this greater clarity not only provides guidance to governments but also provides a standard against which they can be held accountable.

Also vitally important, the Committee has affirmed that States which have committed themselves to international treaties which include health provisions have a legal obligation to take steps towards the progressive realization of the right to health, to the maximum of their available resources. This acknowledges that different countries are at different stages in their ability to fulfill the right to health. It means that what will be expected of a state will change over time depending on its economic and social development. But some core obligations, such as ensuring that no one is discriminated against in terms of their access to available basic treatment, are to be fulfilled regardless of available resources.

This clarification of the content of the right to health at international level has been of great importance to the growing body of human rights case law at domestic and regional levels. Well known cases such as the *Treatment Action Campaign* case in South Africa in 2002, in which the Constitutional Court of South Africa held that the Constitution, which protects the right of access to healthcare services, drew in part on South Africa's obligations under the International Covenant. As many of you will know, that decision required the South African government to devise and implement a comprehensive and coordinated program to progressively realize the right of pregnant women and their newborn children to have access to treatment in order to prevent mother-to-child transmission of HIV. Similar developments in case law can be seen at regional level, in Europe and Latin America in particular.

Such real world examples illustrate that the right to health can be justiciable, that it is receiving increasing attention from the human rights community, and that legal cases can lead to actual changes in government policy and, ultimately, to improvements in people's well-being. The momentum towards greater recognition and public awareness of the right to health provides an opportunity for further progress which should not be missed.

## **Strengthening health systems to realize the right to health**

I wish to stress, however, that although legal strategies are of critical importance in achieving greater recognition of and accountability for the right to health, this is only one dimension of what applying human rights to health challenges means in practice. In 2002, during my final year in the UN, the Commission on Human Rights, which has now been replaced by the Human Rights Council, created a new mandate - a UN Special Rapporteur on the Right to Health. The Special Rapporteur, Professor Paul Hunt of Essex University, has played a leading role in encouraging human rights and health advocates to think not only about strictly legal strategies but also about how the underlying principles of human rights and the right to health can help inform and shape policymaking and action concerning health interventions at all levels.

In understanding what human rights-based approaches add to existing efforts, consider, for example, the importance of health indicators. Concern for human rights focuses attention on the disadvantaged and requires the active and informed participation of individuals and communities. A clearer picture often emerges when indicator data is disaggregated on various grounds, such as sex, race and ethnicity. Disaggregated indicators can reveal whether or not some disadvantaged individuals and communities are suffering from de facto discrimination. Equally important, for the most part, existing health indicators are rarely designed to monitor issues like participation and accountability, although these are essential in ensuring better access to health care. Nothing I am suggesting here is a radical departure from existing health indicator methodologies. Rather, a human rights-based approach to indicators can reinforce, enhance and supplement commonly used tools.

Paul Hunt has increasingly focused his work on how human rights principles and tools of accountability can be more directly applied to the task of strengthening health systems. He has argued that the right to health can be understood as a right to an effective and integrated health system, encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all. As he

has put it: “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 the call for an effective health system accessible to all.”

This insight reflects a growing recognition within the international community of the need to give greater priority to strengthening health systems. It could be seen most recently in the UN World Summit last September at which 170 Heads of State and Government committed themselves:

“To improve health systems in developing countries and those with economies in transition with the aim of providing sufficient health workers, infrastructure, management system and supplies to achieve the health-related Millennium Development Goals by 2015.”

World leaders at the World Summit also agreed to:

“...adopt, by 2006, and implement comprehensive national development strategies to achieve the internationally agreed development goals and objectives, including the Millennium Development Goals.”

These commitments are significant because they begin to address the neglect of health systems we have seen over the last two decades in many countries. Responsibility for the current state of health systems, particularly in developing countries, is a complex and controversial subject. Rather than seeking to assign blame, the point now is to welcome the recognition that more must be done and to see to it that effective strategies are developed and follow up implementation ensured.

Paul Hunt has urged health ministers in low-income and middle-income countries to prepare national health programs during 2006 that are bold enough to achieve the MDG health goals and form a central part of the development strategies mandated by the 2005 World Summit for adoption this year. I welcome the growing attention to health systems

and the challenge that has been set for developing and developed countries alike to give the highest priority to putting in place the strategies and resources needed to make real progress over the next decade.

One issue I would ask you all to reflect on during your discussions over the next two days is the extent to which we are on track, more than half way thru 2006, in finalizing these national health plans as part of broader development strategies. Where there is lack of progress, what needs to be done now to hold to this important global commitment before the end of the year?

### **Realizing Rights activities to promote the right to health**

Despite the growing agreement that a functioning health system is the essential mechanism for ensuring equitable access to health, political, social and economic factors are making it difficult to move in the right direction, even with the best intentions. My colleagues and I at Realizing Rights have committed ourselves to working with leading experts and health organizations over the next five years to address some of these roadblocks.

First, we are convinced that cultivating and galvanizing political leadership at all levels – local, district and national – is the key to unlocking both the finances and the creative energy necessary to address the issue of access to health over the coming years. Political leadership is of course needed to put in place the laws, regulations and policies to strengthen health systems, and to address disparities and discrimination that are still all too prevalent in many countries, for example, with regard to women's health, an area where we believe dramatically increased capacity and attention is needed.

As I am sure you are aware, the impact health crises are having on women and girls is of grave concern. In Africa alone, close to 5,000 women are newly infected with the HIV virus each day. 67% of those infected between the ages of 15 and 24 are girls and young women. Yet just 17 % of resources for HIV/AIDS today are targeted at women. We

now know that married women can be at a greater risk of contracting HIV than their unmarried counterparts. In some parts of sub-Saharan Africa, marriage is actually a risk factor for contracting AIDS. What is lacking is the political leadership needed to address these social dynamics.

With support from the Gates Foundation, we are working with the International Center for Research on Women, European Parliamentarians for Africa, The Center for the Study of AIDS at the University of Pretoria, and the International Community of Women Living with AIDS on a multi-year effort to build the capacity of African parliamentarians to advocate for increased focus on how women are impacted by health crises and on greater access to health care for women in Africa. The project - *Parliamentarians for Women's Health* – is building a cadre of national leaders in Botswana, Namibia, Tanzania and Kenya who will have the knowledge, tools and sensitivities to address women's unmet health needs. We hope that their increased knowledge and commitment to women's health issues will not only make an impact in their respective countries but will also generate increased awareness amongst wider parliamentary networks who together can lobby for increased budget allocations and other interventions needed to make lasting improvements in women's health status and access to services in African countries.

With quality information and increased know how, parliamentarians could be doing more to hold their Ministers of Health and other government officials to account in relation to their responsibilities concerning health. They could also be encouraging their respective national human rights institutions - independent, constitutionally established bodies mandated to promote and protect human rights now in place in over 100 countries - to assess government policies and performance from the perspective of the right to health.

Our experience tells us that ministers of health also face enormous political and economic challenges, not only within their own governments in the struggle over allocation of limited resources, but also on the international stage as they seek to play a leading role in influencing policies of donors. These challenges have become even more complex

following the Paris Declaration on aid effectiveness in 2005 and the move by many donors towards general budget support and joint assessment strategies at country level. As a result, health ministers are increasingly responsible both for convincing their own governments to give due priority to health in the national budget, and for managing the complex architecture of health interventions by Global Funds, Donors, significant Foundations and NGOs. The extent of the burden of responsibility now carried by health ministers, as their countries take more of an ownership and leadership role in health, was born in on me at the recent AIDS conference in Toronto when I participated in a satellite event focusing on the health system in Mozambique.

It is clear that more attention needs to be given to strengthening the management and technical capacities of health ministers and their ministries. I am glad, therefore, to serve as Chair of the Council of Women World Leaders, which encourages women holding ministerial office to form networks and prioritize issues of common concern. During the recent World Health Assembly here in Geneva, we brought together a number of women ministers of health who are committed to working more actively as a network – and with their male counterparts - to strengthen their individual and collective voices in the management and monitoring of health care systems. We will bring to the members of this network the expertise developed in a new Working Group on Financing for Health, chaired by David de Ferranti, who is able to draw on his former experience at the World Bank. The next meeting of the network will be in Maputo in mid-September during a meeting of African ministers of health.

One of the significant obstacles these ministers face - which we at Realizing Rights are seeking to help address - is the lack of skilled health personnel. As you know, many experts believe the lack of health workers is one of the most critical constraints in improving health systems, particularly in Africa. The WHO *World Health Report 2006* focuses on this problem and points out that Sub-Saharan Africa has the lowest concentration of health personnel per population of any region in the world—just 2.3 per 1,000 people, compared with the world average of 9.3 out of 1,000. According to World

Bank estimates, Sub-Saharan Africa has only 1.3% of the world's health workforce, yet it accounts for 25% of global disease burden.

I recently visited Ghana, where we witnessed the shortage of health workers and its impact on the country's health system. We visited the Oboum health clinic near Accra which serves a population of about 60,000 people. It had good practices – we saw good work on ante-natal health care, vaccinations for young babies, monitoring of infants' weight and the strong commitment of its one trained nurse, and thirteen nursing assistants. But it was clear the facilities, and level of personnel, were not adequate. There was a lack of electricity, reliable clean water, essential drugs - - in spite of this there was a remarkable spirit of trying to make do. In fact, Ghana has worked mightily to promote the right to health for all through its community-based integrated health system, CHPS, which has attempted to move health care services out from wealthier urban areas into poorer rural communities.

Ghana is renowned for producing well trained medical staff. But it is also losing them faster than any other country in sub-Saharan Africa. The country has only a third of the nurses and doctors it needs. No one can dispute that the opportunity for any individual to migrate is an important and precious freedom. But it must not prevent us from recognizing that the migration of health professionals is proving deadly for too many of Africa's sons and daughters.

In Ghana, in 2002, 72 new doctors graduated from Ghana's two medical schools, but 68 of them have since emigrated. In most years about one in four newly-trained midwives and nurses goes abroad. The aging populations of Britain, Germany, the United States and other richer countries are the beneficiaries of this reverse trend.

As Ghana's Ministry of Health has found, the motivations for health worker migration are more complex than salary levels alone. Health professionals are concerned about career development, management systems, and quality of facilities. Countries like Ghana need help to develop health systems that professionals want to build careers in. But we

must also recognize that these changes will take longer than Africa can afford to wait. The right to health for millions of people cannot continually be denied. We need a constructive debate on what can be done today.

One approach which offers great potential involves the use of para-professional health workers to fill gaps in services. Properly trained community health workers such as village health teams know their communities' health priorities and can take on many critical health interventions. In Tanzania, as we learned during a visit there earlier this year, roughly 90% of Caesarian sections are being delivered by these substitute workers, referred to as Assistant Medical Officers, with encouraging results for maternal mortality. These midlevel providers, less likely to migrate, have powerful potential to deliver healthcare to those most in need, and least able to claim it.

Yet, despite this potential, these health workers are virtually invisible in policy documents and government strategic plans. Few efforts are underway to expand their training and little is known about their current use and practice in Africa or about the factors at individual, organizational and environmental levels that enable or block their performance.

We are currently working with colleagues from the Averting Maternal Death and Mortality initiative at Columbia University's Mailman School of Public Health, the African-based Regional Network for the Prevention of Maternal Mortality and the Centre for Global Health at Trinity College Dublin to develop a new project which will help build the evidence base on the role of mid-level providers in maternal and newborn health and promote greater political leadership and critical policy action on this issue.

We also believe more can be done to foster the aspirations of African health workers who have migrated to give back some of their time and talents to their countries of origin. Diasporas are a vitalizing force that is often overlooked. I saw their power to turn brain drain to brain gain in Ireland, when the involvement of the diaspora helped develop what was then Western Europe's poorest economy into one of its leaders.

And while such approaches must be part of any strategy to strengthen health systems in Africa, we should recognize that investments made by African countries in their own health systems are currently being used to support health in richer nations. With that recognition must come responsibility for helping create a virtuous cycle of co-development which can improve health in the global North and South. Here again, the human rights framework reinforces this understanding. While the primary obligation for implementing the right to health falls upon each State to look after the rights of its own citizens, governments also have the obligation to take steps individually and *through international assistance and cooperation* towards the full realization of various rights, including the right to health.

The responsibility of those States that are in a position to provide international assistance and cooperation towards the enjoyment of economic, social and cultural rights is recognized in the Charter of the United Nations, the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention on the Rights of the Child and elsewhere. Fortunately, that mind shift toward a greater sense of shared responsibility is beginning to happen.

For example, recognizing that emigration trends are likely to persist, we are beginning to see assistance to southern countries to train more health staff to meet local needs, as India has done with its information technology sector. In this way richer countries would fund training of the skills they and countries of origin both need. This is then a development 'gain' for the local economy and the local health service, while northern countries gain because training costs are lower. One pilot project worth study is underway to train nurses in Malawi. At the same time, policy makers from different countries must find ways in which health migration can be jointly organized by origin and destination countries. The UK/South African agreement on the recruitment of health workers is one example of how this process could be taken forward.

In two weeks time, we at Realizing Rights, in collaboration with the newly established Global Health Workforce Alliance, The Commonwealth Secretariat Health Section and

Physicians for Human Rights will be convening in New York government officials and health experts from the global North and South to assess and promote bilateral and multilateral agreements and other policy innovations on health worker migration. Our hope is that this dialogue between sending and recipient countries will lead not only to greater understanding of the scope of the health worker challenge but also to tangible forms of bilateral cooperation and co-development in the future.

The meeting will take place just two days before the UN General Assembly High Level Dialogue on International Migration and Development which presents a unique opportunity to frame more constructive migration policies at national and international levels in years to come. We hope the outcomes of our meeting on health worker migration, and further processes it may launch, will serve as an example for discussion at the UN and help encourage more integrated approaches to migration and development policies in the years ahead.

Let me stress that the notion of shared responsibility for health stretches beyond the realm of national governments and international organizations like the UN or the WHO. It must involve all actors in society, particularly those who are increasingly influential in a more interconnected world. The greater involvement and recognition of responsibility for health on the part of the private sector, as can be seen, for example, in the launch in September last year of the Global Health Initiative of the World Economic Forum and the recent publication on the “Business of Health” by the World Business Council on Sustainable Development - two more Geneva-based organizations - are welcome signs of progress which should be encouraged.

It is clear that the pharmaceutical sector has particular responsibilities concerning access to health. You all know the statistic that 90% of the world’s research resources in that industry go towards only 10% of the diseases. We need to devise strategies and mechanisms to rectify the deleterious imbalance between the market and its failure to incentivize private industry to invest in science – the research and development – that will bring vaccines and other medicine to the developing world; thereby encouraging

pharma and the players around it to harness science and technology to improve the health not just of those populations in which wealth is concentrated, but to those who are poor, and disinherited, those who continue to be marginalized and overlooked.

The issue of access to essential medicines is another vital issue requiring the direct involvement of the pharmaceutical industry. We are currently working with Paul Hunt who is focusing on this issue as part of a report he will submit to the UN later this year. One part of this report will include draft guidelines for companies concerning access to medicines in the context of the right to health in areas ranging from R&D to pricing, from patent policies to clinical trials, and from lobbying policies to impacts on health systems. We believe that clarifying the normative framework in terms of the respective responsibilities of government and private sector actors around access to medicines as a component of the right to health would have enormous value added for pharmaceutical corporations in terms of improving the visibility, clarity, coherence, effectiveness and credibility of their corporate responsibility programs. We are hoping the draft guidelines will be tested by leading companies such as those from the Business Leaders Initiative on Human Rights which I am pleased to Chair and Realizing Rights supports. The two pharmaceutical companies taking part in this initiative, Novartis and NovoNordisk, have both found it highly beneficial to adopt a right to health perspective in their CSR programs and are eager to continue this area of work. I would be delighted if all of the leading corporations in the industry would test Paul Hunt's draft guidelines over the coming year and provide him with constructive feedback.

## **Conclusion**

To conclude, as we have been brought together for this Forum by a leading university and its medical school, allow me to say how important a role I believe universities around the world can play by joining their efforts and speaking out with a collective voice about the importance of human rights in achieving access to health for all. It has been a great pleasure for me to work closely with Allan Rosenfield and his colleagues at Columbia University's Mailman School of Public Health in New York over the past few years. Columbia is another institutional partner of Realizing Rights and I now serve as a

professor at Columbia. In addition, in my capacity as Chancellor of Dublin University, I am encouraging Trinity College to develop a consortium within the University on global public health.

I have been impressed by the commitment of universities like Columbia and Trinity to practical action at country level. But the many good local and national practices are still not being scaled up sufficiently around the world. The combined voices and authority of health experts, working in collaboration with human rights experts and advocates, are still not being heard by elected officials and the wider public.

My question to all of you is: how do we develop more linkages, more synergies and more bottom-up and top-down practical co-operation to realize the full potential of the multiple initiatives that exist today? How do we link the academic research and expertise of leading universities with networks of civil society actors worldwide who can change the power dynamics and focus on improved health services for all?

In 2000, the American Public Health Association issued a statement titled “Human Rights: The Foundation of Public Health Practice” which I would commend to all of you and to other health associations and professionals as an important model of shared commitment that can be built upon. The statement concludes, and I quote:

“As public health professionals, we can take on the following challenges:

- \* To adopt human rights as the foundation of public health practice, research, and policy in all countries
- \* To use the Universal Declaration of Human Rights and other human rights documents as the guiding principles for the protection and promotion of the public's health
- \* To train health professionals to foster human development and health security
- \* To make policymakers accountable for decisions affecting human health and dignity
- \* To galvanize society's involvement in the prevention of human suffering and the promotion of social justice

The goal is to improve not only health status but human development, which embraces equity, solidarity, social justice, human rights, and moral and ethical imperatives. The time has come to herald human rights as both the foundation of public health practice and the compass of public policy actions.”

Such a statement would have even more resonance if it made specific reference to the central importance of the right to the highest attainable standard of health. A supportive joint statement coming out of this Geneva Forum about the value of the right to health would be a significant step which I would encourage and pledge my commitment to support.

In the end, nothing could be more important to promoting greater enjoyment of the right to health than strengthening health systems around the world. A nation’s health system is its life-force. This is as true for Switzerland as it is true for my native Ireland; and it is as true for Europe as it is for Africa. A country’s health is fundamental not only to its wellness, but to its social cohesion, its prosperity and perhaps even to its political stability. The strength, therefore, of every country’s health system and within every country, its local and community-based capacities – is of paramount importance.

Strengthening health systems will require shared responsibility, sustained capacity and strengthened accountability at every level. I believe passionately that the broad human rights framework and existing mechanisms have much to contribute to achieving those aims.

Human rights are the closest thing we have to a shared values system for the world. We should take every opportunity to see them not simply as shared goals, but as legal obligations and policy making tools which can assist those charged with making complex decisions – whether in the areas of trade, migration, the environment, security or public health.

Thank you once again for inviting me to be with you and thank you for your commitment to achieving global access to health – the right to health - for all people.