

THE RIGHT TO HEALTH: LEGAL CONTENT THROUGH SUPRANATIONAL MONITORING

Ph.D thesis

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Declaration

I, Claire Lougarre confirm that the work presented in this thesis is my own. Where information has been derived from other sources, I confirm that this has been indicated in the thesis.

Abstract

Whilst economic, social and cultural rights benefit from a better protection worldwide than when they were first recognised in the Universal Declaration of Human Rights 1948, they remain criticised for being too vague and, thus, not legally enforceable. This is particularly relevant to the right to health, since it embraces complex ethical, economic and legal issues often calling into question its substance. Such criticisms, nonetheless, threaten its implementation: how can key actors contribute to realising a right of which they do not understand the meaning? This thesis, therefore, aims at clarifying what the human right to health entails, and will focus on how this can be done through supranational monitoring. Mandated to supervise the implementation of human rights instruments, supranational human rights bodies (SNHRBs) embody the most authoritative interpretation of the right to health. When evaluating whether or not states comply with their obligations and when justifying why, SNHRBs effectively delineate the legal content of this right. Therefore, this thesis will analyse how SNHRBs contribute to clarifying the legal content of the right to health in the course of their quasi-judicial monitoring procedures, and how their interpretation can be optimised for that purpose. I will particularly study the interpretation of the Committee on Economic, Social and Cultural Rights (United Nations) and the European Committee of Social Rights (Council of Europe), for they are the most illustrative of how supranational monitoring of the right to health feeds into its substance, and vice versa. Such comparative analysis will enable me to develop a theoretical account assisting SNHRBs in interpreting the legal content of the right to health more clearly, to highlight ‘best practice’, and to discuss compatibility between universal and regional standards. As a result, this thesis lies primarily in international human rights law but will also involve aspects of public international law and, modestly, public health.

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List of abbreviations

AAAQ	Availability, Accessibility, Acceptability, and Quality of healthcare
African Charter	African Charter on Human and Peoples' Rights
African Commission	African Commission on Human and Peoples' Rights
CoE	Council of Europe
CPR	Civil and Political Rights
ESC	European Social Charter
ESCR	Economic, Social and Cultural Rights
European Committee	European Committee of Social Rights
FGM	Female Genital Mutilation
GC14	UN General Comment 14
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICMW	International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families
Protocol of San Salvador	Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights
SNHRBs	Supranational Human Rights Bodies
SRH	Sexual and Reproductive Health
UDHR	Universal Declaration of Human Rights
UN	United Nations
UN Charter	Charter of the United Nations
UN Committee	UN Committee on Economic, Social and Cultural Rights
UN Special Rapporteur on the right to health	Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health
WHO	World Health Organisation

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INTRODUCTION

The problem with the right to health is therefore not so much a lack of codification, but rather the absence of a consistent implementation practice through reporting procedures and before judicial and quasi-judicial bodies as well as an ensuing lack of conceptual clarity. These problems are interrelated: a lack of understanding of the meaning and scope of a right makes it difficult to implement and the absence of a frequent practice of implementation in turn hampers the possibility of obtaining a greater understanding of its meaning and scope. (Toebes)¹

The object of the thesis

Acknowledging criticisms on the vagueness of the right to health

The right to health is a social right that is widely recognised in international human rights law as well as in domestic law, and whose realisation is supported by numerous academics, NGO workers, and physicians. In 1946, states adopted the World Health Organisation (WHO) Constitution, recognising that:

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.²

Almost seventy years later, this statement resonates across various international and regional human rights treaties, the most noteworthy perhaps being Article 25 of the Universal Declaration of Human Rights (UDHR),³ and Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR).⁴ Its recognition is however not limited to international human rights law. Social rights are being

¹ Brigit Toebes, *The Right to Health as a Human Right in International Law* (Intersentia/Hart 1999) 346.

² Constitution of the World Health Organisation, as amended 1946, Preamble.

³ Universal Declaration of Human Rights 1948, Art 25.

⁴ International Covenant on Economic, Social and Cultural Rights 1966, Art 12.

increasingly constitutionalised and many countries now protect the right to health in their constitutions.⁵

This right has nonetheless been subject to repeated criticisms over the last seven decades, on the basis that its content is excessively vague and impossible to define with precision. While American legal scholars have formulated particularly high levels of scepticism, concerns have been expressed worldwide.

Firstly, the right to health is often criticised for not relying on solid conceptual foundations. It is not the purpose of this thesis to justify the legitimacy of the right to health, or to summarise existing literature on health and social justice, as considerations of space would not allow it. However, it is fundamental to highlight the lack of consensus on this issue, as it impedes the possibility to develop a meaning for the right to health, which, in turn, threatens its application in practice. Certain authors argue that no adequate philosophical grounds justify the existence of a legal right to health. Those authors tend to view the right to health as what Fried calls a 'bottomless pit',⁶ which results in a rather minimalist approach to human rights law (e.g. O'Neill,⁷ Cohen,⁸ or to a lesser extent, Griffin,⁹ Rawls¹⁰).

Secondly, economic, social and cultural rights (ESCR) have long been criticised for being too vague, programmatic and unrealistic;¹¹ and the right to health is no

⁵ Eleanor D Kinney and Brian Alexander Clark, 'Provisions for Health and Health Care in the Constitutions of the Countries of the World' (2004) 37 Cornell International Law Journal 285.

⁶ Charles Fried, *Right and Wrong* (Harvard University Press 1978), Chap 5 'Positive Rights'.

⁷ Onora O'Neill, 'The Dark Side of Human Rights' (2005) 81 International Affairs (Royal Institute of International Affairs 1944) 427.

⁸ Joshua Cohen, 'Minimalism About Human Rights: The Most We Can Hope For?' (2004) 12 Journal of Political Philosophy 190.

⁹ James Griffin, *On Human Rights* (Oxford University Press 2008).

¹⁰ John Rawls, 'The Law of Peoples' (1993) 20 Critical Inquiry 36.

¹¹ E.g. O'Neill (n 7); Michael J Dennis and David P Stewart, 'Justiciability of Economic, Social, and Cultural Rights: Should There Be an International Complaints Mechanism to Adjudicate the Rights to Food, Water, Housing, and Health' (2004) 98 American Journal of International Law 462.

exception. On the contrary, it gives rise to particular concerns in this regard, which even its supporters admit.

Toebees, for instance, declares that:

An economic and social right that is characterized by particular vagueness is the international human right to health.¹²

Whilst Ruger asserts that:

One would be hard pressed to find a more controversial or nebulous human right than the "right to health" [...].¹³

It is not the purpose of this thesis to demonstrate the justiciability of the right to health,¹⁴ or to summarise existing literature on ESCR. This would go beyond the scope of this project. Nevertheless, it is crucial to report the existence of concerns regarding the vagueness of the right to health, sometimes even legitimate, as they indicate confusion on what this right means, which, in turn, threatens its realisation. Two elements seem to be particularly criticised in that respect. First, the vagueness of its normative scope, as it is often argued that the formulation of 'the highest standard of health attainable' could result in considerable costs and unrealistic expectations. Second, the vagueness of the requirement for states to 'progressively realise' the right to health, as authors frequently contend that states can use the latter to justify an insufficient implementation of this right. Such criticisms, therefore, point at the importance for the normative scope of the right to health and the obligations it creates, to be appropriately interpreted. This includes addressing adequately both individuals' needs and states' resources.¹⁵

¹² Brigit Toebees, 'Towards an Improved Understanding of the International Human Right to Health' (1999) 21 Human Rights Quarterly 661, 661.

¹³ Jennifer Prah Ruger, 'Toward a Theory of a Right to Health: Capability and Incompletely Theorized Agreements' (2006) 18 Yale Journal of Law & the Humanities 273, 273.

¹⁴ See for that purpose Conor Gearty and Virginia Mantouvalou, *Debating Social Rights* (Hart Publishing 2011).

¹⁵ See Norman Daniels, *Just Health: Meeting Health Needs Fairly* (Cambridge University Press 2008).

Thirdly, the increasing adjudication of the right to health in countries such as South Africa, Colombia, Brazil, and India, and its potential for being exported have recently triggered another wave of criticism. This thesis does not aim to discuss the adjudication of the right to health in domestic courts or to summarise existing literature on the leading case law in that respect. Considerations of space do not allow it. However, it is crucial to mention the concerns raised in that regard, as they both reflect and contribute to a confusion of what the right to health means, which, in turn, threatens its realisation. Various politicians and academics fear that courts are given power to make budgetary decisions in healthcare. They argue that such power should be kept between the hands of the legislator for democratic reasons, and that courts are not equipped to reach such decisions. These concerns were expressed, for instance, by the UK Joint Committee on Human Rights, in the light of the South African experience,¹⁶ or by authors such as Sunstein.¹⁷ Furthermore, several academics have recently started to use empirical evidence to demonstrate that the adjudication of the right to health reveals negative outcomes in certain jurisdictions. According to authors such as Ferraz, Wang, Brinks and Gauri,¹⁸ claimants involved in such litigation are usually well-off. Brinks and Gauri argue that decisions granting them access to treatments benefiting a large section of the population, including the poor, may be beneficial to the wider population in the long run. However, Ferraz and Wang highlight that decisions can grant access to expensive treatments that only benefit a minority, taking away resources that could be used for wide-scale health programmes. Such concerns reflect the need for the right to health to be interpreted in a way that complies with human rights law requirements while being suitable for adjudicatory purposes.

¹⁶ Joint Committee on Human Rights, 'A Bill of Rights for the UK?' (Twenty-ninth Report of Session 2007–2008) HL Paper 165-I, HC 150-I, paras 182–191 <<http://www.publications.parliament.uk/pa/jt200708/jtselect/jtrights/165/165i.pdf>> [accessed 8 September 2015].

¹⁷ Cass Sunstein, 'Against Positive Rights' (1993) 2 East European Constitutional Review 35.

¹⁸ Octavio Luiz Motta Ferraz, 'Harming the Poor through Social Rights Litigation: Lessons from Brazil' (2010) 89 Texas Law Review 1643; Daniel W Liang Wang and Octavio Luiz Motta Ferraz, 'Reaching out to the Needy - Access to Justice and Public Attorneys' Role in Right to Health Litigation in the City of Sao Paulo' (2013) 18 Sur - International Journal on Human Rights 159; Varun Gauri and Daniel M Brinks, *Courting Social Justice: Judicial Enforcement of Social and Economic Rights in the Developing World* (Cambridge University Press 2010), Chap 8.

To conclude, criticisms raised against the right to health target: the weakness of its conceptual foundations; its excessively vague, programmatic and unrealistic formulation; as well as the inadequacy of its adjudication; all outlining the same issue. The legal content of the right to health (i.e. a normative content fit to practical considerations) is not clearly defined. Such lack of conceptual clarity, however, affects key actors in the realisation of this right and can thus hinder its implementation. How can states, supranational human rights bodies (SNHRBs), and NGOs contribute towards realising the right to health if they do not know what it means? As a result, it is fundamental to clarify what this right entails. So far, nonetheless, little research has attempted to delineate the legal content of the right to health and even less so by using the most authoritative source in human rights law: its interpretation by (quasi-judicial) SNHRBs.

Clarifying the legal content of the right to health through supranational monitoring

The role of SNHRBs in clarifying the legal content of the rights they are mandated to monitor is crucial. SNHRBs supervise the implementation of the right to health at the international and regional levels of human rights protection, through various monitoring procedures (mainly states' reporting and individuals' complaints). While some SNHRBs dealing with the right to health may have similar competence than judicial bodies (i.e. when reviewing the admissibility and merits of a complaint through written and oral proceedings), their monitoring procedures mostly take place in a quasi-judicial setting. This can be asserted by examining: their composition (i.e. experts, rather than trained judges); and their key role (interpreting and monitoring the implementation of the treaty they are mandated to supervise through, mostly, non-legally binding means). However, SNHRBs must (collegially) decide whether states comply with their obligations and justify why, when evaluating the implementation of the right to health. As a result, they effectively delineate its legal content or at least, have the potential to do so. However, this is not a one-way relationship: supranational monitoring and legal content feed into each other. Not only do SNHRBs contribute to delineating the legal content of the right to health, the latter adapts itself to the procedures reviewing it, in order to fit practical considerations. Analysing such contributions is thus important. So far, various

authors have used findings from supranational monitoring on an ad hoc basis to discuss the right to health.¹⁹ Nevertheless, few authors explore how such findings can and should contribute to clarifying the legal content of this right, and none has done so systemically and comprehensively.²⁰ This thesis, therefore, will explore how SNHRBs contribute to clarifying the right to health in the course of quasi-judicial monitoring procedures, and how to optimise their interpretation for that purpose.

Identifying the research question

In this thesis, I aim to assist in remedying the vagueness that presently affects the substance of the right to health. I will do so by asking two intertwined questions: (i) how do SNHRBs contribute to clarifying the legal content of the right to health in the course of their quasi-judicial monitoring procedures, and (ii) how can their interpretation be optimised for that purpose? I, thus, explore how SNHRBs contribute to clarifying the legal content of this right when interpreting it through their reporting and complaint procedures. Such analysis enables me to then study how SNHRBs' contributions can be optimised, by developing a theoretical framework enabling them to interpret adequately the right to health when monitoring it. As a result, this thesis lies primarily in international human rights law but will also involve elements of public international law, as well as (modestly) public health and health ethics.

The scope of the thesis

Focus

This thesis will attempt to answer those questions by focusing on two SNHRBs in particular, building upon the comparative analysis that arises from Part I, to develop the theoretical framework laid out in Part II. It is worth noting that 'SNHRBs' will be understood as collegial human rights bodies, which have (quasi-judicial) competence

¹⁹ E.g. Toebes 1999a (n 1); John Tobin, *The Right to Health in International Law* (Oxford University Press 2012).

²⁰ E.g. Evelyne Schmid, 'Socio-Economic and Cultural Rights and Wrongs after Armed Conflicts: Using the State Reporting Procedure before the United Nations Committee on Economic, Social and Cultural Rights More Effectively' (2013) 31 *Netherlands Quarterly of Human Rights* 241. (However, this article is limited to situations of conflicts).

to reach decisions on states' compliance with the right to health; that competence being established in legally binding treaties.

This thesis will focus on how the right to health is interpreted at the international level in the UN, as this project primarily lies in international human rights law. Therefore, it will examine how the UN Committee on Economic, Social and Cultural Rights (UN Committee) interprets Article 12 ICESCR. Furthermore, with a total of 164 states parties, the ICESCR represents the widest forum through which the right to health can be interpreted and its subsequent legal content, implemented, amongst treaties of general application.

This thesis will also study how the right to health is interpreted at the regional level, in order to put the UN interpretation into perspective. This will enable me to highlight best practice and to discuss compatibility between international and regional levels of monitoring. I have chosen to focus on Europe and will therefore examine how the European Committee of Social Rights (European Committee) interprets Article 11 of the European Social Charter (ESC). Focusing on the Council of Europe (CoE) offers several advantages. First, the CoE represents a powerful system of human rights protection, increasing the likelihood for the right to health to be strictly monitored and thus, clarified through this process. Second, it will provide a different perspective on resource availability, since Europe is the wealthiest regional system of human rights protection but is also suffering from the remnants of the economic crisis. Third, the European Committee remains relatively unknown and few researchers have analysed its jurisprudence. Fourth, Europe is where I am based and received my legal education, which gives me a better insight into the norms this region has set and the legal challenges it faces. Fifth, the findings of the African and the Inter-American frameworks do not contribute to clarifying precisely what the right to health means. This is due to the fact that the right to health cannot be adjudicated through a complaint procedure in the Inter-American system, and that the interpretation of its content in the African system is unclear. Furthermore, space limitations do not allow an in-depth analysis of each system.

It is also worth noting that key instruments and key publications on the right to health often define the content of the right by distinguishing its scope from the nature

of states' obligations to realise it.²¹ While both notions are clearly intertwined, such distinction remains a common and useful way to break down complexity in legal scholarship. As such, it will be used throughout the thesis, to enhance the clarity and, thus, quality of the arguments developed in later chapters.

Finally, I will often use examples in the area of sexual and reproductive health (SRH) as a comparative framework to assess the different approaches of the Committees. These examples encapsulate particularly well the need for states to guarantee adequate health care and policies, sometimes in opposition with religious or cultural beliefs, as well as to address health discrimination against vulnerable groups. I will use arguments primarily based on health considerations (although influenced by a feminist approach to bodily integrity), since health is the focus of my project.

Setting limits

For the purpose of clarity, it is worth noting that the right to health studied in this thesis is neither to be defined through the angle of the interdependence of rights, nor to be confused with health rights.

Health issues and human rights law have an intricate relationship, as outlined by Mann.²² Firstly, certain health policies can result in human rights abuses (which must be born in mind by decision-makers in the field of healthcare). This can often be observed, for instance, in internment cases of mental health patients that breach their right to liberty. Secondly, certain human rights abuses can be associated with detrimental effects on the health of victims. Abuses of civil and political rights (CPR) such as the right to life or the freedom from torture can have an adverse impact on victims' health. For example, the overuse of solitary confinement in prisons is considered as torture because of its adverse consequences on prisoners'

²¹ UNCESCR, 'General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art 12)' (2000), Parts I and II; Toebe 1999a (n 1), Part C; Tobin (n 19), Chap 4 to 9.

²² Jonathan M Mann and others, 'Health and Human Rights' 1 Health and Human Rights 6.

mental health.²³ Similarly, abuses of ESCR, such as the right to food, the rights to water and sanitation, the right to housing, the right to work in healthy conditions, and the right to a healthy environment can have adverse implications for victims' health. For instance, the failure to secure adequate sanitation facilities can contribute to the spread of diseases among a community. Such interactions, however, do not necessarily define the content of the right to health with precision. Instead, they reflect the interdependence of rights in human rights law.

Furthermore, the right to health should not be confused with health rights. Health rights correspond to individuals' rights to health protection in their relations with state or non-state actors as consumers, employees, patients, social security beneficiaries etc. Such relations do not automatically give rise to fundamental inalienable rights protecting the dignity of every human being and are thus not always regulated by international human rights law. For instance, the obligation for food companies to label information likely to affect the health of their consumers and the entitlement it creates do not necessarily fall under human rights law. As argued in this thesis, the right to health obliges states to provide everyone with access to a health system ensuring the highest standard of health attainable, necessary to preserve their fundamental dignity as human beings. Therefore, while certain authors argue that the right to the highest standard of health attainable should be described as a 'right to healthcare',²⁴ this thesis will use the formulation 'right to health' for the sake of clarity and to reflect its most contemporary understanding.

Finally, due to space constraints inherent to any research project, I have eliminated three elements from the scope of my thesis. Firstly, my thesis will not cover non-state actors' obligations to realise the right to health. The role of non-state actors as

²³ *Babar Ahmad and Others v United Kingdom* [2012] Fourth Section, Applications No. 24027/07, 11949/08, 36742/08, 66911/09 and 67354/09, Judgment of 10 April 2012 [205–212] (European Court of Human Rights).

²⁴ E.g. Allen Buchanan, 'The Right to a Decent Minimum of Health Care' (1984) 13 *Philosophy & Public Affairs* 55; Hessler and Buchanan 'Specifying the content of the human right to health care' in Allen Buchanan, *Justice and Health Care: Selected Essays* (Oxford University Press 2009); Tom L Beauchamp and Ruth R Faden, 'The Right to Health and the Right to Health Care' (1979) 4 *Journal of Medicine and Philosophy* 118; Norman Daniels, *Just Health Care* (Cambridge University Press 1985) (although his position has changed since).

duty-bearers remains contested and uncertain in international human rights law. While this thesis acknowledges their importance, it focuses on state actors instead, as they are the primary duty-bearers in this discipline. For instance, it is up to states to regulate the activities of pharmaceutical companies, private clinics and physicians, or to impose taxes on individuals and companies to fund a health system, essential to the realisation of the right to health. Secondly, my thesis will not cover extra-territorial obligations to realise the right to health. The legal aspect of extra-territorial obligations (i.e. states' obligations to realise rights outside their borders) is heavily disputed and remains unclear in international human rights law. Whilst I recognise the principle of international assistance and cooperation, as enshrined in the Charter of the United Nations (UN Charter) or the ICESCR,²⁵ I limit my discussion to the protection of individuals within states' borders. Thirdly, since my thesis explores the *legal* content of the right to health, I will focus on quasi-judicial collegial SNHRBs. Therefore, I will not examine in depth the comments of non-judicial human rights institutions (e.g. UN Special Rapporteurs, CoE Commissioner for Human Rights etc.), as these do not contribute as precisely to delineating the right to health in a (quasi) judicial setting. More precisely, I will not study in detail the contributions of the UN Special Rapporteur on the right to health within the UN or within legal scholarship (at the exception of few reports), for this would represent another project.

The methodology of the thesis

The interpretative approach

In order to explore how SNHRBs contribute to clarifying the legal content of the right to health (and later, how their interpretation can be optimised for that purpose), I will observe both the texts on which they base their interpretation, and the substance they have given or should give to this right through monitoring. This is particularly relevant to Part I.

While this thesis does not entirely rely on an intentionalist approach to interpretation, since it also advocates for a dynamic approach at times, parties' intentions remain crucial and can assist SNHRBs in clarifying the legal content of the right to health.

²⁵ Charter of the United Nations 1945, Art 1(3); ICESCR (n 4), Art 1(2) and 2(1).

Therefore, I will study how this right is formulated in international and regional human rights instruments, and will study the *Travaux Préparatoires* of the relevant provisions. Since this thesis focuses on the UN and the CoE, this will involve an in-depth analysis of Article 12 ICESCR and Article 11 ESC.

I will also examine thoroughly how this right is interpreted in the reporting and complaint procedures of SNHRBs. This exercise will rely on grounded theory, since it aims at deriving a theory (here, an account of how SNHRBs can and should clarify the legal content of the right to health) from systematically collected and analysed data.²⁶ On that basis, I have used a coding method when examining the comments of both Committees (i.e. categorisation of unstructured data). I have also had the opportunity to verify my hypotheses through semi-structured interviews with four members of the UN Committee; and through semi-structured discussions with my supervisor Mr Colm O’Cinneide, who sits in this institution and served as an internal rapporteur on Article 11 ESC.

Finally, in Part II, I will build upon the analysis of relevant treaties and their interpretations, to develop a theoretical framework enabling SNHRBs to optimise their contributions to clarifying the legal content of the right to health. Such framework will take a doctrinal approach, using relevant literature. This thesis, however, must identify the principles that will guide recommendations made in later chapters and justify why, to demonstrate the merits of the said recommendations.

Setting principles of interpretation

The doctrinal and empirical aspects of my research rely on four normative principles of interpretation, designed to fit both the purposes and the needs of SNHRBs’ monitoring procedures. Their application is particularly relevant to Part II. When giving life to the right to health through their monitoring procedures, SNHRBs should thus: first, seek an effective enjoyment of the right to health; second, set reasonable expectations on how it is to be realised; and third, encourage an implementation that is context-sensitive (when this does not contradict the latter two

²⁶ Juliet Corbin ‘Grounded Theory’ (Chap 13) in Bridget Somekh and Cathy Lewin (eds), *Theory and Methods in Social Research* (Second edition, SAGE Publications Ltd 2011).

principles). Furthermore, SNHRBs must, overall, develop principled consistency in their interpretation, partly deriving from Dworkin's vision of law as integrity.²⁷

A similar approach was developed by Tobin in *The Right to Health in International Law*, although not tailored to SNHRBs.²⁸ Tobin argues that the interpretation of the right to health (which he considers being subject to a process of constructive engagement with key actors) should be driven by four principles. It should be: principled; clear and practical; coherent; as well as context-sensitive.²⁹ As argued in this thesis, Tobin's approach is rich in relevance and originality. However, since he aims at convincing the interpretative community, his principles skew the (hierarchical) relationship between the necessity to comply with human rights law and that to incorporate views from key actors. Furthermore, his principles do not follow any chronology or order of importance. As a result, Tobin does not offer any solution in the event these principles generate incompatible interpretations of the right to health.³⁰ Finally, while Tobin's approach is sophisticated, it fails to address the need to ensure a relatively consistent interpretation of this right and that to take into consideration resource availability. The principles of interpretation I suggest build upon a similar idea: setting fundamental principles driving the interpretative process to facilitate the development of a satisfactory legal content of the right to health. However, they differ from Tobin's in purpose (i.e. clarifying what this right means to improve its realisation, rather than to convince the interpretative community); and in content (except regarding context-sensitivity).

Those four principles will be used in Chapters 1, 2 and 3, when contextualising the right to health in human rights law and discussing the adequacy of the UN and the European Committees' interpretation. They will then be used in Chapters 4, 5, and 6, when drawing the theoretical framework SNHRBs should use to clarify what the right to health entail and assessing how this can be coherently applied across SNHRBs.

²⁷ Ronald Dworkin, *Law's Empire* (Hart Publishing 1986).

²⁸ Tobin (n 19).

²⁹ *ibid* 88–118.

³⁰ Claire Lougarre, '(Book Review) John Tobin, *The Right to Health in International Law*, Oxford: Oxford University Press, 2012' (2014) 77 *The Modern Law Review* 336.

An effective enjoyment of the right to health

First and foremost, SNHRBs' interpretation should be driven by the need to ensure an effective enjoyment of the right to health. This principle derives from the very purpose of the right, i.e. the enjoyment of the highest standard of health by every individual; and from the mandate of SNHRBs, i.e. supervising its implementation. It thus embraces an interpretation reproducing a degree of fidelity to the text. Since individuals are subjects to human rights law protection, they should be put at the centre of the interpretative process. In order for the enjoyment of the right to health to be effective, it must guarantee adequate health care and policies, responsive to individuals' and populations' needs. As a result, SNHRBs should interpret the right to health by relying (directly or indirectly) on established research in medicine, public health, health ethics, health economics, and health law. This principle, thus, builds upon Tobin's idea of constructive engagement but primarily aims at ensuring the highest standard of health attainable, not convincing the interpretative community.

Reasonable expectations to realise the right to health

Secondly, SNHRBs' interpretation of the right to health should set reasonable and realistic expectations upon states. This principle stems from states' obligation to progressively realise this right and its contingency on resource availability. Furthermore, as argued by Quinot and Liebenberg (referring to Sadurski),³¹ a reasonableness test improves the transparency of the legal reasoning, and avoids unfair or irrational decisions.³² Absolutist interpretations of ESCR can also be detrimental to their credibility among states and, thus, impede their implementation. Therefore, this principle of interpretation goes beyond Tobin's principle of 'practicality and clarity', since it involves a more robust legal analysis relying on requirements of progressive realisation and fairness. SNHRBs, however, should

³¹ Sadurski 'Reasonableness and Value Pluralism in Law and Politics' in Giorgio Bongiovanni, Giovanni Sartor and Chiara Valentini, *Reasonableness and Law* (Springer Science & Business Media 2009).

³² Geo Quinot and Sandra Liebenberg, 'Narrowing the Band: Reasonableness Review in Administrative Justice and Socio-Economic Rights Jurisprudence in South Africa' (2011) 22 Stellenbosch Law Review 639.

strictly scrutinise reasonableness, as the effective enjoyment of the right to health is of crucial importance.

Context sensitivity

Thirdly, SNHRBs' interpretation of the right to health should incorporate considerations relevant to the environment in which it is to be implemented, but only to the extent that it does not contravene the two principles above. Since states are under the obligation to implement the right to health through measures they deem appropriate, SNHRBs should give some flexibility to the implementation process. Furthermore, using the specificities of the environment in which the right is to be implemented is more likely to improve its realisation. As outlined by Tobin, this principle originates from the jurisprudence of the European Court of Human Rights on states' margin of appreciation, and aims at gaining states' trust. This principle mostly matches Tobin's concept of context sensitivity and imposes the same limits: it must be used towards the object and purpose of the right.

Principled consistency

Fourthly, when following all three principles mentioned above, SNHRBs' interpretation of the right to health should be driven by the overall need to ensure principled consistency. This umbrella requirement derives from Dworkin's vision of law as 'integrity', in which judges seek to fit and justify their decisions through the existing framework in which such decisions are to be understood, i.e. a legal framework prioritising equal treatment for all individuals.³³ The requirement of principled consistency, therefore, serves two purposes in this thesis. The first is to ensure that SNHRBs' interpretation of the right to health is justified by reference to an existing legal framework, i.e. human rights law. Not only does this framework reflect states' consent, crucial to the creation of rules under public international law, it also encapsulates moral considerations driving legal activity worldwide: dignity and equality. The second purpose of the requirement of principled consistency is to ensure a certain degree of legal certainty. Since the right to health is to be monitored

³³ Dworkin 1986 (n 27), Chap 6.

and adjudicated, both duty-bearers and right-holders are entitled to know what it consists of. This represents a basic component of the rule of law.³⁴ Legal certainty benefits duty-bearers, when trying to implement the right to health and when facing allegations or findings of non-compliance. It also benefits right-holders (individuals and NGOs representing their interests), when facing potential violations of the right to health, and when bringing a complaint on that basis. As a result, SNHRBs must interpret the right to health in a way that is as clear, consistent and transparent as possible.

Underlying conceptual foundations

Since this thesis explores how SNHRBs contribute to clarifying the legal content of the right to health, and how their interpretation can be optimised for that purpose, outlining the principles that should guide their interpretation is insufficient. It is fundamental that this thesis also outlines the philosophical premises in which it considers the right to health is grounded. Such premises are clearly inherent to the nature and, thus, the content of the right to health.³⁵ Furthermore, this will enable me to meet the criterion of transparency, justify arguments made in later chapters, and advocate for a principled (and thus, consistent) interpretation of this right.

Cosmopolitanism

The atrocities committed by the Nazi regime in World War II targeted individuals because of their affiliation to a specific group. Individuals were imprisoned, beaten or killed on the basis of their religion, health status, sexual preference, ethnicity, nationality or political opinion. It is precisely to fight against the belief that such ‘groups’ entitles individuals with different rights, that human rights law was created

³⁴ UNGA, ‘The Rule of Law at the National and International Levels’ (2014) UN Doc. A/RES/69/123.’

³⁵ Ronald Dworkin, *Taking Rights Seriously* (Harvard University Press 1978); Dworkin 1986 (n 27). A parallel can be drawn between what this thesis describes as principles of interpretation and underlying conceptual foundations of the right to health, and what Dworkin describes as the fit and the justification tests. In the fit test, judges must identify principles of justice and fairness that best ‘fit’ the existing legal framework in which they operate; and in the justification test, judges must identify which interpretation is the most ‘justifiable’ on grounds of morality. However, both tests are inherently intertwined, similarly to the principles of interpretation and the underlying conceptual foundations I advocate.

in the 1950s, and why it continues to exist. As a result, I argue that SNHRBs should understand the right to health through a cosmopolitan approach. According to such an approach, considerations of justice and universal values of human dignity, non-discrimination and assistance to the vulnerable, do not stop at national boundaries.³⁶ Individuals, therefore, are entitled to benefit from equal standards of rights, regardless of any characteristic, including their nationality or the jurisdiction they live in. The contrary would defeat the purpose of human rights law.³⁷ The cosmopolitan approach has received considerable support among human rights lawyers, including in the context of the right to health.³⁸ This approach will also be used in my analysis, when arguing that SNHRBs should interpret the right to health as entitling everyone, regardless of their migrant status or the cultural beliefs endorsed by the state they live in.

Egalitarianism

This thesis also asserts that the right to health is better defended by an egalitarian ideology than through libertarianism. This is clearly demonstrated on two accounts: progressive realisation and concentration of powers. Firstly, it could be argued that the notion of resource constraints, present in right to health provisions, implies that states cannot access certain resources because they are the property of individuals or legal entities. However, such hypothesis conflicts with states' obligation to take steps in order to progressively achieve the highest standard of health attainable for everyone. Progress necessarily means that states will have to obtain further resources, presumably held by others, to realise better health standards. It would thus be inadequate to use a libertarian approach in the context of the right to health, as the latter prioritises the right to self-ownership and limits states' interferences in that

³⁶ Charles R Beitz, *Political Theory and International Relations* (Revised edition, Princeton University Press 1999); See also Immanuel Kant, 'Toward Perpetual Peace' and *Other Writings on Politics, Peace, and History* (Reprinted in Yale University Press 2006).

³⁷ Kok-Chor Tan, *Justice without Borders: Cosmopolitanism, Nationalism, and Patriotism* (Cambridge University Press 2004) 198.

³⁸ Hammonds and Ooms 'Realising the Right to Health: Moving from a Nationalist to a Cosmopolitan Approach' in Gunilla Backman, *The Right to Health: Theory and Practice* (Studentlitteratur 2012) 73–92.

respect.³⁹ Secondly, whether a right to property includes natural resources or is limited to financial resources,⁴⁰ it can allow a concentration of economic power. It is no revelation that concentration of power is a short step from abuse. Nevertheless, in the libertarian framework, states are encouraged to not interfere with the resources detained by individuals or legal entities (without consent). This contrasts with right to health requirements obliging states to fund basic universal healthcare, to regulate medical fees in the private sector, or to limit the length of patents registered by pharmaceutical companies. The effects of the libertarian ideology have long been recognised and proved to be detrimental on access to non-profitable services such as healthcare.⁴¹ For the purposes of the right to health, it is therefore fundamental that SNHRBs give priority to guaranteeing everyone access to a health system that is affordable, of good quality as well as culturally and ethically acceptable. As a consequence, my thesis will rely on an egalitarian doctrine, involving inevitably principles of distributive justice, which I will nonetheless not discuss in depth due to space constraints.

A (restricted) capabilities approach

Whilst the egalitarian doctrine has received considerable support as a philosophical premise to human rights law, it has also been criticised for not challenging inequalities occurring prior to accessing such rights. For instance, it is one thing to provide everyone with an entitlement to affordable contraception, but it is another to ensure everyone has similar opportunities to use this service. Various psychosocial factors can affect the decision of using contraceptives (e.g. age, gender, level of income, education background etc.). For example, young women may renounce using contraception as a result of gender identity, by conceding to pressure from young men to not use condoms, by identifying themselves through traditional gender

³⁹ See John Locke, *Two Treatises of Government* (printed for Awnsham Churchill, at the Black Swan in Ave-Mary-Lane, by Amen-Corner 1689): Locke argues that the right to property is a natural right.

⁴⁰ For a differentiation between right and left libertarianism, see Hillel Steiner, *An Essay on Rights* (Wiley-Blackwell 1994). In this book the author defends a left-libertarian approach, by advocating that natural resources cannot be owned.

⁴¹ Allyson M Pollock, *NHS Plc: The Privatisation of Our Health Care* (Verso Books 2005).

roles involving maternity etc.⁴² Therefore, the capabilities approach which promotes individuals' opportunities to be and do what they consciously value, is fundamental in health. Authors such as Sen, Nussbaum and Ruger have discussed these issues thoroughly.⁴³ This thesis contends that the right to health requires that states design their policies according to what they have identified as factors refraining considerably specific groups from using specific services.⁴⁴ Such an assertion is echoed through the concept of vulnerability, protected by human rights law. However, Venkatapuram argues that a capabilities approach applied to health does not solely involve adequate health policies. It also involves social arrangements to guarantee that everyone is truly being given equal opportunities to become healthy.⁴⁵ This thesis agrees it is fundamental that societies address the psychosocial determinants of health inequalities to improve access for all to the highest standard of health. Nevertheless, considering this as a normative requirement under the right to health would inflate and blur its legal content significantly. Since this thesis aims, on the contrary, at assessing how SNHRBs contribute to clarifying the legal content of the right to health, and exploring how their interpretation can be optimised for that purpose, I will not endorse an inflated capabilities approach.

The narrative of the thesis

This thesis, aimed at exploring how SNHRBs contribute to clarifying the legal content of the right to health, and how their interpretation can be optimised for that purpose, is divided in two parts.

⁴² Sally Brown and Kate Guthrie, 'Why Don't Teenagers Use Contraception? A Qualitative Interview Study' (2010) 15 *The European Journal of Contraception and Reproductive Health Care* 197; Teresa Yago Simón and Concepción Tomás Aznar, 'Condicionantes de género en anticoncepción: diseño y validación de un cuestionario [Gender-determinant factors in contraception: design and validation of a questionnaire]' (2013) 45 *Atencion Primaria / Sociedad Española De Medicina De Familia Y Comunitaria* 418.

⁴³ Martha Nussbaum and Amartya Sen, *The Quality of Life* (Clarendon Press 1993); Ruger 2006 (n 13) 283–287: Ruger criticises the egalitarian rights-based theory developed by Daniels, by pointing at the fact that such theory focuses on the inputs given to healthcare (resources) rather than its outputs (the realisation of health or health capability).

⁴⁴ Jennifer Prah Ruger, *Health and Social Justice* (OUP Oxford 2010).

⁴⁵ Sridhar Venkatapuram, *Health Justice: An Argument from the Capabilities Approach* (Polity Press 2011) 27–30.

Part I provides a critical overview of how the right to health is currently recognised and interpreted in international human rights law, seeking potential conceptual clarity of its legal content amongst SNHRBs, through their monitoring of this right. Chapter 1 starts by contextualising the recognition of the right to health in international human rights law, and argues that neither human rights law nor academics have sufficiently clarified its legal content, leaving SNHRBs' potential underexplored. As a result, Chapters 2 and 3 explore SNHRBs' contributions to clarifying the right to health in their monitoring procedures, through a comparative study between the UN and the European Committees. When these bodies evaluate the implementation of the right to health through their monitoring procedures, they delineate its legal content differently, with distinct benefits and shortcomings. Therefore, a number of fundamental questions regarding the normative scope of the right to health and states' obligations to realise it, remain unclear or ignored.

Part II builds upon the shortcomings identified in Part I, to produce a theoretical framework bringing further conceptual clarity on how the legal content of the right to health should be read in monitoring procedures, in order to optimise SNHRBs' interpretation. Based on the methodology used in Part I, this thesis advocates for the legal content of the right to health to be understood through first, its normative scope and second, the nature of the obligations it creates. Therefore, Chapter 4 studies the scope of the right to health, by suggesting what SNHRBs should consider as appropriate healthcare and whom they should consider as right-holders. Chapter 5 then demonstrates that SNHRBs should understand states' obligations through a timeframe, by arguing how they should monitor progressive realisation, and why they should rely on reasonableness rather than minimum core. Finally, Chapter 6 verifies that the theoretical framework developed in Chapters 4 and 5 can operate at all supranational levels of monitoring, contending that SNHRBs should seek harmony and flexibility in their mutual interpretations, to ensure both coherence and fairness.

PART I:

**THE RIGHT TO HEALTH IN SEARCH OF CONCEPTUAL
CLARITY**

In Part I, I will provide a critical overview of how the right to health is currently recognised and interpreted in international human rights law, by seeking potential conceptual clarity amongst SNHRBs and through their monitoring of this right. Chapter 1 will thus study the recognition of the right to health in international human rights law. Chapter 2 will examine the interpretation given to this right by the UN Committee on Economic, Social and Cultural Rights when monitoring Article 12 ICESCR, and will identify its shortcomings. Finally, Chapter 3 will analyse that of the European Committee of Social Rights, when monitoring Article 11 ESC, and will also identify the shortcomings of its interpretation.

Chapter 1 Introductory remarks: the relevance and vagueness of the right to health in international human rights law

Introduction

Since this thesis aims at exploring how SNHRBs contribute to clarifying the right to health in the course of their quasi-judicial monitoring procedures (Part I), and, later, how their interpretation can be optimised for that purpose (Part II), it is essential to understand first where this right comes from and what challenges it currently faces. This will facilitate the development of an adequate overview of how this right is recognised and interpreted within international human rights law, and what questions remain unanswered. Is the right to health solely the product of the post-WWII era or is it still relevant nowadays? Are the criticisms targeting its vagueness justified; and have human rights lawyers addressed these criticisms in order to improve its implementation?

By contextualising the right to health in international law, this chapter achieves two goals. Firstly, it asserts the relevance of the right to health by highlighting the firm historical roots on which its legal recognition sits, prior to the WHO Constitution, and ever since. Secondly, it nonetheless stresses the current vagueness surrounding the legal content of the right to health, the threat this represents for its implementation, and scholars' failure to clarify it adequately or to study SNHRBs' potential in doing so.

For the past two decades, human rights scholarship has focused on developing a human rights-approach to health but has failed to engage meaningfully with the substance of the right to health, as few authors attempted to clarify its legal content.⁴⁶ This, however, is problematic. How can we expect states to realise a right they do not know the meaning of, and how can we expect SNHRBs to monitor it adequately without deciding what a sound interpretation of this right entails? In order to explore SNHRBs' (potential) contributions to defining the legal content of the right to health, it is thus essential to understand its background first: how far we have come and how far we still have to go.

⁴⁶ At the exception, for instance, of Tobin (n 19); or Toebe 1999a (n 1).

Therefore, this chapter is structured as follows. First (1.1), I will outline the historical origins of the right to health prior to its recognition in the WHO Constitution 1946, and its widespread recognition in international human rights law ever since. Second (1.2), I will highlight the excessive vagueness of what this right entails at present, and the subsequent need for legal scholars to clarify its legal content, especially by exploring how SNHRBs might contribute to such clarification.

1.1 The right to health, a right historically relevant for human rights law

Before attempting to clarify what the right to health means by analysing SNHRBs' interpretation, it is crucial to understand where it comes from, in order to contextualise its recognition in human rights law and give a meaning to its content.⁴⁷ This section will thus demonstrate the timeless involvement of states in public health, and the shift from utilitarian motives to legal duties in that respect. It will focus in particular on the European region, for it provides various insightful examples of how states progressively intervened in matters related to populations' health, and represent a strong focus in this thesis. Subsection 1.1.1 will start by giving a brief historical background on the role of states in protecting the health of their populations from early civilisations to early 20th century. Subsection 1.1.2 will then examine the drafting of the Preamble of the WHO Constitution in 1946, a turning point in the recognition of the right to health. Finally, subsection 1.1.3 will study the widespread recognition of the right to health in human rights law since 1946.

1.1.1 From early civilisations to early 20th century: the role of the state in health protection

This section will only focus on wide-scale public health movements and in particular within the European region, as my thesis studies the supranational protection of the right to health by taking Europe as a point of comparison. The history of public

⁴⁷ Tobin (n 19) 14–43: Tobin analysed the historical roots of the right to health in depth to demonstrate that it is not the product of a communist ideology.

health having been thoroughly reported by authors such as Rosen or Porter,⁴⁸ this section will only examine key measures taken in decisive periods of time. First (1.1.1.1), I will show that states have been involved in health matters affecting their populations since the earliest times. I will then study (1.1.1.2) how the Enlightenment period and the Industrial revolution contributed to the recognition of states' duty to protect the health of their populations. Finally (1.1.1.3), I will examine the emergence of states' desire to cooperate and secure public health at an international level in the 20th century.

1.1.1.1 Early involvement of the state to preserve the health of the community

This subsection will demonstrate the early involvement of states in health matters affecting their populations. In ancient civilisations, by building drainage or water supply systems; in the Greco-Roman world, by institutionalising the function of physician; or in the Middle Ages, by establishing quarantine measures to avoid the spread of communicable diseases.

Drainage and water supply systems in early civilisations

In early civilisations, when medical means were lacking, the function of water was essential to human health. Used for drinking and food purposes, water was relied on for survival. The existence of irrigation techniques in 3,500 B.C to increase crops yields,⁴⁹ and the existence of water supply or drainage systems to ensure drinkable water and personal hygiene in 2,000 B.C.,⁵⁰ both outline the use of systems facilitating access to water. Many authors have argued that the construction of such systems required organised and forced labour, as well as a complex bureaucracy,

⁴⁸ George Rosen, *A History of Public Health* (Expanded edition, Johns Hopkins University Press 1993) [original edition: G Rosen, *A History of Public Health* (MD Publications 1958)]; Dorothy Porter, *Health, Civilization and the State: A History of Public Health from Ancient to Modern Times* (Routledge 1998).

⁴⁹ Steven Mithen, 'The Domestication of Water: Water Management in the Ancient World and Its Prehistoric Origins in the Jordan Valley' (2010) 368 *Philosophical Transactions: Mathematical, Physical and Engineering Sciences* 5249, 5268–5269.

⁵⁰ Rosen 1993 (n 48) 1–3.

suggesting the existence of a state.⁵¹ Therefore, one could conclude that states' involvement in protecting individuals' health (interpreted as survival in such era) is present since the mists of time.

The function of physician in the Greco-Roman world

States' interest in medical practice, however, seems to have appeared in Ancient Egyptian society and through its organisation of healthcare. Public medical services such as court physicians, dentists, physicians to the military, and physicians to pyramid builders emerged in 2,600 B.C.⁵² Nevertheless, it is the appearance of public physicians in Classical Greece (600-400 B.C) that revolutionised public health. Firstly, Greek physicians disseminated the belief that the cause of diseases was natural, and not divine.⁵³ Action could thus be taken more easily to prevent their occurrence (i.e. through sleep, food and exercise) than previously, when diseases were associated with gods' anger. Secondly, while Greek physicians were itinerant, cities could encourage them to stay within the community, by offering them an annual salary paid through a tax raised for that purpose.⁵⁴ Municipal doctors were mostly recruited to serve the needy and research suggests that those residing in Athens were perhaps providing free services to the poor.⁵⁵ Therefore, the provision of public medical assistance to the community and to the poor in particular, seems to have appeared in early democratic elements of the Greco-Roman world.

⁵¹ Mithen (n 49) 5250–5251: the author argues that what academics disagree on is whether irrigation systems catalysed the formation of states or whether bureaucracies existed before such systems were created.

⁵² Porter (n 48) 17.

⁵³ Hippocrates, *The Law, Oath of Hippocrates, on the Surgery, and on the Sacred Disease* (Translation by Francis Adams, Dodo Press 2009), 'On the Sacred Disease'. In this piece on epilepsy, written in 400 B.C., the author declares: '*It is thus with regard to the disease called Sacred: it appears to me to be nowise more divine nor more sacred than other diseases, but has a natural cause from the originates like other affections.*'

⁵⁴ Rosen 1993 (n 48) 6–13.

⁵⁵ Porter (n 48) 18. See also Louis Cohn-Haft, *The Public Physicians of Ancient Greece* (Department of History of Smith College 1956).

Quarantine measures in the Middle Ages

Moving forward in time, states' involvement in public health matters emerged even more clearly through the management of epidemics, in the Middle Ages. The growth of cities led to various outbreaks of epidemics between 500 and 1,500 A.D.⁵⁶ The key response of the authorities at the time was to isolate the persons contaminated, in order to protect the rest of the population (often at dreadful costs for those excluded from society). The Church Council of Lyons (583) started by prohibiting the association of lepers with persons considered as healthy, which influenced various edicts across Europe to order the construction of leper houses detached from the rest of the city.⁵⁷ Such experience shaped the institutionalisation of quarantines during the Black Death pandemic. When the pandemic hit Europe in the 14th century, Councils of Mediterranean cities adopted laws requiring that persons coming from endemic areas be isolated for 30 to 40 days, to avoid risks of contagion.⁵⁸ Whilst such measures mainly served utilitarian purposes (i.e. public order), they certainly reflected the role of medieval authorities in the preservation of populations' health. Furthermore, individuals affected by contagious diseases were not always left without medical care. In Europe, monastic infirmaries played an important role in assisting victims of contagious diseases; and in the late Middle Ages, city authorities started to fund public hospitals for that purpose.⁵⁹ Therefore, the concept of assistance to the sick was developing in the Middle Ages. However, such assistance remained voluntary and, thus, ad hoc.

⁵⁶ Rosen 1993 (n 48) 35–47.

⁵⁷ Porter (n 48) 27–31; Third Lateran Council 1179 (eleventh Ecumenical Council). Text available at <<http://www.papalencyclicals.net/Councils/ecum11.htm>> [accessed 8 September 2015].

⁵⁸ Philip A Mackowiak and Paul S Sehdev, 'The Origin of Quarantine' (2002) 35 *Clinical Infectious Diseases* 1071.

⁵⁹ L Cilliers and FP Retief, 'The Evolution of the Hospital from Antiquity to the End of the Middle Ages' (2002) 25 *Curationis* 60: the authors argue that the Muslim world was characterised by more developed hospitals; Rosen 1993 (n 48) 50–53: the author contends that the number of lepers' hospitals in England or France represented a third or a half of all hospitals.

1.1.1.2 The emergence of states' duty to protect the health of their citizens

Up to the 17th century, public health measures did not clearly reflect a sense of duty. However, as acknowledged by Rosen, '[t]he 80 years from 1750 to 1830 form a pivotal period in the evolution of public health.'⁶⁰ By laying down the foundations of the welfare state, the 18th and 19th centuries witnessed the emergence of states' duty to protect the health of their citizens. This was particularly facilitated by the natural rights doctrine developed during the Enlightenment, and by the organisation of national sanitary movements to combat epidemics in the Industrial Revolution.

Natural rights and health in the Enlightenment period

Motivated by humanitarian ideals and the belief states should improve individuals' conditions, the contribution of the philosophers of the French and American revolutions regarding health matters should not be ignored. Jefferson argued that sick populations were the product of sick political systems and that liberty and pursuit of happiness led to a healthy life.⁶¹ This influenced the draft of the United States Declaration of Independence in 1776, which recognises liberty and pursuit of happiness as inalienable rights.⁶² In his *Encyclopédie* (1751-1772), Diderot explicitly advocated for the creation of a public assistance scheme in France, involving medical care to the poor. He also stressed that hospitals should be available everywhere, and belong to the same network for efficiency purposes.⁶³ While the French Declaration of the Rights of the Man and of the Citizen, signed a few decades later, does not recognise a right to health, it recognises natural rights similar to those recognised by

⁶⁰ Rosen 1993 (n 48) 107.

⁶¹ Porter (n 48) 57.

⁶² Declaration of Independence 1776 (United States).

⁶³ Denis Diderot and Jean Le Rond d'Alembert (eds), *Encyclopédie, ou, Dictionnaire raisonné des sciences, des arts et des métiers* (Third edition, Geneve: Chez Pellet; Neufchatel: Chez la Société typographique 1751) vol 8, Article 'Hôpital'. Text available at <<https://archive.org/details/encyclopédieoud01soci>>, and at <<http://artflsrv02.uchicago.edu/cgi-bin/philologic/getobject.pl?c.7:1096.encyclopédie0513>> [accessed 8 September 2015]. Translation from the author of this thesis: '*The sovereign is father of his subjects ; why should he not be the general clerk of his poor subjects ?*' [...] '*There is certainly a need for hospitals everywhere, but should they not be connected by a general service of correspondence ?*'.

the American Declaration of Independence.⁶⁴ Moreover, in the years following the adoption of the French Declaration, French authorities created various bodies and systems to monitor and provide medical assistance to the population, especially those in need. The Enlightenment thus gave rise to a new concept: state's *moral* duty to ensure the health of individuals, in the name of fundamental rights to which all human beings are entitled at birth.

Utilitarianism and public health in the Industrial Revolution

The Industrial Revolution, which started in Great Britain in the late 18th century, and spread across Europe and the United States in the 19th century, also contributed to shaping states' duty to protect individuals' health, but through the creation of sanitary movements. The sudden increase of populations' sizes, the wave of Irish emigration, and the growth of workforce needs in cities did not necessarily lead to the construction of more housing facilities. As a result, the working class often lived in overcrowded buildings and insalubrious sanitary conditions, as described by Engels.⁶⁵ In the 19th century, an unprecedented sanitary movement emerged in the United Kingdom, driven by the utilitarian doctrine developed by the Philosophical Radicals, led by Bentham. It started by the drafting of the Chadwick report in 1834, highlighting the connection between diseases and poverty.⁶⁶ The latter argued, on one hand, that workers' deaths caused great economic costs by leaving widows and orphans behind; and on the other hand, that the spread of diseases was particularly fierce in the damp, overcrowded and insanitary conditions in which working classes lived. Chadwick, a British lawyer, suggested the UK could thus make an important economy by creating a diseases prevention programme.⁶⁷ His report led to the Poor

⁶⁴ Declaration of the Rights of the Man and of the Citizen 1789 (France).

⁶⁵ Friedrich Engels, *The Condition of the Working Class in England* (David McLellan ed., Reissued edition, First published in Germany in 1845, Oxford University Press 2009).

⁶⁶ Poor Law Commissioners, UK Home Department 'Report on the Sanitary Condition of the Labouring Population of Great Britain, Presented to Both Houses of Parliament by Command of Her Majesty' (1842), digitized on <<http://ocp.hul.harvard.edu/dl/contagion/005087620>> [accessed 8 September 2015]. Such connection is outlined in the first part of the report, published in 1842.

⁶⁷ Rosen 1993 (n 48) 175–187.

Law Amendment Act in 1834,⁶⁸ and to the establishment of municipal bodies monitoring public health matters, centralised under the Central Board of Health in 1848,⁶⁹ following a cholera epidemic.⁷⁰ It is worth noting that similar sanitary movements occurred in Europe and in the United States. In 1830, French physician Villermé wrote a report on mortality rates in Paris (which influenced the Chadwick report). He, too, concluded that the spread of diseases was clearly connected to the insalubrious conditions in which poor persons lived, i.e. inadequate water supply or drainage systems.⁷¹ Another report was also drawn with regard to the conditions of the working class in New York by Griscom, in 1845.⁷² It led to comparable findings, and suggested the creation of hygiene education programmes among the poor. Whilst the reformers of the Industrial Revolution used utilitarian and economic considerations, foreign to the foundations of what later became human rights law, their demands also shaped states' duty to provide medical assistance for everyone.

1.1.1.3 The rise of international cooperation in health

Up to the 19th century, the history of public health mostly recounts national initiatives, partly due to the fact that most health risks came from the inside. Such initiatives were examined through the European lens to provide concise examples that are coherent with the object of this thesis, but that is not to say national public health measures failed to occur elsewhere. Furthermore, the industrial revolution opened the world to international trade and transports, bringing a supranational dimension to public health protection. This subsection will examine the emergence of states' desire to cooperate through two angles. First (1.1.3.1), it will study states'

⁶⁸ Act for the Amendment and better Administration of the Laws relating to the Poor in England and Wales 1834 (UK).

⁶⁹ Public Health Act 1848 (UK).

⁷⁰ See also Rosen 1993 (n 48) 192–197; and Porter (n 48) 118–121.

⁷¹ Louis René Villermé, 'De la mortalité dans les divers quartiers de la ville de Paris' (1830) 3 *Annales d'hygiène publique et de médecine légale* 294.

⁷² John Hoskins Griscom, 'The Sanitary Condition of the Laboring Population of New York: With Suggestions for Its Improvement' (Harper and Brothers 1845), digitized on <<http://archive.org/details/sanitaryconditi00grisgoog>> [accessed 8 September 2015]; see also Porter (n 48) 151–152.

cooperation to combat epidemics at a regional level. Second, (1.1.3.2), it will explore states' desire to collaborate at an international level and on broader health issues.

Controlling epidemics at a regional level

Following a global wave of epidemics in the 19th century, countries decided to cooperate at a supranational level by initiating regional sanitary movements. From 1851 to 1938, European states organised fourteen International Sanitary Conferences, in an attempt to understand and design supranational quarantine regulations against the spread of cholera, plague, and yellow fever.⁷³ In 1902, American nations decided, in turn, to collaborate against the proliferation of cholera and yellow fever by starting to hold International Sanitary Conferences in parallel with those organised by European states.⁷⁴ Furthermore, they established the Pan American Sanitary Bureau that same year, the first supranational health organisation ever created. The Pan American Sanitary Bureau (now known as the Pan American Health Organisation) was in charge of receiving states' reports regarding the sanitary conditions in their ports and territories at the time.⁷⁵ Such practice could thus be seen as partly reflecting what later became states' obligation to report on the health of their populations under human rights law (and more precisely, the right to health). It is worth noting, however, that no regional sanitary movement was initiated by African or Asian countries, presumably because most of them were under the colonial rule of Western Empires at the time. As a result, the premise of international health cooperation seem to originate mainly from Europe and the Americas. It is interesting to note the influence of the Latin American socialist tradition in this concern, which Tobin argues is built upon Catholic values of justice.⁷⁶ Nevertheless,

⁷³ See the reports of the International Sanitary Conferences (first to eleventh) at <<http://ocp.hul.harvard.edu/contagion/sanitaryconferences.html>> [accessed 8 September 2015].

⁷⁴ Norman Howard-Jones and WHO, 'The Pan American Health Organization : Origins and Evolution' / Norman Howard-Jones' (WHO 1981) <<http://apps.who.int/iris/handle/10665/39250>> [accessed 8 September 2015]. Such conferences are now called 'Pan American Sanitary Conferences' and continue to exist under the WHO affiliation.

⁷⁵ *ibid*: the creation of this procedure follows recommendations formulated during the Second International Conference of the American States.

⁷⁶ Tobin (n 19) 19–23.

research on the history of public health tends to focus on the Western world (e.g. Rosen 1958, Porter 1993); and until recently, neglected African and Asian medical history.⁷⁷

Protecting health at an international level

Regional sanitary movements quickly gave rise to an international cooperation in health protection. In 1907, 12 states signed the Rome Agreement to create the first worldwide health organisation: the Office International d'Hygiène Publique (International Office of Public Health), mandated to prevent the spread of epidemics.⁷⁸ By 1933, the Rome Agreement had 51 states parties, among which some representing regions that were previously left aside: e.g. Africa, Arab states and South-East Asia.⁷⁹ At first, the Office International d'Hygiène Publique focused on disseminating information and designing measures to control epidemics. However, it slowly expanded its interests to hygiene issues and the construction of health facilities.⁸⁰ In 1920, shortly after the creation of the League of Nations, the international community decided to set up another health body, working in parallel

⁷⁷ Africa: K David Patterson, 'Disease and Medicine in African History: A Bibliographical Essay' (1974) 1 *History in Africa* 141, 148: '*African medical history is a virtually untouched field*'. It is worth noting that a few books have been published since but they remain scarce, e.g. Steven Feierman, *The Social Basis of Health and Healing in Africa* (University of California Press 1992). Asia: Milton J Lewis and Kerrie L MacPherson, *Public Health in Asia and the Pacific: Historical and Comparative Perspectives* (Routledge 2008). The following two reviewers consider that this book is the first to finally address comprehensively the history of modern public health in this region: Shi-Yung Liu, 'Review, Public Health in Asia and the Pacific: Historical and Comparative Perspectives' (2008) 193 *The China Quarterly* 189; and Alison Bashford, 'Review, Public Health in Asia and the Pacific: Historical and Comparative Perspectives' (2009) 83 *Bulletin of the History of Medicine* 790.

⁷⁸ Arrangement for the creation at Paris of an Office International d'Hygiène Publique 1907 (states parties: Belgium, Brazil, Egypt, Spain, United States, France, Great Britain, Italy, Netherlands, Portugal, Russia, Switzerland).

⁷⁹ Office International d'Hygiène Publique, 'Vingt-Cinq Ans D'activité de l'Office International d'Hygiène Publique: 1909-1933' (WHO archives, 1933) 5–6, digitized on <<http://www.who.int/library/collections/historical/fr/index2.html>> [accessed 8 September 2015].

⁸⁰ John Charles, 'Origins, History, And Achievements Of The World Health Organization' (1968) 2 *The British Medical Journal* 293.

with the Office International d'Hygiène Publique.⁸¹ The Health Organisation was therefore created in 1923, in accordance with Articles 23(f) and 25 of the Covenant of the League of Nations.⁸² Whilst this organisation was, again, created in the midst of an epidemic (typhoid), the provisions on which it relies clearly reflect states' desire to improve individuals' health, rather than simply prevent communicable diseases. Article 23 required that states take steps in international prevention and control of diseases; and Article 25, that states promote national Red Cross organisations to improve health, prevent diseases and mitigate suffering.⁸³ Moreover, the work of the Health Organisation rapidly extended beyond the realm of epidemics' prevention. It conducted various studies on rural hygiene, housing, school health, health facilities and health insurance. These studies assisted the signature of international agreements and enabled the Health Organisation to develop the concept of health promotion.⁸⁴

1.1.2 1946: the recognition of the right to health in the Constitution of the World Health Organisation

In 1945, 49 states gathered to create a successor to the League of Nations, after it had failed to prevent the atrocities of World War II, and signed the Charter of the United Nations.⁸⁵ Its Article 55 is of the utmost significance in the history of the right to health. Not only does it mark the birth of human rights law, it also shows the importance given to international health cooperation in the aftermath of a World War and at the earliest stages of the UN. It reads:

⁸¹ 'Conference on International Health' (1920) 1 League of Nations Official Journal 88 (Report to the Council of the League of Nations on the Measures to be taken against the further spread of Typhus in Poland).

⁸² LON 'Covenant of the League of Nations' (1920) 1 League of Nations Official Journal 3, Art 23(f) and 25.

⁸³ *ibid*, Art 23(f) and 25. Art 24 also recognises the possibility for the League to create international bureaux for matters of international interest.

⁸⁴ Rosen 1993 (n 48) 482–484.

⁸⁵ UN Charter (n 25) ; UN Treaty Collection, 'Status of the Charter of the United Nations' <https://treaties.un.org/pages/ShowMTDSGDetails.aspx?src=UNTSOnline&tabid=2&mtdsg_no=I-1&chapter=1&lang=en#Participants> [accessed 8 September 2015].

With a view to the creation of conditions of stability and well-being which are necessary for peaceful and friendly relations among nations based on respect for the principle of equal rights and self-determination of peoples, the United Nations shall promote:

a) higher standards of living, full employment, and conditions of economic and social progress and development;

b) solutions of international economic, social, health, and related problems; and international cultural and educational cooperation; and

c) universal respect for, and observance of, human rights and fundamental freedoms for all without distinction as to race, sex, language, or religion.⁸⁶

Following this statement, states created the World Health Organisation (WHO) a month later,⁸⁷ before dissolving the Health Organisation and the Office International d'Hygiène Publique that same year.⁸⁸ As outlined by Bok, all the delegates who came together to create the WHO knew too well the disastrous impact World War II had had on public health. Therefore, they all agreed from the outset that access to higher standards of living, better nutrition, medical care, and health insurance, should be guaranteed as a right for everyone.⁸⁹ When drafting the Preamble of the WHO Constitution, the five appointed physicians and the Technical Preparatory Committee thus reflected this desire,⁹⁰ as it now reads:

⁸⁶ UN Charter (n 25), Chapter IX Art 55.

⁸⁷ WHO Constitution (n 2).

⁸⁸ 'Resolution for the Dissolution of the League of Nations, Adopted by the Assembly on April 18, 1946' (1947) 1 International Organization 246; Protocol concerning the Office International d'Hygiène Publique 1946.

⁸⁹ Bok, 'Rethinking the WHO Definition of Health' in Kristian Heggenhougen and Stella R Quah (eds), *International Encyclopedia of Public Health* (Academic Press 2008) 590–591.

⁹⁰ WHO, Interim Commission, 'Official Records of the World Health Organisation No. 1, Minutes of the Technical Preparatory Committee for the International Health Conference Held in Paris from 18 March to 5 April 1946' <<http://www.who.int/library/collections/historical/en/index3.html>> [accessed 8 September 2015].

The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition.⁹¹

The creation of the WHO does not only represent a major landmark in the history of public health, it also recognises for the first time the existence of a right to health.

1.1.3 From 1946 to 2015: the recognition of the right to health in human rights law

Whilst the right to health was first recognised by the WHO Constitution in 1946, it legally came to light through the development of human rights law and is still relevant today. Therefore, Section 1.1.3 will discuss, firstly (1.1.3.1), the widespread recognition of the right to health in human rights instruments; secondly (1.1.3.2), its monitoring in human rights mechanisms; and thirdly (1.1.3.3), its relevance nowadays.

1.1.3.1 The widespread recognition of the right to health in human rights instruments

After the WHO Constitution recognised a right to health in its Preamble, many human rights treaties and documents embraced its legal existence. For the ease of the reader, this subsection provides a timeline of the most influential human rights treaties that have a right to health provision. Those include regional,⁹² and international conventions.⁹³ By ‘influential’, this subsection understands legally

⁹¹ WHO Constitution (n 2), Preamble.

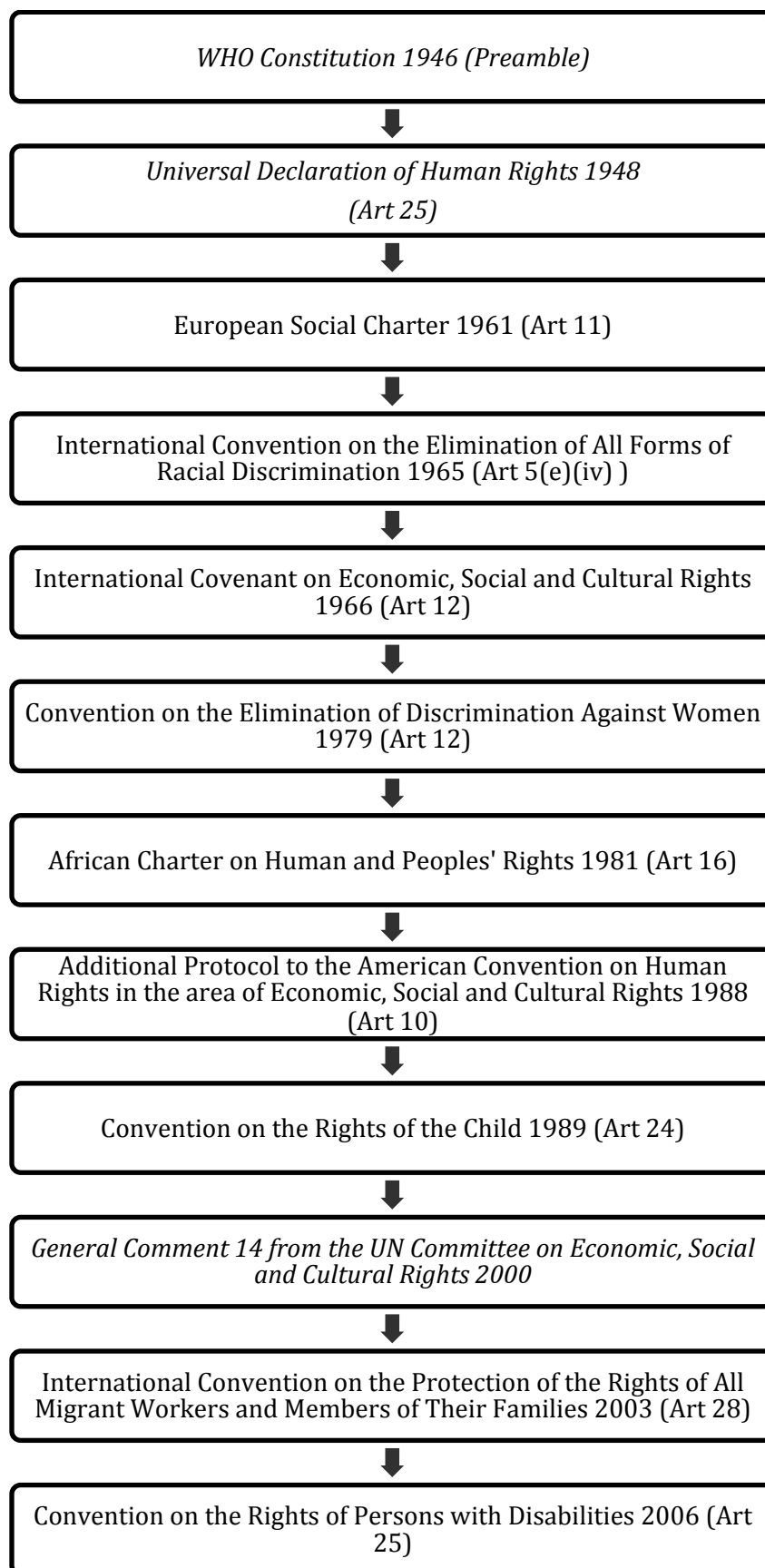
⁹² Regional human rights treaties: Europe: European Social Charter 1961 (ESC 1961), Art 11; European Social Charter (as amended) 1996 (ESC 1996), Art 11. Africa: African Charter on Human and Peoples’ Rights 1981 (African Charter), Art 16. Americas: Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights 1988 (Protocol of San Salvador), Art 10. This timeline does not include any instrument from the Arab world, Asia, or Oceania for they are either inadequate or inexistent; see the Arab Charter on Human Rights 2004 (Arab Charter), Art 39.

⁹³ International (human rights) treaties: WHO Constitution (n 2), Preamble (this is an international treaty but not of human rights nature); International Convention on the Elimination of All Forms of Racial Discrimination 1966 (CERD), Art 5(e)(iv); ICESCR (n 4), Art 12.; Convention on the Elimination of All Forms of Discrimination Against Women 1979 (CEDAW), Art 12.; Convention on the Rights of the Child 1989 (CRC), Art 24; International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families 1990 (ICMW), Art 28; Convention on the Rights of Persons with Disabilities 2006 (CRPD), Art 25.

binding agreements to which a particularly high number of States are parties, and that represent a landmark in human rights law. The ‘landmark’ status of these instruments can be measured by a relatively frequent use in litigation or in advocacy. This timeline also includes two instruments that are not legally binding, due to their importance in human rights law. Those include: the UDHR, the first international human rights instrument; and General Comment 14 (GC14), guidelines drafted by the UN Committee on the implementation of the right to health.⁹⁴

⁹⁴ Non-binding human rights instruments: UDHR (n 3), Art 25; UNCESCR, ‘GC14’ (n 21).

Figure 1 Timeline of major supranational human rights instruments recognising a right to health



1.1.3.2 The monitoring of the right to health in human rights mechanisms

The implementation of the right to health can be subject to various monitoring procedures in the UN, the CoE and the African Union. Such procedures include: periodic states reports; ad hoc complaints; and ad hoc inquiries in presence of gross human rights violations (except in the CoE framework). Several SNHRBs conduct these procedures: the UN Committee; the European Committee; and the African Commission on Human and Peoples' Rights (African Commission). Regrettably, the range of monitoring procedures available in other regions with regard to the right to health is limited. In the Inter-American system of human rights protection, the implementation of this right is exclusively reviewed through a reporting procedure.⁹⁵ ESCR complaints can only be brought under provisions specific to trade union rights and the right to education in this framework.⁹⁶ Furthermore, the 'human rights framework' of the League of Arab States is heavily criticised and does not offer better alternatives. The Arab Human Rights Committee only supervises the application of the right to health through a reporting procedure, which, so far, merely 4 states out of the 14 who ratified the Charter, have respected.⁹⁷ Finally, such procedures do not exist in the rest of Asia. Table 1 below provides an overview of the monitoring procedures existing at present in SNHB.

⁹⁵ Protocol of San Salvador (n 92), Art 19(1) to (5): such reports are examined by what is now the Inter-American Council for Integral Development.

⁹⁶ *ibid*, Art 19(6): complaints are brought before the Inter-American Commission on Human Rights.

⁹⁷ The Arab Human Rights Committee was created in 2009. See Mohamed Y Mattar, 'Article 43 of the Arab Charter on Human Rights: Reconciling National, Regional, and International Standards' (2013) 26 *Harvard Human Rights Journal* 91, 94; or Mervat Rishmawi, 'The Arab Charter on Human Rights and the League of Arab States: An Update' (2010) 10 *Human Rights Law Review* 169.

Table 1 Monitoring and enforcement mechanisms on the right to health in SNHRBs⁹⁸

<i>Procedures</i>	<i>United Nations</i>	<i>Council of Europe</i>	<i>African Union</i>	<i>Organisation of American States</i>	<i>League of Arab States</i>	<i>ASEAN</i>
<i>Reporting</i>	✓	✓	✓	✓	✓	✗
<i>Complaints from individuals</i>	✓ (individual)	✓ (collective)	✓ (individual and collective)	✗	✗	✗
<i>Complaints from states</i>	✓	✗	✓	✗	✗	✗
<i>Inquiry procedures</i>	✓	✗	✓	✗	✗	✗
<i>Special Rapporteur</i>	✓	✗	✗	✗	✗	✗
<i>Enforcement mechanism</i>	✗	✗	✗	✗	✗	✗

⁹⁸ This table is based on various documents. In the UN: UNCESCR, ‘Rules of Procedure of the Committee’ (1993) UN Doc E/C.12/1990/4/Rev.1; UNCESCR, ‘Provisional Rules of Procedure under the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights’ (2013) UN Doc E/C.12/49/3. In the CoE: ESC 1961 (n 92), Art 21 to 24; Additional Protocol of 1995 providing for a system of collective complaints 1995 (Additional Protocol ESC). In the African Union: African Charter (n 92), Art 45 to 59. In the Organisation of American States: Protocol of San Salvador (n 92), Art 19. In the League of Arab States: Arab Charter (n 92), Art 48.

It is worth noting that supranational systems provide different monitoring opportunities for the right to health. However, the human rights treaties that recognise a legally-binding right to health (which excludes the WHO Constitution, the UDHR and GC14) are all monitored through a reporting procedure, based on provisions recognising such mechanism. These procedures oblige states to periodically report on the implementation of the right to health provisions they are bound to. In each system, the civil society is also invited to submit parallel reports. This prevents SNHRBs from reviewing the implementation of the right to health by relying solely on governmental sources. SNHRBs then assess the content of all reports on an impartial basis. Once this task is completed, they reach conclusions on the adequacy of the realisation of the right to health in each country, and make their comments public. This thesis argues that reporting procedures represent the jurisprudence of SNHRBs to a certain extent. Firstly, reporting procedures ultimately aim at verifying whether states comply with their obligation to fulfil the right to health of their populations. Therefore, if they do not comply, this represents a violation of the right (whether explicitly recognised by the human rights body or not). Secondly, the standards developed through the reporting procedures are often used later, in cases opposing a more identifiable plaintiff (individuals) and defendant (states). Obviously, reporting procedures involve no complaint, no (real) plaintiff or defendant, no legal representative, no remedies, or no enforcement measures. These are incorporated within another type of monitoring: complaint procedures.

Contrarily to reporting procedures, complaints mechanisms are often created by independent Protocols, which attract less states parties. At the regional level, both the African and the European systems of human rights protection have complaints mechanisms with regard to the right to health. Individuals living in states that consented to be bound by such mechanisms (or NGOs, on their behalf) can thus bring a complaint alleging a violation of their right to health. Such complaints can be brought before two quasi-judicial regional human rights bodies. The African Commission, which has jurisdiction over 53 states in the complaint procedure,⁹⁹ and

⁹⁹ African Charter (n 92), Art 55-59; African Commission on Human and Peoples' Rights, 'Ratification Table: African Charter on Human and Peoples' Rights' <<http://www.achpr.org/instruments/achpr/ratification/>> [accessed 8 September 2015].

the European Committee, restricted to 15 states in that regard.¹⁰⁰ At the international level, most UN human rights treaties that have a right to health provision also have complaints mechanisms, except the International Convention on the Rights of Migrant Workers. Therefore, individual communications based on an alleged violation of the right to health can be brought before several quasi-judicial committees. The UN Committee on Economic, Social and Cultural Rights can receive individual complaints from 15 different jurisdictions (since 2013);¹⁰¹ and the Committee on the Elimination of Racial Discrimination, from 55.¹⁰² The Committee on the Elimination of Discrimination against Women can review communications from 104 jurisdictions;¹⁰³ and the Committee on the Rights of Persons with Disabilities, from 83.¹⁰⁴ Finally, the Committee on the Rights of the Child can review communications from 11 different jurisdictions.¹⁰⁵

¹⁰⁰ Additional Protocol ESC 1995 (n 98); CoE, ‘Signatures and Ratifications of the European Social Charter, Its Protocols and the European Social Charter (revised), Situation at 26 March 2013’ <http://www.coe.int/t/dghl/monitoring/socialcharter/Presentation/SignatureRatificationIndex_en.asp> [accessed 8 September 2015].

¹⁰¹ Optional Protocol to the International Covenant on Economic, Social and Cultural Rights 2008 (OP to ICESCR) (entered into force 2013) ; UN Treaty Collection, ‘Status of the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights’ <https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3-a&chapter=4&lang=en> [accessed 8 September 2015].

¹⁰² CERD (n 93), Art 14; UN Treaty Collection, ‘Status of the International Convention on the Elimination of All Forms of Racial Discrimination’ <https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-2&chapter=4&lang=en> [accessed 8 September 2015]. In order for complaints to be reviewed, states must submit a declaration under this provision, which only 56 states have done as of 16 April 2015.

¹⁰³ Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women 1999; UN Treaty Collection, ‘Status of the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women’ <https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-8-b&chapter=4&lang=en> [accessed 8 September 2015].

¹⁰⁴ Optional Protocol to the Convention on the Rights of Persons with Disabilities 2006; UN Treaty Collection, ‘Status of the Optional Protocol to the Convention on the Rights of Persons with Disabilities’ <https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-15-a&chapter=4&lang=en> [accessed 8 September 2015].

¹⁰⁵ Optional Protocol to the Convention on the Rights of the Child on a communications procedure 2011; UN Treaty Collection, ‘Status of the Optional Protocol to the Convention on the Rights of the Child on a Communications Procedure’

It is thus clear that the supranational forums in which the right to health can be adjudicated or at least, monitored are numerous, as Table 1 above demonstrated. Moreover, as states are increasingly constitutionalising the right to health,¹⁰⁶ the possibility for adjudicating this right at a domestic level is also on the rise. This thesis, however, does not focus on national initiatives to protect the right to health but on supranational frameworks instead. In view of these observations, the existence of the right to health as a legal right capable of being monitored at a supranational level is indisputable. However, is this right created more than sixty years ago still relevant?

1.1.3.3 The relevance of the right to health today

As argued by Tobin, the historical origins of the right to health demonstrate that it is neither the product of a communist ideology, nor the result of utopian beliefs.¹⁰⁷ Instead, the right to health is firmly rooted in pragmatic and instrumentalist considerations at the core of states' interests, i.e. preventing the spread of diseases. It also emerges from the longstanding primacy given to human life, whether in religious or secular systems, and the subsequent duty for states to protect the vulnerable. Therefore, states consented to be bound by the obligation to protect the health of their population not only implicitly, through a historical account of public health, but also explicitly, through the recognition of the right to health in human rights law. However, these concerns are still relevant today and so is the need for a right to health to exist.

Such relevance is clearly reflected by states' failure to meet the health-related Millennium Development Goals. In 2000, the UN General Assembly adopted the historic United Nations Millennium Declaration in a plenary meeting, establishing Millennium Development Goals to be achieved by 2015.¹⁰⁸ According to Millennium

<https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-11-d&chapter=4&lang=en> [accessed 8 September 2015].

¹⁰⁶ Gunilla Backman and others, 'Health Systems and the Right to Health: An Assessment of 194 Countries' (2008) 372 *The Lancet* 2047.

¹⁰⁷ Tobin (n 19) 41–43.

¹⁰⁸ UNGA, 'United Nations Millennium Declaration' (2000) UN Doc A/RES/55/2.

Development Goals 4, 5 and 6, states had to endeavour to reduce by two-thirds the under-five mortality rate, and by three quarters the maternal mortality ratio. They also had to halt the spread of HIV, as well as the incidence of malaria and other major diseases. Furthermore, they had to achieve universal access to reproductive healthcare as well as to HIV/AIDS treatment. Fifteen years later, most of these targets have not been achieved. For instance, according to the WHO Statistics Report 2014, only 33% of states had achieved or were on track to meet the targets set for infant mortality; and the decline of maternal mortality rate was still far below the target.¹⁰⁹ We are clearly very far from a situation where individuals enjoy a right to health, let alone the ‘highest standard of health attainable’. Whilst this is particularly true for low-income and middle-income countries, European and Northern American countries are also facing difficulties in ensuring access to healthcare. For instance, the share of the population considering their need for medical examination or treatment is unmet, in the European Union, still varies considerably depending on individuals’ income.¹¹⁰ In the United States, 14.7% of the population (i.e. 45.5 million persons) cannot afford any health insurance.¹¹¹ Furthermore, while consensus on the need to implement this right is growing in the international community, the absence of research clarifying what it entails undermines its reality. How can states realise a right of which they do not understand the meaning? It is therefore fundamental that human rights lawyers clarify the legal content of the right to health to encourage the development of coherent strategies towards a better realisation of this right.

¹⁰⁹ WHO, ‘World Health Organisation Statistics 2013’ (2013) 13 and 15 (as well as 20–34) <http://www.who.int/gho/publications/world_health_statistics/EN_WHS2013_Full.pdf> [accessed 8 September 2015].

¹¹⁰ Eurostat, ‘Self Reported Unmet Need for Medical Examination or Treatment, by Income Quintile’ <<http://ec.europa.eu/eurostat/tgm/refreshTableAction.do?tab=table&plugin=1&pcode=tsdph270&language=en>> [accessed 8 September 2015].

¹¹¹ U.S. Centers for Disease Control and Prevention, National Center for Health Statistics, ‘Health Insurance Coverage: Early Release of Estimates From the National Health Interview Survey, 2012’ (2013) <<http://www.cdc.gov/nchs/nhis/released201306.htm>> [accessed 8 September 2015].

1.2 The right to health, a right vaguely defined in human rights law

Whilst it is crucial to understand where the right to health comes from to contextualise its recognition in human rights law, it is equally important to understand the challenges it faces today, to identify the issues it must overcome. Section 1.1 demonstrated that states have shown their perpetual involvement in public health throughout history, and have clearly expressed their desire to be bound to this right by ratifying human rights instruments. Therefore, this thesis does not attempt to justify the relevance, existence, or justiciability of the right to health. What it does instead, is asking where we are now and what needs to be done. Section 1.2 will thus point at the need for the right to health to be more clearly defined in international human rights law. First (1.2.1), I will assert that the content of the right to health remains excessively vague, whether in human rights instruments or jurisprudence, which impedes its implementation. Second (1.2.2), I will highlight the failure of legal scholarship to clarify sufficiently and coherently what this right entails in practice, and the (underexplored) potential of SNHRBs in this respect.

1.2.1 Excessive vagueness in human rights law

As discussed in the introduction of this thesis, the right to health has been attacked on various fronts: for its weak conceptual foundations; its excessively vague, programmatic and unrealistic formulation; as well as its inadequate adjudication. It is worth noting, nonetheless, that all criticisms point towards the same problem: the legal content of the right to health (i.e. a normative content fit to practical considerations) is not clearly defined. Are those criticisms justified? In subsections 1.2.1.1 and 1.2.1.2, I will highlight that at first glance, human rights instruments and jurisprudence do not clarify what this right means in practice. In subsection 1.2.1.3, I will then discuss the negative impact that such excessive vagueness can subsequently have on the implementation of this right.

1.2.1.1 Vagueness in human rights instruments

Human rights instruments define the right to health as ‘the right of everyone to the highest standard of health attainable’, which states must realise ‘progressively’.

At the international level, for instance, the ICESCR declares that:

‘The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. [...] Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.’¹¹²

Comparable statements can be found at the regional level. The ESC recognises that:

‘Everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable.’¹¹³

Similarly, the African Charter, recognises that:

‘Every individual shall have the right to enjoy the best attainable state of physical and mental health’.¹¹⁴

However, neither of those two instruments explicitly refers to the progressive realisation of the right to health, contrarily to the Protocol of San Salvador, which declares that:

‘Everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being [...] The States Parties to this Additional Protocol to the American Convention on Human Rights undertake to adopt the necessary measures, both domestically and through international cooperation, especially economic and technical, to the extent allowed by their available resources, and taking into account their degree of development, for the purpose of achieving progressively and pursuant to their internal

¹¹² ICESCR (n 4), Art 12 and 2(1).

¹¹³ ESC 1996 (n 92), Part I (11).

¹¹⁴ African Charter (n 92), Art 16.

legislations, the full observance of the rights recognized in this Protocol.’¹¹⁵

Such formulations, however, fail to clearly indicate how this right should be interpreted in practice, i.e. in adjudicatory or monitoring procedures. Does the highest standard of health attainable mean that individuals have the right to be healthy, or the right to obtain expensive treatments for free? Does the obligation to progressively realise the right to health mean that as long as any progress is made, in an indefinite length of time, states comply with it?

The UN Committee tried to clarify its interpretation of Article 12 ICESCR in 2000, by drafting GC14 on the right to health.¹¹⁶ This document provides a wide range of conceptual frameworks, through which states’ obligations and, thus, the scope of this right, are to be understood. It outlines an obligation to respect, protect, and fulfil the right to health (including to facilitate, provide, and promote it). It also describes: the obligation to progressively realise this right; minimum core obligations; the obligation of international assistance and cooperation; as well as obligations of non-state actors. Finally, it declares that states must provide healthcare that is available, accessible, acceptable, and of good quality.

Nevertheless, GC 14 remains highly theoretical. As argued in more depth in Chapter 2 (subsection 2.2.2), the requirements of availability, accessibility, acceptability and quality of healthcare could potentially enable the UN Committee to clarify the normative scope of the right to health. However, the UN Committee rarely refers to these requirements in its reporting procedure, and the framework itself presents limits impeding its implementation to practical situations (e.g. crystallising the scope of the right through a narrow definition). Furthermore, and as argued in Chapter 2 (subsections 2.3.1 and 2.3.2), while GC14 recognises states’ obligation to progressively realise the right to health and minimum core obligations, it does not specify how these may be monitored, and the UN Committee rarely refers explicitly to such obligations in its reporting procedure. Therefore, it is unclear how GC14

¹¹⁵ Protocol of San Salvador (n 92), Art 10 and 1.

¹¹⁶ UNCESCR, ‘GC14’ (n 21).

effectively clarifies how ‘the highest standard of health attainable’, or states’ obligations to realise it, may be materialised in adjudicatory or monitoring procedures. Furthermore, while GC 14 may have authoritative force, it is not legally binding. Human rights instruments, therefore, do not particularly clarify what the right to health entails when applied or interpreted in practice.

1.2.1.2 Vagueness in human rights jurisprudence

Although this thesis does not examine the domestic interpretation of the right to health, it is worth noting that national courts rarely adjudicate health issues under the label ‘human right to health’. The few jurisdictions that do so (i.e. South Africa, India, Colombia, Brazil, Argentina) have generated a highly contested case law, with different models of review that are far from being followed worldwide. As argued by O’Cinneide, this does not mean that domestic courts fail to protect social rights standards,¹¹⁷ or that a generic framework of social rights review is desirable at a national level.¹¹⁸ However, these elements highlight the impossibility of clarifying what the right to health means through domestic litigation and hence, the need to explore how SNHRBs contribute to clarifying its legal content in the course of their quasi-judicial monitoring procedures.

In 1999, Toebe declared nonetheless:

The problem with the right to health is [...] the absence of a consistent implementation practice through reporting procedures and before judicial and quasi-judicial bodies as well as an ensuing lack of conceptual clarity. These problems are interrelated: a lack of understanding of the meaning and scope of a right makes it difficult to implement and the absence of a frequent practice of implementation in turn hampers the possibility of obtaining a greater understanding of its meaning and scope.¹¹⁹

¹¹⁷ O’Cinneide ‘The constitutionalization of social and economic rights’, in Helena Alviar García, Karl Klare and Lucy A Williams (eds), *Social and Economic Rights in Theory and Practice: Critical Inquiries* (Routledge 2014): the author argues that a ‘socially engaged’ constitutionalism is on the rise.

¹¹⁸ O’Cinneide ‘The Problematic of Social Rights – Uniformity and Diversity in the Development of Social Rights Review’, in Liora Lazarus, Christopher McCrudden and Nigel Bowles (eds), *Reasoning Rights: Comparative Judicial Engagement* (Hart Publishing 2014).

¹¹⁹ Toebe 1999a (n 1) 346.

Unfortunately, in 2015 SNHRBs still do not benefit from a well established or at least, well-known jurisprudence with regard to the right to health for three main reasons. Firstly, the UN Committee has not reached any Merits Decisions yet through its complaint procedure, due to the recent entry into force of the Optional Protocol to the ICESCR.¹²⁰ Furthermore, its Concluding Observations are often vaguely formulated and are not legally binding. Secondly, at the regional level, while the African Commission can review the right to health through a complaint procedure, it only started to effectively delineate its normative content in 2001 and has reached very few decisions since.¹²¹ Moreover, the reporting procedure of the African Commission tends to copy the UN model and is characterised by the same vagueness (without mentioning the little online availability of its Concluding Observations).¹²² Thirdly, the Inter-American system does not allow for ESCR to be reviewed through its complaint procedure. Furthermore, its ‘ad hoc’ reporting procedure offers little to study from, whether in quantity or substance, regarding the right to health.¹²³ Therefore, at first glance, these three SNHRBs do not seem to be able to contribute positively to clarifying the legal content of the right to health through their monitoring procedures. However, the interpretation of the UN Committee is still worth studying as it has an authoritative status internationally, and that of the European Committee of Social Rights brings hope. The complaint procedure of the European Committee has produced few but rich Merits Decisions on the right to health. Moreover, its reporting procedure has produced numerous and clear recommendations. However, no research has summarised the jurisprudence of the European Committee or that of the UN Committee in this respect. As a result, it is still uncertain whether and how they have contributed to clarifying the legal

¹²⁰ OP to ICESCR (n 101).

¹²¹ Christopher Mbazira, ‘Enforcing the Economic, Social and Cultural Rights in the African Charter on Human and People’s Rights: Twenty Years of Redundancy, Progression and Significant Strides’ (2006) 6 African Human Rights Law Journal 333, 342–357; Manisuli Ssenyonjo, ‘Analysing the Economic, Social and Cultural Rights Jurisprudence of the African Commission: 30 Years since the Adoption of the African Charter’ (2011) 29 Netherlands Quarterly of Human Rights 358, 367–370 and 375–377.

¹²² All the Concluding Observations of the African Commission can be found online at <<http://www.achpr.org/states/reports-and-concluding-observations/>> [accessed 8 September 2015].

¹²³ All the Concluding Observations of the Inter-American Commission can be found online at <<http://www.oas.org/en/iachr/reports/country.asp>> [accessed 8 September 2015].

content of the right to health in the course of their quasi-judicial monitoring procedures.

1.2.1.3 The negative impact of (excessive) vagueness

Law, and more particularly in this thesis, human rights law, does not aim at defining concepts with as much precision as possible. As rightly noted by Waldron:

Perhaps, then, we sometimes try too hard to determine a precise prescriptive meaning for legal [and constitutional] provisions. Our urge is to get into a position where we can always answer the question, "Well, is this prohibited or is it not?" However, sometimes the point of a legal provision may be to start a discussion rather than settle it [...].¹²⁴

Therefore, it is necessary that the legal interpretative process ensure a certain degree of flexibility, to avoid crystallising definitions or concepts into rigid frameworks. Such crystallisation can fail to reflect their complexity or can impede their evolution, thus impeding principles of justice and fairness to flow adequately. It is worth noting that the need for a flexible interpretative process is particularly relevant to SNHRBs, as legal pluralism and states' margin of appreciation are crucial in international human rights law. However, the need for flexibility does not justify the excessive vagueness that currently plagues the content of the right to health, and a better balance must be struck between clarity and flexibility to guarantee legal certainty.

As mentioned in the introduction of this thesis, the lack of conceptual clarity surrounding the legal content of the right to health can affect various actors in the realisation of this right and can, as a result, hinder its implementation. It is thus fundamental to clarify what the right to health means. First, states can be confused on the standards they must meet, and what they must report on. Therefore, an unclear legal content of the right to health represents either an opportunity for states to formulate excuses for non-compliance, or a risk for them to breach human rights law unnecessarily (on substantial or procedural grounds). Such lack of clarity also increases the likelihood for violations of the right to health to be ignored by states

¹²⁴ Jeremy Waldron, 'Vagueness in Law and Language: Some Philosophical Issues' (1994) 82 California Law Review 509, 539.

not knowing or not willing to know what to do to remedy them. Finally, it can be interpreted as setting unrealistic expectations, which may discourage states. Second, NGOs can be at a loss for strategies when facing rights for which content is unclear. As a result, they tend to focus on rights which they believe are more accepted, ‘enforceable’, and ‘immediate’, to carry on with their primary work of ‘naming and shaming’.¹²⁵ This, however, contributes to a lack of visibility when it comes to right to health violations and makes little progress towards finding solutions. Third, the insufficient conceptual clarity surrounding the legal content of the right to health is both reflected by, and feeds on, its inadequate adjudication by domestic courts. Courts often avoid holding a claim admissible and reviewing its merits on the basis of a violation of the right to health, potentially denying protection and remedies to victims. Some courts (e.g. Brazil) may do so but ignore issues of resources constraints and health prioritisation, thus, inadequately inflating the content of this right. Fourth, this lack of conceptual clarity can also affect SNHRBs, when monitoring the implementation of the right to health. It leaves them uncertain of what to monitor, what to follow up, and when to reach a finding of conformity or non-conformity. Furthermore, SNHRBs may waste time asking states to provide data and waiting for the latter to be sent, if states are not aware of what to report on. As a result, individuals are the main victims of such uncertainty. A lack of understanding of what the right to health entails jeopardises its realisation by states, its protection by NGOs, its adjudication by national courts, and its monitoring by SNHRBs.

1.2.2 Absence of clarification in the literature and SNHRBs’ (underexplored) potential

The excessive vagueness surrounding the legal content of the right to health, whether in human rights instruments or jurisprudence, is highly problematic. Whilst such vagueness manifests itself through different aspects, the failure of legal scholars to sufficiently clarify the legal content of the right to health clearly represents both a cause and a symptom of underlying problems. I will thus discuss, first (1.2.2.1), the increasing focus on the right to health in the literature, contrasted with, second

¹²⁵ Eitan Felner, ‘Closing the “Escape Hatch”: A Toolkit to Monitor the Progressive Realization of Economic, Social, and Cultural Rights’ (2009) 1 *Journal of Human Rights Practice* 402, 405–408.

(1.2.2.2), the fact that few academics have (successfully) attempted to clarify the content of this right. Therefore (1.2.2.3), I will highlight SNHRBs' potential contributions to clarifying such content and legal scholarship's failure to analyse it in more depth. This will enable me, finally (1.2.2.4), to identify the gap in the literature that this thesis aims to fill.

1.2.2.1 Increasing focus on the right to health in the literature

The right to health is part of the economic, social and cultural rights' family (ESCR). Albeit they were explicitly recognised in 1966 by the ICESCR, ESCR only started to receive thorough academic attention since the late 1980s.¹²⁶ This is not the case for civil and political rights (CPR), which became the subject of considerable research as early as the late 1960s.¹²⁷ As a result, human rights law has often been divided into two sets of rights: the 'first generation' of rights, i.e. CPR; and the 'second generation', i.e. ESCR. Such categorisation is detrimental to ESCR, including the right to health, as those rights have often been interpreted as being less important than CPR. This situation is aggravated by the belief that CPR are easier and cheaper to enforce, while ESCR are too complex, expensive and vague to be adjudicated or monitored. Whilst it is true that enforcing ESCR represents considerable challenges compared to CPR litigation, the vagueness calling into question their existence or justiciability could be potentially remedied, if attempts were made to clarify their legal content. Such clarification could assist the main actors involved in the implementation of ESCR (namely: judges, human rights bodies, individuals, NGOs, and of course, states), and could thus contribute in improving their realisation. However, the 20-year gap of research, jurisprudence and advocacy leaves ESCR inevitably behind in that respect, including the right to health. It is therefore fundamental that this gap is filled by clarifying what ESCR entails one by one, for clarity purposes. This is all the more fundamental regarding the right to health, as it

¹²⁶ E.g. see the seminal article in early literature on international ESCR, dated 1987: Philip Alston and Gerard Quinn, 'The Nature and Scope of States Parties' Obligations under the International Covenant on Economic, Social and Cultural Rights' (1987) 9 Human Rights Quarterly 156.

¹²⁷ E.g. see the seminal article in early literature on international CPR, dated 1968: Egon Schwelb, 'Civil and Political Rights: The International Measures of Implementation' (1968) 62 American Journal of International Law 827.

is closely related to the keystone right to life, and embraces particularly intricate medical, economic, ethical and legal issues.

Literature, case law and advocacy on the right to health have nonetheless increased considerably over the last fifteen years. A new journal called '*Health and Human Rights*' started to publish online and open-access articles in 1994, under Mann's editorship.¹²⁸ Furthermore, respectable human rights and medical journals regularly publish articles concerning the right to health.¹²⁹ Nevertheless, few researchers have attempted to clarify the 'legal content' of the right to health, i.e. a normative content fit to adjudicatory or monitoring procedures.

Firstly, most publications focus on the practical applications of a human rights-based approach to health issues, rather than on the right to health itself. For instance, Backman examines specific themes such as maternal mortality, HIV, mental disability, essential medicines, undocumented migrants and palliative care in *The Right to Health: Theory and Practice*.¹³⁰

Secondly, few publications provide an overarching theoretical framework clarifying the content of the right to health, perhaps due to a superior number of edited collections focusing on a range of thematic or geographic issues.¹³¹ For example, the authors who contributed to the edited collection *Realising the Right to Health* offer enlightening findings in respect of specific aspects of the right to health (e.g.

¹²⁸ The journal *Health and Human Rights* is available at <<http://www.hhrjournal.org/>> [accessed 8 September 2015].

¹²⁹ E.g. Toebe 1999b (n 12); Mary Robinson, 'Realising the Human Right to Health' (2009) 374 *Lancet* 1121.

¹³⁰ Backman (n 38).

¹³¹ E.g. Jose M Zuniga, Stephen P Marks and Lawrence O Gostin, *Advancing the Human Right to Health* (Oxford University Press 2013); Brigit Toebe, Milan M Markovic and Rhonda Ferguson (eds), *The Right to Health: A Multi-Country Study of Law, Policy and Practice* (TMC Asser Press 2014); Colleen M Flood and Aeyal Gross (eds), *The Right to Health at the Public/Private Divide: A Global Comparative Study* (Cambridge University Press 2014).

vulnerable groups, the role of healthcare practitioners, etc.), but do not discuss its overall content.¹³²

Thirdly, recent publications tend to assess the adjudication of the right to health in national courts, but not in supranational bodies governed by international human rights law. Yamin and Gloppen, for instance, have exposed fascinating case studies on health litigation in Argentina, Brazil, Colombia, Costa Rica, India, and South Africa in *Litigating Health Rights: Can Courts bring More Justice to Health?*¹³³ However, none accounts for the adjudication or monitoring of the right to health in supranational procedures.

Finally, authors such as Wolff or Ruger, who defend the philosophical premises of the right to health, do not study the practical relevance of its content in litigation, as the nature of their projects does not allow it.¹³⁴ As a result, few researchers have attempted to explore how the normative content of the right to health should be interpreted in the light of international human rights law and in a manner fitted to practical considerations. It is nonetheless fundamental that such ‘legal content’ be clarified, in order to facilitate the development, monitoring, and enforcement of adequate standards at the international level.

1.2.2.2 Few attempts to clarify the content of the right to health

Prior to undertaking such task, one must be aware that the right to health is often criticised for not relying on solid conceptual foundations and that paradoxically, this has led academics to develop a multiplicity of justifications in response, increasing the likelihood for different interpretations to be developed as a result. Wolff rightly describes the situation as the following:

¹³² Andrew Clapham and Mary Robinson (eds), *Realizing the Right to Health* (Rüffer & Rub 2009).

¹³³ Alicia Ely Yamin and Siri Gloppen, *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Harvard University Press 2011).

¹³⁴ E.g. Jonathan Wolff, *The Human Right to Health* (W W Norton & Co 2013); Ruger 2006 (n 13).

Our problem is not that there are no foundations for human rights, but that there are too many.¹³⁵

It is true, as argued by Beitz, that human rights values – such as those embodied within the right to health – can be endorsed without us having to agree on the origins of their foundations.¹³⁶ Without such ‘agreement to disagree’, human rights law and more particularly here, the right to health, would never be able to possess any substantive content, or be capable of meaningful enforcement.¹³⁷ However, it is unclear how the right to health should be interpreted when theories that agree on its existence clash with one another;¹³⁸ or how its interpretation should respond to conflicts between minimalist and maximalist theories of rights.¹³⁹ Such lack of consensus highlights the need for the right to health to fit in a theoretical framework that is clear, convincing, and coherent with human rights law, in order to promote the effective enjoyment of the highest standard of health attainable by all individuals.

Two scholars in particular have attempted to clarify the legal content of the right to health in international human rights law, by drawing comprehensive theoretical frameworks. This work was undertaken by Toebe, in *The Right to Health as a Human Right in International Law*;¹⁴⁰ and by Tobin, in *The Right to Health in International Law*.¹⁴¹ Toebe’s research, while highly informative, is restricted to describing how the right to health is understood in the UN system and does not include recent and crucial developments, since it was published in 1999. Her findings

¹³⁵ Wolff (n 134) 19–20.

¹³⁶ Beitz (n 36).

¹³⁷ Cass R Sunstein, ‘Incompletely Theorized Agreements’ (1995) 108 Harvard Law Review 1733.

¹³⁸ E.g. William T Blackstone, ‘On Health Care as a Legal Right: An Exploration of Legal and Moral Grounds’ (1975) 10 Georgia Law Review 391; Alan Soble, ‘Philosophical Justifications, Political Activity, and Adequate Health Care’ (1976) 11 Georgia Law Review 525.

¹³⁹ E.g. Buchanan (n 24); Katharine G Young, ‘The Minimum Core of Economic and Social Rights: A Concept in Search of Content’ (2008) 33 The Yale Journal of International Law 113.

¹⁴⁰ Toebe 1999a (n 1).

¹⁴¹ Tobin (n 19).

thus need to be updated and compared with other frameworks, to produce a more comprehensive analysis of what the right to health entails at the supranational level.

In his more recent book, Tobin uses the comments of the UN Committee on Economic, Social and Cultural Rights as well as the UN Committee on the Rights of the Child, to shed light on the legal content of the right to health. Nevertheless, he argues that the right to health is bound to be indeterminate and to thus bear an: *‘accepted meaning [...] at a particular point in time [...] which attracts and achieves dominance over all other alternative understandings within the interpretative community’*.¹⁴² He, therefore, suggests that the right to health be defined in a way aimed at convincing the ‘interpretative community’, which he understands as the actors involved in its realisation. Such approach represents an invaluable contribution to the ESCR literature, for that it attempts to draw principled and realistic human rights standards. However, it is also problematic for moral, practical and legal reasons, which I have discussed in detail in an earlier publication.¹⁴³ Firstly (the moral argument), human rights law cannot always be built upon consensus among key actors: what if the consensus points at a solution incompatible with right to health standards? Secondly (the practical argument), in the event key actors in the realisation of the right to health cannot reach a consensus, who should have the last word? Thirdly (the legal argument), what legal certainty can be offered with such evolutionary interpretative process? Although Tobin’s framework outlines how the legal content of the right to health should be construed, it leaves important questions unanswered and, thus, is not entirely fit for monitoring procedures, as these require further legal certainty.

As a result, another theoretical framework, expanding on Toebe’s and Tobin’s findings, should be developed to clarify what the normative content of the right to health entails in light of practical considerations. Nevertheless, such an enterprise has never been carried out in depth, and the legal content of the right to health remains unclear.

¹⁴² *ibid* 80.

¹⁴³ Lougarre (n 30).

1.2.2.3 The underexplored role of SNHRBs in clarifying content

Such lack of conceptual clarity, whether found in human rights law, or reflected and perpetuated by legal scholarship, affects key actors in the realisation of this right and can thus hinder its implementation. How can states contribute towards realising the right to health if they do not know what it means? Therefore, and as outlined in the introduction of this thesis, the role of (quasi-judicial) SNHRBs is undeniably crucial as they can contribute to clarifying its content. Since SNHRBs are mandated to supervise the implementation of the right to health at the international and regional levels, their interpretation of what this right entails has a high degree of authority in human rights law, and has the potential to assist states in realising it. Furthermore, SNHRBs effectively delineate the content of the right to health in the course of their quasi-judicial monitoring procedures, when deciding whether or not it has been respected, and justifying why.

Numerous scholars have studied the role and importance of human rights bodies in supranational monitoring.¹⁴⁴ Nevertheless, few authors have explored how SNHRBs contribute to clarifying the legal content of the right to health in the course of their quasi-judicial monitoring procedures, or how their interpretation can be optimised for that purpose. Tobin, who has developed the most up-to-date and comprehensive theoretical framework to clarify the right to health,¹⁴⁵ uses findings from SNHRBs but only on an ad hoc basis, to exemplify or assert arguments already developed. This is not surprising given that his framework aims at building content through constructive engagement with the interpretative community, in order for such content to be convincing. Therefore, any actor with an interest in the realisation of the right to health becomes a subject of research, as a member of the interpretative community (e.g. health professionals, NGOs, multinational corporations, etc.).¹⁴⁶ Furthermore, Tobin considers that SNHRBs have not developed a clear methodology to interpret the right to health and that they subsequently tend to produce a results-driven

¹⁴⁴ For instance in the UN: Philip Alston and James Crawford, *The Future of UN Human Rights Treaty Monitoring* (Cambridge University Press 2000); Helen Keller and Geir Ulfstein (eds), *UN Human Rights Treaty Bodies: Law and Legitimacy* (Cambridge University Press 2015).

¹⁴⁵ Tobin (n 19).

¹⁴⁶ *ibid* 81–85.

jurisprudence. He argues that their case law may thus persuade those who approach the law similarly, but not those who wish to know what the law should be.¹⁴⁷ As a result, of the few scholars who have analysed SNHRBs' interpretation of the right to health, none have carried out a systemic and comprehensive analysis that can be used as a starting point for study and recommendations.¹⁴⁸ This thesis, therefore, will explore the legal content of the right to health in the light of and for the purposes of supranational monitoring.

1.2.2.4 Conclusion: the gap in the literature

To conclude, the literature on the right to health highlights four features. First, the right to health is often integrated and dissolved in discussions on health and human rights law, i.e. application of a human right-based approach to health issues. Second, attempts to understand what the right to health means often focus either on its adjudication or on its normative content, but rarely merge both aspects through one framework. Third, the rare projects endeavouring to clarify the content of this right are either out-dated or do not provide a framework that guarantees sufficient legal certainty, which is necessary in adjudicatory or monitoring procedures. Fourth, no research has thoroughly studied how SNHRBs can contribute towards clarifying what the right to health entails, or how to optimise their interpretation.

Therefore, existing research has not adequately addressed criticisms raised against the complexity, vagueness and costs of the right to health, leading to scepticism on its implementation. Such a situation leaves key actors unaware of how to interpret the legal content of this right, which contributes to poor realisation. As a result, it is clear that SNHRBs must contribute to remedying the excessive vagueness surrounding the legal content of the right to health by giving it more teeth, while keeping a certain degree of flexibility to adequately monitor unique situations. This thesis will thus assess how SNHRBs contribute to clarifying the legal content of the right to health in the course of their quasi-judicial monitoring procedures (in Part I), and how their interpretation can be optimised for that purpose (in Part II).

¹⁴⁷ *ibid* 76.

¹⁴⁸ E.g. Schmid (n 20). However, her analysis is limited to situations of conflicts.

Conclusion

Chapter 1 contextualised the recognition of the right to health in international human rights law and highlighted the vagueness surrounding its legal content, in order for subsequent chapters to develop an informed analysis of how it is and should be interpreted. Firstly, Section 1.1 discussed the context in which the right to health came to life. It demonstrated states' timeless involvement in public health matters and the slow shift from utilitarian motives to legal duties, before the WHO Constitution officially recognised this right in 1946. It then discussed the legal recognition of the right to health in international human rights law ever since: its worldwide recognition in human rights instruments, the existence of monitoring procedures supervising its implementation, and its relevance today. Secondly, Section 1.2 pointed at the need for greater clarity on what this right entails. While acknowledging the need for some flexibility in the interpretative process, it outlined the excessive vagueness of the right to health in human rights law and the negative impact this had on its realisation. It then highlighted the lack of research clarifying the normative content of this right in light of practical considerations such as monitoring or adjudicatory procedures; and SNHRBs' (underexplored) potential in doing so.

After having contextualised the right to health in international human rights law and pointed at the vagueness surrounding its meaning, Part I will analyse in greater details whether SNHRBs contribute to clarifying its legal content, and how. For this purpose, I will study how (collegial) SNHRBs interpret this right in the course of their quasi-judicial monitoring procedures. Chapters 2 and 3 will thus examine how the UN Committee on Economic, Social and Cultural Rights and the European Committee of Social Rights have interpreted the right to health, since their interpretations are respectively the most authoritative and precise of all SNHRBs. The findings derived from this critical analysis will enable me to develop, in Part II, a theoretical account bringing further conceptual clarity to optimise SNHRBs' interpretation. Therefore, Chapter 4 will focus on the normative scope of the right to health, and Chapter 5 will focus on states' obligations. Finally, Chapter 6 will discuss

whether international and regional interpretations are compatible and how they can coexist coherently.

Chapter 2 The interpretation of Article 12 ICESCR by the UN Committee on Economic, Social and Cultural Rights: conceptual clarity, a long way to go

Introduction

As outlined by Chapter 1, the right to health sits on firm historical roots and is widely recognised in human rights law, but paradoxically, its legal content remains excessively vague. Since Part I of this thesis aims at exploring how SNHRBs contribute to clarifying the legal content of the right to health in the course of their quasi-judicial monitoring procedures, it is logical to first seek clarification from its most authoritative interpretation. Therefore, Chapter 2 will examine how the UN Committee on Economic, Social and Cultural Rights (UN Committee) interprets Article 12 ICESCR,¹⁴⁹ the leading right to health provision at the international level. Certain questions arise as a result. How does the UN Committee interpret the right to health when monitoring its implementation worldwide? Has it developed an insightful framework dealing adequately with the diversity of states parties' cultures and resources? What can we learn from it, based on the principles of interpretation this thesis advocates?

First recognised by the WHO Constitution in 1946 and two years later by the UDHR,¹⁵⁰ the right to health is now enshrined in most UN core human rights instruments, including the ICESCR, adopted in 1966. Its sixty years of legal existence, worldwide acceptance and decades of monitoring would lead lawyers to believe that this right now benefits from a clear normative scope and imposes precise obligations upon states. However, Chapter 2 highlights that the contribution of the UN Committee towards clarifying the right to health is limited. Although it drafted the highly influential GC14 in 2000,¹⁵¹ the UN Committee has since failed to delineate clearly what this right means through its monitoring procedures.

¹⁴⁹ ICESCR (n 4), Art 12.

¹⁵⁰ WHO Constitution (n 2), Preamble; UDHR (n 3), Art 25.

¹⁵¹ UNCESCR, 'GC14' (n 21).

There is significant research highlighting the pitfalls of the ICESCR and the challenges faced by the UN Committee when supervising its application. Over the last thirty years, authors such as Alston, Craven, Sepúlveda or Quinn have thoroughly discussed these issues.¹⁵² However, few researchers have attempted to evaluate the contributions of the UN Committee in clarifying the legal content of a right enshrined in the ICESCR, by methodically reviewing its monitoring procedures. In particular, no author has so far carried out an in-depth analysis of what such contributions might be regarding Article 12 ICESCR. For instance, Toebe and Tobin, who wrote influential books on the right to health in the UN, conducted a more ad hoc analysis in this concern.¹⁵³ It is thus essential that such research be conducted, to address both the excessive vagueness surrounding this right and the gap left by legal scholars on the potential of SNHRBs such as the UN Committee to clarify it. When evaluating whether or not states have implemented Article 12 ICESCR and when justifying why, the UN Committee effectively delineates its legal content. This Chapter will thus analyse the comments expressed by the UN Committee when evaluating the implementation of Article 12 ICESCR in its reporting procedure.¹⁵⁴ This research will involve a systemic analysis of the sixty Concluding Observations drafted between 2008 and 2012, and an ad hoc analysis of more recent Concluding Observations.

Chapter 2 is structured as follows. First (2.1), Chapter 2 will present Article 12 ICESCR, the monitoring procedures specific to this provision, and the methodology used for this research. Second (2.2), it will demonstrate that the UN Committee has not sufficiently clarified the normative scope of the right to health, as it failed to develop precise universal standards defining the ‘highest standard of health attainable’. Third (2.3), Chapter 2 will highlight that the UN Committee has not clarified states’ obligations to implement this right either, as it does not seem to use

¹⁵² Phillip Alston, ‘Out of the Abyss: The Challenges Confronting the New U.N. Committee on Economic, Social and Cultural Rights’ (1987) 9 Human Rights Quarterly 332; Matthew CR Craven, *The International Covenant on Economic, Social and Cultural Rights: A Perspective on Its Development* (Clarendon Press 1995); Magdalena Sepúlveda, *The Nature of the Obligations under the International Covenant on Economic, Social, and Cultural Rights* (Intersentia 2003).

¹⁵³ Toebe 1999a (n 1); Tobin (n 19).

¹⁵⁴ ICESCR (n 4), Art 12.

any tangible framework in its monitoring procedures. Finally (2.4), I will discuss the impact of such an absence of methodology on the legal content of the right to health, through a critical overview of the UN Committee's interpretation. While normative scope and states' obligations are issues inherently intertwined, distinguishing them is a useful way to break down complexity, often applied in legal scholarship.

2.1 The right to health in the International Covenant on Economic, Social, and Cultural Rights

In order to discuss how the UN Committee interprets the right to health and whether this clarifies its content, it is necessary to introduce Article 12 ICESCR (2.1.1), the procedures that can be used to monitor it (2.1.2), and to outline the methodology of my analysis (2.1.3).

2.1.1 The provision: Article 12 ICESCR (and General Comment 14)

Several provisions in the ICESCR deal with health. Articles 7(b) and 10(b) respectively recognise adults' right to work in healthy conditions; and children' right to protection from labour harmful to their health. Article 12, however, recognises the right to health as enshrined in the WHO Constitution 1946.¹⁵⁵ This Chapter will focus on this provision as it is the most detailed provision on health and has received the most attention in this respect. Article 12 ICESCR reads:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
 - a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;

¹⁵⁵ WHO Constitution (n 2), Preamble.

- b) The improvement of all aspects of environmental and industrial hygiene;
- c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
- d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.¹⁵⁶

What makes the study of Article 12 ICESCR worthwhile is not only the inspiration it draws from the WHO Constitution, but also the legal force and scope of the Covenant itself. Since the UN opened the ICESCR for signature in 1966, more than 160 states have ratified it.¹⁵⁷ The binding nature of this Covenant and its worldwide ratification by states from every global region highlight its importance in human rights law with regard to ESCR, including the right to health.

Furthermore, Article 12 ICESCR is subject to a General Comment drafted by the UN Committee in 2000: GC14.¹⁵⁸ In GC14, the UN Committee outlines what the right to health entails by building upon experience gained through its reporting procedure, in order to assist states parties in fulfilling their obligations.¹⁵⁹ These ‘guidelines’ explore the normative content, states’ obligations, violations, domestic implementation, and non-state actors relevant to Article 12 ICESCR. Although GC14 is not legally binding, it encapsulates the authoritative interpretation of the UN Committee on the right to health. Therefore, this document has not only considerably contributed to clarifying the right to health amongst the human rights community, it has also been used in litigation by other SNHRBs and by national judges.

¹⁵⁶ ICESCR (n 4), Art 12.

¹⁵⁷ *ibid*; UN Treaty Collection, ‘Status of the International Covenant on Economic, Social and Cultural Rights’ <https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en> [accessed 8 September 2015].

¹⁵⁸ UNCESCR, ‘GC14’ (n 21), para 14.

¹⁵⁹ ECOSOC, ‘Report on the Forty-Fourth and Forty-Fifth Sessions of the Committee on Economic, Social and Cultural Rights’ (2010) UN Doc. E/2011/22 E/C.12/2010/3, paras 55 to 58.

However, GC14 partially fails to respond to the demands of clarity expressed in this thesis, and this for two reasons. Firstly, it causes confusion by setting an excessive number of theoretical frameworks in which the right to health should be understood. Numerous frameworks are used to define the normative scope of the right to health, including: AAAQ requirements (i.e. availability, accessibility, acceptability and quality of healthcare); Article 12(2) requirements; and non-discrimination requirements. Numerous frameworks are also used to define states' obligations, including: progressive realisation requirements; minimum core obligations; as well as the tripartite typology (i.e. obligations to respect, protect and fulfil). It is however unclear how these should interact with each other; or which one should be applied and why. Secondly, GC14 can also be criticised for failing to explain what the normative scope of the right to health or states' obligations to realise it, mean in practice (and more specifically, in the monitoring procedures of the UN Committee). What entitlements derive from the 'highest standard of health attainable', and what does the 'obligation to progressively realise the right to health' entail? It is worth noting that GC14 is inherently limited by the need to be '*reader- friendly, of reasonable length and readily understandable to a broad range of readers, primarily States parties to the Covenant*'.¹⁶⁰ Nevertheless, these shortcomings should be addressed.

2.1.2 The monitoring procedures

Similarly to systems in place for other UN human rights treaties, a supervisory body monitors the implementation of the rights enshrined in the ICESCR. It is the UN Committee, who oversees the realisation of the right to health through various monitoring procedures.

Firstly, it assesses states' compliance with Article 12 by drafting Concluding Observations on periodic states reports. Articles 16 and 17 of the Covenant oblige states parties to report on the observance of the rights enshrined in the ICESCR, including the right to health.¹⁶¹ Furthermore, the Rules of Procedure of the

¹⁶⁰ *ibid* 58.

¹⁶¹ ICESCR (n 4), Art 16 and 17.

Committee specify that these reports must be submitted before the UN Committee every five years and that in return, it will provide states with suggestions and recommendations.¹⁶² Such comments are called ‘Concluding Observations’. Consensuses point to the recommendatory nature of Concluding Observations, highlighting their interpretative role with regard to the ICESCR. However, it can also be legitimately argued that these documents are legally binding, since they are based on Articles 16 and 17 the ICESCR, which have a binding status upon states.¹⁶³ While the reporting procedure of the UN Committee has often been criticised for being too weak,¹⁶⁴ it remains informative of what the right to health means in practice and is worth examining.

Secondly, the Optional Protocol to the ICESCR establishes three other monitoring procedures through which the UN Committee can assess states’ conformity to Article 12.¹⁶⁵ The individual communications procedure is initiated by an individual alleging that her right to health has been violated.¹⁶⁶ The inquiry procedure is initiated by the UN Committee, when receiving allegations of serious, grave or systematic violations of the right to health by reliable sources.¹⁶⁷ Finally, the inter-state communications procedure is initiated by a state alleging that another state fails to fulfil its obligations with regard to the right to health.¹⁶⁸ However, the Optional Protocol to the ICESCR

¹⁶² UNCESCR, ‘Rules of Procedure 1993’ (n 98), see section XV ‘Reports from States Parties Under Articles 16 and 17 of the Covenant’.

¹⁶³ University of Bristol and Arts and Humanities Research Council, ‘Implementation of UN Treaty Body Concluding Observations: The Role of National and Regional Mechanisms in Europe Summary and Recommendations from the High Level Seminar Held on 19 - 20 September 2011’, pp. 1–2 <http://www2.ohchr.org/english/bodies/HRTD/docs/Summary_Proceedings_Bristol_Sept2011_24.10.2011.pdf> [accessed 8 September 2015].

¹⁶⁴ Leckie ‘The Committee on Economic, Social and Cultural Rights: Catalyst for change in a system needing reform’ in Alston and Crawford (n 144) 130–133: Leckie highlights that compliance with reporting obligations and recommendations issued in Concluding Observations rely on the ‘good faith’ of states parties. He also criticises the lack of independence of Committee members (sometimes represented by states’ former officials such as foreign ministers or ambassadors); the deferent approach to states’ sovereignty that constructive dialogue often leads to; and the insufficiency of resources.

¹⁶⁵ OP to ICESCR (n 101); UNCESCR, ‘Rules of Procedure OP-ICESCR 2013’ (n 98).

¹⁶⁶ OP to ICESCR (n 101), Art 1 to 9.

¹⁶⁷ *ibid*, Art 11 to 13.

¹⁶⁸ *ibid*, Art 10.

entered into force in May 2013 and no decision has been reached yet under these three procedures.¹⁶⁹

It is worth noting that other institutions in the UN can monitor the realisation of the right to health, most notably the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (UN Special Rapporteur on the right to health). The Special Rapporteur, whose mandate was created in 2002 (and extended in 2007),¹⁷⁰ carries out various activities relevant to the interpretation of Article 12 ICESCR. She/he can: gather, request, receive and exchange information from all relevant sources; develop a dialogue with all relevant actors; report on the realisation of the right to health; make recommendations for improvement; and submit an annual report on her/his activities.¹⁷¹ Furthermore, this mandate has been interpreted as enabling the Special Rapporteur to conduct country visits, release various reports or statements, and most interestingly for this thesis, receive individual complaints alleging a violation of the right to health. However, my research focuses on the interpretation that SNHRBs develop in the course of quasi-judicial monitoring procedures (understood as collegial human rights bodies, which competence to reach a decision on the compliance of the right to health is established in legally binding treaties). Therefore, whilst the procedures used by the Special Rapporteur are essential to the realisation of the right to health, they will not be examined in this research, nor their contributions to legal scholarship (at the exception of few reports).

2.1.3 Methodology of my analysis

As the purpose of this thesis is to explore how SNHRBs can and should contribute to clarifying what the right to health means, studying how the UN Committee interprets

¹⁶⁹ UN Treaty Collection, 'Status of OP to ICESCR' (n 101).

¹⁷⁰ Commission on Human Rights, 'The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (mandate of the Special Rapporteur)' (2002) UN Doc. E/CN./RES/2002/31; Human Rights Council, 'The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (mandate of the Special Rapporteur)' (2007) UN Doc. HRC/RES/2007/6/29.

¹⁷¹ Commission on Human Rights, 'Resolution 2002/31' (n 170), para 5; Human Rights Council (n 170), para 1.

this right through its monitoring procedures is crucial. By evaluating whether Article 12 ICESCR is realised or not when monitoring its implementation, the UN Committee effectively defines the legal content of the right to health. However, the procedures established by the Optional Protocol have not led to any finding yet. As a result, this chapter will focus on the Concluding Observations of the UN Committee, drafted during its reporting procedure on Article 12 ICESCR.

Considering this procedure has existed since the ICESCR entered into force in 1976, it has generated a large volume of comments on Article 12. In fact, these are so numerous that I chose to use a sample of sixty Concluding Observations (those drafted from 2008 to 2012), to draw a systemic analysis of the interpretation of the right to health by the UN Committee.¹⁷² It is worth noting that this sample corresponds to comments expressed on 23 European states, 14 African, 11 American, 8 Asian, 3 Middle Eastern, and 2 Oceanian states. My analysis will also include more recent Concluding Observations but on a more ad hoc basis, since no major development has occurred in the manner the UN Committee interprets Article 12, since 2012.

Furthermore, I conducted interviews with four members of the UN Committee from 26 to 28 May 2014 in Geneva, to verify or reject hypotheses raised after analysing this sample. These questions were asked at the 53rd Pre-Sessional Working Group (during breaks), and were thus inherently limited to five members of the UN Committee, although one member was not available for interview. The reasons for choosing to interview the Pre-Sessional Working Group were both practical and strategic. Timing and funding only enabled me to be in Geneva by the end of the 52nd session and very few members were available then, due to heavy workloads and strict timetables. I thus chose to interview members of the Pre-Sessional Working Group instead. Being under less pressure, due to reduced workloads and fewer members present (i.e. 5 instead of 18), interviewees were more likely to give time and depth to their answers. Since my goal was to analyse qualitative data verifying or rejecting hypotheses made when studying these Concluding Observations, such

¹⁷² Except UNCESCR, 'Concluding Observations on Congo Made in the Absence of an Initial Report' (2012) UN Doc E/C12/COG/CO/1. The latter was drafted in 2013 (although part of the 2012 reporting cycle).

characteristics were more essential than a high number of interviewees. To meet this goal, the interviews I conducted were semi-structured, open-ended, in person, and anonymous.

Two observations can be drawn from the analysis of those sixty Concluding Observations and the Geneva interviews. First, the UN Committee has not clarified successfully what the right to health means in its reporting procedure. When it reviews the implementation of Article 12 ICESCR, the UN Committee does not use clear indicators or legal standards. Instead, it seems to use the information provided by states and by NGOs reports, to highlight the health issues that arise from their reading. Second, when the UN Committee reviews states' realisation of the right to health in its Concluding Observations, it does not reach any findings of conformity or non-conformity to Article 12. Instead, it expresses its concern or satisfaction on how the State party has implemented the right to health. This lack of methodology in the reporting procedure restricts my analysis of the UN Committee's interpretation of Article 12, to what repeatedly represents a source of concern or satisfaction. This also means that very few obligations are explicit (as it is case in the jurisprudence of the European Committee for instance), most of them being 'implied' instead. The analysis of this sample led me to the conclusions developed in the next three subsections, confirmed by my interviews with four members of the UN Committee.

2.2 The normative scope of the right to health: unclear standards

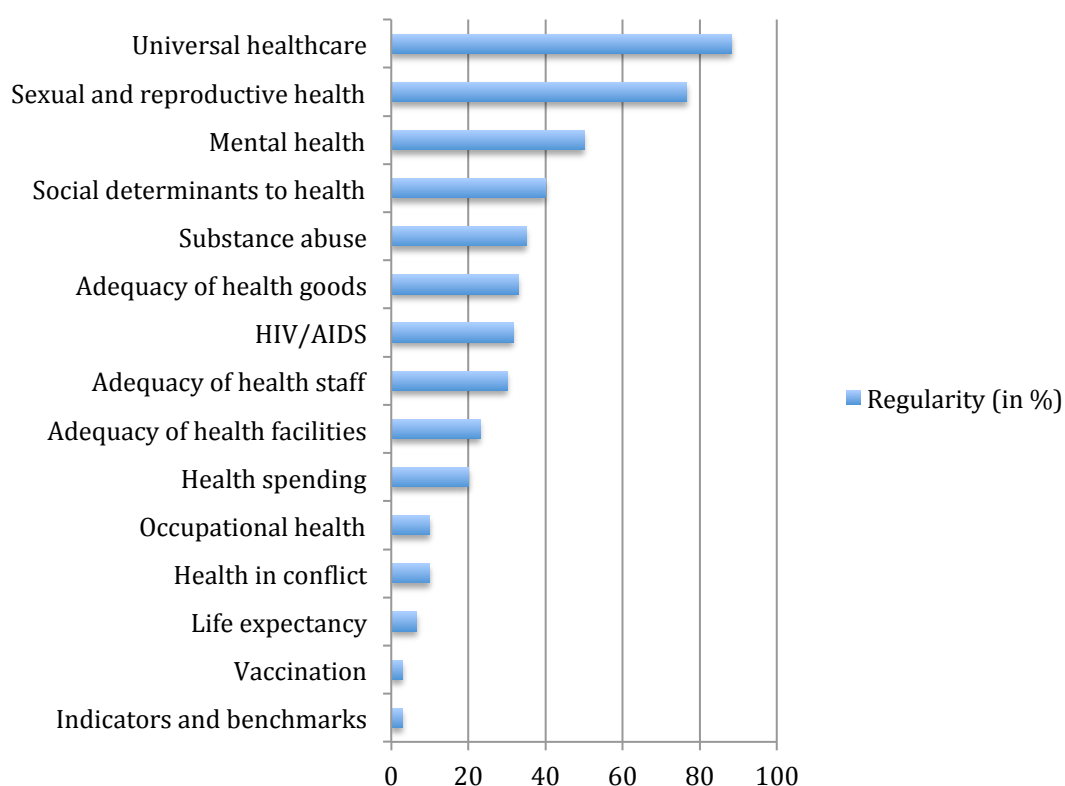
In order to assess how the UN Committee interprets the right to health and whether it clarifies its legal content in its monitoring procedures, I will first focus on how it regards the normative scope of this right. The UN Committee does not use clear indicators or legal standards in its reporting procedure, and does not reach findings of non-conformity. Therefore, it is difficult to define with certainty what standards it expects states to achieve. In this subsection, I explore how the UN Committee interprets what the 'highest standard of health attainable' entails, by analysing systemically the sixty Concluding Observations drafted from 2008 to 2012, focusing on Article 12 ICESCR. I will first (2.2.1) focus on health issues that repeatedly

represent a source of concern in the reporting procedure, and argue how these implicitly point at unmet standards. However, no obvious (or legitimate) reason explains why certain health issues are mentioned more often than others. Following this (2.2.2), I will argue that the AAAQ framework set by GC14 could clarify the standards states must achieve to realise the highest standard of health attainable in the reporting procedure. Unfortunately, the UN Committee rarely refers to this framework and inherent problems arise with its application. To conclude, the Concluding Observations of the UN Committee do not assist in clarifying the normative scope of Article 12 ICESCR.

2.2.1 Topics reviewed by the UN Committee

Analysing systemically the 2008-2012 Concluding Observations drafted by the UN Committee has enabled me to identify which health issues it tends to review and how often. This is outlined in Figure 2 below.

Figure 2 Health issues raised in the reporting procedure



The UN Committee does not explicitly use any thematic indicators prompting its Concluding Observations to systematically address the same health topics. Therefore, it is difficult to delineate the legal content of the highest standard of health attainable by studying how it is interpreted in the reporting procedure. However, the UN Committee clearly emphasises certain health issues more than others, e.g. universal healthcare, sexual and reproductive health (SRH), and mental health. Those issues, surprisingly, do not explicitly correspond to the themes listed in Article 12(2): infant mortality; environmental and industrial hygiene, prevention, treatment and control of diseases; and medical assistance.¹⁷³ Since the reasons behind such ‘prioritisation’ are entirely unknown, three hypotheses can be reasonably formulated, and will be developed in subsections 2.2.1.1, 2.2.1.2, and 2.2.1.3.

2.2.1.1 Frequent failures to realise Article 12?

The first hypothesis as to why the UN Committee reviews certain topics more than others in its Conclusions on Article 12 ICESCR, presumes that the themes often raised reflect the most common failures to realise the right to health amongst States parties. While an in-depth analysis of the sixty states at stake cannot be realistically carried out in this chapter, several examples suffice to discredit this hypothesis. The data of the WHO and the World Bank clearly stress that life expectancy and health expenditure, which are rarely mentioned by the UN Committee, are often inadequate among the states examined.¹⁷⁴ For instance, the life expectancy in Tanzania amounts to 59 years old and is among the 40 lowest in the world.¹⁷⁵ This issue, nonetheless, did not appear in the Concluding Observations of the UN Committee.¹⁷⁶ The same can be said for the (low) health expenditure in Peru, which fell from 5.7% in 2008, to

¹⁷³ ICESCR (n 4), Art 12(2).

¹⁷⁴ WHO, ‘Interactive Chart on the Life Expectancy at Birth: Both Sexes’ <http://gamapserver.who.int/gho/interactive_charts/mbd/life_expectancy/atlas.html> [accessed 8 September 2015]; World Bank, ‘Health Expenditure, Total (% of GDP) 2010-2014’ <<http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS>> [accessed 8 September 2015].

¹⁷⁵ WHO, ‘Interactive Chart on Life Expectancy’ (n 174).

¹⁷⁶ UNCESCR, ‘Concluding Observations on the United Republic of Tanzania’s Initial to Third Periodic Reports’ (2012) UN Doc E/C12/TZA/CO/1-3.

4.8% in 2011,¹⁷⁷ but was ignored in the comments of the UN Committee.¹⁷⁸ Therefore, the topics that are most often reviewed by the UN Committee under Article 12 do not automatically reflect the most common failures to realise the right to health amongst States parties.

2.2.1.2 Urgent issues within the country under review?

The second hypothesis as to why the UN Committee reviews certain topics more than others in its Conclusions on Article 12 ICESCR, supposes that the topics often raised coincidentally correspond to issues categorised as urgent by states or NGOs. Such urgency could potentially emerge from the reading of states' or NGOs' reports; or from oral discussions between the UN Committee, states, and NGOs (known as 'constructive engagement'). This could explain why, for instance, life expectancy is rarely mentioned. It cannot be improved on a short period of time and thus does not bear the same 'compelling' aspect as the necessity to provide primary healthcare or SRH services to vulnerable populations. This chapter cannot carry out an in-depth analysis of the sixty states studied in the 2008-2012 sample. However, the analysis of various exchanges between the UN Committee, states' representatives and NGOs, suffice to discredit this hypothesis. This will be argued through the examples of Tanzania, Yemen and Sri Lanka, states with different incomes and from different regions.¹⁷⁹

In the case of the 2012 review of Tanzania, the UN Committee highlights urgent issues previously mentioned in reports drafted by the state (e.g. maternal and infant mortality, access to medical facilities),¹⁸⁰ or by NGOs (e.g. SRH).¹⁸¹ However, it

¹⁷⁷ World Bank, 'Health Expenditure' (n 174).

¹⁷⁸ UNCESCR, 'Concluding Observations on Peru's Combined Second to Fourth Periodic Reports' (2012) UN Doc E/C12/PER/CO/2-4.

¹⁷⁹ Michael O'Flaherty, 'The Concluding Observations of United Nations Human Rights Treaty Bodies' (2006) 6 Human Rights Law Review 27, 38–41. O'Flaherty concludes that a '*highly inconsistent pattern of correlation can be detected*' when comparing the topics mentioned in the List of Issues and the Concluding Observations of various UN treaty bodies, including the UN Committee.

¹⁸⁰ United Republic of Tanzania, 'Combined Initial, Second and Third Periodic Reports on Implementation of the ICESCR' (2011) UN Doc E/C12/TZA/CO/1-3, paras 113, 114, 121 and 131.

ignores issues such as malaria or tuberculosis, representing yet important health crises which the government itself acknowledges.¹⁸² Such omission may be due to the state's efforts to remedy this situation, but no declaration explicitly supports this assertion. When reviewing Yemen in 2011, the UN Committee raised three issues under Article 12, partly reflecting what the state and NGOs stressed in their reports (i.e. limited access to healthcare, high maternal and infant mortality;¹⁸³ Al-Akhdam people's health).¹⁸⁴ However, its Concluding Observations fail to mention crucial issues repeatedly raised by both sides, such as Yemen's inability to match its healthcare budget with population growth.¹⁸⁵ Once again, such omission is not justified in the procedure. Finally, the example of Sri Lanka highlights similar issues. The Concluding Observations of the UN Committee fail to comment on the shortage of medical staff plaguing almost every hospital, yet repeatedly reported by NGOs.¹⁸⁶ Again, no explicit reason explains why this issue was ignored. Instead, the UN Committee mentions problems such as the adverse effects of civil war on

¹⁸¹ Center for reproductive rights, 'Supplementary Information on the United Republic of Tanzania' (2011), available on the 49th session of the UNCESCR (12 Nov 2012 - 30 Nov 2012)

<http://tbinternet.ohchr.org/_layouts/treatybodyexternal/SessionDetails1.aspx?SessionID=441&Lang=en> [accessed 8 September 2015].

¹⁸² United Republic of Tanzania (n 180), paras 115, 118, 124, and 126: the Tanzanian government deplored the number of deaths caused by HIV/AIDS and declared that Malaria was the '*number one killer*' in its report. It also admitted that tuberculosis was '*on the rise*'.

¹⁸³ Yemen, 'Second Periodic Report on Implementation of the ICESCR' (2009) UN Doc E/C12/YEM/2, para 153.

¹⁸⁴ The All Youth Network for Society Development in association with the International Dalit Solidarity Network, 'Alternative Report on Human Rights of the Al-Akhdam in Yemen' (2011), available on the 46th session of the UNCESCR (2 May 2011 - 20 May 2011)

<http://tbinternet.ohchr.org/_layouts/treatybodyexternal/SessionDetails1.aspx?SessionID=447&Lang=en> [accessed 8 September 2015].

¹⁸⁵ Yemen report (n 183), para 156; National Organization for Defending Rights and Freedoms, 'Alternative Report to the CESCR on Yemen' (2011), 14, available on the 46th session of the UNCESCR (2 May 2011 - 20 May 2011) <http://tbinternet.ohchr.org/_layouts/treatybodyexternal/SessionDetails1.aspx?SessionID=447&Lang=en> [accessed 8 September 2015].

¹⁸⁶ Collective for Economic, Social and Cultural Rights in Sri Lanka, 'Civil Society Report on the Implementation of the ICESCR' (2010), paras 117, 124, 129, 130, available on the 45th Session of the UNCESCR (1 Nov 2010 - 19 Nov 2010) <http://tbinternet.ohchr.org/_layouts/treatybodyexternal/SessionDetails1.aspx?SessionID=449&Lang=en> [accessed 8 September 2015].

individuals' health or the general lack of SRH across the country.¹⁸⁷ Whilst such issues are crucial, it is unsure which sources the UN Committee used to formulate such comments.

To conclude, the topics often raised in the Concluding Observations of the UN Committee on Article 12 ICESCR do not particularly follow from the information submitted by states' and NGOs' reports. It is not desirable that the UN Committee fully relies on such documents as they can be inaccurate, vague or biased. For instance, Tanzania's report declared that its health spending amounted to 11% of its GDP in 2009, while the World Bank reported 5.6% that same year.¹⁸⁸ As for Sri Lanka's report, the government announced that health targets were met, without giving any figures; and it did not provide any negative information about its health system.¹⁸⁹ Such conflicts of interest can also arise for NGOs, such as whether religious NGOs working on health issues should be expected to report on the number of deaths due to clandestine abortions. The interviews conducted with members of the UN Committee in May 2014, stress their willingness to not rely entirely on such documents in order to remain impartial.¹⁹⁰ They are above all independent experts. However, when states' or NGOs' reports highlight health issues of crucial importance, it seems illogical that the UN Committee does not mention them in its Concluding Observations. Such omissions defy the purpose of the 'constructive engagement' the UN Committee wishes to establish with governments and civil society.

2.2.1.3 The existence of an agenda?

The third hypothesis that could explain the emphasis of the UN Committee on certain health topics over others, is the existence of an agenda prioritising efforts in specific areas. This agenda could be potentially set by the UN Committee or by

¹⁸⁷ UNCESCR, 'Concluding Observations on Sri Lanka's Combined Second to Fourth Periodic Reports' (2010) UN Doc E/C12/LKA/CO/2-4, paras 28–30 and 32–35.

¹⁸⁸ Tanzania report (n 180), para 10; World Bank, 'Health Expenditure' (n 174).

¹⁸⁹ Sri Lanka, 'Combined Second, Third and Fourth Periodic Reports on the Implementation of the ICESCR' (2010) UN Doc E/C12/LKA/2-4, paras 30, 31, 49, and 118.

¹⁹⁰ Interviews with four members of the UN Committee on Economic, Social and Cultural Rights, 26–28 May 2014, Geneva (see Appendix).

influential participants to the reporting procedure, such as UN specialised agencies and NGOs.

Firstly, no document drafted by the UN Committee explicitly supports the possibility of an agenda pushing for certain issues more than others. Its reporting guidelines highlight, on the contrary, that states must account for a wide range of issues when describing the implementation of Article 12. These include: universal access to primary healthcare; physical and economic access to health; appropriateness of drugs and medical personnel; and availability of SRH services. States must also report on: diseases caused by water contamination; immunisation and infectious diseases; substance abuse; HIV/AIDS; affordability of essential drugs; and mental healthcare.¹⁹¹

Secondly, since no agenda seems to have been set by the UN Committee, one may question what influence UN specialised agencies have on its reporting procedure. The Rules of Procedure of the UN Committee acknowledge the possibility for UN specialised agencies to submit reports together with States parties to the ICESCR.¹⁹² However, such reports cannot be found on the online archives of the United Nations. One of the Committee members I interviewed explained that the UN Committee was often in contact with the Office of the High Commissioner for Human Rights, but that their exchanges were confidential.¹⁹³ This Chapter will not study the position of each UN specialised agency on the right to health as a result. However, it can be observed that universal health coverage, the only issue that the UN Committee reviews almost systematically, is the focus of several WHO Annual Reports since 2008.¹⁹⁴ Moreover, SRH (the second issue most often raised by the UN Committee) is at the heart of two particularly influential documents. These are: the Millennium

¹⁹¹ UN Secretary-General, 'Compilation of Guidelines on the Form and Content of Reports to Be Submitted by States Parties to the International Human Rights Treaties' (2009) UN Doc. HRI/GEN/2/Rev.6, paras 55–57.

¹⁹² UNCESCR, 'Rules of Procedure 1993' (n 98), rule 64.

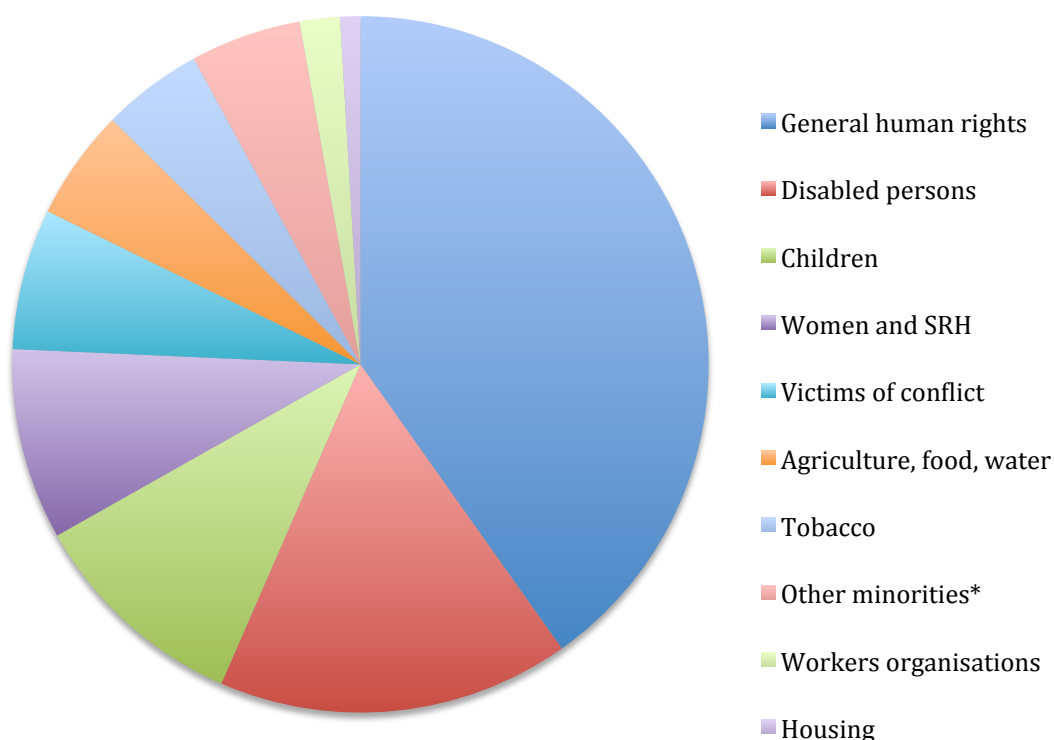
¹⁹³ Interviews UN Committee members (n 190).

¹⁹⁴ WHO, 'The World Health Report: Research for Universal Health Coverage (Annual Report)' (2013); WHO, 'The World Health Report: Health Systems Financing: The Path to Universal Coverage (Annual Report)' (2010).

Development Goals,¹⁹⁵ regularly mentioned by the UN Committee; and its recent General Discussions on the right to health.¹⁹⁶ Their influence, nevertheless, remain highly hypothetical.

Finally, it is necessary to examine whether the types of NGOs who submit shadow reports have an impact on the topics arising from the Concluding Observations regarding the right to health. Figure 3 below summarises the types of NGOs that have submitted shadow reports from 2008 to 2012 (very few reports from the year 2008 were available).

Figure 3 Types of NGOs shadow reports



* Older persons, Roma people, persons living with HIV, LGBT, indigenous people

¹⁹⁵ UNGA, 'Millennium Declaration' (n 108), para 19.

¹⁹⁶ UNCESCR, 'Day of General Discussion on the Right to Sexual and Reproductive Health (1)' (2010) UN Doc E/C.12/2010/SR.49; UNCESCR, 'Day of General Discussion on the Right to Sexual and Reproductive Health (2)' (2011) UN Doc E/C.12/2010/SR.50.

This pie chart, when read with Figure 2 ('Health issues raised in the reporting procedure'), shows that there is no clear correlation between the issues raised in shadow reports, and those raised in the Concluding Observations of the UN Committee. The issues that are most often reviewed by the UN Committee (SRH, mental health, HIV) do not reflect a particularly high number of shadow reports from relevant NGOs. Furthermore, the NGOs submitting the most shadow reports, namely those working on children's rights and persons with disabilities' rights, do not trigger a prevalence of comments on such issues in the Concluding Observations of the UN Committee on Article 12. Interestingly, these two themes are over-represented by two international NGOs reporting for almost every state: Global Initiative to End All Corporal Punishment of Children; and International Disability Alliance. The interviews carried out with UN Committee members highlighted that certain NGOs were particularly present in reporting procedures, partly due to having their headquarters in Geneva. However, neither the prevalence of certain NGOs nor their number in a specific field seem to detract the UN Committee members from their independent status, which they all reaffirmed when talking about shadow reports in interviews.¹⁹⁷ As a result, it cannot be said that the agenda of the UN Committee is particularly connected to the types of NGOs involved in the reporting procedure.

To conclude, there is no apparent reason as to why the UN Committee reviews certain health topics more often than others, in its Concluding Observations. It might be due to a combination of the three hypotheses developed above, and to the background expertise of the Committee's members, but this remains uncertain. More research needs to be done to understand the reasons motivating the review of the UN Committee in this concern. These findings also highlight the lack of transparency of the reporting procedure, and the lack of methodology of the UN Committee. Therefore, the UN Committee does not contribute successfully to clarifying what the highest standard of health attainable means, when monitoring Article 12 ICESCR through its reporting procedure.

¹⁹⁷ Interviews UN Committee members (n 190).

2.2.2 The AAAQ framework and the highest standard of health attainable

It is thus worth studying GC14, as it provides guidelines on the ‘normative content’ of the right to health, building upon the experience gained by the UN Committee in its reporting procedure.¹⁹⁸ In this document, the UN Committee recognises four requirements particularly crucial to achieving the highest standard of health attainable: availability, accessibility, acceptability and quality of healthcare (i.e. the AAAQ framework).¹⁹⁹ I will demonstrate in subsection 2.2.2.1 that the AAAQ framework could potentially enable the UN Committee to clarify the normative scope of the right to health. However, I will argue in subsection 2.2.2.2 that the potential of the AAAQ framework to assist the UN Committee to successfully do so is limited.

2.2.2.1 Potential to improve conceptual clarity

GC14 clarifies the normative scope of the right to health by materialising the highest standard of health attainable into four requirements. According to this document, health facilities, goods, services, personnel and information are elements that must be: available; accessible; acceptable; and of good quality.²⁰⁰ These four requirements, constituting the AAAQ framework, are then further divided into more detailed ‘sub-requirements’. Health facilities, goods, services and personnel must thus be:

- Functioning and available in sufficient quantity (availability);
- Physically and financially accessible to everyone, without discrimination (accessibility);
- Respectful of medical ethics, and culturally appropriate (acceptability);
- Scientifically or medically appropriate, and of good quality (quality).²⁰¹

¹⁹⁸ UNCESCR, ‘GC14’ (n 21), part I; ECOSOC, Report of 44th and 45th sessions UNCESCR (n 159), paras 55 to 58.

¹⁹⁹ UNCESCR, ‘GC14’ (n 21), para 12.

²⁰⁰ *ibid.*

²⁰¹ *ibid.*

In order to test the potential of the AAAQ framework to clarify what the highest standard of health attainable entails, I will use the example of childbirth care. In this instance, health facilities, goods, services, personnel, and information to which the AAAQ requirements apply, are the following. They include maternity wings, whether in public hospital or private clinics (*the facilities*); as well as obstetric equipment and medicines such as forceps, pain relieving drugs etc. (*the goods*). They also include procedures such as epidural anaesthesia or caesarean section (*the services*); obstetricians and midwives (*the personnel*); as well as medical advice provided in case of complications (*the information*). Furthermore, according to the AAAQ framework, all these elements must be functioning and in sufficient numbers, compared to the needs of the population (*availability*). They must also be spread adequately throughout the country in order to be geographically accessible to everyone, including to persons living in rural areas. Their costs must be affordable to everyone, including for persons living in poverty. Medical advice in case of obstetric complications must be given to all future parents (*accessibility*). Furthermore, obstetric care must respect medical ethics (e.g. physicians must obtain informed consent of the patient before administering epidural anaesthesia). It must also be culturally appropriate (e.g. possibility for the patient to choose the position during delivery if it does not involve any medical risks)²⁰² (*acceptability*). Finally, obstetric care must be scientifically and medically appropriate (e.g. evidence-based procedures with best outcome for the patient and the foetus, such as caesarean section when the foetus is in transverse position). It must also be of good quality (e.g. trained midwives) (*quality*).

At first glance, the AAAQ framework seems to successfully clarify what the highest standard of childbirth care attainable entails. It applies fundamental requirements of healthcare delivery to key elements of childbirth in a coherent, comprehensive and transparent manner. As a result, it represents an improvement from the erratic review operated by the UN Committee in its Concluding Observations on Article 12 ICESCR. It is also worth noting that the AAAQ framework is sometimes used by

²⁰² Sabine Gabrysch and others, 'Cultural Adaptation of Birthing Services in Rural Ayacucho, Peru' (2009) 87 Bulletin of the World Health Organization 724, 726.

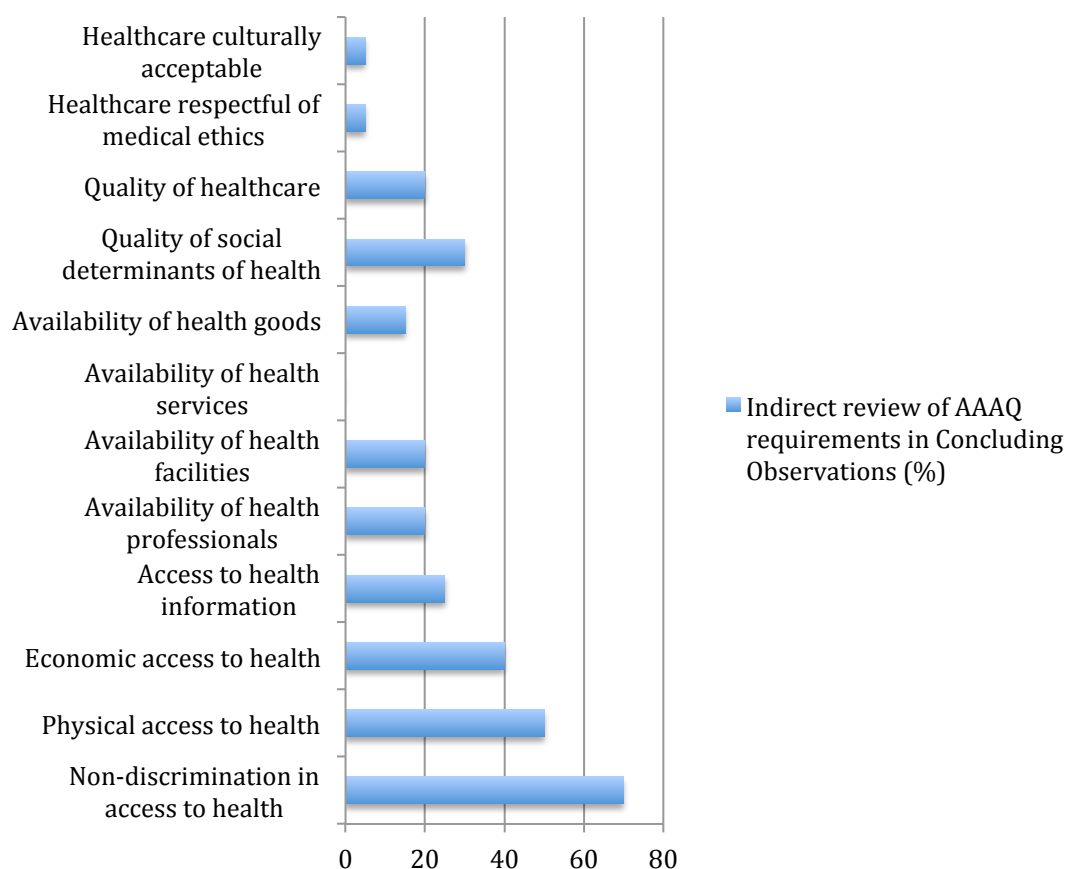
NGOs,²⁰³ and by academics,²⁰⁴ when seeking conceptual clarity in human right law. Finally, the UN Committee indirectly endorses the relevance of the AAAQ framework in its reporting procedure, by regularly expressing dissatisfaction regarding situations in which such requirements are unmet. For instance, concerns expressed against insufficient medical staff in geriatrics, indirectly relate to the requirement ‘availability’, and to the sub-requirement ‘availability of health professionals’.²⁰⁵ Such practice is reflected in Figure 4.

²⁰³ E.g. Physicians for Human Rights, ‘Tools & Resources: AAAQ Framework.’ <<http://phrtoolkits.org/toolkits/medical-professionalism/the-human-rights-basis-for-professionalism-in-health-care/aaaq-framework/>> [accessed 8 September 2015]; International Federation of Health and Human Rights Organisations, ‘Site Visits - Applying the AAAQ Framework in Health Institutions.’ <<http://www.ifhhro-training-manual.org/index.php?r=training/view&id=14&sid=7>> [accessed 8 September 2015]; Kenyan ESCR Coalition, International Network for Economic Social & Cultural Rights, ‘Challenging Poverty and Inequality through Human Rights’ (2008) at International Strategy Meeting on Economic, Social and Cultural Rights and ESCR-NET General Assembly <<http://www.escr-net.org/docs/i/836924>> [accessed 8 September 2015].

²⁰⁴ E.g. Judith V Welling, ‘International Indicators and Economic, Social, and Cultural Rights’ (2008) 30 Human Rights Quarterly 933, 951–952: Welling argues that ‘*The significance and value of the newly delineated norms [AAAQ framework] is clear, and should inform the creation of indicator sets linking closely with the Covenant [ICESCR]*’; Sital Kalantry, Jocelyn E Getgen and Steven Arrigg Koh, ‘Enhancing Enforcement of Economic, Social, and Cultural Rights Using Indicators: A Focus on the Right to Education in the ICESCR’ (2010) 32 Human Rights Quarterly 253, 273–279: the authors use this framework to suggest a set of indicators enabling the UN Committee to monitor the right to education (although for the right to education, the element ‘quality’ has become ‘adaptability’).

²⁰⁵ E.g. see concerns expressed in: UNCESCR, ‘Concluding Observations on Germany’s Fifth Periodic Report’ (2011) UN Doc E/C12/DEU/CO/5, para 27; UNCESCR, ‘Concluding Observations on The Kingdom of the Netherlands’ Combined Fourth and Fifth Periodic Report’ (2010) UN Doc E/C12/NL/CO/4-5, para 29.

Figure 4 Indirect review of AAAQ requirements in Concluding Observations (based on the 2008-2012 sample)



However, the UN Committee does not explicitly acknowledge the relevance of the AAAQ framework in its Concluding Observations on Article 12 ICESCR. These connections result from my own analysis of the issues addressed in the 2008-2012 sample of Concluding Observations.

2.2.2.2 Limited capacity to improve conceptual clarity

Whilst the AAAQ framework could improve the ability of the UN Committee to clarify the normative scope of the right to health in its reporting procedure, three limits arise.

Firstly, the failure of the UN Committee to use the AAAQ framework in its Concluding Observations on Article 12 ICESCR reflects a discrepancy between the standards drawn *in abstracto* in GC14, and those effectively applied in monitoring.

Therefore, its interpretation could be criticised for being insufficiently coherent and principled. This was confirmed through the interviews conducted in Geneva in May 2014: none of the four UN Committee members declared using the AAAQ framework, and some were unaware of its meaning.²⁰⁶

Secondly, the focus of the UN Committee on accessibility issues in its Concluding Observations, as showed by Figure 4, reflects the key role that the accessibility requirement plays in the AAAQ framework, but can be problematic on two aspects. The accessibility requirement plays a key role in monitoring healthcare delivery. Logically, individuals cannot benefit from a health service that is available, acceptable and of good quality, if they cannot access it in the first place.²⁰⁷ For instance, healthcare that is unaffordable for the poor in the United States; or healthcare that is not within safe physical reach for Palestinians in Israel. Furthermore, the accessibility requirement plays a key role in monitoring the non-discrimination principle, a cornerstone of human rights law. In its Concluding Observations, the UN Committee often expresses concern regarding health discrimination with regard to Article 2(2) ICESCR (and not necessarily Article 12).²⁰⁸

However, such focus on accessibility issues in Concluding Observations can impede the capacity of the UN Committee to successfully clarify the normative scope of the right to health for two reasons. First, whilst AAAQ requirements are bound to be intertwined, an all-inclusive umbrella requirement (i.e. accessibility) might cause repetition and confusion in monitoring procedures. For instance, does a service have to be available to be accessible, or does it have to be accessible to be available? Second, focusing on accessibility issues should not result in an insufficient review of the availability, acceptability, and quality of healthcare, as showed by Figure 4, since these remain crucial. For instance, a health service that is not acceptable or not of

²⁰⁶ Interviews UN Committee members (n 190), Question 3.

²⁰⁷ It is worth noting that medical experts also defend the centrality of accessibility: Jean-Frederic Levesque, Mark F Harris and Grant Russell, 'Patient-Centred Access to Health Care: Conceptualising Access at the Interface of Health Systems and Populations' (2013) 12 *International Journal for Equity in Health* 18.

²⁰⁸ ICESCR (n 4), Art 2(2).

good quality may discourage patients from using it, regardless of the fact that it is accessible and available in sufficient numbers. In Ecuador, maternal care that did not offer women the choice of a delivery position adapted to their cultural background (although safe for women's and foetus' health), was reported as deterring them from having an institutional delivery.²⁰⁹ This thesis acknowledges, nonetheless, that evaluating the acceptability and quality of healthcare requires greater medical expertise than assessing its availability or accessibility, and does not always bear the same urgency.

Finally, the third limit to the potential of the AAAQ framework in clarifying the right to health, is that it may crystallise and, thus, restrict its normative scope as a result. It is worth noting that Levesque, Harris and Russell, who synthesised how access to health was conceptualised in the literature, suggested five dimensions to healthcare. They advise that healthcare be understood through the dimensions of approachability; acceptability; availability and accommodation; affordability; and appropriateness. Interestingly, this framework partially covers the AAAQ requirements but adds two supplementary requirements: i.e. providing healthcare in a timely manner; and according to patients' needs.²¹⁰ These two requirements cannot be found within the AAAQ framework although they are essential to achieving the highest standard of health attainable.

To conclude, whilst the AAAQ framework could potentially contribute to clarifying the normative scope of the right to health, it remains unused by the UN Committee, and when (indirectly) applied in its reporting procedure, is inherently limited. As a result, the AAAQ framework does not contribute entirely adequately to defining what the highest standard of health attainable means in the reporting procedure of the UN Committee.

²⁰⁹ La revolución Ciudadana Avanza, Care and Ministerio de Salud Pública, 'Culturally Appropriate Delivery Care: A Right of Women and Newborns (Área de Salud N°12 Hospital Raúl Maldonado Mejía Cantón-Cayambe, Ecuador)' (2010) <http://www.care.org/sites/default/files/documents/MH-PCA_ingles.pdf> [accessed 8 September 2015].

²¹⁰ Levesque, Harris and Russell (n 207) 22–23.

2.3 States' obligations to realise the right to health: unclear framework

After having assessed the (unsuccessful) contributions of the UN Committee to the clarification of the normative scope of the right to health, I will examine whether it has interpreted more precisely states' obligations to realise this right, when monitoring it. Section 2.3 will thus study how the UN Committee expects states to implement the right to health, mainly based on a systemic analysis of sixty Concluding Observations, drafted from 2008 to 2012. Three findings can thus be highlighted when examining the 'concerns' and 'recommendations' it formulates against states in difficulty under Article 12 ICESCR. Firstly (2.3.1), I will demonstrate that the UN Committee explicitly requires that states progress in the field of healthcare, and that it follows up such evolution. Secondly (2.3.2), I will highlight that the UN Committee rarely refers to the notion of minimum core, but often expects states to immediately realise certain aspects of health. Lastly (2.3.3), I will discuss the substantive obligations arising from that to report under Article 12, i.e. collect and submit data. It is worth noting that this section will not study states' obligations in the light of the dichotomic obligations of result and conduct; or the tripartite typology obligation to respect, protect and fulfil, yet recognised in GC14.²¹¹ This thesis refutes their relevance since those categories frequently overlap,²¹² are not used in the monitoring procedures of the UN Committee; and more importantly, listing the measures required by Article 12 is pointless, as these are too diverse to be crystallised into a framework. Instead, I will focus on progressive realisation and minimum core, more established concepts.

2.3.1 Obligation of progressive realisation under Article 12 ICESCR

Article 12 ICESCR imposes a central obligation upon States parties: achieving the highest standard of health attainable for their populations. However, it does not specify how, and more particularly, in what timeframe it expects them to do so (since

²¹¹ UNCESCR, 'GC14' (n 21), paras 30, 31, 33–37, 43 and 44. See also UNCESCR, 'General Comment No. 3: The Nature of States Parties' Obligations (Art 2, Para. 1)' (1990), para 1.

²¹² Such criticisms also appear in: Scott Leckie, 'Another Step towards Indivisibility: Identifying the Key Features of Violations of Economic, Social and Cultural Rights' (1998) 20 Human Rights Quarterly 81, 92; and will be discussed in Chapter 5. For a detailed account on the debate on obligations of result and conduct, see Sepúlveda (n 152) 184–196.

this section does not study obligations of conduct). Such details, however, can be found in Article 2(1) ICESCR, key provision of the Covenant. This provision reads:

Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.²¹³

When applied to the right to health, the obligation of progressive realisation appears in GC14,²¹⁴ but not explicitly in the Concluding Observations of the UN Committee. This section will nonetheless argue that the UN Committee implicitly recognises this concept in its reporting procedure on Article 12 ICESCR, (2.3.1.1) by expecting states to ‘progress’; (2.3.1.2) and by carrying out a follow-up. Such means, although insufficiently explicit, enable the UN Committee to delineate the nature of this obligation under the right to health.

2.3.1.1 States under an obligation of ‘progress’

Craven, Alston, and Quinn have examined in great depth the meaning of each term in Article 2(1), by studying the *Travaux Préparatoires* of the ICESCR.²¹⁵ What transpires from their analysis is that while states must progressively realise the rights enshrined in the ICESCR, they must fulfil three requirements. First, states must adopt appropriate and comprehensive means to realise the right to health, including but not exclusively legislative measures. Second, states’ actions must be directed towards one goal: the full realisation of the right, i.e. the highest standard of health attainable. Third, states must use the maximum resources available to realise the right to health, which should not be restricted to budgetary considerations.

Therefore, when asking for information on a particular health issue, the UN Committee often specifies that data must demonstrate the ‘*progress*’ made by the

²¹³ ICESCR (n 4), Art 2(1).

²¹⁴ UNCESCR, ‘GC14’ (n 21), paras 30 and 31.

²¹⁵ Craven (n 152) 106–152; Alston and Quinn (n 126) 164–191.

state in this field.²¹⁶ Likewise, when the information provided by the state shows that its performance in healthcare has improved, the UN Committee expresses satisfaction. For instance, it recently commended Sri Lanka for *'its significant progress towards the achievement of the Millennium Development Goals, especially in the field of health'*.²¹⁷ However, if such information does not show sufficient progress (or if there is no information at all), the UN Committee can require that the state take further measures. For instance, it asked Kenya to progressively extend the scope of its health insurance in order to reimburse hospitalisation fees and to cover the entirety of workers and unemployed persons.²¹⁸ Finally, the UN Committee has explicitly referred to the obligation of progressive realisation and to Article 2(1) a few times, when urging states to increase their spending on health services.²¹⁹ For instance, it requested the Philippines to expand its health expenditure because this figure was low, had decreased, and did not follow the overall GDP growth.²²⁰

The UN Committee also encourages states to develop health indicators and benchmarks,²²¹ stating that these enable states to monitor their own performance in healthcare.²²² Subsection 2.2.1, nevertheless, shows that states' reports could be

²¹⁶ E.g. UNCESCR, 'Concluding Observations on Ecuador's Third Periodic Report' (2012) UN Doc E/C12/ECU/CO/3, para 30: 'The Committee requests the State party to provide information on the progress made in the field of mental and psychosocial health in its next periodic report'.

²¹⁷ E.g. UNCESCR, 'Concluding Observations Sri Lanka 2010' (n 187), para 5.

²¹⁸ UNCESCR, 'Concluding Observations on Kenya's First Periodic Report' (2008) UN Doc E/C12/KEN/CO/1, para 20.

²¹⁹ E.g. UNCESCR, 'Concluding Observations DRC 2009' (n 61), para 16; UNCESCR, 'Concluding Observations on Cambodia's Combined Initial and Second to Fourth Periodic Reports' (2009) UN Doc E/C12/KHM/CO/1, para 27; ICESCR (n 4), Art 2(1).

²²⁰ UNCESCR, 'Concluding Observations on Philippines' Combined Second to Fourth Periodic Reports' (2008) UN Doc E/C12/PHL/CO/4, para 17.

²²¹ E.g. UNCESCR, 'Concluding Observations on Russian Federation's Fifth Periodic Report' (2011) UN Doc E/C12/RUS/CO/5, para 37; UNCESCR, 'Concluding Observations on Australia's Fourth Periodic Report' (2009) UN Doc E/C12/AUS/CO/4, para 28: *'the Committee invites the State party to identify disaggregated health indicators and appropriate national benchmarks in relation to the right to health, in line with the Committee's General Comment No.14 (2000)'*.

²²² E.g. UNCESCR, 'Concluding Observations Sri Lanka 2010' (n 187), para 30: 'The Committee encourages the State party to further develop indicators and benchmarks, disaggregated by sex, age, urban/rural population and social and ethnic group, for monitoring progress achieved in combating poverty'.

inaccurate (e.g. Tanzania) or biased (e.g. Sri Lanka).²²³ Therefore, how can states be trusted with developing their own indicators, or monitoring themselves? How can such indicators guarantee a comprehensive and expert review of the right to health? Moreover, how can the realisation of this right be assessed methodically if each state has a different set of indicators? In order to ensure impartiality, expertise, and methodology in the evaluation of states' progress in healthcare, it is essential the UN Committee design its own indicators. This would enable it to review the performance of each state in each reporting cycle, with regard to the same issues (SRH, communicable diseases, etc.). The UN Committee sometimes uses the targets set by the Millennium Development Goals in the field of health, in order to assess whether a state is on track (e.g. regarding maternal mortality).²²⁴ However, this is insufficient.

Indicators are fundamental to monitor the obligation to progressively realise the right to health, since they are the only means through which compliance can be measured. This argument is supported by Hunt, in his capacity as former UN Special Rapporteur on the right to health,²²⁵ and scholar.²²⁶ He stated that '*there is no alternative but to use indicators to measure and monitor the progressive realization of the right to the highest attainable standard of health*'.²²⁷ All four UN Committee members whom I interviewed declared they used what some called 'indicators' and others called 'statistics', in the reporting procedure.²²⁸ However, it is unclear what indicators the UN Committee uses, since it seems to operate on an ad hoc basis and does not mention the sources used to reach its conclusions. As a result, there is no guarantee states' progress is reviewed comprehensively (i.e. review of all relevant

²²³ Tanzania report (n 180), para 110; World Bank, 'Health Expenditure' (n 174); Sri Lanka report (n 189), paras 30, 31, 49, and 118.

²²⁴ These were used, for instance, in UNCESCR, 'Concluding Observations Cambodia 2009' (n 219), para 32.

²²⁵ Special Rapporteur on the right to health, Paul Hunt, 'Annual Report to the General Assembly (Main Focus: Right to Health Indicators)' (2003) UN Doc A/58/427.

²²⁶ Hunt and McNaughton, 'A Human Rights-Based Approach to Health Indicators', in Mashood Baderin (ed) *Economic, Social, and Cultural Rights in Action* (Oxford University Press 2007).

²²⁷ Special Rapporteur on the right to health, Paul Hunt, 'Annual Report to the Commission on Human Rights (Main Focus: A Human Rights-Based Approach to Health Indicators)' (2006) UN Doc E/CN.4/2006/48, para 29.

²²⁸ Interviews UN Committee members (n 190).

health issues) or coherently (i.e. similar review across reporting cycles and across states, to enable or compare progress). It is nonetheless essential that the UN Committee materialise the obligation to progress in a comprehensive and coherent manner, in order to define the substance of the right to health adequately.

2.3.1.2 The existence of a rudimentary follow-up

The UN Committee clearly expects states' performance to progress in the field of healthcare, but how does it monitor such evolution without indicators in order to give life to this obligation? I will demonstrate that the UN Committee frequently follows up on issues raised in previous Concluding Observations. Such review, nonetheless, is neither systematic nor comprehensive. This will be illustrated through the examples of the United Kingdom, Bolivia, Cameroon and South Korea, in Table 2 below. These countries were selected on the basis of their geographical and economic representation, as well as for having been subject to the reporting procedure more than once in the last 15 years. It is worth mentioning that the latter element severely restricted the number of countries available for this analysis. Most countries have either never reported on the implementation of the Covenant, or reported only once, or submitted reports with considerable delays in between.

This case study stresses that while the UN Committee attempts to follow up states' progress under Article 12 ICESCR, it fails to do so consistently. The example of the United Kingdom points at the absence of follow up on the implementation of Article 12 ICESCR. The examples of Bolivia and Cameroon demonstrate that the UN Committee (explicitly) follows up states progress under Article 12 in its reporting procedure, but that it forgets to review certain peripheral issues. Finally, the example of South Korea highlights that the UN Committee follows up on the implementation of Article 12, but that it does not monitor comprehensively the evolution of states' performance in healthcare. As a result, not only does its monitoring deprive the obligation of progressive realisation from a coherent substance, potential violations can easily go unnoticed. The adoption of indicators and benchmarks in the Concluding Observations of the UN Committee could nonetheless potentially overcome the inconsistency of its monitoring and materialise the requirement to progressively realise the right to health into a legal obligation.

Table 2 Follow up on health issues raised under Article 12 ICESCR from one reporting cycle to the next

Country under review	Health issues raised in previous Concluding Observations	Health issues followed up in next Concluding Observations
United Kingdom ²²⁹	Prevalence of mental health issues among homeless persons	NO
	High prevalence of HIV/AIDS in the Caribbean territories	NO
Bolivia ²³⁰	Inadequate access to healthcare for the poorest	PARTIALLY (and not explicitly)
	Health discrimination against indigenous persons	YES
	High maternal mortality	YES (but not explicitly)
Cameroon ²³¹	Female genital mutilation (FGM)	PARTIALLY
	High maternal mortality	YES
	Inadequate medical facilities	PARTIALLY (and not explicitly)
South Korea ²³²	Marginalisation of certain groups in healthcare	YES (but not explicitly)
	Priority to urban areas in health programmes	NO
	Low budget allocated to health	YES (but not explicitly)

2.3.2 Minimum core obligations under Article 12

The UN Committee clearly recognises the existence of minimum core obligations to realise the right to health in GC14. GC14 dedicates an entire section to this topic in paragraphs 43, 44, and 45, and provides a non-exhaustive list of what such

²²⁹ UNCESCR, ‘Concluding Observations on the United Kingdom of Great Britain and Northern Ireland, the Crown Dependencies and the Overseas Dependent Territories’ Fourth Periodic Report’ (2002) UN Doc E/C12/1/Add79, paras 19, 21, 38, 40; UNCESCR, ‘Concluding Observations on the United Kingdom of Great Britain and Northern Ireland, the Crown Dependencies and the Overseas Dependent Territories’ (2009) UN Doc E/C12/GBR/CO/5, paras 7 and 29.

²³⁰ UNCESCR, ‘Concluding Observations on Bolivia’s First Periodic Report’ (2001) UN Doc E/C12/1/Add60, paras 13, 14, 23, 30, 43; UNCESCR, ‘Concluding Observations on Bolivia’s Second Periodic Report’ (2008) UN Doc E/C12/BOL/CO/2, paras 6, 15, 22, 27(f), 28, 34, 35.

²³¹ UNCESCR, ‘Concluding Observations on Cameroon’s First Periodic Report’ (1999) UN Doc E/C12/1/Add40, paras 15, 25, 26, 33, 42, 45; UNCESCR, ‘Concluding Observations on Cameroon’s Second and Third Periodic Reports’ (2012) UN Doc E/C12/CMR/CO/2-3*, paras 5(d) to (e), 20, 27, 28.

²³² UNCESCR, ‘Concluding Observations on Republic of Korea’s Second Periodic Report’ (2001) UN Doc E/C12/1/Add59, paras 11, 22, 26, 34; UNCESCR, ‘Concluding Observations on Republic of Korea’s Third Periodic Report’ (2009) UN Doc E/C12/KOR/CO/3, paras 22 and 30.

obligations include.²³³ After analysing the sample of 2008-2012 Concluding Observations, two conclusions can be drawn in that respect. First, (2.3.2.1) the UN Committee rarely refers to the concept of minimum core obligations in the context of Article 12; and second, (2.3.2.2), it however recognises states' obligation to take '*immediate steps*'. Such means, although implicit, seem to point towards the recognition of a core obligation to prioritise (at least, in time) certain areas of health.

2.3.2.1 The rare recognition of minimum core obligations

The concept of minimum core obligations did not appear in the text of the ICESCR. It emerged instead in the 1980s, in the literature on ESCR.²³⁴ In 1990, however, this concept received a more authoritative recognition through General Comment 3 on the nature of States' obligations under Article 2(1) of the ICESCR. In this document, the UN Committee describes minimum core obligations as ensuring the realisation of '*at the very least, minimum essential levels of each of the rights*' (of the Covenant).²³⁵ It specifies that in the context of health, these represent '*essential primary health care*', and that without such minima the ICESCR would lose its '*raison d'être*'.²³⁶ The UN Committee confirmed the existence of core obligations to realise the right to health in GC14. Not only does GC14 set a long list of core obligations under Article 12, it also declares that they are non-derogable and that retrogressive measures in that respect would, therefore, violate automatically the right to health.²³⁷

While the UN Committee emphasises the importance of minimum core obligations in its General Comments, it very rarely refers to them in its Concluding Observations (at least under Article 12 ICESCR). The only occasion for which this expression was recently used concerned irregular migrants' health. In 2010, the UN Committee expressed its concern over the fact that irregular migrants had difficulty in accessing

²³³ UNCESCR, 'GC14' (n 21), paras 19, 43–45, 47, 48, and 60.

²³⁴ As outlined by Audrey Chapman and Sage Russell (eds), *Core Obligations: Building a Framework for Economic, Social and Cultural Rights* (Intersentia 2002) 8.

²³⁵ UNCESCR, 'General Comment 3' (n 211), para 10.

²³⁶ *ibid.*

²³⁷ UNCESCR, 'GC14' (n 21), paras 43, 44, 47, and 48.

healthcare in Netherlands, although they were legally entitled to it. As a result, it urged the Netherlands to ‘*meet its core obligations*’ by providing undocumented migrants with minimum essential levels of healthcare.²³⁸ More implicitly, the UN Committee referred to what seemed to be a ‘minimum standard’ in the case of the Dominican Republic. It observed with dissatisfaction that the public health system of this state was ‘*seriously underfunded*’. It thus urged the Dominican Republic to increase its healthcare expenditure in order to ‘*at least*’ align with the international standard amounting to 3% of its GDP.²³⁹ It is worth noting that during the interviews carried out in Geneva, 3 members out of 4 declared being sceptical about core obligations and thus favouring a more flexible approach, based on resource availability.²⁴⁰

As a result, the UN Committee has not developed any clear ‘minimum’ standards when monitoring Article 12 ICESCR. Moreover, it does not reach any findings of non-conformity in its Concluding Observations, contrarily to what the non-derogability approach in GC14 would suggest.²⁴¹ It is thus difficult to clearly delineate what minimum standards states are required to fulfil under the right to health, based on the reporting procedure of the UN Committee. The UN Committee, nonetheless, implicitly recognises the notion of minimum core by regularly requesting that States parties take ‘immediate steps’ to redress certain situations.

2.3.2.2 States under the obligation to take ‘immediate’ steps

In General Comment 3, the UN Committee declares that fulfilling minimum core obligations must be considered ‘*as a matter of priority*’, as they guarantee minimum levels of rights.²⁴² In their book *Core Obligations: Building a framework for Economic, Social and Cultural Rights*, Chapman and Russell also translate the notion of priority into a timing perspective, to differentiate core and progressive

²³⁸ UNCESCR, ‘Concluding Observations Netherlands 2010’ (n 205), para 25(b).

²³⁹ UNCESCR, ‘Concluding Observations on Dominican Republic’s Third Periodic Report’ (2010) UN Doc E/C12/DOM/CO/3, para 30.

²⁴⁰ Interviews UN Committee members (n 190).

²⁴¹ UNCESCR, ‘GC14’ (n 21), para 48.

²⁴² UNCESCR, ‘General Comment 3’ (n 211), para 10.

obligations.²⁴³ They argue that States parties to the ICESCR must immediately address the minimum levels required by the Covenant, while progressively realising other standards. While they declare that such distinction does not result in a hierarchy benefiting to minimum core obligations,²⁴⁴ two observations should be made. First, this assertion is overly optimistic. For many states, realising all the core obligations listed by GC14 may mean having no resources left to realise the progressive aspects of the right to health; especially if the obligation of progressive obligation is derogable and core obligations are not. This would thus result in a *de facto* and a *de jure* hierarchy of obligations, benefiting to the minimum core. Second, how can minimum core obligations be realistically defined, what with the diversity of resources (and willingness) to realise the right to health amongst States parties to the ICESCR?

The 2008-2012 sample of Concluding Observations examined highlight that the UN Committee implicitly recognises the existence of core obligations, by using a terminology that reflects the priority and urgency of certain situations. After having expressed its concern over a specific health issue, the UN Committee occasionally urges states to take ‘*immediate steps*’ or to take measure ‘*without delay*’ to redress the situation. It has done so for ten states, out of the sixty studied in the sample. Furthermore, all instances seem to correspond to what GC14 lists as ‘core obligations’.²⁴⁵

- Provision of healthcare on a non-discriminatory basis (5 states urged to take urgent measures)²⁴⁶

²⁴³ Chapman and Russell (n 234) 9.

²⁴⁴ *ibid.*

²⁴⁵ UNCESCR, ‘GC14’ (n 21), paras 43 and 44.

²⁴⁶ *ibid.*, para 43(a); UNCESCR, ‘Concluding Observations on The Former Yugoslav Republic of Macedonia’s First Periodic Report’ (2008) UN Doc E/C12/MKD/CO/1, paras 12, 21, 26 (on health discrimination) and para 32 (on immediate steps); UNCESCR, ‘Concluding Observations on Ukraine’s Fifth Periodic Report’ (2008) UN Doc E/C12/UKR/CO/5, paras 11 and 34; UNCESCR, ‘Concluding Observations Kenya 2008’ (n 218), para 20; UNCESCR, ‘Concluding Observations United Kingdom 2009’ (n 229), para 33; UNCESCR, ‘Concluding Observations Australia 2009’ (n 221), para 28.

- Provision of essential food and water, as well as basic shelter, housing, and sanitation (4 states urged to take urgent measures)²⁴⁷
- Provision of reproductive, maternal and child healthcare (2 states urged to take urgent measures)²⁴⁸
- Guarantee of an equitable distribution of health services (2 states urged to take urgent measures)²⁴⁹
- Provision of health education and information on the main health problems in the community (2 states urged to take urgent measures)²⁵⁰
- Prevention, treatment and control of epidemic and endemic diseases (1 state urged to take urgent measures)²⁵¹
- Provision of immunisation against major diseases (1 state urged to take urgent measures)²⁵²
- Development of a national health strategy (1 state urged to take urgent measures)²⁵³
- Provision of essential medicines (3 states urged to take urgent measures)²⁵⁴

²⁴⁷ UNCESCR, 'GC14' (n 21), para 43(b) and (c); UNCESCR, 'Concluding Observations Australia 2009' (n 221), para 28; UNCESCR, 'Concluding Observations Ukraine 2008' (n 246), paras 26 and 49; UNCESCR, 'Concluding Observations on Madagascar's Second Periodic Report' (2009) UN Doc E/C12/MDG/CO/2, para 25; UNCESCR, 'Concluding Observations on Kazakhstan's First Periodic Report' (2010) UN Doc E/C12/KAZ/CO/1, para 35.

²⁴⁸ UNCESCR, 'GC14' (n 21), para 44(a); UNCESCR, 'Concluding Observations Kenya 2008' (n 218), para 32; UNCESCR, 'Concluding Observations on Serbia's Document Submitted by the United Nations Interim Administration Mission in Kosovo Following Initial Periodic Report' (2008) UN Doc E/C12/UNK/CO/1, para 30.

²⁴⁹ UNCESCR, 'GC14' (n 21), para 43(e); UNCESCR, 'Concluding Observations Kenya 2008' (n 218), para 32(a) and (c); UNCESCR, 'Concluding Observations Serbia 2008' (n 248), para 30.

²⁵⁰ UNCESCR, 'GC14' (n 21), para 44(d); UNCESCR, 'Concluding Observations Kenya 2008' (n 218), para 32(d); UNCESCR, 'Concluding Observations Serbia 2008' (n 248), para 30.

²⁵¹ UNCESCR, 'GC14' (n 21), para 44(c); UNCESCR, 'Concluding Observations Kenya 2008' (n 218), para 32(c), (d), and (e) (however, the connection with a core obligation here is less evident).

²⁵² UNCESCR, 'GC14' (n 21), para 44(b); UNCESCR, 'Concluding Observations Kenya 2008' (n 218), para 32(c), (d), and (e) (again, the connection with a core obligation here is less evident).

²⁵³ UNCESCR, 'GC14' (n 21), para 43(f); UNCESCR, 'Concluding Observations Kenya 2008' (n 218), para 32(c), (d), and (e) (the connection with a core obligation is, again, less evident).

- Provision of an appropriate training of health personnel (1 state urged to take urgent measures)²⁵⁵

However, no standard emerges from the analysis of the (limited) requests of the UN Committee to take ‘*immediate steps*’ in the reporting procedure. It may use this formulation for one state and not another, although they encounter similarly urgent issues. For instance, Germany was the only state that was asked to immediately redress the insufficient number of health personnel (in geriatrics). However, Germany is certainly not the only state that presents inadequate numbers of health professionals, among the sixty states studied in this sample. For instance, Benin had 0.1 physicians per 1,000 persons in 2008 (while Germany had 3.5) but this was not mentioned in the Concluding Observations on Benin.²⁵⁶ This highlights, once again, how the absence of indicators in the reporting procedure impairs the possibility for the UN Committee to develop a coherent legal content of the right to health, which application effectively guarantees everyone’s highest standard of health attainable. Moreover, the Committee considers on one hand that core obligations are ‘non-derogable’,²⁵⁷ but on the other it does not reach any findings of non-conformity in its reporting procedure. If infringements are not sanctioned, the point of having non-derogable obligations is unclear and such practice deprives them of their substance.

²⁵⁴ UNCESCR, ‘GC14’ (n 21), para 43(d); UNCESCR, ‘Concluding Observations Kenya 2008’ (n 218), para 32(d); UNCESCR, ‘Concluding Observations Ukraine 2008’ (n 246), paras 26, 29 and 49; UNCESCR, ‘Concluding Observations on Democratic Republic of the Congo’s Combined Second to Fourth Periodic Reports’ (2009) UN Doc E/C12/COD/CO/4, para 25.

²⁵⁵ UNCESCR, ‘GC14’ (n 21), para 44(e); UNCESCR, ‘Concluding Observations Germany 2011’ (n 205), para 27. It is worth noting that this obligation should be reworded as that to provide health personnel appropriately trained and in sufficient number. The number of medical personnel is as important as their training and represents a basic primary healthcare requirement; see Declaration of Alma-Ata 1978, para VII(7): ‘*Primary health relies [...] on health workers [...] to respond to the expressed health needs of the community*’.

²⁵⁶ World Bank, ‘Physicians (per 1,000 People) 2005-2014’ <<http://data.worldbank.org/indicator/SH.MED.PHYS.ZS>> [accessed 8 September 2015]; UNCESCR, ‘Concluding Observations on Benin’s Second Periodic Report’ (2008) UN Doc E/C12/BEN/CO/2.

²⁵⁷ UNCESCR, ‘GC14’ (n 21), para 47.

2.3.3 Substantive obligations arising from that to report under Article 12

States' obligation to report on the implementation of the rights enshrined in the ICESCR is procedural in nature, and is recognised in Articles 16 and 17 of the Covenant.²⁵⁸ However, substantive obligations arise from the obligation to report, as witnessed in the documents and practice of the UN Committee. Since these contribute to clarifying the legal content of the right to health, and more particularly the nature of states' obligations to realise it, it is worth studying them. One substantive requirement in particular emerges from the UN Committee's 1993 Rules of Procedure,²⁵⁹ GC14,²⁶⁰ and its 2009 reporting guidelines:²⁶¹ i.e. states' obligation to collect (specific) data. Similar observations can be drawn from the reporting procedure on Article 12 ICESCR, in which the UN Committee often expresses its concern over the absence of information on certain health issues, and asks states to provide data in the next reporting cycle. When discussing how the UN Committee substantively interpreted the obligation to report under Article 12, I will thus, first (2.3.3.1), demonstrate the existence of an obligation to collect data; and second (2.3.3.2), explore the specificity of the data that states must submit and, thus, collect.

2.3.3.1 The obligation to collect data

The obligation upon States parties to the ICESCR to submit data on their performance in the field of healthcare clearly aims at achieving two goals. The first goal is the most explicit: the submission of data enables the UN Committee to monitor how states implement the right to health. The UN Committee can then evaluate states' efforts to fulfil the highest standard of health attainable, and the timeframe in which such progress is achieved (progressively, immediately). However, the focus remains on the monitoring role of the UN Committee.

²⁵⁸ ICESCR (n 4), Art 16 and 17.

²⁵⁹ UNCESCR, 'Rules of Procedure' (n 98), rules 58 to 64.

²⁶⁰ UNCESCR, 'GC14' (n 21).

²⁶¹ UNCESCR, 'Guidelines on Treaty-Specific Documents to Be Submitted by States Parties under Articles 16 and 17 of the ICESCR' (2009) UN Doc. E/C.12/2008/2, paras 55–57 on Article 12.

The second goal is more implicit and yet crucial: the obligation to submit data forces States parties to *collect* it in the first place. Such a goal gives a substantive meaning to the obligation, as it focuses on what states ought to do at the domestic level to realise the right to health. It suggests, as argued by Alston, that states are primarily accountable for *devising* adequate means to implement the right to health.²⁶² This has been implicitly recognised by the UN Committee. In its Concluding Observations on Moldova, for instance, it expressed concern over the absence of disaggregated data regarding certain vulnerable groups, urging the state to establish an appropriate system of data *collection*.²⁶³

Data collection is essential to build and maintain appropriate health systems, as it is the only way for states to detect inadequacies and to thus address them. This is especially relevant in the context of disaggregated data, as it facilitates the identification of health discrimination perpetuated against disadvantaged groups. The obligation to *collect* data – rather than to submit data – therefore contributes significantly in defining the legal content of the right to health in that respect. A state cannot be complying with Article 12 without knowing whether the number and repartition of hospitals across its territory is sufficient, for example. Finally, while it is fundamental that states carry out data collection, it is equally fundamental that this process leads to accurate and reliable results. The UN Committee has expressed its dissatisfaction when this was not the case.²⁶⁴

2.3.3.2 The obligation to collect specific data

Analysing the 2008-2012 sample of Concluding Observations enabled me to observe that the UN Committee clearly expects states to submit and, thus, collect specific

²⁶² Alston 1987 (n 152) 357.

²⁶³ UNCESCR, ‘Concluding Observations on Republic of Moldova’s Second Periodic Report’ (2011) UN Doc E/C12/MDA/CO/2, para 6: ‘The Committee recommends that the State party take urgent measures to establish a system for the collection and monitoring of annual data on Covenant rights, disaggregated by disadvantaged and marginalized individuals and groups, including (although not exclusively) Roma, persons with disabilities, persons living with HIV/AIDS and non-citizens’.

²⁶⁴ E.g. UNCESCR, ‘Concluding Observations on Turkmenistan’s First Periodic Report’ (2011) UN Doc E/C12/TKM/CO/1, para 23: ‘*The Committee urges the State party to review the collection of statistical information with regard to health issues*’.

information when reporting on the implementation of Article 12. It repeatedly expresses its concern over lack of qualitative, quantitative, and disaggregated data. Such data is informative of how the UN Committee expects states to perform and thus, the nature of their obligations under the right to health.

Firstly, the UN Committee requires that states provide both qualitative and quantitative data to demonstrate their efforts in the field of healthcare.

The UN Committee often requests that states provide and thus collect quantitative information. It regularly requires ‘*statistical*’ and ‘*comparative*’ data, in order to evaluate states’ performance in healthcare through figures and over periods of time.²⁶⁵ Finally, it may ask states to use indicators and benchmarks,²⁶⁶ or to report on the percentage of their gross domestic product allocated for healthcare.²⁶⁷

The UN Committee also frequently requires that states provide qualitative data, and thus collect it in the first place. It may request that they submit ‘*updated and detailed information*’²⁶⁸ describing measures taken in the field of healthcare. It often asks states to provide information on measures such as strategies,²⁶⁹ programmes,²⁷⁰ or legislation.²⁷¹

²⁶⁵ E.g. UNCESCR, ‘Concluding Observations on New Zealand’s Third Periodic Report’ (2012) UN Doc E/C12/NZL/CO/3, para 28; UNCESCR, ‘Concluding Observations on Brazil’s Second Periodic Report’ (2009) UN Doc E/C12/BRA/CO/2, para 29.

²⁶⁶ E.g. UNCESCR, ‘Concluding Observations Sri Lanka 2010’ (n 187), para 30.

²⁶⁷ E.g. UNCESCR, ‘Concluding Observations on India’s Second to Fifth Periodic Reports’ (2008) UN Doc E/C12/IND/CO/5, paras 33 and 73 (however, such requests are rare).

²⁶⁸ E.g. UNCESCR, ‘Concluding Observations on Turkey’s First Periodic Report’ (2011) UN Doc E/C12/TUR/CO/1, para 33.

²⁶⁹ E.g. UNCESCR, ‘Concluding Observations on Mauritius’ Combined Second to Fourth Periodic Reports’ (2010) UN Doc E/C12/MUS/CO/4, para 29: request for further information on strategies implemented to combat chronic diseases, especially diabetes, tobacco use, and obesity.

²⁷⁰ E.g. UNCESCR, ‘Concluding Observations on Angola’s Combined First to Third Periodic Report’ (2008) UN Doc E/C12/AGO/CO/3, para 36: request for further information on programmes implemented to provide universal access to healthcare.

²⁷¹ E.g. UNCESCR, ‘Concluding Observations on Poland’s Fifth Periodic Report’ (2009) UN Doc E/C12/POL/CO/5, para 28: request for further information on legislation implemented to address unsafe abortions.

This approach is implicitly recognised by the reporting guidelines of the UN Committee, when reading the list of data that it requests states to provide.²⁷² Using both qualitative and quantitative data enables the UN Committee to carry out an in-depth analysis, by evaluating the implementation of the right to health in figures, and understand failures or successes in words. However, requests to provide quantitative and qualitative data are irregularly formulated in the reporting procedure.

Secondly, the UN Committee often asks for disaggregated data in order to identify potential health discrimination.

The UN Committee evaluates data on a wide range of disaggregated grounds in its Concluding Observations. It often requests data disaggregated by geographic area (per regions or per urban/rural areas),²⁷³ by sex,²⁷⁴ age,²⁷⁵ ethnicity,²⁷⁶ religion,²⁷⁷ or ‘any prohibited ground of non-discrimination’.²⁷⁸ It has also requested that states provide disaggregated data regarding Roma people, persons living with HIV/AIDS, persons with disabilities, and non-nationals.²⁷⁹

The necessity to provide disaggregated data is required by the UN Committee in both GC14,²⁸⁰ and its reporting guidelines.²⁸¹ This approach also enables the UN Committee to identify potential health discrimination, prohibited by the principle of non-discrimination enshrined in Article 2(2) ICESCR.²⁸² Nevertheless, requests to provide disaggregated data are irregularly formulated in the reporting procedure of the UN Committee.

²⁷² UNCESCR, ‘ICESCR Reporting Guidelines 2009’ (n 261), para 3.

²⁷³ E.g. UNCESCR, ‘Concluding Observations Peru 2012’ (n 178), para 20.

²⁷⁴ E.g. UNCESCR, ‘Concluding Observations Kazakhstan 2010’ (n 247), para 32.

²⁷⁵ E.g. UNCESCR, ‘Concluding Observations Turkmenistan 2011’ (n 264), para 22.

²⁷⁶ E.g. UNCESCR, ‘Concluding Observations Brazil 2009’ (n 265), para 11.

²⁷⁷ E.g. UNCESCR, ‘Concluding Observations India 2008’ (n 267), para 58(e).

²⁷⁸ E.g. UNCESCR, ‘Concluding Observations Russia 2011’ (n 221), para 37.

²⁷⁹ E.g. UNCESCR, ‘Concluding Observations Moldova 2011’ (n 263), para 6.

²⁸⁰ UNCESCR, ‘GC14’ (n 21), paras 16, 20, 57, and 63.

²⁸¹ UNCESCR, ‘ICESCR Reporting Guidelines 2009’ (n 261), para 3(g).

²⁸² ICESCR (n 4), Art 2(2).

Thirdly, the UN Committee asks states to provide data on a wide range of health issues.

GC14 specifies that it aims at assisting states in fulfilling their reporting obligations under Article 12, but does not mention what information states must collect before submitting their reports.²⁸³ The 2009 reporting guidelines of the UN Committee, however, are quite specific and list twelve health issues that states must report against.²⁸⁴ These issues, nonetheless, are not consistently monitored for each country, which emphasises the need for the UN Committee to adopt a set of *thematic* indicators.

In practice, the UN Committee often requires that states provide information on broad health issues. These can include: life expectancy of the population;²⁸⁵ mental health²⁸⁶ (e.g. suicide,²⁸⁷ conditions of mental health patients),²⁸⁸ or SRH²⁸⁹ (e.g. abortion services).²⁹⁰ Information can also be frequently requested on issues such as: substance abuse (e.g. drug consumption and availability of dependence therapy);²⁹¹ accessibility and affordability of water and sanitation;²⁹² prevalence of HIV/AIDS;²⁹³ or occupational health.²⁹⁴

²⁸³ UNCESCR, 'GC14' (n 21), para 6.

²⁸⁴ UNCESCR, 'ICESCR Reporting Guidelines 2009' (n 261), paras 55–57 (on Article 12).

²⁸⁵ E.g. UNCESCR, 'Concluding Observations Brazil 2009' (n 265), para 11.

²⁸⁶ E.g. UNCESCR, 'Concluding Observations Kazakhstan 2010' (n 247), para 32.

²⁸⁷ E.g. UNCESCR, 'Concluding Observations on France's Third Periodic Report' (2008) UN Doc E/C12/FRA/CO/3, para 48.

²⁸⁸ E.g. UNCESCR, 'Concluding Observations on Uruguay's Combined Third and Fourth Periodic Report' (2010) UN Doc E/C12/URY/CO/3-4, para 26.

²⁸⁹ E.g. UNCESCR, 'Concluding Observations New Zealand 2012' (n 265), para 28(d).

²⁹⁰ E.g. UNCESCR, 'Concluding Observations Poland 2009' (n 271), para 28.

²⁹¹ E.g. UNCESCR, 'Concluding Observations on Hungary's Third Periodic Report' (2008) UN Doc E/C12/HUN/CO/3, para 49.

²⁹² E.g. UNCESCR, 'Concluding Observations Turkey 2011' (n 268), para 33(b).

²⁹³ E.g. UNCESCR, 'Concluding Observations on Chad's Combined First to Third Periodic Report' (2009) UN Doc E/C12/TCD/CO/3, para 29.

²⁹⁴ E.g. UNCESCR, 'Concluding Observations Turkey 2011' (n 268), para 33(a).

The UN Committee also regularly requires that states provide, and thus collect, information on health issues specific to vulnerable groups. These can include: access to health for vulnerable groups in general,²⁹⁵ or more particularly, for persons with disabilities,²⁹⁶ persons living with HIV/AIDS,²⁹⁷ and for the poorest sectors of the populations (e.g. poverty-related diseases).²⁹⁸

2.4 Critical overview

By failing to apply any clear framework and failing to reach any finding of non-conformity, the UN Committee does not delineate precisely the legal content of Article 12 ICESCR when monitoring it. A critical overview of its interpretation must thus be drawn, based on the principles of interpretation advocated in the introduction of this thesis. This fourth section will demonstrate that the interpretation of the UN Committee (and more particularly, its lack of methodology) does not only affect the definition of the right to health, it also affects its very substance. Firstly (2.4.1), I will discuss the negative impact that such lack of methodology has on the substance and conceptual clarity of the right to health. Second (2.4.2), I will however acknowledge the positive effect this may represent for the UN Committee, when building a constructive dialogue with States parties and NGOs.

2.4.1 The absence of methodology: a weak interpretation

First, the absence of indicators and decisions of non-conformity weakens the substance of Article 12 ICESCR.

Without indicators or benchmarks in its reporting procedure, the UN Committee does not always review States parties to the ICESCR on the same basis. This absence of transparency contributes to a lack of procedural certainty for states and right-holders,

²⁹⁵ E.g. UNCESCR, ‘Concluding Observations United Kingdom 2009’ (n 229), para 32.

²⁹⁶ E.g. UNCESCR, ‘Concluding Observations Uruguay 2010’ (n 288), para 25.

²⁹⁷ E.g. UNCESCR, ‘Concluding Observations Moldova 2011’ (n 263), para 23.

²⁹⁸ E.g. UNCESCR, ‘Concluding Observations on Latvia’s First Periodic Report’ (2008) UN Doc E/C12/LVA/CO/1, para 51.

but more importantly, fails to guarantee principled consistency or protect an effective enjoyment of the right to health. For instance, in 2012 the UN Committee requested New Zealand to provide information on measures taken in the field of mental health,²⁹⁹ but did not ask any other state to submit similar information that same year. It is however unlikely that mental health issues were not worth reporting on, that year. For instance, the European Observatory on Health Systems and Policies had reached alarming findings regarding Spain in 2010. It stated that the provision of mental healthcare was uneven among autonomous communities; that services were not appropriately or systematically assessed; and that information systems were ‘*very deficient and uncoordinated*’.³⁰⁰ However, the UN Committee expressed no concern regarding Spanish mental health services in its 2012 Concluding Observations, ignoring what could constitute violations of individuals’ right to health.³⁰¹ This example thus highlights how the lack of indicators can leave certain countries or certain aspects of the right to health unmonitored. It is therefore necessary that the UN Committee develop thematic indicators and benchmarks in its reporting procedure on Article 12. This would strengthen the coherence of the normative scope of the right to health, and would enable the UN Committee to review adequately states’ obligations to realise it, enabling its interpretation to achieve principled consistency and protect an effective enjoyment of this right. As argued by Griffey:

‘In the contexts of monitoring and implementation, statistical human rights indicators and benchmarks are necessary to facilitate progressive realisation, as well as to satisfy immediate obligations of core content and non- discrimination.’³⁰²

²⁹⁹ UNCESCR, ‘Concluding Observations New Zealand 2012’ (n 265), para 28(c).

³⁰⁰ European Observatory on Health Systems and Policies, ‘Spain: Health System Review’ (2010), 226-227 available at <http://www.euro.who.int/__data/assets/pdf_file/0004/128830/e94549.pdf> [accessed 8 September 2015].

³⁰¹ UNCESCR, ‘Concluding Observations on Spain’s Fifth Periodic Report’ (2012) UN Doc E/C12/ESP/CO/5.

³⁰² Brian Griffey, ‘The “Reasonableness” Test: Assessing Violations of State Obligations under the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights’ (2011) 11 Human Rights Law Review 275, 290.

The use of indicators, however, requires the adoption of a violations approach in order for the UN Committee to clarify what conforms to or violates the right to health through its reporting procedure. The UN Committee has not endorsed such an approach as it favours a constructive dialogue with states. How can a state feel committed to collect and submit data if it already knows that no public declaration will be made on its compliance (or lack of) with the right to health? This is confirmed through the poor reporting practices of States parties. The 1993 Rules of Procedure of the UN Committee specify that states must report on the implementation of the rights enshrined in the ICESCR one year after having ratified it and once every five years.³⁰³ Therefore, States parties to the ICESCR since its entry into force (i.e. the majority of those reviewed in the 2008-2012 sample)³⁰⁴ should have submitted eight reports by now, or at least four since the drafting of the initial Rules of Procedure in 1993. However, among the sixty states examined in this chapter, only a third had submitted four to five reports. Ten had submitted only one report and many states had never reported yet.

Second, the absence of indicators and decisions of non-conformity deprives the right to health from its conceptual clarity.

The example above, in which the UN Committee only asked New Zealand to report on mental health in 2012, highlights this point. How can states understand that Article 12 ICESCR obliges them to provide mental health services, personnel, screening, and treatment, if they are not asked, or not systematically asked, to report on those issues? A few years after its creation, Alston declared that one of the greatest challenges the UN Committee had to overcome was to clarify the norms set by the ICESCR. He argued that the only way to achieve this was to review states' reports through a systematic methodology, in order for its interpretation to be coherent and provide guidance to States parties.³⁰⁵ 25 years later, this argument

³⁰³ UNCESCR, 'Rules of Procedure 1993' (n 98), rule 58(2).

³⁰⁴ All states parties' reports can be found at <http://tbinternet.ohchr.org/_layouts/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=9&DocTypeID=29> [accessed 8 September 2015].

³⁰⁵ Alston 1987 (n 152) 351–355.

remains valid and such developments, necessary to meet the principles of interpretation suggested by this thesis.

Finally, by ‘refusing’ to hold violations of Article 12, the UN Committee fails to delineate what is acceptable or not and therefore, to specify what realising the right to health entails. When analysing the 2008-2012 sample of Concluding Observations, it is clear that the UN Committee recognises situations raising issues of non-compliance with the ICESCR. For instance, it declared that the assimilation of transsexual and inter-sexed persons to persons with mental illness ‘violated’ their sexual and reproductive rights.³⁰⁶ It also recommended that Switzerland ‘complied’ with its ‘Covenant obligations’ because its intellectual property protection was going beyond the standards set by the World Trade Organisation and could adversely affect access to medicines.³⁰⁷ Such instances, nevertheless, are rare and the terms used by the UN Committee are usually vague. For example, it qualifies discrimination in access to healthcare as ‘*human rights violations*’,³⁰⁸ and declares that FGM ‘*violate the physical integrity and human dignity of women*’,³⁰⁹ rather than finding a breach of Article 12. How can the right to health be understood in legal terms if it never amounts to findings of conformity or non-conformity, and how can an effective enjoyment of this right be protected? Soon, the UN Committee will have to reach findings of compliance through its communications procedure. It will be interesting to observe whether it will export this approach to its reporting procedure, in order to avoid contradictions between both procedures. In the meanwhile, Leckie’s suggestion that Concluding Observations include an additional category entitled ‘Violations of the Treaty’ is worth considering.³¹⁰

³⁰⁶ UNCESCR, ‘Concluding Observations Germany 2011’ (n 205), para 26.

³⁰⁷ UNCESCR, ‘Concluding Observations on Switzerland’s Second and Third Periodic Reports’ (2010) UN Doc E/C12/CHE/CO/2-3, para 24.

³⁰⁸ UNCESCR, ‘Concluding Observations DRC 2009’ (n 254), para 17.

³⁰⁹ UNCESCR, ‘Concluding Observations Chad 2009’ (n 293), para 19.

³¹⁰ Leckie ‘The Committee on Economic, Social and Cultural Rights: Catalyst for change in a system needing reform’ in Alston and Crawford (n 144) 143–144.

2.4.2 The absence of methodology: a flexible interpretation?

The absence of indicators from the reporting procedure of the UN Committee presents one advantage that is worth mentioning. Without any ‘check list’ in mind, the UN Committee can interpret the substance of the right to health with more flexibility and be more open to new information brought from external actors. This can potentially increase dialogue with NGOs in the reporting procedure, whose expertise and insight can be highly valuable to the UN Committee’s review. The importance of civil society is recognised in various documents. According to the 1993 Rules of Procedure, NGOs who have consultative status with the Economic and Social Council are entitled to submit written and oral information to the UN Committee.³¹¹ The list of such organisations is relatively extensive.³¹² GC14 even declares that NGOs and associations of health professionals facilitate the implementation of the right to health, and that their assistance should thus be evaluated when reviewing states’ compliance with Article 12 ICESCR.³¹³ It can however be dangerous for the UN Committee to rely too heavily on NGOs’ reports. Depending on their expertise and on the quality of their research, NGOs shadow reports may be targeting certain issues only, or may simply be unreliable. For instance, in its 2012 shadow report, the Icelandic Human Rights Centre declared that ‘Icelanders are the 5th most obese nation in the world’. Whilst the number of obese adults is high in Iceland (more than 20%), according to WHO it is the 81st country with the highest prevalence, not the 5th.³¹⁴

Finally, the absence of findings of non-conformity represents two benefits. First, it reflects the non-adversarial aspect of the reporting procedure, which aims to generate

³¹¹ UNCESCR, ‘Rules of Procedure 1993’ (n 98), rule 69.

³¹² ECOSOC, ‘List of Non-Governmental Organizations in Consultative Status with the Economic and Social Council as of 1 September 2010’ UN Doc E/2010/INF/4.

³¹³ UNCESCR, ‘GC14’ (n 21), para 64.

³¹⁴ The Icelandic Human Rights Centre, ‘Supplementary Report on the Implementation of CESCR (Prior to the List of Issues)’ (2012), para 73, available from the 49th Session of the UNCESCR (12 Nov 2012 - 30 Nov 2012) <http://tbinternet.ohchr.org/_layouts/treatybodyexternal/SessionDetails1.aspx?SessionID=441&Lang=en> [accessed 8 September 2015]; WHO, ‘Interactive Chart on the Prevalence of Obesity, Ages 18+, Both Sexes’ <http://gamapserver.who.int/gho/interactive_charts/ncd/risk_factors/obesity/atlas.html> [accessed 8 September 2015].

a constructive dialogue between the UN Committee and States parties to the ICESCR.³¹⁵ This is confirmed by the Travaux Préparatoires of the ICESCR, where the approach of a ‘*cooperative*’ implementation was unanimously adopted over a ‘*censorial*’ one.³¹⁶ Second, since the role of the UN Committee is limited to *assisting* states in implementing the rights enshrined in the ICESCR, and not *sanctioning* them, it can address controversial issues more easily. It has, for instance, reviewed topics such as abortion, irregular migrants’ health, and mental health services comprehensively. This argument plays in favour of the UN Committee, as this thesis outlines that SNHRBs’ interpretation of the right to health must be fit to their monitoring procedures to be effective.

Conclusion

In this Chapter, I examined how the UN Committee interpreted the right to health and whether this contributed adequately to clarifying its legal content, by analysing its monitoring procedures on Article 12 ICESCR. Therefore, I studied the comments formulated in its reporting procedure, by analysing systemically all Concluding Observations drafted from 2008 to 2012, and by examining several Concluding Observations drafted more recently (no major developments can be noted). The interpretation of the right to health by the UN Committee, however, does not delineate the legal content of this right with much precision. In Section 2.1, I introduced Article 12 ICESCR and the procedures that can be used to monitor it, before outlining the methodology of my analysis in this regard. In Section 2.2, I argued that the UN Committee implicitly recognised standards delineating what the highest standard of health attainable meant, but that the normative scope of the right to health remained unclear. While it is clear that the UN Committee refers to certain health issues more than others in its Concluding Observations, no apparent or legitimate reason justifies such prioritisation. The AAAQ framework set by GC14 could potentially clarify the normative scope of the right to health but since it is not

³¹⁵ Alston 1987 (n 152) 358.

³¹⁶ ECOSOC, Commission on Human Rights, ‘Summary Record of the 238th Meeting’ (1951) UN Doc. E/CN.4/SR.238, p 18 (Mr Whitlam, Australia).

used in the reporting procedure, it remains abstract. In Section 2.3, I studied how the UN Committee expected states to achieve such standards, and concluded that it recognised three types of obligations under Article 12 ICESCR. Firstly, I demonstrated that the UN Committee explicitly expected states to progress in the field of healthcare and attempted to follow up their performance. Secondly, I highlighted that it rarely referred to the notion of minimum core but sometimes expected states to *immediately* address certain health crises, seemingly pointing towards an implicit recognition of this concept. Thirdly, I discussed the substantive obligations arising from that to report on the implementation of the right to health, by exploring the recognition of requirements to collect specific data. Finally, I used these findings to draw a critical overview in Section 2.4, using the principles of interpretation this thesis advocates. I argued, first, that the UN Committee failed to adopt clear indicators or reach decisions of non-conformity in its Concluding Observations, which adversely affected its ability to clarify what the right to health meant in practice. I also acknowledged the positive aspect of its approach, since it allowed a flexible understanding of what Article 12 ICESCR entails. However, I concluded that the absence of indicators or findings of non-conformity eventually eroded the possibility for the UN Committee to define the legal content of the right to health, contrary to the aim and principles of interpretation set by this thesis.

Chapter 3 The interpretation of Article 11 ESC by the European Committee of Social Rights: attempts of clarification

Introduction

While it is fundamental to study the universal standards set by the UN interpretation of the right to health, outlined in Chapter 2, it is essential to also seek clarification at a regional level. Since Part I of this thesis aims at analysing how SNHRBs contribute to clarifying the legal content of the right to health in the course of their quasi-judicial monitoring procedures, the interpretation of both international and regional bodies should be examined (and, later in this thesis, compared). Furthermore, regional systems group states with more similar features and thus represent a better chance for mutual standards to be easily defined and enforced in human rights law. Certain questions arise as a result. How is the right to health interpreted at a regional level? Does regional monitoring offer a more insightful framework than the UN? What can we learn from it, based on the principles of interpretation advocated by this thesis?

Human rights literature has paid considerable attention to the protection of ESCR in the African and Inter-American systems. Few authors, however, have explored the European Social Charter (ESC),³¹⁷ its mechanisms,³¹⁸ and even less, the legal content of the rights it enshrines³¹⁹ (including the right to health).³²⁰ Such dearth of literature is regrettable for two main reasons. Firstly, the European region is particularly affected by the adoption of austerity policies that threaten to narrow the fulfilment of

³¹⁷ See David J Harris, 'A Fresh Impetus for the European Social Charter' (1992) 41 *The International and Comparative Law Quarterly* 659.

³¹⁸ See Robin R Churchill and Urfan Khaliq, 'The Collective Complaints System of the European Social Charter: An Effective Mechanism for Ensuring Compliance with Economic and Social Rights?' (2004) 15 *European Journal of International Law* 417; Alston, 'Assessing the Strengths and Weaknesses of the European Social Charter's Supervisory System', and Jean-François Akandji-Kombé, 'The Material Impact of the Jurisprudence of the European Committee of Social Rights', in Grainne De Burca and Bruno de Witte (eds) *Social Rights In Europe* (Oxford University Press 2005).

³¹⁹ See Matti Mikkola, 'Social Human Rights of Migrants under the European Social Charter' (2008) 10 *European Journal of Social Security* 25.

³²⁰ The only paper available on the right to health in the ESC to date is Henriette Roscam Abbing, 'The Right to Care for Health: The Contribution of the European Social Charter' (2005) 12 *European Journal of Health Law* 183. This short article provides an overview of how the ESC deals with health, but not an in-depth analysis of how it defines the legal content of the right to health.

the right to health to limited healthcare. It is therefore fundamental for the CoE to clarify what this right means in order to assist the main actors involved in its implementation and to improve its realisation in Europe. Secondly, the CoE offers better enforcement potential than other systems of human rights protection on three aspects. First, the overall high income of European states (especially when compared to the rest of the world) is essential to realise rights such as health. Second, the weight given to the jurisprudence of the European Court of Human Rights can promote that of its sibling: the European Committee of Social Rights (the European Committee). Third, the European Committee has developed innovative methodologies to monitor the right to health such as indicators and averages, which no other human rights system seems to be using.

When human rights bodies evaluate the implementation of the right to health through their monitoring procedures, they effectively delineate its legal content since they must declare whether or not it is realised, and justify why. In an attempt to assess whether the legal content of the right to health has been clarified in the CoE, this chapter will examine how the European Committee interprets Article 11 ESC.³²¹ More particularly, it will study the comments formulated by the European Committee when evaluating the implementation of Article 11 in its reporting and complaint procedures. This research will thus involve an assessment of all the Conclusions and Merits Decisions drafted and reached from 1969 to April 2015.³²²

This chapter is structured as follows. Section 3.1 will present Article 11 ESC, the monitoring procedures specific to this provision, and the methodology used for this research. Sections 3.2 and 3.3 will then demonstrate that the European Committee defines the legal content of the right to health in two ways. First, the European Committee defines the legal content of the right to health directly, through clear jurisprudential standards on Article 11 ESC, which delineate the normative scope of this right. Second, it defines the legal content of the right to health indirectly, through the methodology used to evaluate states' compliance with Article 11 ESC, which delineate states' obligations to realise this right. Finally, Section 3.4 will draw a

³²¹ ESC 1961 (n 92), Art 11; ESC 1996 (n 92), Art 11.

³²² As of April 2015, the Merits Decisions from Complaint No. 91/2013 onwards had not been published or reached yet.

critical overview of the European Committee's interpretation by discussing the impact of its jurisprudence and methodology on the legal content of the right to health. Issues specific to the normative scope of a right and states' obligations to realise it, are inherently intertwined. However, distinguishing them is a useful way to break down complexity, and is often applied by legal scholars.

3.1 The right to health in the European Social Charter

In order to discuss how the European Committee interprets the right to health and whether this clarifies its content, it is necessary to introduce Article 11 ESC (3.1.1), the procedures that can be used to monitor it (3.1.2), and to outline the methodology of my analysis (3.1.3).

3.1.1 The provisions

Several provisions of the ESC deal with health.³²³ Articles 3, 7 and 8 recognise the right to healthy working conditions for adults in general, with particular protection provided to young persons and pregnant women. Articles 13 and 19 guarantee the right to medical assistance for persons without adequate resources, legal migrants, and irregular migrants during their journey back to their home countries.³²⁴ Finally, Articles 23 and 30 ensure the right to healthcare for elderly persons and persons socially excluded or poor.³²⁵ It is worth noting that Articles 23 and 30 were added by the revised version of the ESC and are thus not applicable to States who are solely parties to its initial version.³²⁶

This chapter, however, focuses on Article 11, for it is the most detailed provision of the Charter on health, and the one that has received the most consideration in the

³²³ ESC Secretariat, 'The Right to Health and the European Social Charter (2009)' <http://www.coe.int/t/dGHI/monitoring/Socialcharter/Theme%20factsheets/FactsheetHealth_en.pdf> [accessed 8 September 2015].

³²⁴ ESC 1961 (n 92), Art 3, 7, 8, 11, 13, and 19; ESC 1996 (n 92), Art 3, 7, 8, 11, 13, and 19.

³²⁵ ESC 1996 (n 92), Art 23 and 30.

³²⁶ CoE, 'Signatures and Ratifications of the ESC and Its Protocols' (n 100).

literature in this respect. Contrarily to the other health provisions of this instrument, which are limited to particular groups of individuals or to specific aspects of health, Article 11 embraces the right of the population as a whole to benefit from an appropriate health system.

Article 11 reads:

With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in cooperation with public or private organisations, to take appropriate measures designed inter alia:

1. to remove as far as possible the causes of ill-health;
2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.³²⁷

How did this provision come to life? It is worth noting that states' officials recognised the need for the ESC to ensure 'general health protection' at the earliest stages of its drafting.³²⁸ Furthermore, when the 'Committee of Experts on Public Health' drafted the text of rights relating to health, it clearly drew inspiration from international standards. The Travaux Préparatoires of the ESC expressly refer to the Preamble of the WHO Constitution, to the draft provision on health in the ICESCR,³²⁹ and recognised a right to 'the highest attainable standard of health'.³³⁰ However, states' officials expressed the desire to avoid duplicating standards set by other organisations, including the United Nations, by taking a 'more radical approach to social matters',

³²⁷ ESC 1961 (n 92), Art 11; ESC 1996 (n 92), Art 11. The sole difference between the formulation of Article 11 in the 1961 and the 1996 versions of the ESC, is the addition of the wording '*as well as accidents*' in paragraph 3.

³²⁸ CoE, 'Collected Travaux Préparatoires of the European Social Charter, Volume I' (1953-1954), p 6: 'Memorandum by the Secretariat-General' (16 April 1953), para 16.

³²⁹ CoE, 'Collected Travaux Préparatoires of the European Social Charter, Volume IV' (1957), p 121: 'Report prepared by the Social Division on Rights relating to health, a proper standard of living etc.' (20 June 1957) CE/Soc (57) 12 Or. Fr. p 121.

³³⁰ WHO Constitution (n 2), Preamble; see the current text of ICESCR (n 4), Art 12.

through a better protection and harmonisation of social standards across Members States.³³¹ As a result, the Committee of Experts on Public Health drafted Article 11 in ‘more precise terms’, in order to bind states with realistic obligations.³³² The drafters, nonetheless, added the formulation ‘inter alia’ to ensure that the measures listed in paragraphs 1, 2, and 3 were not interpreted exhaustively; and referred to the additional protection (i.e. medical assistance) provided by what is now Article 13.³³³ Lastly, Article 11 now recognises a ‘right to protection of health’ but the preamble of the ESC mentions a ‘right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable’.³³⁴ Such formulation testifies the drafters’ ambition: approaching health (and other social matters) comprehensively, while creating specific legal obligations. For clarity purposes, however, this chapter will refer to a ‘right to health’.

What makes the study of Article 11 ESC worthwhile is that the ESC is the only legally binding treaty that recognises explicitly a right to health in Europe. The ESC was developed in parallel with the European Convention on Human Rights,³³⁵ but focuses on ESCR rather than on CPR. However, it is unconventional in that its States parties can select the provisions they wish to be bound to, on condition that they accept a minimum of six ‘core’ articles and a total of sixteen articles.³³⁶ While Article 11 on the right to the protection of health is not a ‘core’ article, its three paragraphs have been accepted by all States parties except Armenia.³³⁷ The Charter entered into force in 1961 and was ratified by thirty-two states over the course of more than thirty years. In 1996, an amended version entered into force, recognising twelve additional rights. These new provisions mainly protect workers’ rights but also include a right to

³³¹ CoE, ‘Collected Travaux Préparatoires ESC, Volume I’ (n 328), p 16: ‘Report presented by Mr Heyman on behalf of the Committee on Social Questions’ (18 September 1953) Doc. 188.

³³² CoE, ‘Collected Travaux Préparatoires ESC, Volume IV’ (n 329), pp. 122–124.

³³³ *ibid.*

³³⁴ ESC 1996 (n 92), Art 11 and Preamble.

³³⁵ (European) Convention for the Protection of Human Rights and Fundamental Freedoms (as amended) 1950 (ECHR).

³³⁶ ESC 1996 (n 92), Art A(1); ESC 1961 (n 92), Art 20(1): minimum of fifteen provisions in the initial version.

³³⁷ CoE, ‘Table of Accepted Provisions (as of March 2015)’ <http://www.coe.int/t/dghl/monitoring/socialcharter/Presentation/ProvisionsIndex_en.asp> [accessed 8 September 2015].

housing, as well as a right to social protection for elderly persons and persons socially excluded or poor. Thirty-three states have ratified the revised version but ten States parties to the 1961 Charter still refuse to do the transfer and two versions of the Charter co-exist as a result.³³⁸ This, nevertheless, does not particularly affect the recognition of the right to health since its formulation is relatively similar in both versions. I will thus study Article 11 ESC by reference to both versions of Charter, unless stated otherwise.

3.1.2 The monitoring procedures

The European Committee monitors the implementation of Article 11 ESC through two procedures: the procedures of collective complaints and that of state reports. However, such monitoring procedures only apply to states that have ratified the ESC and have accepted this provision,³³⁹ which excludes a total of five states within the CoE. These are: Liechtenstein, Monaco, San Marino, Switzerland, and Armenia.³⁴⁰

The procedure of collective complaints, unlike that of state reports, was created recently: by the Additional Protocol of 1995 providing for a system of collective complaints.³⁴¹ According to its Article 1, complaints may only be submitted by trade unions, and by international NGOs that have consultative status within the CoE and that are on a list established by the Governmental Committee.³⁴² National NGOs may lodge complaints, but only if the State party in which they reside has formally consented to it, which at present solely concerns Finland.³⁴³ Therefore, not only is this

³³⁸ CoE, ‘Signatures and Ratifications of the ESC and Its Protocols’ (n 100): the states parties to the 1961 Charter but not to its revised version include: Croatia, Czech Republic, Denmark, Germany, Greece, Iceland, Luxembourg, Poland, Spain, and the United Kingdom (Liechtenstein and Switzerland have signed but not ratified the 1961 Charter).

³³⁹ ESC 1961 (n 92), Art 21 and 22; ESC 1996 (n 92), Art C: in theory, states that have not accepted Article 11 must also report to the Committee “*when requested, at regular intervals*”, but this is not applied in practice.

³⁴⁰ CoE, ‘Signatures and Ratifications of the ESC and Its Protocols’ (n 100): Liechtenstein, Monaco, San Marino, and Switzerland are the four states that have not ratified any version of the ESC; CoE, ‘Table of Accepted Provisions of the ESC’ (n 337): Armenia is the only state that has not accepted Article 11.

³⁴¹ Additional Protocol ESC 1995 (n 98).

³⁴² *ibid*, Art 1.

³⁴³ *ibid* Art 2; CoE, ‘List of Declarations Made with Respect to Treaty No. 158 (Additional Protocol to the European Social Charter Providing for a System of Collective Complaints)’

procedure restrictive in access, it is also restrictive in outcome, since it tends to be used for violations of the right to health that have a collective dimension, i.e. affecting a group of individuals rather than one person in particular.³⁴⁴ As a result, the complaint procedure has provided few findings useful for this research: there have only been seven Merits Decisions involving alleged violations of Article 11 so far.³⁴⁵

By contrast, the reporting procedure is more established since it has been in existence since 1961, through Articles 21 to 24 of the first version of the Charter.³⁴⁶ This procedure obliges States parties to the Charter to regularly report on the implementation of each provision, and enables the European Committee to assess whether such implementation is appropriate, in documents called ‘Conclusions’.³⁴⁷ Before 2006, States had to report every two years on the provisions that they were bound to.³⁴⁸ Since then, the provisions of the Charter have been divided into four thematic groups (including ‘Health, social security and social protection’) and states must report on one thematic group per year, which means every four years for Article 11.³⁴⁹ From 1969 to 2000, the European Committee had no substantive methods to assess the realisation of the right to health in its reporting procedure. However, in 2001, it started to use a wide range of health indicators, a tool that enabled the development of clear and precise legal standards under Article 11. Whilst elements of

<<http://conventions.coe.int/Treaty/Commun/ListeDeclarations.asp?NT=158&CM=8&DF=&CL=ENG&VL=1>> [accessed 8 September 2015].

³⁴⁴ Additional Protocol ESC 1995 (n 98), Art 1(b): NGOs must have a consultative status within the Council of Europe and be on a list established by the Governmental Committee.

³⁴⁵ The Merits Decisions of the European Committee are available at <http://www.coe.int/t/dghl/monitoring/socialcharter/Complaints/Complaints_en.asp> [accessed 8 September 2015].

³⁴⁶ ESC 1961 (n 92), Art 21 to 24.

³⁴⁷ The Conclusions of the European Committee are available at <http://www.coe.int/t/dghl/monitoring/socialcharter/Conclusions/ConclusionsYear_en.asp> [accessed 8 September 2015]

³⁴⁸ ESC 1961 (n 92), Art 21.

³⁴⁹ European Committee of Social Rights (ECSR) ‘New system for the presentation of reports on the application of the European Social Charter’ (2006) CM(2006)53, item 4.2.

the reporting procedure have been criticised on several grounds,³⁵⁰ it remains very informative of what the right to health means in practice.

3.1.3 Methodology of my analysis

As the purpose of this thesis is to explore how SNHRBs can and should contribute to clarifying what the right to health means, studying how the European Committee interprets this right through its monitoring procedures is crucial. When evaluating whether the right to health is realised or not in its monitoring procedures on Article 11 ESC, the European Committee effectively defines its legal content. The complaint procedure has produced several findings, which will be analysed in this chapter. However, these are relatively limited since to date, the European Committee has only reached 6 Merits Decisions. Therefore, this chapter will focus on the reporting procedure. In this procedure, the implementation of the right to health has been examined in all States parties to the ESC (i.e. 43) across a period of time (1969-2013) covering twenty reporting cycles.

The analysis of the Conclusions and Merits Decisions of the European Committee on Article 11 ESC from 1969 to 2013 stresses three findings. First, the European Committee systematically reviews the implementation of Article 11 by evaluating states' performance against each paragraph of Article 11, rather than against the provision as a whole.³⁵¹ Second and as a result, it has developed various health indicators under each paragraph, which it consistently uses in its Conclusions since 2001.³⁵² Third, the structure and constancy of this review have enabled the European Committee to derive legal standards from the indicators developed under Article 11(1), (2), and (3).

³⁵⁰ Alston 2005 (n 318): The author criticises the procedure for being slow, failing to provide a clear channel for the participation of civil society, for being dependant on the Committee of Ministers' decision to take further action, and for not involving any political sanction.

³⁵¹ Except in ECSR, 'Conclusions I (1969)'.

³⁵² Since ECSR, 'Conclusions XV-2 (2001)'. In its last reporting cycle on Article 11 ESC (i.e. in 2013), the European Committee exceptionally merged several indicators, thus reducing their number. However, since it is unsure whether this method will be kept in the next reporting cycle on Article 11 (2017), I will focus on the indicators created in 2001.

Chapter 3, therefore, will demonstrate that the findings of the monitoring procedures have greatly contributed to clarifying the legal content of the right to health. Firstly, the European Committee delineates the normative scope of the right to health by deriving express standards from the text of the ESC. Secondly, it also delineates the content of states' obligations through implied standards derived from the methodology used in its review.

3.2 The normative scope of the right to health: the recognition of express obligations in the jurisprudence of the committee

When the European Committee reviews the implementation of Article 11 ESC in its monitoring procedures, it systematically refers to states' obligations to provide curative, promotional, and preventive health (as enshrined in the three paragraphs of this provision). These duties, deriving from the wording of Article 11, will thus be called express obligations. It is nonetheless essential to examine how the European Committee interprets the legal content of each express obligation, as this contributes directly to defining the legal content of the right to health. I will thus reach two conclusions, based on a systemic analysis of all the European Committee's Conclusions and Merits Decisions up to 2015. Firstly (3.2.1), I will demonstrate that the standards developed under each express obligation delineate precisely the normative scope of Article 11. Secondly (3.2.2), I will analyse what threshold must be reached for such standards to be considered violated in order to appreciate their substance.

3.2.1 The standards developed under Article 11

The European Committee has laid down various legal standards while monitoring the implementation of Article 11, which now form part of its jurisprudence on the right to health. The legal aspect of these standards can be easily demonstrated by the association of three features observed throughout the Conclusions and Merits Decisions on Article 11. First, the European Committee addresses states with words such as: 'must', 'should', 'require' and 'request', pointing towards a normative terminology. Second, the European Committee interprets these standards as ruling

principles applicable to all States parties to the Charter and refers to them as such, whether in its reporting procedure, its collective complaint procedure, or its reporting guidelines. Finally, the European Committee holds findings of conformity to Article 11 when it considers that these standards are respected; and findings of non-conformity when it considers they are not respected..

It is worth noting that most standards have been developed in the reporting procedure, since this procedure enables the European Committee to review the realisation of Article 11 in each state every four years. As a result, standards often correspond to the themes raised by the indicators used in this procedure. Few standards, however, have been clarified, expanded or created through the complaint procedure. Table 3 below summarises the standards developed under Article 11 in both procedures. This jurisprudence can be found partially on the Case law Digest of the European Committee (2008) but this table presents more updated (and accurate) data.³⁵³

³⁵³ ECSR, 'Case Law Digest of the European Committee' (as of September 2008) <http://www.coe.int/t/dghl/monitoring/socialcharter/Digest/DigestIndex_en.asp> [accessed 8 September 2015].

Table 3 Standards developed by the European Committee under Article 11 ESC

Article 11 (1) – OBLIGATION TO PROVIDE CURATIVE HEALTH

<u>Health indicator</u>	<u>Standards developed by the European Committee</u>
None in particular (mostly applied to the two indicators below)	States' performance must improve, ³⁵⁴ must not be significantly below the European average, and must not reflect strong disparities between urban and rural areas or between regions'. ³⁵⁵
Life expectancy and main causes of death of the population	Health systems must respond appropriately to avoidable health risks, and states must reach the best results possible, according to the knowledge available. ³⁵⁶
Infant and maternal mortality	States must undertake measures to bring maternal and infant deaths down to zero risk, ³⁵⁷ especially countries with highly developed healthcare systems. ³⁵⁸

³⁵⁴ First established in ECSR, 'Conclusions 2005', Lithuania p 336; ECSR, 'Conclusions XVII-2 (2005)', Latvia p 497.

³⁵⁵ First established in ECSR, 'Conclusions 2005', Lithuania p 336.

³⁵⁶ First established in ECSR, 'Conclusions XV-2 (2001)', Denmark pp. 126–127.

³⁵⁷ First established in ECSR, 'Conclusions XV-2 (2001)', Belgium p 94.

³⁵⁸ First established in ECSR, 'Conclusions 2003', France p 147 (this standard was formulated in more 'formal' terms in cycles XIX-2 (2009) and 2009).

Access to healthcare Healthcare systems must be accessible to everyone,³⁵⁹ and potential restrictions on the application of Article 11 must not impede access to healthcare for disadvantaged groups.³⁶⁰

Costs of healthcare must be borne, at least in part, by the community.³⁶¹ States must take steps to reduce healthcare costs for patients, especially the most disadvantaged ones, and guarantee that they do not become an excessive burden.³⁶²

Health services must be provided without unnecessary delays.³⁶³

Healthcare professional, facilities The numbers of health staff and facilities must be sufficient;³⁶⁴ the living conditions in psychiatric hospitals must be adequate and preserve human dignity.³⁶⁵

³⁵⁹ First established in ECSR, ‘Conclusions XV-2 (2001)’, Cyprus p 25.

³⁶⁰ First established in ECSR, ‘Conclusions XVII-2 (2005)’, Statement of interpretation on Article 11, para 5; and ECSR, ‘Conclusions 2005’, Statement of interpretation on Article 11, para 5; ESC 1996 (n 92), Art E (non-discrimination clause).

³⁶¹ First established in ECSR, ‘Conclusions I (1969)’, Statement of Interpretation of Article 11, p 59 [this document cannot be accessed online].

³⁶² First established in ECSR, ‘Conclusions XVII-2 (2005)’, Netherlands p 595.

³⁶³ First established in ECSR, ‘Conclusions 2007’, Albania p 53; CoE, ‘Recommendation Rec(99)21 of the Committee of Ministers to Member States on Criteria for the Management of Waiting Lists and Waiting Times in Health Care’ (1999).

³⁶⁴ First established in ECSR, ‘Conclusions 2007’, Albania p 53.

³⁶⁵ First established in ECSR, ‘Conclusions XVII-2 (2005)’, Statement of interpretation of Article 11, para 5; ECSR, ‘Conclusions 2005’, Statement of interpretation of Article 11, para 5.

Article 11 (2) – OBLIGATION TO PROVIDE PROMOTIONAL HEALTH

<u>Health indicator</u>	<u>Standards developed by the European Committee</u>
Health education in schools	<p>Health education must be included in school curricula and provided during the entire period of schooling. It must cover: smoking and alcohol abuse; sexual and reproductive education (prevention of sexually transmitted diseases and AIDS in particular); road safety; and promotion of healthy eating habits.³⁶⁶ These topics can vary depending on the main public health problems affecting the country.³⁶⁷</p> <p>Sex education in schools must be relevant, culturally appropriate, of sufficient quality, objective, and based on contemporary scientific evidence. It should not involve censoring, withholding or intentionally misrepresenting information. Finally, it must be adequate in terms of time and resources.³⁶⁸</p>
Public information and awareness-raising	<p>Public information and awareness-raising campaigns must represent a public health priority.³⁶⁹ States must take measures to prevent activities damaging to health and to promote a sense of individual responsibility. These campaigns must deal with healthy eating, sex</p>

³⁶⁶ First established in ECSR, ‘Conclusions XV-2 (2001)’, Belgium p 97.

³⁶⁷ First established in *ibid*, Belgium pp. 96–99.

³⁶⁸ First established in *International Centre for the Legal Protection of Human Rights (INTERIGHTS) v Croatia* [2009] Complaint No. 45/2007, Decision on the Merits [47] (ECSR) (no decision has referred to these standards yet).

³⁶⁹ First established in ECSR, ‘Conclusions 2005’, Moldova pp. 450–452.

education, environmental issues,³⁷⁰ and health problems that are predominant in the country.³⁷¹

States must also demonstrate through concrete measures that they implement public health education policies in favour of groups affected by specific problems.³⁷²

Counselling and screening for pregnant women, children and adolescents Counselling and screening services must be provided free of charge, regularly and throughout the country.³⁷³ Free medical checks must be provided during the period of schooling and with adequate: frequency, objectives, coverage, and staff.³⁷⁴

Counselling and screening for the rest of the population Prevention through screening has a considerable impact on improving a populations' health and must therefore be fully used when it is proved to be efficient.³⁷⁵ Screening must be systematic for diseases that represent the main causes of death of a population.³⁷⁶

³⁷⁰ First established in *ibid.*

³⁷¹ First established in ECSR, 'Conclusions XV-2 (2001)', Belgium pp. 97–98.

³⁷² First established in *Marangopoulos Foundation for Human Rights (MFHR) v Greece* [2006] Complaint No. 30/2005, Decision on the Merits [203 to 221] (ECSR).

³⁷³ First established in ECSR, 'Conclusions 2005', Moldova pp. 450–452.

³⁷⁴ First established in ECSR, 'Conclusions XV-2 (2001)', France pp. 208–211.

³⁷⁵ First established in *ibid.*, Belgium pp. 96–99.

³⁷⁶ First established in ECSR, 'Conclusions 2005', Moldova pp. 450–452.

Article 11 (3) – OBLIGATION TO PROVIDE PREVENTIVE HEALTH

<u>Health indicator</u>	<u>Standards developed by the European Committee</u>
Air, water, and noise pollution, as well as ionising radiation	States must devote a reasonable portion of their budget to environmental protection and enact legislation ‘ <i>sufficiently advanced and detailed</i> ’ in this concern. ³⁷⁷ They must guarantee a right to a healthy environment by ensuring that environmental standards and rules are properly applied through appropriate supervisory machinery. ³⁷⁸ As a result, states must take specific steps, such as introducing threshold values for emissions. ³⁷⁹
Asbestos	States must prohibit the use, production, and marketing of asbestos. ³⁸⁰ States must take measures in order to monitor its presence in dwellings, and set up an obligation on companies regarding the elimination of waste that contains asbestos. ³⁸¹
Food safety	States must develop national standards taking into account scientific data, and create a system monitoring these norms throughout the food chain. States must also establish preventive measures (especially through the labelling process), and monitor food-borne diseases. ³⁸²

³⁷⁷ First established in ECSR, ‘Conclusions XV-2 (2001)’, Slovak Republic pp. 201–205.

³⁷⁸ First established in Marangopoulos Foundation for Human Rights v Greece (n 372) [195 and 203].

³⁷⁹ ECSR, ‘Conclusions 2005’, Moldova pp. 453–454.

³⁸⁰ First established in ECSR, ‘Conclusions XV-2 (2001)’, Austria p 59.

³⁸¹ First established in *ibid*.

³⁸² First established in ECSR, ‘Conclusions XV-2 (2001), Addendum 1’ Cyprus, pp. 31–35.

Measures to combat smoking and alcoholism	States must adopt prevention policies that restrict the supply of tobacco, alcohol and drug through controls on their production, distribution, advertising and pricing. States must provide statistics on their consumption trends to assess the effectiveness of these policies. ³⁸³
Prophylactic measures	States must have high immunisation levels through widely accessible immunisation programmes. States must reduce the incidence of certain diseases (diphtheria, measles, meningitis Hib, poliomyelitis, tetanus, whooping cough) and neutralise the virus reservoir according to the objectives set by the World Health Organisation. ³⁸⁴
Accidents prevention (since Conclusions 2003)	States must demonstrate their ability to cope with infections diseases (for example, measures to report and notify diseases, special treatment for AIDS patients, and emergency measures in case of epidemics). ³⁸⁵
	States must take preventive measures against road accidents, domestic accidents, accidents at school, accidents during leisure time, including those caused by animals. ³⁸⁶

³⁸³ First established in ECSR, ‘Conclusions XVII-2 (2005)’, Malta pp. 560–561.

³⁸⁴ First established in ECSR, ‘Conclusions XV-2 (2001)’, Belgium p 103.

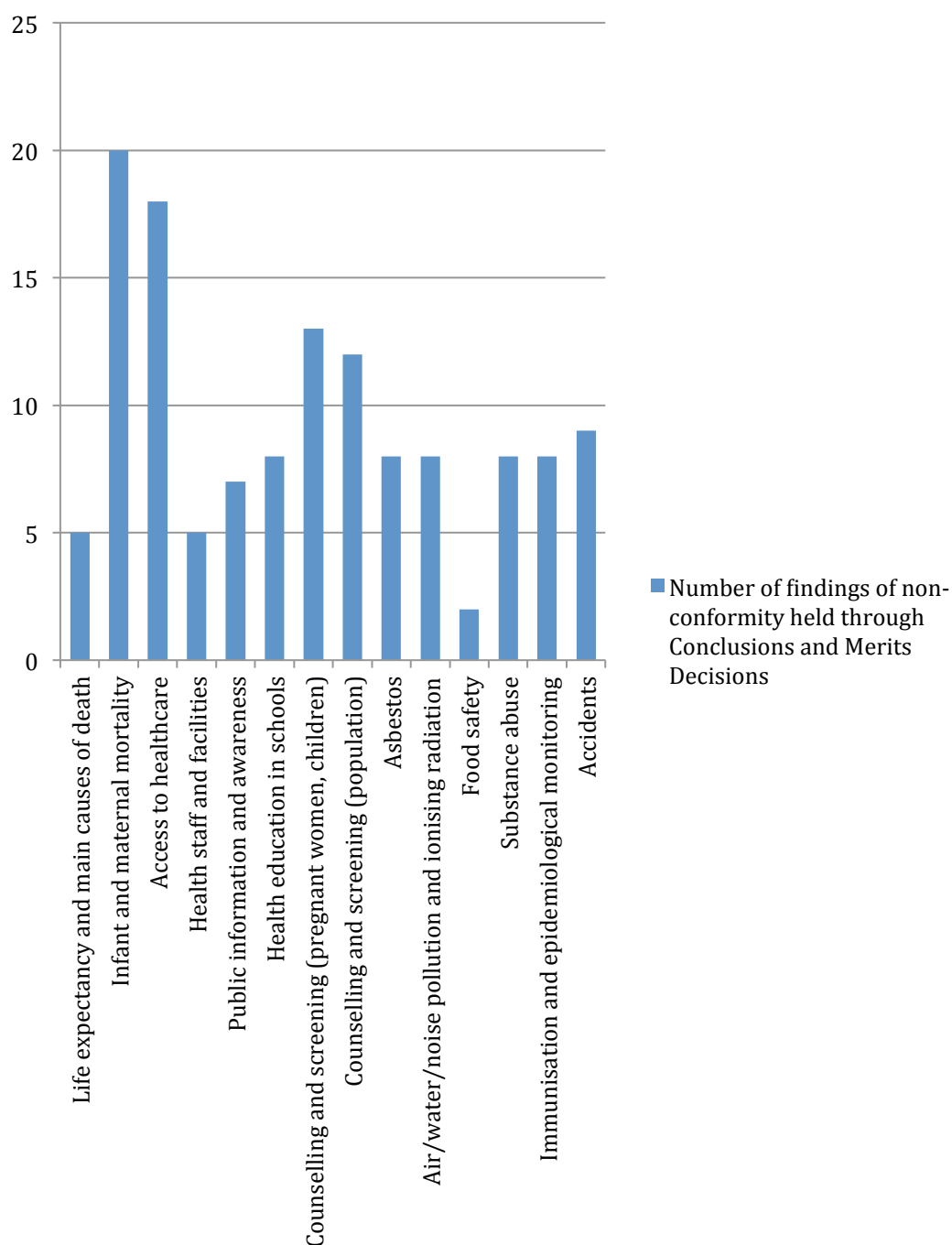
³⁸⁵ First established in ECSR, ‘Conclusions XVII-2 (2005)’, Latvia p 504.

³⁸⁶ First established in ECSR, ‘Conclusions 2005’, Romania p 608.

3.2.2 Boundaries and non-compliance under Article 11

When it assesses the implementation of Article 11 in its monitoring procedures, the European Committee reaches decisions of conformity or non-conformity, depending on whether states are considered as having realised the right to health or not. While the standards developed under Article 11 are relatively specific, their practical meaning is inevitably refined in the course of monitoring procedures and more precisely, when analysing what constitutes a breach of these requirements. Such exercise may enable lawyers to further delineate the legal content of each standard, but two observations are worth making. Firstly, most decisions of non-conformity to Article 11 result from a lack of information provided by states in their reports, which does not particularly clarify the signification of these standards. Clarification should thus be sought instead in decisions of non-conformity that are based on an inadequate performance in the field of healthcare (see more details in figure 6, subsection 3.3.1.2). Secondly, certain standards have led to more breaches of Article 11 than others, and their practical meaning may have been more refined in consequence. It is nonetheless worth noting that certain standards encompass a larger number of issues than others (e.g. standards developed under the indicator ‘access to healthcare’) and may thus lead to more findings of non-conformity. Figure 5 below illustrates how many Article 11 violations have been found under each standard.

Figure 5 Number of findings of non-conformity held by the European Committee under each indicator since 1969³⁸⁷



³⁸⁷ From 'Life expectancy' to 'Health staff and facilities': Article 11(1); From 'Public information' to 'Counselling and screening': Article 11(2); From 'Asbestos' to 'Accidents': Article 11(3).

Section 3.2 outlined how the European Committee interpreted the obligations expressly set by Article 11 ESC. It concluded that by laying down legal standards through thematic indicators, and (potentially) clarifying what they mean in practice through findings of non-conformity, the European Committee's interpretation directly contributed to delineating the legal content of the right to health. The European Committee, however, does not limit its understanding of Article 11 to the obligations to provide curative, promotional and preventive health. By choosing certain methods over others to measure states' conformity to these express obligations, it indirectly defines what the right to health entails.

3.3 States' obligations to realise the right to health: recognition of implied obligations in the methodology of the committee

When the European Committee evaluates whether or not states have realised the obligations expressly set by Article 11, it uses certain methods more than others. These reveal how states are expected to perform under the obligations to provide curative, promotional and preventive health. Section 3.3 will thus explore how such methods indirectly define the right to health, since they point towards 'implied obligations'. The analysis of the European Committee's Conclusions from the 1969 to the 2013 reporting cycles and its Merits Decisions from 1998 to April 2015, identifies repetitive techniques used to review the implementation of Article 11. These include, for instance: disaggregated data (to identify discrimination); European averages (to compare); timelines (to assess progress); and requests to submit data (to review standards, monitoring systems, and effectiveness of measures). This section, nevertheless, will focus on the two implied obligations the European Committee uses the most to assess states' compliance and occasionally, to hold them in breach of this provision. These include: (3.3.1) the obligation to submit specific data on health; and (3.3.2) the obligation to perform comparably with European averages in the field of healthcare.

3.3.1 The states' obligation to submit data on health: a necessary standard

It is clear from the methodology and the jurisprudence of the European Committee that states are most often asked to submit relevant data on health. Such observation, although more relevant to the reporting procedure, suggests the existence of an implied obligation. While this implied obligation is procedural by nature, it contributes to defining the legal content of the right to health in practice. First (3.3.1.1), it directly enables the European Committee to carry out an in-depth evaluation of states' performance in healthcare. Second (3.3.1.2), the violations of Article 11 based on a failure to submit data, indirectly measure the realisation of the right to health.

3.3.1.1 The use of specific data to evaluate states' performance in healthcare

The European Committee uses a wide range of data when assessing states' performance against the health indicators developed in its reporting procedure. The information it requests includes: qualitative and quantitative data, which facilitate an in-depth evaluation of states' performance in healthcare; as well as disaggregated data, which enable the identification of health discrimination.

Qualitative and quantitative data: an in-depth analysis

The type of data examined by the European Committee generally depends on the health indicator under review.

Certain health indicators require that states mainly submit quantitative data. This is the case for the majority of indicators relevant to Article 11 (1), on curative health. Parameters such as 'life expectancy', 'main causes of death', 'infant and maternal mortality', or 'healthcare professionals and facilities', prioritise figures, mortality rates and statistics. Nonetheless, qualitative data is incorporated to explain inadequate performances in that regard.

Other health indicators require that states submit more qualitative data. This can be said for most indicators developed under Article 11 (2), on health promotion. Parameters such as 'health education in school', 'public information and awareness-

raising’, or ‘counselling and screening services’, prioritise a description of the content and operation of these services. Quantitative data is also needed to measure the availability of such services but it is not systematically incorporated.

Finally, health indicators can sometimes rely equally on both qualitative and quantitative information. This is especially relevant to indicators specific to Article 11 (3) on preventive health. Parameters such as ‘prevention of risks’ and ‘prophylactic measures’ usually entail a description of the existing legislation, measures and supervisory mechanisms, as well as an evaluation of threshold levels, rates, trends, and statistics.

The attempt of the European Committee to combine a results-based approach with a qualitative analysis provides a fascinating insight into the monitoring of social rights, as no other human rights body goes into such depth. However, certain questions arise.

First, it is important to question how the balance between the use of quantitative and qualitative data should be determined. This Chapter does not pretend to address the complexity of this issue, as it primarily aims at discussing how the evaluation of Article 11 by the European Committee contributes to defining the legal content of the right to health. However, further research is needed on that aspect.³⁸⁸

Second, a question arises regarding the quality of the data. In its Conclusions, the European Committee observes that the data submitted by states can sometimes be inaccurate,³⁸⁹ or unreliable.³⁹⁰ As a result, most of the data that it reviews emanates from more ‘trustworthy’ sources. The European Committee often uses data published

³⁸⁸ A very interesting discussion on the interactions between quantitative and qualitative data can be found in Alan Bryman, *Social Research Methods* (Fourth edition, Oxford University Press 2012), Chap 26 ‘Breaking down the quantitative/qualitative divide’.

³⁸⁹ ECSR, ‘Conclusions XV-2 (2001), Addendum 1’, Cyprus p 24: the Committee notes an imperfect registration system when assessing the life expectancy of the population (only 45% of deaths are recorded).

³⁹⁰ ECSR, ‘Conclusions 2003’, Slovenia p 491 (on air pollution): ‘Noting that pollution data are collected by the polluters themselves, the Committee would like to be informed whether the mechanism of pollution control is subject to a supervisory system, which would assure reliability of collected data’.

by European governmental agencies (OECD; Eurostat; European Observatory on Health Care Systems). Sometimes, it also uses data published by the United Nations (WHO; Committee on Economic, Social and Cultural Rights; UNICEF). Many of these organisations, however, rely on data initially provided by states.³⁹¹ The European Committee should therefore incorporate data emanating from NGOs' shadow reports more often, in order to balance the potential subjectivity of governmental sources. Since it does not receive NGOs reports in great quantity for each country, it is crucial that the European Committee engages more substantially with civil society to raise awareness of its procedures.³⁹² It is worth noting, however, that the number of NGOs reports submitted is increasing and that the European Committee started incorporating their findings in its 2013 reporting cycle, with regard to Article 11. This allowed the European Committee to review a topic it had never monitored before: transgender persons' health.³⁹³

Disaggregated data: identifying health discrimination

The European Committee uses different types of disaggregated data in order to identify potential health discrimination.

It often uses gender-disaggregated data when measuring the life expectancy, main causes of death, and issues of substance abuse within the population. It has also emphasised the protection of women's (reproductive) health by creating the indicators 'maternal mortality rate', and 'counselling and screening services for pregnant women'. However, women's health is evaluated through the restricted

³⁹¹ See for instance OECD, 'OECD Health Data 2013 Electronic Questionnaire: Guidelines for Updating OECD Health Data' <<http://www.oecd.org/statistics/data-collection/health.htm>> [accessed 8 September 2015], p 3: 'These Guidelines aim to assist the national correspondents'.

³⁹² CoE, 'Comments from INGOs / Trade Unions under the Reporting Procedure of the European Social Charter' <http://www.coe.int/t/dghl/monitoring/socialcharter/Reporting/StateReports/CommentsINGO_en.asp> [accessed 8 September 2015]: participation seems to be increasing.

³⁹³ ECSR, 'Conclusions 2013', Georgia p 6: 'As regards the right to protection of health of transgender persons the Committee received submissions from the International Lesbian and Gay Association (European Region) (ILGA) stating that in Georgia there is a requirement that transgender people undergo medical treatment, including sterilisation, as a condition of legal gender recognition'.

prism of maternal healthcare, rather than through that of sexual and reproductive freedom (as required by the CoE).³⁹⁴ Issues such as access to contraception or access to safe abortion procedures remain largely unmonitored, including in states such as Poland, Ireland or Slovakia, yet often sanctioned by the European Court of Human Rights in that regard.³⁹⁵ The European Committee should thus systematically review SRH issues in its reporting procedure, in order to monitor more adequately the right to health.

The European Committee sometimes uses age-disaggregated data when assessing the main causes of death, the prevalence of substance abuse, or the availability of counselling and screening services within the population. It has also emphasised the protection of children and young people's health by creating the indicators 'health education in school', 'counselling and screening for children and adolescents', and 'infant mortality'. Nonetheless, it does not review elderly people's health under Article 11. Only states bound to Article 23(2)(b) of the 1996 Charter, which recognises the right to healthcare for older persons, must report on this issue.³⁹⁶ These states, however, are fewer than those bound to Article 11, and many of them correspond to the 'bad performers' under Article 11 (Belgium, Romania, Moldova, Bulgaria, Georgia and Azerbaijan). Such lack of protection is problematic.

Finally, the European Committee often uses geographically disaggregated data when reviewing the number of healthcare professionals and facilities, or the availability of counselling and screening services. Through this, it asserts the importance of equal access to healthcare between urban and rural areas and between different regions. It is regrettable, however, that the European Committee does not systematically apply

³⁹⁴ CoE Parliamentary Assembly, 'Resolution 1607 Access to Safe and Legal Abortion in Europe' (2008) <<http://assembly.coe.int/nw/xml/XRef/Xref-XML2HTML-en.asp?fileid=17638&lang=en>> [accessed 8 September 2015].

³⁹⁵ See the jurisprudence of the European Court of Human Rights: On access to lawful abortion: A, B and C v Ireland [2010] Grand Chamber, Application No. 25579/05, Judgment of 16 December 2010; Tysiac v Poland [2007] Fourth section, Application No. 5410/03, Judgment of 20 March 2007; On forced sterilisation: KH and Others v Slovakia [2009] Fourth section, Application No. 32881/04, Judgement of 28 April 2009; On access to contraceptives: Pichon and Sajous v France [2001] Third Section, Application No. 49853/99, Admissibility decision of 2 October 2001.

³⁹⁶ ESC 1996 (n 92), Art 23 § 2 (b); CoE, 'Table of Accepted Provisions of the ESC' (n 337).

this review. This would highlight incongruous public policies between federated provinces, or regional differences such as the desertion of certain areas by medical staff. For instance, the number of health personnel per 100,000 inhabitants in the province of Flevoland (Netherlands) amounted to 127 in 2009, one the lowest in Europe.³⁹⁷ Nevertheless, the European Committee did not mention any regional disparities in that regard, in its 2009 Conclusions.³⁹⁸

To conclude, the European Committee uses disaggregated data to identify health discrimination perpetuated against three vulnerable groups in particular: women, children, and persons living in rural areas. It sometimes also holds states responsible for breaching Article 11 due to health discrimination based on ethnic origins (Roma people)³⁹⁹ or based on economic status (the poor or persons socially excluded).⁴⁰⁰ The use of disaggregated data to identify health discrimination is an irregular practice; it highlights a superficial understanding of what constitutes vulnerability in health. (For instance, it is clear that women represent a group especially vulnerable SRH issues, but maybe less so to other health issues since their life expectancy is generally higher than that of men). The European Committee could thus remedy this inconsistency by combining two types of reviews. One that systematically evaluates the accessibility of healthcare for vulnerable groups common to all States parties; and another that evaluates access to health for groups particularly vulnerable within the state under review. This would ensure a more thorough monitoring of health discrimination, and materialise the obligation to submit data more coherently as a result. It is worth noting that the former UN Special Rapporteur on the right to health supports such alternative. Hunt declared that vulnerability in health was contextual

³⁹⁷ Eurostat, 'Health Personnel by NUTS 2 Regions' <http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=hlth_rs_prsrg&lang=en> [accessed 8 September 2015].

³⁹⁸ ECSR, 'Conclusions 2009', Netherlands p 568–569.

³⁹⁹ For instance, this occurred several times in the 2009 cycle: ECSR, 'Conclusions XIX-2 (2009)', Croatia pp. 58–59, Czech Republic p 91–92, Greece p 210, Hungary pp. 248 and 251; ECSR, 'Conclusions 2009', Bulgaria pp. 160–162, Italy p 407, Slovenia p 723. It also occurred several times in Merits Decisions: *Médecins du Monde – International v France* [2012] Complaint No. 67/2011, Decision on the Merits (ECSR); *European Roma Rights Centre (ERRC) v Bulgaria* [2008] Complaint No. 46/2007, Decision on the Merits (ECSR).

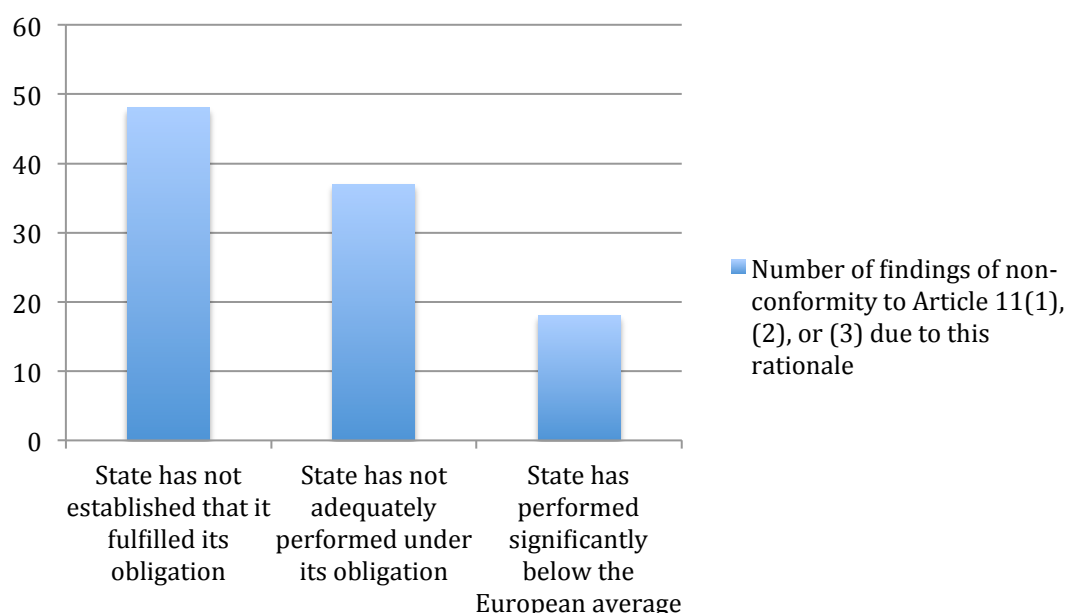
⁴⁰⁰ ECSR, 'Conclusions 2009', Bulgaria.

but that data should be disaggregated ‘*at least [by] sex, race, ethnicity, rural/urban and socio-economic status.*’⁴⁰¹

3.3.1.2 The use of an absence of data to find a breach of the right to health

Not only does the European Committee use extensive data when evaluating states’ performance in healthcare, it also bases most of its findings of non-conformity to Article 11 on states’ failure to provide such information. Figure 6 below illustrates clearly this assertion.⁴⁰² However, do these decisions contribute in defining the legal content of the right to health?

Figure 6 Rationales of Article 11 violations in the Conclusions of the European Committee



First, it can be argued that violations of Article 11 based on a failure to submit data do not delineate directly the content of the right to health. Such findings highlight

⁴⁰¹ Special Rapporteur on the right to health, 'Annual Report 2006' (n 227), para 49(b).

⁴⁰² This chart is based on reporting cycles from 1969 to 2013 (inclusive). The European Committee reaches findings of non-conformity to Article 11 paragraph per paragraph. It may thus find a state up to three times in breach of Article 11 ESC in the same cycle. Furthermore, it usually bases violations of Article 11(1), (2), or (3) on either a failure to submit data or a poor performance in healthcare (the latter being sometimes associated with a performance significantly below the European average). As a result, it is possible to find several rationales in the same finding of non-conformity.

states' non-compliance with a procedural requirement, not necessarily a poor performance in healthcare. A state may fail to provide the information requested by the European Committee but still be providing appropriate curative, promotional and preventive health. Such violations, numerous in the jurisprudence of the European Committee, can thus give the distorted impression that States parties to the Charter often under-perform under the obligations expressly set by Article 11.

Second, it can be demonstrated, however, that violations of Article 11 based on a failure to submit data delineate indirectly the content of the right to health. The analysis of the reporting procedure on Article 11 stresses that the European Committee does not simply expect states to provide data. It expects them to use this information in order to show they adequately implemented the right to health. This is especially true when the European Committee must decide whether states have repaired violations of the right to health found in previous reporting cycles. For instance, Poland was found in breach of Article 11 in 2003 because of its excessive waiting times. In 2005, it had implemented a new system but was still found in violation of Article 11 for not having provided enough information. In 2009, the European Committee received a considerable amount of qualitative data but reserved its position until reception of quantitative data.⁴⁰³ The submission of information thus serves a purpose closely related to the realisation of the right to health: demonstrating compliance with the express obligations this right imposes upon states.

Third, violations of Article 11 based on a failure to submit data can delineate directly the content of the right to health. Hypothetically, the reason why states do not provide the information requested by the European Committee is likely to be their reluctance to display poor health records. Such instances can potentially correspond to a breach of the obligations expressly set by Article 11. This hypothesis is especially relevant after having observed that states held in breach of Article 11 for not having submitted data, had usually also failed to provide it in previous reporting

⁴⁰³ Non-conformity in ECSR, 'Conclusions XVI-2 (2003)', Poland; and in ECSR, 'Conclusions XVII-2 (2005)', Poland. Deferral in ECSR, 'Conclusions XIX-2 (2009)', Poland.

cycles.⁴⁰⁴ Moreover, holding states in breach of the right to health for not complying with their obligation to submit data highlights their obligation to collect it in the first place. Data collection is essential to build and maintain appropriate health systems, as it enables states to detect inadequacies and address them. How can a state be complying with its obligation to provide targeted health education if it does not know about the main diseases affecting its population? In this context, the obligation to collect data – rather than to submit it – contributes significantly in defining the legal content of the right to health.

3.3.2 The states' obligation to perform comparably with the European average: an illegitimate standard?

Following the obligation to submit data on health under Article 11 ESC, what clearly transpires from the methodology and jurisprudence of the European Committee is an obligation to perform 'comparably' with European averages, in the field of healthcare. This obligation, which arises in both the reporting and the complaint procedures, yet contributes to delineating the legal content of the right to health. First (3.3.2.1), I will analyse how, in theory, this implied obligation inadequately contributes towards defining the legal content of the right to health. Second (3.3.2.2), I will discuss how, in practice, European averages may be a heuristic method to assess the realisation of the right to health.

3.3.2.1 The legitimacy of European averages

The European Committee repeatedly uses European averages when it assesses states' performance against the health indicators developed under Article 11. It also bases many of its findings of non-conformity on states' failures to meet such figures (see Figure 6 above). The use of European averages as a method to evaluate the realisation of the right to health should therefore be questioned for several reasons.

First, the European Committee should not rely on the average states' practice to set human rights objectives regarding the right to health. This argument echoes the criticisms formulated against the 'European consensus', a method of interpretation

⁴⁰⁴ See for instance ECSR, 'Conclusions XVII-2 (2005)', Greece p 315 (regarding the submission of statistics on tobacco consumption).

sometimes used by the European Court of Human Rights.⁴⁰⁵ With the European consensus, the Court interprets the rights enshrined in the European Convention in the light of how they are applied in the majority of the States parties. This, however, has occasionally played against the recognition or protection of human rights,⁴⁰⁶ impeding the dynamism of the Court's jurisprudence. As a result, certain authors advocate for an autonomous interpretation,⁴⁰⁷ which this paper supports in the case of the European Committee. Interpreting what the right to health requires should not rely on the average states' practice but on human rights law, itself inspired from the expertise of health professionals, economists, NGOs, and other key actors.⁴⁰⁸

Second, the European averages used by the European Committee are not always accurate. These figures, calculated by the OECD or Eurostat, do not always reflect the entire European region since states sometimes fail to submit data to these agencies.⁴⁰⁹ Furthermore, Eurostat is an agency from the European Union. Therefore, its averages are based on the data of 27 countries (not 47), incidentally also the wealthiest of the CoE.

⁴⁰⁵ This method emerged in *Tyrer v United Kingdom* [1978] Chamber, 2 EHRR 1, Judgment of 25 April 1978 (ECtHR) [31]: 'The Court must also recall that the Convention is a living instrument which, as the Commission rightly stressed, must be interpreted in the light of present-day conditions. In the case now before it the Court cannot but be influenced by the developments and commonly accepted standards in the penal policy of the member States of the Council of Europe in this field' [i.e. regarding judicial corporal punishment].

⁴⁰⁶ *Rees v United Kingdom* [1987] Plenary, 9 EHRR 56, Judgment of 17 October 1986 (ECtHR) [37]: the right of transsexuals to have their acquired gender recognised on formal documentation is not recognised because there is '*little common ground*' between states in this area.

⁴⁰⁷ Daniel Regan, 'European Consensus: A Worthy Endeavour for the European Court of Human Rights' (2011) 14 *Trinity College Law Review* 51; George Letsas, *A Theory of Interpretation of the European Convention on Human Rights* (Oxford University Press 2009), see Chapter 3 on Intentionalism, Textualism and Evolutive Interpretation.

⁴⁰⁸ Tobin (n 19). See Tobin's notion of constructive engagement and its shortcomings in Lougarre (n 30).

⁴⁰⁹ Eurostat, 'Healthy Life Years and Life Expectancy at Age 65, by Sex' <<http://epp.eurostat.ec.europa.eu/tgm/refreshTableAction.do?jsessionid=9ea7d07e30e649f36a96b2024db9a48ac7acf09c8ed9.e34OaN8Pc3mMc40Lc3aMaNyTaxyMe0?tab=table&plugin=1&pcode=tsdph220&language=en>> [accessed 8 September 2015]: Turkey never submitted its figures.

Third, even if European averages were entirely accurate, it is legitimate to question the adequacy of the standards they set for each State party to the Charter. Using an average to assess the performance of European states with the most satisfactory health figures and the highest income is incoherent. In this case, not only does an average fail to set increasing objectives with regard to the right to health, it also lowers relevant standards. This is incompatible with the principle of progressive realisation, implicitly enshrined in the ESC.⁴¹⁰ Moreover, using an average to evaluate the performance of European states with the worst health figures and the lowest income is also inadequate. In this case, it may set standards that are impossible to achieve. The Charter, nevertheless, expects states to realise Article 11 ‘*as far as possible*’, which means that the objectives set by the European Committee must be reasonable.⁴¹¹

Finally, European averages are only used to assess states’ performance under health indicators that mainly require quantitative data. This creates an imbalanced monitoring of Article 11 in favour of curative healthcare, since ‘quantitative’ indicators correspond mostly to Article 11(1). Such indicators include: ‘life expectancy’; ‘main causes of death’; ‘infant and maternal mortality’; ‘access to healthcare’ (when reviewing healthcare budget or rates of reimbursement); and ‘health staff and facilities’. Fewer ‘quantitative’ indicators are found under Article 11(3), on preventive health: ‘substance abuse’ (when assessing consumption trends); and ‘immunisation’ (when evaluating coverage rates). None appears under Article 11(2), on promotional health. For obvious reasons, comparing performances in healthcare is easier with quantitative data, as poor results can be more quickly highlighted. As a result, this may lead the European Committee to evaluate certain standards more strictly than others. Health promotion and preventive health,

⁴¹⁰ ESC 1961 (n 92), Preamble; ESC 1996 (n 92), Preamble: ‘Considering that the aim of the Council of Europe is [...] facilitating their [states parties] economic and social progress [and...] ‘to improve their [populations]’ standard of living and their social well-being’.

⁴¹¹ ESC 1961 (n 92), Part I (11); ESC 1996 (n 92), Part I(11): ‘*Everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable*’. Furthermore, Art 11 (1) and (3) in both versions of the Charter mention the need to remove causes of ill-health or prevent diseases ‘*as far as possible*’.

however, are as fundamental as curative health, since they involve policies with long-term effects and can be less costly.⁴¹²

3.3.2.2 The European average: a heuristic method to measure the realisation of the right to health?

It has been demonstrated that the use of European averages to evaluate states' performance inadequately contributes in defining the right to health. After having observed how such averages are applied in practice however, this argument can be nuanced on four grounds.

First, the number of times that a failure to perform comparably with the European average is invoked by the European Committee to hold a breach of Article 11 ESC, is proportionately low compared to the number of times it uses absence of data or poor performance as rationale. This can be observed in Figure 6. Moreover, the issue of European averages is always associated with either an absence of data or, more often, an inadequate performance under Article 11. Therefore, while the European Committee relies on European averages to assert what breaches Article 11, such figures do not have an overwhelming impact on its findings of non-conformity.

Second, the findings of non-conformity based on a failure to perform comparably with the European average only target performances that are considerably below such figure. The European Committee never uses European averages to find violations of Article 11 when states' performances fall short of the average. Instead, it uses European averages as a comparative means to hold states with the worst results in the region, in breach of the right to health. The European Committee draws, therefore, a legal threshold where significantly poor results in healthcare are unacceptable, regardless of external factors such as the availability of resources within the state. While such an observation does not entirely justify the use of averages, it is in line with the minimum core approach developed by the United Nations and casts an interesting light onto the monitoring of the right to health in

⁴¹² WHO, 'Annual Report 2010' (n 194), 90.

Europe, and social rights more generally.⁴¹³ Later in this thesis, I will challenge the notion of minimum core by demonstrating the impossibility to determine what it means and by thus suggesting the adoption of a test of reasonableness instead. However, the levels of resources of the States parties to the ESC and their proximity in other areas, including healthcare, seems to allow a requirement that ‘core’ common standards are fulfilled under Article 11.

Third, violations based on a failure to perform comparably with the European average are often found in relation to an unsatisfactory evolution of states’ performance. For instance, the European Committee found Latvia and Lithuania in breach of Article 11(1) on the basis that their life expectancies were considerably below the European average, but also because they were stagnant or in decline.⁴¹⁴ This seems to echo the principle of progressive realisation implicitly recognised by the Charter. The European Committee, nevertheless, does not systematically use this rationale as it may hold a state in violation of Article 11, regardless of its efforts to improve. For example, it found Turkey in breach of Article 11(1) due to its high infant and maternal mortality rates, but without giving any weight to the considerable decrease of these figures since the last reporting cycle. It focused, instead, on the fact that these rates were still significantly above the European average.⁴¹⁵ This may, again, reflect the adoption of a minimum core approach and its prevalence over the principle of progressive realisation in certain instances.

Finally, the use of European averages has enabled the European Committee to integrate the issue of resource availability in its review, as it tends to evaluate states’ performance in healthcare depending on their level of income. As a result, the European Committee sometimes assesses the performance of a state with low income, by comparing it with the overall performance of states with similarly low incomes. This technique highlights the worst results among that group. For instance, it declares in 2001 that *‘the results achieved by Turkey in the field of health are*

⁴¹³ The UN Committee first adopted the minimum core approach in UNCESCR, ‘General Comment 3’ (n 211), para 10.

⁴¹⁴ Non-conformity in ECSR, ‘Conclusions XIX-2 (2009)’, Latvia; ECSR, ‘Conclusions 2009’, Lithuania.

⁴¹⁵ Non-conformity in ECSR, ‘Conclusions 2009’, Turkey.

significantly worse than in many other countries with a comparable income level'.⁴¹⁶ Moreover, the European Committee occasionally sets stricter standards for states with the best health systems. For example, it requires that states maintain infant and maternal mortality rates as close as possible to zero, '*especially for states with highly developed healthcare systems*'.⁴¹⁷

This Chapter outlined that the legal content of the right to health is defined by obligations expressly set by Article 11. It is also defined by obligations implied in the reporting procedure: submitting data on health and performing comparably to the European average. Whilst the latter is controversial, it enables the European Committee to lay down thresholds under which states are regarded as breaching the right to health. Considering the level of revenue available in Europe, this approach is defensible. However, it is desirable that the European Committee combines European averages more often with sub-averages in relation with states' income, in order to promote unity and fairness in its review.

3.4 Critical overview

By translating Article 11 ESC into clear express and implied obligations, the European Committee delineates precisely the legal content of Article 11 ESC. A critical overview of its interpretation must nonetheless be drawn, based on the principles of interpretation the introduction of this thesis advocates. This fourth section will demonstrate that the interpretation of the European Committee does not only define the right to health, it also affects its very substance. First (3.4.1), I will examine how the ambitious interpretation of the right to health, developed through the monitoring procedures of the European Committee, can be challenging for the coherence of its legal content. Second (3.4.2), I will argue that the evaluation of the right to health can sometimes be defective and, as a result, can weaken its substance.

⁴¹⁶ ECSR, 'Conclusions XV-2 (2001), Addendum 1', Turkey p 255 (regarding Turkey's performance under the indicators 'life expectancy' and 'main causes of mortality').

⁴¹⁷ See the standard established in ECSR, 'Conclusions 2003', France.

3.4.1 The challenges set by an ambitious interpretation of the right to health

Because it relies on a comprehensive but precise range of indicators and standards, the interpretation of the right to health by the European Committee represents a unique and ambitious development in human rights law. Nevertheless, it is fundamental to assess how the European Committee's interpretation affects the substance of the right to health and whether it clarifies it adequately. I will do so by challenging: (3.4.1.1) the adequacy of its thematic indicators; and (3.4.1.2) that of its legal standards.

3.4.1.1 The indicators used by the European Committee

Assessing the realisation of ESCR against indicators raises several issues as outlined by Green.⁴¹⁸ This subsection does not intend to address the breadth of such issues. Instead, it will explore the questions specifically raised by the thematic health indicators used in the reporting procedure of the European Committee on Article 11 ESC, in order to assess their appropriateness.

First, are indicators restricted to quantitative data? I have demonstrated in subsection 3.3.1.1 that the European Committee developed indicators embracing both quantitative and qualitative data, which enabled a comprehensive understanding of what realising the right to health meant. For instance, the indicator 'measures to combat smoking and alcoholism' requires both qualitative data (such as legislative framework) and quantitative data (such as consumption trends). Therefore, indicators are not restricted to quantitative data in that instance.

Second, are indicators designed to measure states' compliance with their obligations, or to measure individuals' effective enjoyment of their right? In the context of Article 11, most indicators measure the accessibility and availability of health services. This clearly evaluates both states' compliance with their obligations to realise the right to health, and individuals' enjoyment of this right. For instance, the European Committee uses the indicator 'environmental pollution' to hold states

⁴¹⁸ Maria Green, 'What We Talk About When We Talk About Indicators: Current Approaches to Human Rights Measurement' (2001) 23 Human Rights Quarterly 1062.

responsible for breaching their obligation to prevent environmental pollution under Article 11(3);⁴¹⁹ and to find a violation of individuals' right to a healthy environment.⁴²⁰ However, certain indicators used to assess the general state of health of the population seem to only measure states' compliance with their Article 11 obligations. The connection between one's enjoyment of her or his right to health and indicators such as 'life expectancy', 'main causes of death', or 'infant and maternal mortality rates', for instance, is far from obvious. This does not mean that such indicators are pointless. On the contrary, they allow for gross malfunctions of a health system to be identified. However, these indicators focus on duty-bearers and since Article 11 recognises a human right to protection of health, it is important to define who the right-holders are. The reporting procedure primarily aims at monitoring states' compliance with the Charter and does not offer any remedies. Therefore, it does not represent the most adequate forum to recognise victims of Article 11 violations (in contrast to the complaint procedure). Health indicators, nonetheless, also embrace right-holders: i.e. the population as a whole and several vulnerable groups recognised through the reporting procedure. It is thus crucial that the European Committee widens its understanding of vulnerability, as recommended in subsection 3.3.1.1, in order to measure individuals' effective enjoyment of their right to health more adequately.

Third, where should the boundary be drawn between human rights indicators and general development indicators? This question is closely related to the issue discussed above, that is, do indicators measure the enjoyment of a human right? I have demonstrated that the indicators used by the European Committee to review the accessibility and availability of health services, are not solely restricted to measuring states' compliance with Article 11. They also measure individuals' enjoyment of their right to health, which is reflected by the possibility for the standards developed under these indicators to be used in the complaint procedure. For instance, in *Marangopoulos Foundation for Human Rights (MFHR) v. Greece*, the European Committee used the standards developed under the indicator 'environmental

⁴¹⁹ ECSR, 'Conclusions XIX-2 (2009)', Greece; ECSR, 'Conclusions 2009', Cyprus, Georgia, Moldova.

⁴²⁰ *Marangopoulos Foundation for Human Rights v Greece* (n 372) [195 and 203].

pollution' to find a violation of individuals' right to a healthy environment.⁴²¹ This highlights that indicators reviewing the availability and accessibility of health services are clearly human rights indicators. Certain indicators, nevertheless, cannot directly measure individuals' enjoyment of the right to health, as they focus on the general state of health of the population (e.g. life expectancy and main causes of death). As a result, they have never been used to assert a breach of Article 11 in the complaint procedure and resemble at first glance general development indicators. That said, these ambiguous indicators can indirectly measure the individual dimension of the right to health when used in parallel with other indicators. For instance, the standards on 'public information and awareness-raising' and on 'health education' oblige states to design health promotion campaigns according to what has been identified under the indicator 'main causes of death of the population'. Such indicators are therefore necessary for a comprehensive review of the right to health by the European Committee, including both its individual and its collective dimension.

Finally, how many indicators are necessary to define adequately the content of a right and thus, to measure appropriately its implementation in the context of Article 11? On one hand, the high number of current indicators (i.e. 18 up to 2009) could be criticised for inflating the legal content of the right to health in theory, and for committing states to submit a considerable amount of data in practice. When discussing the obligation to submit data, I demonstrated that the indicators developed under Article 11 enabled a comprehensive understanding of what the right to health meant, and an in-depth evaluation of how it was realised. Whilst it is true that most violations of Article 11 are due to a failure to submit data, these indicators do not necessarily require states to produce new data. In fact, the European Committee frequently uses data emanating from European agencies, to whom states have already had to submit this information. On the other hand, these same indicators could also be criticised for failing to embrace fundamental issues such as ethnicity, socio-economic status, and elderly persons' health. These issues sometimes appear in the findings of the European Committee but they should be reviewed systematically, in order to ensure a uniform monitoring of such essential aspects of Article 11.

⁴²¹ *ibid.*

To conclude, albeit thematic health indicators can be criticised, they have enabled the development of a more comprehensive and transparent interpretation of the right to health than that developed by the UN Committee. The use of indicators is also especially relevant to monitoring the obligation to progressively realise the right to health, as they facilitate a follow-up of states' performance. Finally, it is worth noting that indicators are recommended by various international human rights institutions: e.g. the UN Committee on Economic, Social and Cultural Rights,⁴²² and the UN Special Rapporteur on the right to health.⁴²³ The recommendations formulated in that respect correspond relatively well to the practice of the European Committee. For instance, the Special Rapporteur specifies that indicators must be connected to established norms, must be disaggregated, and must evaluate national strategies as well as access to information, which the Article 11 indicators do. Therefore, indicators contribute to fulfilling the principles suggested by my thesis, i.e. SNHRBs' interpretation should (1) protect an effective enjoyment of the right to health; (2) set reasonable expectations upon states; (3) be sensitive to the context in which this right is implemented; (4) apply principled consistency (and be fit to supranational monitoring). However, certain improvements remain to be seen: according to these guidelines, no indicator evaluates the participation of the population or the existence of accountability mechanisms in healthcare.⁴²⁴

3.4.1.2 The standards developed by the European Committee

The right to health is explicitly recognised in Article 11 ESC, which has been translated by the European Committee into various legal standards through its reporting and complaint procedures. However, it is also enshrined (more implicitly) in other provisions of the Charter. The coherence of how these standards interact with one another should therefore be discussed, as this can affect the principled consistency of its interpretation and thus, the substance of the right to health.

First, the legal force of the standards that have been developed by the European Committee under Article 11 is not homogeneous. Certain standards have been given

⁴²² UNCESCR, 'GC14' (n 21), paras 57 and 58.

⁴²³ Special Rapporteur on the right to health, 'Annual Report 2006' (n 227), para 49.

⁴²⁴ *ibid.*

more importance than others under this provision. This can be identified either in the preciseness of their formulation, or in the strictness of their monitoring, as these differ considerably. As a result, such differences can either facilitate or impede findings of non-conformity. For instance, the legal standards developed under Article 11 (1), on curative health, seem more precise and have led to more findings of non-conformity than those developed under Article 11 (2), on preventive health. This ‘differentiation’ is particularly relevant to the standards developed under the indicator ‘infant and maternal mortality’. The European Committee declares that conformity to these standards is ‘*decisive*’ in its overall finding of compliance regarding the implementation of Article 11,⁴²⁵ which it does not assert for any other standards. Moreover, high maternal and infant mortality rates are the most common reason why the European Committee finds states in breach of Article 11 (whether basing its findings on states’ performance, or data submission, see Figure 6). The emphasis put on complying with these standards seems to reflect the adoption of a minimum core obligations approach by the European Committee. This chapter does not pretend to address the complex issues raised by a minimum core approach (these will be examined in more depth in chapter 5). Instead, it recommends caution. It is legitimate that the European Committee considers minimum levels of healthcare as being a priority in the realisation of the right to health. It is nevertheless extremely difficult to determine what services are essential and must subsequently be prioritised in healthcare. The European Committee alone does not have the expertise to carry this task, and maternal healthcare does certainly not represent the only service that should be considered as such. Finally, whilst it is important to prioritise certain aspects of Article 11, it is crucial to not under-recognise others (such as health promotion), as they define, too, the legal content of the right to health.

Second, the legal force of the provisions that protect the right to health in the Charter is not homogeneous either. As mentioned in subsection 3.1, Article 11 is not the only provision that embraces the right to health. Articles 3 and 7 deal with occupational health. Articles 13 and 19 provide for medical assistance to persons without adequate resources and to migrant workers. Finally, Articles 23 and 30 recognise the right to

⁴²⁵ Such requirement was first established in ECSR, ‘Conclusions XV-2 (2001)’, Belgium p 94.

healthcare for elderly persons and persons socially excluded or poor.⁴²⁶ These provisions all contribute towards delineating the legal content of the right to health but their scattering throughout the ESC risks blurring the normative scope of this right. Moreover, the interpretation of these provisions by the European Committee does not benefit from the same preciseness when compared to Article 11 (except, possibly, Article 3 and 7).⁴²⁷ Articles 23 and 30 were created in 1996 with the Revised Charter, thus leaving less time for an established jurisprudence to be developed than under Article 11, enshrined in the 1961 Charter.⁴²⁸ As for Articles 13 and 19, they are part of the 1961 Charter but do not benefit from standards as clear as those found under Article 11. Due to their controversial nature (health protection to non-nationals), these provisions are not as widely ratified as Article 11,⁴²⁹ and the European Committee may therefore be unable and unwilling to set regional standards. As a result, the content and protection of the right to health may appear unbalanced, according to what aspects of health, or whose health are at stake.

The uneven legal force of the standards defining the right to health in the ESC partially reflects the European Committee's attempt to strictly monitor certain aspects of the right to health, and to leave a wider margin of appreciation for others. However, the reasons behind such approach are unclear, and the approach itself seems unjustifiable since certain aspects of health are unregulated as a result (e.g. older persons' health). Therefore, such interpretation threatens the coherence given to the substance of the right to health and its implementation, going against the principle of principled consistency advocated by this thesis.

3.4.2 The issues arising from a defective evaluation of the right to health

While the interpretation of the right to health by the European Committee is unique and ambitious, the manner through which it monitors this right presents various shortcomings. It is nonetheless important to assess these shortcomings, as they may affect how the European Committee interprets the legal content of Article 11 ESC,

⁴²⁶ ESC 1961 (n 92), Art 3, 7, 13 and 19; ESC 1996 (n 92), Art 3, 7, 13, 19, 23 and 30.

⁴²⁷ ESC Secretariat, 'The right to health and the ESC' (n 323).

⁴²⁸ ESC 1961 (n 92), Art 11; ESC 1996 (n 92), Art 11, 23 and 30.

⁴²⁹ CoE, 'Signatures and Ratifications of the ESC and Its Protocols' (n 100).

(3.4.2.1) whether through its monitoring procedures, (3.4.2.2) or through the findings of non-conformity held under that provision.

3.4.2.1 The monitoring procedures on Article 11 ESC

The monitoring procedures of the European Committee regarding Article 11 are not fully adequate for several reasons, which affect how the right to health is interpreted. First, albeit the same health indicators are systematically used for every state and in every reporting cycle, the European Committee does not always evaluate them with the same tools. Considering the commonality of issues these tools attempt to assess, there is no apparent or justifiable reason why they should not be applied to all states. For instance, the European Committee consistently reviews states' performance against the indicator 'healthcare professionals and facilities' in its Conclusions, but does not always verify that these figures are fairly distributed between rural and urban areas.⁴³⁰ The danger of 'medical deserts' in rural areas, however, is a common issue. As a result, the implementation of Article 11 is not entirely monitored on the same grounds for each State party to the Charter. Whilst the right to health should be interpreted in a manner that sets reasonable expectations of review upon SNHRBs, such practice threatens the coherence of its normative scope and the procedural certainty of its review. The European Committee should, thus, not only evaluate states' performance with the same health indicators, it should also use the same 'tools' when these enable the identification of common violations of Article 11.

Second, both the reporting and the complaint procedures focus on the collective dimension of the right to health, but fail to translate what entitlements it grants to each individual. The indicators developed in the reporting procedure measure the implementation of Article 11 among the population as a whole and among certain vulnerable groups (children, women, persons living in rural areas, and, sometimes, Roma). By contrast, the collective complaint procedure enables the European Committee to review alleged violations of the right to health against any group of individuals (vulnerable or not). Nevertheless, the complaints can only be brought by

⁴³⁰ E.g. in ECSR, 'Conclusions 2005', France pp. 230–231; or in ECSR, 'Conclusions 2009', Bulgaria p 161.

a restricted number of NGOs, not by the victims themselves,⁴³¹ and must concern 'general' situations.⁴³² By establishing limited monitoring procedures, the ESC deprives the right to health from its individual scope and prevents its content from recognising adequately all right-holders. Therefore, any potential attempt from the European Committee to develop an interpretation that protects an effective enjoyment of individuals' right to health is limited.

3.4.2.2 The findings of non-conformity under Article 11 ESC

While the monitoring procedures on Article 11 present a few shortcomings, the findings of non-conformity that emerge from them weaken the legal content of the right to health on one hand, and strengthen it on the other.

First, the European Committee rarely reaches findings of non-conformity to Article 11, and even less so on the basis of states' direct failure to comply with their express obligations. Instead, most violations of Article 11 are based on a failure to fulfil the implied obligations to submit data (a requirement mainly procedural); or, sometimes, on a failure to perform comparably with European averages (a controversial requirement). Out of the 870 findings reached by the European Committee in its Conclusions on Article 11,⁴³³ 79 correspond to a violation, and only 37 of these 79 violations are due to inadequate performances in the field of healthcare. This represents only 4.2% of the total number of findings. The rarity of these findings of non-conformity seems to point at the reluctance of the European Committee to hold states in breach of the right to health in its reporting procedure. Moreover, its tendency to hide behind violations of implied obligations instead of holding violations of express obligations shows an unwillingness to engage more firmly with the legal standards developed under Article 11. However, out of the seven Merits Decisions involving Article 11 (to date), all correspond to a violation of the right to health, and all are based on states' direct failure to fulfil their express obligations.

⁴³¹ Additional Protocol ESC 1995 (n 98), Art 1(b).

⁴³² CoE, 'European Social Charter Collected Texts 6th Edition' (2008) <http://www.coe.int/t/dghl/monitoring/socialcharter/Presentation/ESCCollectedTexts_en.pdf> [accessed 8 September 2015], see Explanatory report to the 1995 Protocol, para 31.

⁴³³ Calculated according to each decision based on states' compliance with each of their three express obligations, in each reporting cycle (from 1969 to 2013).

The standards drawn from Article 11 have thus been given more legal force through the complaint procedure. Nevertheless, it should be noted that the European Committee seems less and less reluctant to reach findings of non-conformity to Article 11 through the reporting procedure. Whilst it held, respectively, 4, 2, 8, and 5 violations of Article 11 during the 2001, 2003, 2005 and 2007 reporting cycles, it found 30 violations in 2009, and 29 in 2013. Such developments reflect a positive trend but also show that the interpretation of the European Committee must protect more explicitly an effective enjoyment of the right to health through both procedures.

Second, the findings of non-conformity based on states' failure to perform comparably with the European average in healthcare, seem to reflect the adoption of two approaches: the progressive realisation and the minimum core approaches. Such assertion can be deduced from two observations mentioned in subsection 3.3.2 on European averages. The European Committee holds states responsible for breaching Article 11 when their performances fall considerably below the European average, not when they simply fall short of it (which would disregard differences between states' capabilities). This seems to reflect a minimum core obligation to realise the right to health: that to not perform significantly below the European average, regardless of the level of resources available to the state. This thesis challenges the notion of minimum core obligations as understood in Chapter 5. However, the application of this notion may be acceptable in the context of the European framework, where the level of resources and states' proximity in other areas (including healthcare) allow for common core obligations to be set under Article 11. Furthermore, the European Committee usually encourages states that perform below European averages but that demonstrate their efforts to improve the implementation of Article 11. This seems to reflect an obligation to progressively realise the right to health: that to constantly improve one's performance, regardless of the European average. It is worth noting that these findings echo the human rights-based approach of the UN Committee on Economic, Social and Cultural Rights. Such compatibility between the European and the international protection of the right to health can therefore strengthen the legal content of this right. Moreover, the progressive and core approaches as (heuristically for the latter) applied by the European Committee, seem to facilitate an interpretation of the right to health that fulfils relatively well the

principles of interpretation advocated in this thesis. According to these, SNHRBs' interpretation of the right to health should protect an effective enjoyment of the right, set realistic expectations upon states, be context-sensitive, and guarantee principled consistency.

Conclusion

In this Chapter, I examined how the European Committee interpreted the right to health and discussed whether this contributed to clarifying its legal content adequately, by studying its monitoring procedures on Article 11 ESC. Therefore, I analysed the comments formulated by the European Committee when monitoring the implementation of this right: in its reporting procedure, up to the 2013 cycle; and in its complaint procedures, up to April 2015. This research led to the conclusion that the European Committee delineates the legal content of the right to health with precision. In Section 3.1, I introduced the provisions relevant to health in the ESC, justified my choice to focus on Article 11 ESC, and described the procedures through which the latter is monitored; before outlining the methodology of my analysis in this regard. In Section 3.2, I contended that the European Committee recognised three express obligations in its jurisprudence on Article 11, clarifying the normative scope of the right to health. These concern the provision of curative health, health promotion, and preventive health. The use of a normative terminology as well as the repetition and reference to certain standards clearly point at the existence of legal standards under the right to health. Furthermore, the use of findings of non-conformity contributes to clarifying what thresholds must be reached for such standards to be considered violated. In Section 3.3, I then argued that the methodology used by the European Committee to monitor Article 11 ESC, stressed the recognition of implied obligations. Requests to submit specific data and violations held for failure to do so clearly highlight states' obligation to not only report on the implementation of the right to health, but also to collect data in order to understand the health needs of their populations. Furthermore, the use of European averages, although illegitimate in theory, represents a heuristic tool enabling the European Committee to hold states in breach of Article 11 when they perform

comparably below the average. Finally, I used these findings to draw a critical overview of the European Committee's interpretation in Section 3.4, using the principles of interpretation this thesis advocates. Firstly, I analysed the challenges and benefits of its ambitious interpretation, by discussing the use of thematic indicators and the (uneven) legal force of the various health standards developed under the ESC. Secondly, I pointed at the pitfalls of the monitoring procedures and the findings of non-conformity on Article 11, weakening the legal content of the right to health. However, due to its established jurisprudence and its unusual monitoring tools (i.e. health indicators and regional averages), the European Committee's interpretation offers an unprecedented contribution to the clarification of the right to health through supranational monitoring.

PART I:

CONCLUDING REMARKS

This thesis seeks to clarify the legal content of the right to health through supranational monitoring, in an attempt to remedy its conceptual vagueness. As a result, Part I of this thesis explored how SNHRBs could effectively contribute to clarifying the legal content of the right to health in the course of their quasi-judicial monitoring procedures.

Chapter 1 set the background. It contextualised the recognition of the right to health in international law and analysed the issues that this right currently faces, concluding that scholars failed to sufficiently clarify the excessive vagueness surrounding its legal content by examining the potential of SNHRBs in this respect. Chapters 2 and 3, therefore, analysed thoroughly how the UN and the European Committees interpreted the right to health in their monitoring procedures, using a critical, interpretative, and empirical approach. By monitoring the right to health differently, they developed distinct, although not necessarily incompatible, understandings of what it meant in practice. The UN Committee interprets the normative scope of the right to health more comprehensively, and (implicitly) recognises states' obligations to progressively or immediately realise this right. However, the lack of methodology and follow-up in its reporting procedure, impede its ability to develop a clear and consistent understanding of what Article 12 ICESCR entails. It is interesting to observe that the flexibility of this approach enables a constructive dialogue with States parties to the ICESCR, perhaps contributing towards the realisation of the right to health in practice. Contrarily to the UN Committee, the European Committee developed clear standards delineating the normative scope of the right to health, which now form its jurisprudence on Article 11 ESC. Such development has been assisted by the systematic use of indicators for each state and in each reporting cycle, and by the use of European averages. These tools enable the European Committee to identify inadequate performances in the health sector, and to reach findings of non-conformity, thus clarifying states' obligations under the right to health.

To conclude, analysing how the UN and the European Committees interpret the right to health in their quasi-judicial monitoring procedures can delineate its legal content with more precision. However, certain conceptual issues specific to the normative scope of the right to health, the nature of states' obligations to realise it, and the coherence of its content across different SNHRBs, remain unclear. They must nonetheless be addressed for this right to be interpreted, monitored, and implemented adequately. What does 'the highest standard of health attainable' mean? Is such standard the same for every country, regardless of cultures? Is everyone entitled to it? What does the obligation to progressively realise the right to health entail in practice? Should minimum core obligations be non-derogable? How can those questions be interpreted consistently when various SNHRBs are at stake? What margin should SNHRBs retain if any, in this respect?

Part II, therefore, will attempt to answer those questions in the light and for the purposes of supranational monitoring, in order to assist SNHRBs in optimising their interpretation of what the right to health entails in their procedures.

PART II:

THE RIGHT TO HEALTH TOWARDS FURTHER CONCEPTUAL CLARITY

In Part II, I will build upon the shortcomings identified in Part I, to produce a theoretical framework bringing further conceptual clarity on how the legal content of the right to health should be read in monitoring procedures, in order to optimise SNHRBs' interpretation of this right. Chapter 4 will thus study how the normative scope of the right to health should be interpreted in supranational monitoring. Chapter 5 will examine how SNHRBs should understand what states' obligations to realise this right entails. Finally, Chapter 6 will analyse how the legal content of the right to health should be interpreted across the various levels of supranational levels of human rights monitoring, to improve coherence.

Chapter 4 Clarifying the normative scope of the right to health in supranational monitoring

Introduction

As outlined by the introduction of my thesis, an adequate interpretation of the right to health must ensure an effective enjoyment of this right, set reasonable expectations upon states, be sensitive to the context in which it will be implemented and overall, it must guarantee principled consistency. However, how can SNHRBs make these principles coexist when defining the substance and scope of the right to health in practice, through their monitoring procedures? Whilst the monitoring procedures of the UN and the European Committees provide interesting findings in that regard, discussed in Chapters 2 and 3, they leave crucial conceptual issues unaddressed. What does the ‘highest standard of health attainable’ mean, is it the same everywhere, and who is entitled to such standard?

It is essential that such questions be clarified, as excessive vagueness can threaten the realisation of the right to health. This chapter will thus offer a theoretical account assisting SNHRBs in interpreting the normative scope of the right to health adequately, drawing from a critical analysis of the UN and the European Committees’ interpretation, and from an analysis of the relevant doctrine.

Unfortunately, legal scholarship has not yet managed to define comprehensively the substance and scope of the right to health.⁴³⁴ Most publications explore a human rights-based approach to health, thus failing to clarify the legal content of this right and more precisely, its normative scope. However, in *The Right to Health in International Law*, Tobin partially sheds light on what the ‘highest standard of health attainable’ entails, by clarifying its scope of interests, the freedoms associated with health, as well as the ‘availability’ and ‘accessibility’ requirements.⁴³⁵ The shortcomings of his methodology will nonetheless lead this chapter to suggest an

⁴³⁴ Marks ‘The emergence and scope of the right to health’ in Zuniga, Marks and Gostin (n 131) 3–24: When attempting to define the normative content of the right to health, Marks tends to focus on obligations specific to its implementation and on the different human rights with which it interacts, rather than on its substance *per se*.

⁴³⁵ Tobin (n 19) 4.

approach fitting the principles of interpretation set earlier, and drawing from the declaration of former UN Special Rapporteur on the right to health Professor Hunt in his 2006 Annual Report:

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.⁴³⁶

Chapter 4 is thus structured as follows. First (4.1), Chapter 4 will suggest that SNHRBs translate the right to a ‘highest standard of health attainable’ into a right to an adequate health system, for monitoring purposes. Section 4.1 will highlight the difficulties emerging from an expansive definition of health, and the subsequent need to understand the right to health as a right to an adequate health system, before examining how this can be materialised and monitored by SNHRBs. Second (4.2), Chapter 4 will study the importance for such a right to be responsive to the cultural environment in which it is to be understood. Section 4.2 will discuss how culture can threaten the realisation of the right to health on one hand, and enhance its implementation on the other, and will suggest a monitoring framework for SNHRBs’ procedures. Finally (4.3), Chapter 4 will explore the requirement for the right to health to be accessible to all, by focusing on non-nationals. Section 4.3 will thus point at the inconsistent scope of the right to health and the disproportionate restrictions reflecting tensions between universalism and states’ sovereignty, before suggesting a monitoring framework for SNHRBs.

4.1 The right to an adequate health system (the scope of interests)

The requirement according to which states must guarantee the ‘highest standard of health attainable’ is enshrined in most human rights treaties recognising a right to health.⁴³⁷ However, it is unclear what such requirement entitles individuals to; and the latter is often criticised for setting unreasonable expectations upon states. It is

⁴³⁶ Special Rapporteur on the right to health, 'Annual Report 2006' (n 227), para 4.

⁴³⁷ Except in: CERD (n 93), Art 5(e)(iv); CEDAW (n 93), Art 12; ICMW (n 93), Art 28.

nonetheless crucial to explore what the scope of interests of the right to health should entail in supranational monitoring, in order to enable SNHRBs to optimise their interpretation accordingly. In an attempt to clarify such scope through relevant literature and through a comparative analysis of the UN and the CoE, this section will thus suggest that the right to the ‘highest standard of health attainable’ be translated into the right to an ‘adequate health system’ in supranational monitoring. Firstly (4.1.1), I will discuss the issues emerging from the expansive definition of health in human rights law, justifying the need for SNHRBs to understand the right to health as a right to an adequate health system. Secondly (4.1.2), I will discuss how the substance of the right to an adequate health system can be materialised into precise legal requirements in supranational monitoring. Thirdly (4.1.3), I will assess whether the methods developed by SNHRBs such as the UN and the European Committees to rationalise health when monitoring this right, can accommodate this framework.

4.1.1 From the requirement to achieve the highest standard of health attainable to the requirement to set up an adequate health system

The right to health entails a requirement according to which states must achieve the ‘highest standard of health attainable’. Such requirement, however, is inadequately framed in human rights law and this subsection thus suggests that it is understood instead as a requirement to set up adequate health systems, at least for monitoring purposes. This will be demonstrated through: (4.1.1.1) the unrealistic expectations set by the WHO Constitution; (4.1.1.2) the incoherent standards set by human rights instruments; and (4.1.1.3) the recognition of states’ obligation to develop adequate health systems in human rights law.

4.1.1.1 The definition of health in the WHO Constitution: unrealistic expectations

The WHO Constitution 1946 is the first text that recognised the existence of a right to health in the history of international law and more precisely, a ‘right to the highest standard of health attainable’.⁴³⁸ The WHO Constitution is not a human rights treaty and thus does not intend to define the legal content of such right. However, since the

⁴³⁸ WHO Constitution (n 2), Preamble.

definition of health enshrined in its Preamble is recognised worldwide and guides international health policies, it is worth studying it when attempting to clarify what the ‘highest standard of health attainable’ means. The latter reads:

‘Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.’⁴³⁹

This definition, which associates health with a state of complete wellbeing, has generated heated debates amongst physicians, ethicists, and lawyers, as it automatically categorises persons with chronic diseases and with disabilities as being perpetually ill. Some experts argue that such formulation ignores the capacity of the human body to cope and function with chronic health challenges while reaching a feeling of wellbeing.⁴⁴⁰ Others, however, consider that health is not simply about survival and refuse to diminish the suffering experienced by these patients.⁴⁴¹ This chapter has neither the medical expertise nor the philosophical insight required to answer such a question. Instead, its purpose is to examine whether the WHO definition of health can be translated into a legal right, which I will answer negatively.

Firstly, associating health with a state of ‘complete’ physical and mental wellbeing expands the scope of the right to health unrealistically. States cannot necessarily be held responsible for health conditions genetically inherited (e.g. Down syndrome) or for common and benign viral infections (e.g. the common cold), as causation with their (in)actions cannot be established. This does not mean they should not assist individuals in accessing health services in that regard. This means that the right to health does not guarantee a right to be healthy, as recognised by the UN Committee

⁴³⁹ *ibid*, Preamble.

⁴⁴⁰ Machteld Huber and others, ‘How Should We Define Health?’ (2011) 343 *British Medical Journal* 235, 235–236.

⁴⁴¹ D. M. Lewis, ‘WHO definition of health remains fit for purpose (Letter)’ (2011) 343 *British Medical Journal* 435; Angus Tallini, ‘Health Is State of Wellbeing (Letter)’ (2011) 343 *British Medical Journal* 435.

in GC14.⁴⁴² Furthermore, states are not bound to fund every single health service. According to Wang, referring to Daniels' work:

No health care system – no matter how rich the country or how high the health expenditure per person – is able to offer unrestricted access to all treatments that may improve citizens' health.⁴⁴³

Such limits can be found in human rights instruments, which often require that states achieve the highest standard of health *attainable*, and realise it progressively. As a result, individuals cannot claim compensation for suffering from a health condition that cannot be reasonably prevented; and cannot demand access to free treatments on the sole basis that it will improve their health. This would set unrealistic standards upon states. Instead, the right to health entitles individuals with the best care possible for their conditions (e.g. physiotherapy for new-borns with Down syndrome), in the limits of states' resources. Therefore, the notion of 'completion' in the WHO definition should be understood as what is attainable.

Secondly, describing health as a state of complete 'wellbeing' tends to blur the distinction between health and happiness, and between what is fundamental to human dignity, a pillar of human rights law, and what is not. The Travaux Préparatoires of the WHO Constitution highlight intentions to adopt a '*positive health*' approach, going beyond the notion of illness and embracing that of wellbeing instead.⁴⁴⁴ Nevertheless, recognising a right to wellbeing is unrealistic. Whilst it is true that the right to health is a means to happiness in a liberal egalitarian model, it cannot *guarantee* happiness, for such notion is vague and infinite.⁴⁴⁵ Not only does the meaning of wellbeing depend on personal experiences, lifestyles or cultures; the resources it involves are unlimited. What if someone 'needs' regular and expensive spa treatments abroad to reach wellbeing? Moreover, the absence of diseases does

⁴⁴² UNCESCR, 'GC14' (n 21), para 8.

⁴⁴³ Daniel WL Wang, 'Courts and Health Care Rationing: The Case of the Brazilian Federal Supreme Court' (2013) 8 Health Economics, Policy and Law 75, 78; see Daniels 2008 (n 15).

⁴⁴⁴ WHO Interim Commission, 'Official Records No. 1 1946' (n 90), Eight meeting (Friday 22 March 1946), p 19 para 1(c).

⁴⁴⁵ Joseph Raz, 'Legal Principles and the Limits of Law' (1971) 81 Yale Law Journal 823, 836–839.

not necessarily amount to happiness: someone can be perfectly healthy but deeply sorrowful (e.g. grieving the loss of a loved one).⁴⁴⁶ It is worth noting that the Travaux Préparatoires of the WHO Constitution somehow distinguish both notions, by affirming that health is a ‘prerequisite’ to happiness.⁴⁴⁷ Therefore, it is important health remains distinct from wellbeing, at least in the context of this thesis as it aims at clarifying the legal content of the right to health for monitoring purposes.

Thirdly, another problematic aspect of the WHO definition of health is the reference to ‘social’ wellbeing. Authors such as Nussbaum, Sen, and Venkatapuram have promoted such understanding of health through the capabilities approach, by arguing that individuals should be given equal opportunities to access health and wellbeing.⁴⁴⁸ According to them, obstacles to this fulfilment (e.g. socio-economic factors, ethnicity, gender etc.) should be addressed in order for individuals to reach control over their health.⁴⁴⁹ It is of course desirable that all individuals access a state of social wellbeing, by benefiting from adequate opportunities to access a state of social wellbeing. However, it would be excessively difficult to translate this into a legal requirement and could set unreasonable expectations upon states. Such excessive inflation of the right to health would also discredit its legal existence.

To conclude, in its attempt to transcend the biomedical aspect of health, the WHO definition of health has become all-inclusive but remain limited to its individual dimension. Translating it into a legal entitlement is thus impossible for that it would set unrealistic expectations upon states. It is thus important SNHRBs consider the

⁴⁴⁶ See similar discussions in the medical community: Rodolfo Saracci, ‘The World Health Organisation Needs to Reconsider Its Definition of Health’ (1997) 314 *British Medical Journal* 1409.

⁴⁴⁷ WHO Interim Commission, ‘Official Records No. 1 1946’ (n 90), Annex 9 (Suggestions relating to the Constitution of an International Health Organisation), p 58 (Preamble).

⁴⁴⁸ See the work of Nussbaum and Sen (n 43); Venkatapuram (n 45).

⁴⁴⁹ See also Alicia Ely Yamin, ‘Defining Questions: Situating Issues of Power in the Formulation of a Right to Health under International Law’ (1996) 18 *Human Rights Quarterly* 398.

WHO definition as a historic reference,⁴⁵⁰ and turn towards human rights law instead.

4.1.1.2 The highest standard of health attainable in human rights instruments: incoherent standards

Most legally-binding human rights treaties that recognise a right to health embrace a right to ‘*the highest standard of health attainable*’, as mentioned in subsection 1.2.1.1. Such formulation can be found at the international level: in Article 12 ICESCR,⁴⁵¹ Article 24 of the Convention on the Rights of the Child,⁴⁵² and Article 25 of the Convention on the Rights of Persons with Disabilities.⁴⁵³ It can also be found at a regional level: in Article 11 ESC,⁴⁵⁴ Article 16 of the African Charter on Human and Peoples' Rights (African Charter),⁴⁵⁵ Article 10 of the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (Protocol of San Salvador),⁴⁵⁶ and Article 39 of the Arab Charter of Human Rights (Arab Charter).⁴⁵⁷ However, it is unclear what the ‘highest standard of health attainable’ means, and relying on the WHO definition of health has proven to be unhelpful.

In order to provide further guidance as to what this entails, right to health provisions often include paragraphs clarifying the types of care or services individuals are entitled to. However, the formulation found in these paragraphs can be inadequate to delineate the normative scope of the right to health. This will be illustrated through the examples of Article 12 ICESCR and Article 11 ESC.

⁴⁵⁰ As argued by Bok (n 89).

⁴⁵¹ ICESCR (n 4), Art 12.

⁴⁵² CRC (n 93), Art 24.

⁴⁵³ CRPD (n 93), Art 25.

⁴⁵⁴ ESC 1961 (n 92), Art 11 (see formulation of Part I (11)); ESC 1996 (n 92), Art 11 (see formulation of Part I (11)).

⁴⁵⁵ African Charter (n 92), Art 16.

⁴⁵⁶ Protocol of San Salvador (n 92), Art 10.

⁴⁵⁷ Arab Charter (n 92), Art 39.

Defining health by way of examples: Article 12 ICESCR

To clarify what the right to health entails, human rights treaties sometimes list some of its components as examples. However, such lists do not enable SNHRBs to define what the highest standard of health attainable means, since they are intended to be non-exhaustive and are thus inevitably limited. This is the case for instance of Article 12 ICESCR, which reads:

1. The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.
2. The steps to be taken by the States Parties to the present Covenant to achieve the full realization of this right shall include those necessary for:
 - (a) The provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
 - (b) The improvement of all aspects of environmental and industrial hygiene;
 - (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
 - (d) The creation of conditions which would assure to all medical service and medical attention in the event of sickness.⁴⁵⁸

Addressing infant, environmental and occupational health, as well as infectious diseases (listed in paragraph 2(a), (b) and (c)) is fundamental to the realisation of the right to health. Nevertheless, two issues arise.

First, the decision to list certain topics over others is unprincipled. The Travaux Préparatoires of the ICESCR show that drafters considered these issues as representing ‘important problems’.⁴⁵⁹ However, no rationale appears as to why they

⁴⁵⁸ ICESCR (n 4), Art 12.

⁴⁵⁹ ECOSOC Commission on Human Rights, ‘Summary Record of the 223rd Meeting’ (1951) UN Doc. E/CN.4/SR.223, p 12 (Mr Santa Cruz, Chile).

selected these topics in particular. Furthermore, documents drafted by the WHO in the early 1960s point at the existence of other priorities, not reflected in Article 12(2). In its 1960 annual report, the WHO revealed an agenda focused on malaria, communicable diseases, environmental sanitation, public health services, health promotion, medical training, and medical research.⁴⁶⁰ Whilst this agenda targeted infectious diseases and environmental health, listed in Article 12(2) ICESCR, it also targeted elements not listed in this provision, such as health promotion or medical training. Shortly after, the WHO released a report on the world health situation. It specified that over the last decade (1950s), the main causes of mortality had been (in descending order): heart diseases, malignant neoplasms (cancers), vascular lesions affecting the central nervous system, and accidents.⁴⁶¹ None of these conditions appear in the list established by Article 12(2) ICESCR.

Second, it is undesirable to define this right by health topics. Causes of mortality evolve over time, due to medical progress and diseases' outbreaks. The WHO declared recently that ischaemic heart disease, stroke, chronic obstructive pulmonary disease, and lower respiratory tract infections had been the 'top major killers' over the past decade'.⁴⁶² Nevertheless, Article 12(2), which was drafted in the 1940s and the 1950s, does not account for any of these issues. And it should not. It is unsure whether these causes of mortality will be the same in fifty years time, due to the nature of medicine, a rapidly changing and evolving platform.

To conclude, defining the scope of interests of the right to health through non-exhaustive lists is not particularly helpful to clarifying its legal content. Not only do lists fail to grasp the ever-changing aspect of global health, they also prioritise

⁴⁶⁰ WHO, 'Official Records of the World Health Organisation No. 105, The Work of WHO 1960: Annual Report to the Director-General to the World Health Assembly and to the UN' <http://apps.who.int/iris/bitstream/10665/85731/1/Official_record105_eng.pdf> [accessed 8 September 2015].

⁴⁶¹ WHO, 'Official Records of the World Health Organisation No. 122, Second Report of the World Health Situation 1957-1960' (1963), p 9 (on Mortality Statistics) <http://apps.who.int/iris/bitstream/10665/85752/1/Official_record122_eng.pdf> [accessed 8 September 2015]. However, the WHO acknowledges issues of data collection.

⁴⁶² WHO, 'The Top 10 Causes of Death' <<http://who.int/mediacentre/factsheets/fs310/en/>> [accessed 8 September 2015].

certain fields of health over others with no rationale. It is therefore undesirable SNHRBs define health solely by drawing a list of topics.

Defining health by its aims: Article 11 ESC

To clarify what the right to health entails, other human rights treaties may focus on its purposes. However, the drafting of human rights treaties does not necessarily involve experts in medicine, public health, ethics, or health economics. As a result, the conceptual framework on which the scope of the right to health relies may be inadequate. This is the case to a certain extent of Article 11 ESC, which reads:

With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in cooperation with public or private organisations, to take appropriate measures designed inter alia:

- (1) to remove as far as possible the causes of ill-health;
- (2) to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
- (3) to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.⁴⁶³

The framework preventive-curative care reflected by this provision (although less clearly so by the first paragraph) has the advantage of being less likely to change, since it builds upon the main two purposes of healthcare. Healthcare principally aims at avoiding the occurrence of diseases before the manifestation of signs of ill-health; or aims at treating diseases after the manifestation of such signs.

Important criticisms can be raised against the dichotomy preventive-curative healthcare nonetheless. First, such distinction is not always clear. For instance, should surgeries performed to remove solitary malignant cancerous tumours prior to metastasising, be categorised as preventive or curative care? Second, this dichotomy

⁴⁶³ ESC 1996 (n 92); ESC 1961 (n 92). The 1996 version of the ESC contains the wording 'as well as accidents' in its Art 11(3), but not the 1961 version.

is not always comprehensive. For instance, it excludes palliative care, which does not aim at ‘curing’ existing conditions, but at managing patients’ suffering. This, however, certainly does not mean that individuals have no right to palliative care.⁴⁶⁴ Third, a definition of health based on the purposes of healthcare does not clarify what preventive and curative health services states must guarantee. Should states fund mammograms for all girls and women to prevent the occurrence of breast cancer? Should states fund expensive cancer therapy when a cheaper but less effective treatment is available, and under what conditions?

Such questions, related to healthcare prioritisation and the obligation to progressively realise the right to health, involve at least four types of expertise and six parameters. Those include: expertise in public health (to assess the health needs of the population); expertise in medicine (to evaluate the effectiveness, safety and necessity of a treatment); expertise in health economics (to assess its costs and affordability); and expertise in ethics (to determine who should benefit from it, in the event of rationing). Therefore, an effective enjoyment of the right to health means that individuals in need should be able to claim for treatments that are effective, safe, necessary to improve their health, affordable, and that do not clash with the possibility for other persons to receive treatment. However, Wang considers this impossible, as treating one person often implies not being able to treat others.⁴⁶⁵ Furthermore, drawing a theoretical framework applicable to all states is also impossible, for health needs and resource availability may vary from one state to another. SNHRBs must thus delineate the scope of interests of the right to health in a manner that is comprehensive, realistic and coherent.

4.1.1.3 The right to an adequate health system: a more adequate framework

Interestingly, in GC14 the UN Committee declares that the right to health entitles individuals with a right to:

⁴⁶⁴ Backman and Stjernswärd ‘Palliative Care’, in Clapham and Robinson (n 132) 311–350; UNCESCR, ‘GC14’ (n 21), para 34.

⁴⁶⁵ Wang (n 443) 86.

‘a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health.’⁴⁶⁶

It then requires that such systems ensure healthcare that is available, accessible, acceptable and of good quality, as discussed in Chapter 2. A similar approach was advocated by the Special Rapporteur on the right to health, who affirms in his 2006 Annual Report:

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.⁴⁶⁷

Such formulation encapsulates the obligation for states to constantly strive to achieve high standards, since states must guarantee health systems responsive to the health needs of their population. However, it also allows the flexibility and reasonableness needed to determine what services are needed in each state, and whether states can afford these services.⁴⁶⁸ Finally, such formulation is not restricted to the individual dimension of health in the provision of healthcare, as this was the case with the WHO definition. It also embraces its collective dimension, by setting public health requirements such as campaigns promoting healthy behaviour or combatting unhealthy behaviour.

To conclude, the WHO definition of health and that found in human rights instruments do not clarify adequately the scope of interests of the right to health. Therefore, this thesis suggests that SNHRBs understand the right to the ‘highest standard of health attainable’ as a right to benefit from an adequate health system. However, how can SNHRBs translate such requirement into specific legal obligations?

⁴⁶⁶ UNCESCR, ‘GC14’ (n 21), para 8.

⁴⁶⁷ Special Rapporteur on the right to health, ‘Annual Report 2006’ (n 227), para 4; see also Paul Hunt and Gunilla Backman, ‘Health Systems and the Right to the Highest Attainable Standard of Health’ (2008) 10 Health and Human Rights 81.

⁴⁶⁸ See the benefits of a rights-based approach in health when focusing on local systems: Freedman ‘Drilling down: Strengthening local health systems to address global health crises’, in Clapham and Robinson (n 132).

4.1.2 Materialising the right to an adequate health system

Subsection 4.1.1 demonstrated that SNHRBs should not fully rely on the WHO definition of health or the wording found in right to health provisions, for these define health generically or restrict it to an individual dimension. Instead, they should understand the right to health as a right to an adequate health system. Subsection 4.1.2 will thus discuss how such right can be materialised into standards applicable to all states, in supranational monitoring. First (4.1.2.1), I suggest that SNHRBs interpret what constitute an adequate health system by relying appropriately on external expertise. Second (4.1.2.2), I recommend that SNHRBs recognise states' obligation to identify the health needs of their populations (and address them), as a basis for findings of non-conformity. Third (4.1.2.3), I argue that they understand social determinants of health through the principle of the interdependence of rights, to avoid inflating the scope of the right to health.

4.1.2.1 Defining adequate health systems: human rights law and external expertise

Defining precisely what services states must guarantee through their health systems is an excessively challenging task for human rights lawyers alone, including SNHRBs. What is considered as harmful to health changes over time. Research frequently identifies new evidence of how certain substances, activities or behaviours can be harmful to human health (e.g. smoking tobacco).⁴⁶⁹ What if juicing diets (a recent trend) are proved to provoke serious digestive disorders in 10 years time; should states be held responsible for not having sufficiently investigated their risks; and if yes, to what extent?

Moreover, diseases that are now particularly deadly, or disabilities that are particularly burdensome, may be better managed in the years to come thanks to medical and biomedical progress. For instance, HIV mortality is now relatively well controlled through anti-retroviral therapy; amputees' quality of life can be greatly

⁴⁶⁹ Richard Doll and A Bradford Hill, 'The Mortality of Doctors in Relation to Their Smoking Habits' (1954) 1 British Medical Journal 1451: the first time that research revealed smoking could cause lung cancer.

improved thanks to bionic prostheses; and smallpox has been eradicated.⁴⁷⁰ Such parameters modify the concept of health over time and as a result, change states' duties towards their populations in right to health monitoring (and adjudication). However, further questions arise. Does the right to health imply that states must systematically provide access to new treatments improving patients' conditions? If not, what factors should be considered, and how much importance should be given to treatments' effectiveness or costs, and to patients' quality of life?

Finally, health often interacts with the notion of human responsibility. While the latter may determine civil litigation opposing patients with health insurance companies, how should it be approached in right to health monitoring (and adjudication)? Should a state provide expensive palliative care to a heavy smoker with lung cancer, although it deployed multiple awareness-raising campaigns against tobacco and provided free lung cancer screening to its population? Whilst this thesis does not suggest it should not, justifications are required.

Human rights law cannot answer these questions alone and certainly not generically. Therefore, it is crucial that the definition of 'adequate health systems' is constantly guided by the expertise of medical and public health professionals, as well as healthcare lawyers, economists and ethicists. This is how Tobin suggests that the right to health is clarified, by advocating for an interpretative approach based on a constructive engagement with its key actors.⁴⁷¹ Nonetheless, two shortcomings can be observed in this approach.⁴⁷² They highlight both the limits of external expertise and the importance of a principled methodology.

It is morally undesirable that the scope of interests of the right to health is defined entirely through consensus between key actors. What if, hypothetically, the majority of the interpretative community contended that the highest standard of health attainable implied mandatory HIV screening on pregnant women, in breach of

⁴⁷⁰ WHO, 'Smallpox and Its Eradication' (1988) <<http://whqlibdoc.who.int/smallpox/9241561106.pdf>> [accessed 8 September 2015], Chap 24 to 27.

⁴⁷¹ Tobin (n 19).

⁴⁷² Lougarre (n 30).

human rights norms?⁴⁷³ Therefore, I suggest that SNHRBs determine the adequacy of health systems by relying primarily on the cornerstones principles of human dignity and non-discrimination, and then on external expertise. How should this be done?

In order for the scope of interests of the right to health to be coherent, it is necessary that it is interpreted through a principled methodology. What if, hypothetically, half of the interpretative community argued that HIV testing on pregnant women should be mandatory, and the other half believed that it should simply be recommended? As a result, I suggest that SNHRBs interpret the highest standard of health attainable by respecting four principles. These are inspired from the principles developed by Tobin,⁴⁷⁴ but readjusted by order of importance to address his shortcomings and reach the aim of this thesis, i.e. clarifying the legal content of the right to health through and for supranational monitoring. Firstly, SNHRBs' interpretation of the right to health must be coherent within its legal system to ensure principled consistency: it must respect established principles of international human rights law. Secondly, their interpretation must be expertise-based to ensure an effective enjoyment of the right to health and set reasonable expectations upon states. It must rely on established research in medicine, public health, healthcare ethics, health economics, and health law. Thirdly, SNHRBs' interpretation of the right to health must be context-sensitive: it must be adapted to the environment in which the right is to be implemented to be more effective, as later discussed in subsections 4.1.2.2 and 4.2. Finally, their interpretation must be clear and practical to be fit to supranational monitoring, as excessive vagueness threatens the realisation of the right to health.⁴⁷⁵

It could be argued that such methodology is fastidious, and that expertise is not always necessary in right to health monitoring and adjudication, when health systems are obviously inadequate. In Sierra Leone, for example, the number of maternal mortality reached 1,100 deaths per 100,000 live births before the Ebola outbreak, by

⁴⁷³ For instance, see the arguments put forward by Udo Schuklenk and Anita Kleinsmidt, 'Rethinking Mandatory HIV Testing During Pregnancy in Areas With High HIV Prevalence Rates: Ethical and Policy Issues' (2007) 97 *American Journal of Public Health* 1179.

⁴⁷⁴ Tobin (n 19) 88–118.

⁴⁷⁵ Lougarre (n 30) 340–341.

far the highest figure worldwide.⁴⁷⁶ Should Sierra Leone be automatically held accountable for breaching the right to health, since it clearly failed to provide basic maternal care, ‘core’ component of this right?⁴⁷⁷ Whilst this figure clearly reflects an inadequate health system and potentially represents a violation of this right, Sierra Leone’s compliance with human rights law must be also examined in the light of its resources and efforts. As outlined by Article 2(1) ICESCR and by the word ‘attainable’, states must progressively realise the right to health, according to the resources available to them. This will be discussed in depth in Chapter 5. Such requirements are time-consuming, but so is the rule of law. However, this does not mean that no generic obligation can be derived from the right to health.

4.1.2.2 The obligation to identify (and address) health needs

In order to set up any adequate health system, it is fundamental states first understand the particular health needs of their populations. As argued by Alston, states are primarily accountable for *devising* adequate means to implement ESCR.⁴⁷⁸ Furthermore, this facilitates the principle of context-sensitivity advocated by this thesis, according to which SNHRBs interpret the right to health by considering the environment in which it is to be implemented. Whilst it is excessively challenging for human rights lawyers, including SNHRBs, to define what is an adequate health system, they should recognise states’ obligation to identify (and address) the health needs of their populations.

Firstly, such obligation represents the essence of reporting procedures before SNHRBs. Chapters 2 and 3 demonstrate that these procedures do not simply require that states provide data on their health systems. They also require that states collect the data in the first place, which eventually forces them to observe the successes and failures of their health systems. Therefore, identifying populations’ needs is essential to the design of appropriate health policies, as highlighted by the UN and the

⁴⁷⁶ WHO, ‘Trends in Maternal Mortality: 1990 to 2013. Estimates by WHO, UNICEF, UNFPA, The World Bank and the United Nations Population Division’ (2014), p 7 <<http://www.who.int/reproductivehealth/publications/monitoring/maternal-mortality-2013/en/>> [accessed 8 September 2015].

⁴⁷⁷ UNCESCR, ‘GC14’ (n 21), para 44(a).

⁴⁷⁸ Alston 1987 (n 152) 357.

European Committees when commenting on states' reports.⁴⁷⁹ Some may contend that this obligation is costly, as numerous administrative means must be established to collect data in the health sector. However, the analysis of the sources used by the European Committee and the interviews conducted with UN Committee members in May 2014, reveal that data is often available and that reporting procedures tend to require that states compile data rather than collect it. As for states in which the data is unavailable, the obligation to identify health needs represents a preliminary step to providing appropriate healthcare. Assistance by intergovernmental agencies and NGOs is thus crucial in this concern.

Secondly, states' obligation to identify the health needs of their populations is related to the principle of non-discrimination, a pillar of human rights law. According to this principle, states must refrain from committing *de jure* and *de facto* discrimination. States must ensure everyone can access their health systems on the same basis, in law and in practice. Such requirement is clearly recognised through the monitoring procedures of the UN and the European Committees. For example, in its complaint procedure, the European Committee declared that: '*[t]reating the migrant Roma in the same manner as the rest of the population when they are in a different situation constitutes discrimination*'; and found a breach of Article 11 ESC.⁴⁸⁰ However, *de facto* discrimination can be difficult to detect. Avoiding them obliges states to collect disaggregated data in order to verify that groups vulnerable to health discrimination enjoy their right to health to the same extent than the rest of the population. Both the UN and the European Committees regularly request that states provide such disaggregated data in their monitoring procedures.⁴⁸¹ As a result, the principle of non-discrimination implies positive actions from states towards vulnerable groups,

⁴⁷⁹ For instance, in its Conclusions 2013, the European Committee finds Poland in breach of Article 11 for excessively long waiting lists, after having balanced it with the improvements brought by a legislation aimed at effective data collection.

⁴⁸⁰ *Médecins du Monde v France* (ECSR) (n 399) [163].

⁴⁸¹ E.g. UNCESCR, 'Concluding Observations Congo 2012' (n 172), para 20: 'The Committee also requests the State party to furnish recent statistics, disaggregated by sex, urban/rural location and year, on the various indicators, such as morbidity and mortality rates, used to measure the enjoyment of the right to health.'

which seems forgotten by the ‘negative’ dimension of the obligation to respect.⁴⁸² This is clearly established in the jurisprudence of the UN and the European Committees, when reviewing *de facto* health discrimination.⁴⁸³ In its last Concluding Observations on France, for instance, the UN Committee observed that despite the existence of a universal healthcare coverage, undocumented migrant workers and asylum-seekers had difficulty in accessing healthcare. It highlighted that the lack of awareness, the complexity of administrative procedures, and the language barriers impeded their access to the health system, and asked France to remedy the situation.⁴⁸⁴

In order to prevent *de facto* health discrimination, it is nonetheless crucial to conceptualise what vulnerability represents in access to health. GC14, the UN Special Rapporteur on the right to health, the UN and the European Committees all identify the following groups as vulnerable to health discrimination: women; children and adolescents; old persons; persons with disabilities; lesbians, gays, bisexuals and transgender persons; ethnic or national minorities; indigenous populations; the poor; the homeless; migrants, refugees or stateless persons; prisoners; persons living in rural areas; persons living with HIV; and other persons with a particular religion, political opinion or birth status. However, few authors have written about what constitutes a vulnerable group in human rights law. Chapman and Carbonetti interestingly distinguish vulnerable groups with fixed status (e.g. women, persons with disabilities, etc.) from vulnerable groups with variable statuses (e.g. the poor, the homeless).⁴⁸⁵ Fixed vulnerable statuses would involve permanent protection against health discrimination, while variable vulnerable statuses would involve temporary protection. Nevertheless, further questions arise. What are the obligations binding states to guarantee vulnerable groups’ right to

⁴⁸² UNCESCR, ‘GC14’ (n 21), paras 33 and 34: states must ‘refrain from’ denying or limiting access to healthcare for vulnerable groups.

⁴⁸³ E.g. UNCESCR, ‘Concluding Observations Netherlands 2010’ (n 205), para 25(b): the UN Committee urged the state to ensure *de facto* minimum levels of health to undocumented migrants.

⁴⁸⁴ UNCESCR, ‘Concluding Observations France 2008’ (n 287), paras 26 and 47.

⁴⁸⁵ Audrey R Chapman and Benjamin Carbonetti, ‘Human Rights Protections for Vulnerable and Disadvantaged Groups: The Contributions of the UN Committee on Economic, Social and Cultural Rights’ (2011) 33 Human Rights Quarterly 682, 706.

health? Since human rights law clearly recognises persons living with HIV as being a vulnerable group, does that mean any person with a particular health status can be considered as such? If not, why; and how can this work in the context of right to health monitoring? Further research is needed to answer these questions.

Thirdly, states' obligation to identify the health needs of their population derives from the obligation to deploy health promotion campaigns targeting the main health issues affecting the population. Such obligation, recognised by the UN and the European Committees, inevitably involves collecting data to detect what main health issues affect populations' health. This includes, for instance, providing sufficient education in SRH, if teenage pregnancies rates are high;⁴⁸⁶ or providing preventive measures for diseases with a high morbidity or mortality.⁴⁸⁷

Fourthly, identifying the health needs of the population is crucial to an adequate epidemiological monitoring of communicable diseases such as HIV. The evolution of the number of patients infected by a particular virus and the adequacy of measures to control it, are both regularly reviewed by the UN and the European Committees. This, again, requires that states collect a certain type of data to understand what are populations' needs in this concern.

Finally, fulfilling the obligation to identify the health needs of the population can also assist states in prioritising their resources within the health sector. If the data collected shows a particularly high suicide rate and a very low maternal mortality rate, evidently the state does not immediately need to increase the budget allocated to obstetric care but must urgently expand that allocated to mental health services. However, SNHRBs should not translate states' obligation to identify the health needs of their populations into a requirement to constantly collect data for all health issues and for all vulnerable groups. This would set unrealistic expectations upon states. Instead, it requires that states develop an intelligent understanding of health needs. One issue remains, nonetheless: what types of health needs are SNHRBs ready to consider? Should they extend it to social determinants of health?

⁴⁸⁶ As requested by UNCESCR, 'Concluding Observations Ecuador 2012' (n 216), para 28.

⁴⁸⁷ As requested by ECSR, 'Conclusions XIX-2 (2009)', Greece pp. 213-214.

4.1.2.3 The inflation caused by social determinants of health

In order to be in good health, it is crucial individuals access adequate food, water, housing, and live in a healthy environment. Such parameters, commonly called 'social determinants of health', are clearly recognised by the WHO and by the UN Committee, in GC14.⁴⁸⁸ It is also worth noting that the Travaux Préparatoires of the WHO Constitution recognise that wellbeing results from '*positive factors, such as adequate feeding, housing, and training.*'⁴⁸⁹ Nevertheless, defining health needs through social determinants of health raises two issues in the context of right to health monitoring (and adjudication) by SNHRBs: they widen its scope of interests considerably and unduly.

The right to health has often been criticised for being too vague and too complex to be adjudicated. Therefore, incorporating social determinants of health into its definition increases considerably its scope and thus, the complexity of its legal content as each determinant requires a different type of expertise. This decreases the likelihood of successful adjudication and, even, monitoring. Moreover, other parameters have a determining effect on individuals' health. Work-life balance, social background, and education, for instance, have all been proven to affect individuals' health. Why not considering them as social determinants of health? It is desirable to understand health needs through a capabilities approach in order to design better policies, as advocated by Venkatapuram.⁴⁹⁰ However, it is impractical to translate the overall picture in right to health monitoring.

Furthermore, it is unnecessary to extend the scope of the right to health to social determinants such as food, water, sanitation, housing, and healthy environment. These elements have already been translated into rights of their own in human rights law. At the international level, the rights to food, water, sanitation and housing have emerged from Article 11 ICESCR on the right to an adequate standard of living,⁴⁹¹ as

⁴⁸⁸ UNCESCR, 'GC14' (n 21), para 4.

⁴⁸⁹ WHO Interim Commission, 'Official Records No. 1 1946' (n 90), Annex 9 (Suggestions relating to the Constitution of an International Health Organisation), p 58 (Preamble).

⁴⁹⁰ Venkatapuram (n 45).

⁴⁹¹ ICESCR (n 4), Art 11.

attested by various General Comments drafted by the UN Committee.⁴⁹² Furthermore, the UN shows willingness to recognise a right to a healthy environment, as suggested by UNGA resolutions and by the Independent Expert on the issue of human rights obligations relating to the enjoyment of a safe, clean, healthy and sustainable environment.⁴⁹³ At a regional level, these rights are also protected but less homogeneously. Article 21 of the African Charter, on the right to dispose of natural resources, tends to be interpreted as protecting the rights to food, water, and healthy environment.⁴⁹⁴ Articles 11 and 12 of the Protocol of San Salvador clearly recognise rights to food and to a healthy environment.⁴⁹⁵ Finally, Article 31 ESC explicitly protects a right to housing,⁴⁹⁶ and Article 11 is usually interpreted as protecting the right to a healthy environment.⁴⁹⁷

Therefore, it is preferable that SNHRBs understand interactions between the right to health and social determinants through the principle of the interdependence of rights, as argued by Tobin.⁴⁹⁸ This would avoid complexifying the monitoring and adjudication of the right to health. I thus recommend that social determinants of health only be monitored through the right to health under three non-cumulative conditions.

⁴⁹² UNCESCR, 'General Comment No. 4: The Right to Adequate Housing (Art 11 (1))' (1991); UNCESCR, 'General Comment No. 12: The Right to Adequate Food (Art 11)' (1999); UNCESCR, 'General Comment No. 15: The Right to Water (Art 11)' (2003).

⁴⁹³ UNGA, 'Need to Ensure a Healthy Environment for the Well-Being of Individuals' (1990) UN Doc. A/RES/45/94; Human Rights Council, 'Preliminary Report of the Independent Expert on the Issue of Human Rights Obligations Relating to the Enjoyment of a Safe, Clean, Healthy and Sustainable Environment' (2012) UN Doc. A/HRC/22/43, paras 12–17.

⁴⁹⁴ African Charter (n 92), Art 21.

⁴⁹⁵ Protocol of San Salvador (n 92), Art 11 and 12.

⁴⁹⁶ ESC 1996 (n 92), Art 31.

⁴⁹⁷ *Marangopoulos Foundation for Human Rights v Greece* (n 372) [195]: 'The Committee has therefore taken account of the growing link that states party to the Charter and other international bodies (see below) now make between the protection of health and a healthy environment, and has interpreted Article 11 of the Charter (right to protection of health) as including the right to a healthy environment'. See also CoE Parliamentary Assembly, 'Recommendation 1885 Drafting an Additional Protocol to the European Convention on Human Rights Concerning the Right to a Healthy Environment' (2009) <http://www.coe.int/t/dghl/standardsetting/hrpolicy/other_committees/GT-DEV-ENV_docs/erec1885.pdf> [accessed 8 September 2015].

⁴⁹⁸ Tobin (n 19) 130–132.

Firstly, SNHRBs may monitor social determinants of health through the right to health if they have an *actual* impact on individuals' health. They should, thus, not be reviewed for the *potential* impact they may have. Such approach is adopted by the UN Committee, as it only refers to Article 12 ICESCR when food, water, environment or housing issues have an *actual* impact on individuals' health. Malnutrition,⁴⁹⁹ water contamination,⁵⁰⁰ the absence of a sewage system,⁵⁰¹ and air pollution⁵⁰² are thus sometimes mentioned in its comments on Article 12. The UN Committee reviews their *potential* impact (i.e. national standards, monitoring systems, and budgets in place) under Article 11 ICESCR instead. As a result, this approach avoids inflating the scope of the right to health while enabling the development of a more comprehensive and, thus, protective jurisprudence under each right.

Secondly, SNHRBs monitoring the right to health may exceptionally consider the *potential* impact of social determinants on individuals' health, in the context of health promotion campaigns. This approach is adopted by the European Committee in its jurisprudence on Article 11(2), since it considers that states must take measures to warn their populations against risks factors impeding their health. It thus expects states to raise awareness in schools and among the overall population on healthy-eating, environmental issues, and any health issues predominant in the country.⁵⁰³ That way, the relations between social determinants of health and the right to health are acknowledged but limited to a realistic monitoring or adjudicatory framework.

Finally, whilst it is not desirable that SNHRBs monitor social determinants of health through the right to health for their *potential* impact on health (except for promotion

⁴⁹⁹ UNCESCR, 'Concluding Observations Sri Lanka 2010' (n 187), para 33. This issue was reviewed under Articles 11 and 12.

⁵⁰⁰ UNCESCR, 'Concluding Observations Tanzania 2012' (n 176), para 25. This issue was reviewed under Article 12.

⁵⁰¹ UNCESCR, 'Concluding Observations Chad 2009' (n 293), para 31. This issue was reviewed under Article 12.

⁵⁰² UNCESCR, 'Concluding Observations Kazakhstan 2010' (n 247), para 35. This issue was reviewed under Article 12.

⁵⁰³ First established in ECSR, 'Conclusions XV-2 (2001)', Belgium pp. 96–99; and in ECSR, 'Conclusions 2005', Moldova pp. 450–452.

purposes), it represents a heuristic tool to protect rights that do not benefit from sufficient recognition. For instance, when the European Committee evaluates the implementation of Article 11 ESC in its reporting procedure, it systematically reviews standards and measures taken on food safety; water, soil and air pollution; ionising radiation; and asbestos. As a result, it assesses the potential impact that such issues may have on individuals' health (in the event such standards or measures are deemed inadequate). In theory, such monitoring is not desirable since food, water, environment and housing significantly inflate the scope of the right to health. However, the ESC does not explicitly recognise a right to food, water or sanitation. It recognises a right to housing in Article 31 of the revised ESC, but the latter is not ratified by all Member States.⁵⁰⁴ Therefore, if the European Committee did not incorporate these issues in its interpretation on Article 11 ESC, they would remain unmonitored, at the expense of individuals' basic human rights.

To conclude, the right to the highest standard of health attainable should be understood as the right to an adequate health system and its normative content should be materialised into clear legal requirements, to fit supranational monitoring. However, SNHRBs inevitably rationalise this concept by choosing certain methods over others to monitor it, as studied in Chapters 2 and 3. It is thus worth examining whether the methodology used in their monitoring procedures accommodates these suggestions.

4.1.3 Monitoring the right to an adequate health system

This thesis contends that in order for SNHRBs to optimise their interpretation of the scope of interests of the right to health, not only must they rely on a framework clarifying adequately its substance, they must also monitor the concept of health appropriately. Since this thesis focuses on the UN and the European Committees, I will assess whether the approach and methods adopted in their monitoring procedures accommodate the suggestions developed in subsections 4.1.1 and 4.1.2. I will thus reflect on the adequacy of: (4.1.3.1) the use of indicators by the European Committee; (4.1.3.2) and the use of an ad hoc review by the UN Committee.

⁵⁰⁴ ESC 1996 (n 92), Art 31; CoE, 'Table of Accepted Provisions of the ESC' (n 337).

4.1.3.1 Using health indicators for a clearer substance: the European interpretation

Since 2001, the European Committee systematically uses the same eighteen thematic indicators for each State party and in each reporting cycle, to assess states' performance under Article 11 ESC. Each of these indicators measures compliance with one of the three express obligations set by this provision: obligation to provide curative healthcare, health promotion, or preventive healthcare. As discussed in Chapter 3, the structure and consistency of this method has enabled the development of a precise jurisprudence delineating what curative, promotional and preventive services states must guarantee in order to ensure an adequate health system and consequently, to realise the right to health. Therefore, the use of thematic health indicators presents several benefits. First, indicators enable SNHRBs to set common standards within their jurisdiction, and to justify why. Second, they guarantee transparency and legal certainty for both duty-bearers and right-holders. Third, thematic health indicators leave the flexibility needed for SNHRBs to take into consideration the health needs or resources constraints specific to each state. Finally, they can successfully channel the obligation I recommend SNHRBs to recognise: that for states to identify the health needs of their populations.

Nevertheless, such approach tends to freeze the legal content of the right to health into a set list of issues, criticised in the context of Article 12(2) ICESCR. This can be observed through the reporting procedure of the European Committee, as the development of its jurisprudence under Article 11 ESC relies entirely on the themes embraced by these indicators. As a result, if indicators fail to cover a specific health issue, the European Committee is unlikely to monitor it or to develop norms in that regard. For instance, the European Committee has not created any indicator on individuals' access to contraceptives and, consequently, has not developed any standard in this area. The importance for health systems to incorporate reproductive health services is yet clearly acknowledged by experts and human rights law has since recognised states' obligation to provide access to such services.⁵⁰⁵ However, a state could potentially conform to Article 11 ESC without guaranteeing affordable

⁵⁰⁵ UNCESCR, 'GC14' (n 21), para 34, CEDAW (n 93), Art 12.

contraception to its population.⁵⁰⁶ This highlights the importance for SNHRBs to not act alone and the failure of the European Committee to use external expertise to devise and update its indicators in order to grasp what adequate health systems individuals should be entitled to, as I suggested previously.

Therefore, a static monitoring of the right to health by SNHRBs can lead to a static interpretation of what the highest standard of health attainable entails. Thematic indicators can help SNHRBs rationalising health for the purpose of right to health monitoring (or adjudication). However, they must be designed and updated through the guidance of medical and public health experts, to ensure they grasp adequately the scope of interests of this right. Would an ad hoc review be thus more beneficial?

4.1.3.2 Using an ad hoc review for a more comprehensive substance: the UN interpretation

Contrarily to the European Committee, the UN Committee uses no indicators and reaches no findings of non-conformity when assessing the realisation of the right to health. Moreover, it does not use the AAAQ framework created by GC14 in its Concluding Observations.⁵⁰⁷ Therefore, delineating what the UN Committee interprets as being an adequate health system can only be deduced from what repeatedly represents a source of concern or satisfaction in its Concluding Observations. As outlined in Chapter 2, such absence of methodology leads to issues being reviewed for certain states and not others, or for the same state but not in all reporting cycles, without any clear and legitimate rationale to justify it. This clearly impedes the capacity of the UN Committee to develop a jurisprudence on the right to health that is as coherent and precise as the European Committee's. For instance, in 2012, it expressed concern over the high prevalence of HIV/AIDS in Ecuador and

⁵⁰⁶ For instance, see the findings of conformity to Article 11(1) (or the findings of non-conformity that are not based on unaffordable access to contraception), in ECSR, 'Conclusions XX-2 (2013)' Czech Republic, Denmark, Latvia; and in ECSR, 'Conclusions 2013', Bulgaria, Cyprus, Finland, Lithuania, Romania. However, the NGO IPPF recently found that those countries were not reimbursing contraceptive methods in IPPF (European Network), 'Barometer on Women's Access to Modern Contraceptive Choice' (2015), pp. 22–23

<http://www.ippfen.org/sites/default/files/Barometer_final%20version%20for%20web%20%282%29_0.pdf> [accessed 8 September 2015].

⁵⁰⁷ UNCESCR, 'GC14' (n 21), para 12.

not in Tanzania,⁵⁰⁸ while the prevalence of HIV among adults was 0.4% in Ecuador and 5% in Tanzania at the time.⁵⁰⁹ Therefore, not only does its ad hoc review fail to secure transparency or legal certainty for duty-bearers and right-holders, it also fails to interpret the scope of interests of the right to health through the standards I suggested. These include: developing an understanding of what constitutes an adequate health system, by using appropriately external expertise and by recognising states' obligation to identify the health needs of their populations.

Nevertheless, such lack of methodology does not prevent the UN Committee from examining in depth certain health issues. On the contrary, its ad hoc review enables crucial topics that remain unmonitored by the European Committee, to be explored. This is particularly true regarding mental health, and SRH. Two main hypotheses as to why the UN Committee reviews these topics and not the European Committee can be drawn. Contrarily to the ESC, the ICESCR recognises the right to physical *and* mental health,⁵¹⁰ which might motivate the UN Committee to review mental healthcare. Furthermore, the UN Committee receives more NGOs shadow reports than the European Committee in its reporting procedure, many of these concern SRH issues, as discussed in Chapter 2.

To conclude, the UN and the European Committees' interpretations of what constitutes an adequate health system tend to point towards a similar understanding overall. However, they fail to develop an understanding of health that is both comprehensive and coherent. This could be enhanced by using external expertise appropriately to define what constitutes an adequate health system, and by recognising states' obligation to identify (and address) the health needs of their populations.

⁵⁰⁸ UNCESCR, 'Concluding Observations Ecuador 2012' (n 216), para 30; UNCESCR, 'Concluding Observations Tanzania 2012' (n 176).

⁵⁰⁹ WHO, 'Data on the Size of the HIV/AIDS Epidemic: Prevalence of HIV among Adults Aged 15 to 49 (Data by Country, Years 2012, 2006, and 2001)' <<http://apps.who.int/gho/data/node.main.622?lang=en>> [accessed 8 September 2015].

⁵¹⁰ ICESCR (n 4); ESC 1996 (n 92).

4.2 The right to a health system responsive to its cultural environment (the scope of application)

Whilst it is clear that an adequate health system must respond to the health needs of the population and to ‘local priorities’,⁵¹¹ it must also respond to its cultural environment. However, it is unclear how the scope of application of the right to health should be defined in the context of cultural diversity, yet omnipresent in supranational settings. This raises two crucial questions. Are individuals entitled to the same healthcare worldwide, irrespective of their cultures or traditions? How can human rights law avoid becoming a tool of legal exploitation and abuse over cultural diversity? It is thus fundamental this section clarifies what the scope of application of the right to health should entail in supranational monitoring, to enable SNHRBs to optimise their interpretation accordingly. Following the study of relevant literature and the analysis of the two frameworks studied in this thesis, i.e. the UN and the CoE, I offer two arguments. On one hand (4.2.1), cultural relativism can threaten the realisation of the right to health. SNHRBs should thus disregard cultural arguments attempting to justify a violation of this right. On the other hand (4.2.2), cultural considerations can enhance the implementation of the right to health. SNHRBs should thus adopt a context-sensitive approach in their interpretation. Lastly (4.2.3), I will assess whether the approach developed by SNHRBs such as the UN and the European Committees when monitoring the impact of cultural issues on health, can accommodate this framework.

4.2.1 Cultural relativism and health

Human rights law clearly recognises a universal right to health entitling every human being, in every state, to the highest standard of health attainable. However, the concept of universal human rights has been heavily criticised by cultural relativist scholars. In 1947, the American Anthropological Association released a statement warning against the dangers of a colonialist attitude in human rights law.⁵¹² It declared that respect for individuals entailed respect for their cultural differences,

⁵¹¹ Special Rapporteur on the right to health, 'Annual Report 2006' (n 227), paras 4 and 7.

⁵¹² American Anthropological Association, Executive Board, ‘Statement on Human Rights’ (1947) 49 American Anthropologist 539. :

that no qualitative technique could assess cultures, and that standards depended on the culture in which they were formed. Today, authors such as Renteln continue to argue that individual rights and the standards they set are irrelevant to non-Western cultures, where the notions of community and cultural heritages prevail.⁵¹³

Such arguments, nonetheless, can be primarily rejected on three grounds. First, globalisation can soften the sharpest edges of cultural boundaries. Second, the recognition of social rights was initially encouraged by Latin American and Communist states. Third, opposing Western to Asian, African, or South American values dismisses the diversity of cultures in each ‘bloc’.⁵¹⁴ In the context of the right to health, the values of human dignity and equality in access to healthcare, as well as states’ duty to guarantee an adequate health system, are all subject to global consensus (e.g. 164 states are currently bound to Article 12 ICESCR).⁵¹⁵ This was demonstrated in Chapter 1, through the long history of public health and the worldwide recognition of a human right to health. Moreover, it cannot be said that these values have been imposed on ‘non-Western states’, since the latter have adopted regional or national instruments across the globe recognising also a right to the highest standard of health attainable. Therefore, SNHRBs should not allow culture to justify a breach of the right to health. According to GC14, the only justifications SNHRBs may accept to review should be based on severe public health matters or resources’ constraints, and these should be limited in time.⁵¹⁶

However, rejecting cultural relativists’ arguments in theory neither prevents clashes between the right to health and cultural beliefs from occurring, nor does it solve them in practice. Two types of tensions usually arise between the implementation of the right to health and the cultural beliefs of a community, begging questions on how SNHRBs should monitor the right to health in such circumstances.

⁵¹³ Alison Dundes Renteln, ‘Relativism and the Search for Human Rights’ (1988) 90 *American Anthropologist* 56.

⁵¹⁴ Amartya Sen, *Human Rights and Asian Values* (Carnegie Council on Ethics and International Affairs 1997).

⁵¹⁵ E.g. UN Treaty Collection, ‘Status of the ICESCR’ (n 157).

⁵¹⁶ ICESCR (n 4), Art 2(1) and 4; UNCESCR, ‘GC14’ (n 21), paras 28 and 29.

Firstly, when implementing the right to health involves eliminating traditional practices harmful to health.⁵¹⁷ Practices such as binding of new-borns; blood letting; cosmetic mutilation (e.g. neck rings); withholding food; male circumcision; FGM; etc. have all been proved to be harmful to human health.⁵¹⁸ As a result, they contravene the possibility for individuals to enjoy the highest standard of health attainable. SNHRBs should thus not allow such practices to persist in the name of cultural heritage.⁵¹⁹ However, should SNHRBs ask states to blindly impose prohibitions that communities disagree with, in the name of a right to health they do not wish to benefit from? Secondly, tensions between cultural beliefs and the right to health can also arise in situations where implementing this right involves creating services going against the religious beliefs present in the state. This is especially recurrent in the field of SRH. Public health experts clearly agree that access to abortion services, sexual health education, and affordable contraception to teenagers, are fundamental to populations' health.⁵²⁰ As a result, not providing them would contravene the highest standard of health attainable of the population and SNHRBs

⁵¹⁷ UNCESCR, 'GC14' (n 21), paras 21, 22, 35, 36, 37 and 51.

⁵¹⁸ Council on Violence against Children, 'Violating Children's Rights: Harmful Practices Based on Tradition, Culture, Religion or Superstition' (2012), pp. 19–39 <http://srsg.violenceagainstchildren.org/sites/default/files/documents/docs/InCo_Report_15_Oct.pdf> [accessed 8 September 2015].

⁵¹⁹ It is worth noting that such argument is also supported by the Independent expert in the field of cultural rights, Farida Shaheed, 'Annual Report to the Human Rights Council (Main Focus: The Right of Access to and Enjoyment of Cultural Heritage)' (2011) UN Doc A/HRC/17/38, para 74: '*International instruments clearly state that practices contrary to human rights cannot be justified with a plea for the preservation/safeguard of cultural heritage, cultural diversity or cultural right*'. She refers to (among others) the UNESCO Convention for the Safeguarding of the Intangible Cultural Heritage 2003, Art 2 (1): '*consideration will be given solely to such intangible cultural heritage as is compatible with existing international human rights instruments, as well as with the requirements of mutual respect among communities, groups and individuals, and of sustainable development*'. 161 states have ratified his Convention: <<http://www.unesco.org/culture/ich/index.php?lg=en&pg=00024>> [accessed 8 September 2015]. The UN Committee goes even further in UNCESCR, 'General Comment No. 21: Right of Everyone to Take Part in Cultural Life (Art 15 (1) (a))' (2009), para 64: '*A violation also occurs when a State party fails to take steps to combat practices harmful to the well-being of a person or group of persons*'.

⁵²⁰ E.g. UNFPA and Guttmacher Institute, 'Adding It Up 2014: The Costs and Benefits of Investing in Sexual and Reproductive Health' (2014) <<http://www.unfpa.org/sites/default/files/pub-pdf/Adding%20It%20Up-Final-11.18.14.pdf>> [accessed 8 September 2015].

should thus urge states to fulfil their obligations.⁵²¹ However, should SNHRBs encourage states to entirely ignore parents who have religious convictions against the use of such services, considering their (human) right to educate their children in conformity with their beliefs?⁵²²

To conclude, SNHRBs should dismiss cultural relativists' arguments attempting to justify (in)actions that constitute a breach of the right to health. This is fundamental to an adequate interpretation of the right to health, i.e. one that promotes everyone's effective enjoyment of the highest standard of health attainable, and that meets the requirement of principled consistency. However, how can they address clashes between culture and human rights law?

4.2.2 A context sensitive approach to the right to health

While the scope of application of the right to health should not be restricted for cultural considerations, SNHRBs should incorporate such considerations (to a certain extent) in their procedures, for both normative and practical reasons.

Normative reasons respond to the legitimate concerns raised by cultural relativists, i.e. the need to accommodate cultural diversity, and that to respect states' sovereignty for democracy purposes. Such reasons are reflected in two aspects of human rights law, making the context sensitive approach meet the requirement of principled consistency. First, the context-sensitive approach translates the margin of appreciation doctrine initially developed by the European Court of Human Rights, to ESCR.⁵²³ According to this doctrine, states are allowed a certain degree of flexibility on how they wish to implement human rights standards, in order for SNHRBs to respect the sovereignty principle and in practice, to gain further trust from states. Second, the context sensitive approach reflects the acceptability requirement

⁵²¹ UNCESCR, 'GC14' (n 21), paras 11, 16, 21, 34 and 44(d).

⁵²² International Covenant on Civil and Political Rights 1966, Art 18(4); ECHR (n 335), Art 2.

⁵²³ See early works of Thomas A O'Donnell, 'The Margin of Appreciation Doctrine: Standards in the Jurisprudence of the European Court of Human Rights' (1982) 4 Human Rights Quarterly 474; Howard Charles Yourow, 'The Margin of Appreciation Doctrine in the Dynamics of European Human Rights Jurisprudence' (1987) 3 Connecticut Journal of International Law 111.

developed by GC14.⁵²⁴ The latter requires that health facilities, goods and services are culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities (and in line with medical ethics), while designed to improve their health.⁵²⁵

Practical reasons also justify the need for SNHRBs to take cultural considerations into account in their interpretation. Much research shows the importance of involving key actors in the realisation of the right to health, especially with regard to harmful traditional practices. Their assistance in the promotion of safer practices is essential to a successful implementation of right to health standards among the community. In the context of FGM for instance, statutory bans and criminalisation that are not accompanied by a comprehensive eradication strategy can be detrimental. In certain African countries, this has led to either an absence of enforcement or to underground practice.⁵²⁶ As a result, various authors argue that the influence of FGM practitioners should be used to inform communities about the dangers of such procedures,⁵²⁷ and to design efficient counter-practices symbolising entry into womanhood to replace FGM.⁵²⁸ Therefore, SNHRBs should adopt a context sensitive approach when interpreting the scope of application of the right to health, since it contributes to an effective enjoyment of the latter.

It is worth noting that this approach, also suggested by Tobin,⁵²⁹ focuses on the stage at which cultural considerations must be incorporated. Cultural beliefs can be taken into consideration during the design of measures aimed at implementing the highest standard of health attainable, but not when deciding what this standard should be. Therefore, SNHRBs may ask states to design context-sensitive measures, but only if those contribute to improving their health systems, which adequacy must be assessed

⁵²⁴ UNCESCR, 'GC14' (n 21), para 12(c).

⁵²⁵ *ibid.*

⁵²⁶ Bonny Ibhawoh, 'Between Culture and Constitution: Evaluating the Cultural Legitimacy of Human Rights in the African State' (2000) 22 Human Rights Quarterly 838, 857–858.

⁵²⁷ Vanja Berggren and others, 'An Explorative Study of Sudanese Midwives' Motives, Perceptions and Experiences of Re-Infibulation after Birth' (2004) 20 Midwifery 299.

⁵²⁸ Tobin (n 19) 314–324.

⁵²⁹ *ibid* 110–118; see also Wolff (n 134) 27.

by relevant experts in health and determined by human rights law, as argued in subsection 4.1. However, the distinction between normative content and implementation is not always self-evident: are such considerations set in the substance of the right or contextual to its application? While there is no clear-cut answer to this question, the following framework enables SNHRBs to optimise their interpretation by clarifying how such issues may be monitored in practice. It is based on the need for the context sensitive approach to be principled when applied to supranational monitoring (for coherence and fairness purposes),⁵³⁰ and it considers two situations.

Firstly, the realisation of the right to health can *potentially* conflict with the existence of a traditional practice. I will illustrate this through the example of obstetric and neonatal care, as many traditional practices involve the (intended) protection of pregnant women, mothers, and new-borns. In the first instance, medical research shows that traditional practice X has medical virtues and/or does not represent any risk for women's or new-borns' health (e.g. vertical crouching position in delivery in Peru).⁵³¹ In this case, no conflict arises between the implementation of the highest standard of health attainable and traditional practice X. Therefore, practice X can presumably be respected, especially if it is not costly, and as long as it does not breach human rights law. It is worth noting that the absence of culturally appropriate healthcare, notably in the context of childbirth, can be detrimental as individuals may refuse to use institutional services and put their lives at risk.⁵³² In the second instance, medical research shows that traditional practice Y represents a risk for the health of women or new-borns (e.g. tight swaddling of new-borns in Turkey).⁵³³ In this case, a conflict arises between the implementation of the highest standard of health attainable and traditional practice Y. Practice Y should, therefore, be eliminated. However, a dialogue with key actors in the community is essential. It

⁵³⁰ O'Donnell (n 523): similar criticism was formulated in the early days of the margin of appreciation in the European Court of Human Rights.

⁵³¹ Gabrysch and others (n 202).

⁵³² *ibid.*

⁵³³ Emine Geçkil, Türkan Şahin and Emel Ege, 'Traditional Postpartum Practices of Women and Infants and the Factors Influencing Such Practices in South Eastern Turkey' (2009) 25 *Midwifery* 62, 66 and 70.

enables the design of measures adapted to the environment in which they are to be implemented to increase their efficiency (e.g. health promotion campaigns explaining the dangers of tight-swaddling).

Secondly, the realisation of the right to health can *automatically* conflict with cultural or religious beliefs that are against a type of healthcare necessary to secure the highest standard of health attainable. In such instance, there should be little margin of appreciation. I will illustrate this through the example of abortion services, as SRH is a field encountering great cultural or religious oppositions. Research clearly highlights the importance of abortion services to achieve the highest standard of health attainable as they prevent the use of clandestine procedures, dangerous for women's health.⁵³⁴ As a result, states must ensure the availability of such services, regardless of the fact they transgress religious values (e.g. legal ban in states where Catholicism is influent). A dialogue with key actors is essential to identify the measures such service should be accompanied by, in order to ensure its use in the community. In this case, it could include campaigns revealing the dangers of clandestine abortions, and discussions with religious leaders enabling them to understand that access to abortion does not increase promiscuity (although issues related to what some believe to be 'foetus' right to life' remain unsolved).⁵³⁵

To conclude, SNHRBs should reject cultural relativist argument attempting to justify the right to the highest standard of health attainable, but their interpretation should be sensitive to the context in which this right ought to be implemented. However, it is worth examining whether the approach adopted in their monitoring procedures accommodates these suggestions.

⁵³⁴ WHO, 'Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008 (6th edition)' (WHO 2011) <http://www.who.int/reproductivehealth/publications/unsafe_abortion/9789241501118/en/>.

⁵³⁵ Nana Oye Lithur, 'Destigmatising Abortion: Expanding Community Awareness of Abortion as a Reproductive Health Issue in Ghana' (2004) 8 African Journal of Reproductive Health / La Revue Africaine de la Santé Reproductive 70.

4.2.3 Cultures and monitoring of the right to health by SNHRBs

This thesis contends that in order for SNHRBs to optimise their interpretation of the scope of application of the right to health, not only must they rely on a framework clarifying its substance appropriately, they must also monitor the impact of cultural issues on health adequately. Since this thesis focuses on the UN and the European Committees, I will assess whether the approach adopted in their monitoring procedures accommodates the suggestions developed in subsections 4.2.1 and 4.2.2.

The UN Committee

Most of the comments expressed by the UN Committee during the reporting procedure regarding health and culture, concern traditional practices that are *harmful* to individuals' health, and more particularly FGM. This issue is mentioned in 26% of the 2008-2012 Concluding Observations studied. The UN Committee clearly adopts a context sensitive approach in that regard, since it requires the ban of the practice, accompanied by a comprehensive strategy involving key actors. In its recent Concluding Observations on Benin, for instance, the UN Committee listed several context-specific measures that the state should implement to prevent FGM. It recommended that Benin prohibited FGM via legislation, while training judges and officers to enforce it. It also advised the creation of awareness-raising campaigns; adequate assistance to victims; and programmes to re-orientate and support practitioners who decide to stop practicing excision. Finally, it requested data regarding the number of reported FGM cases, as well as the number of convictions and penalties imposed on the persons responsible.⁵³⁶ Whilst such monitoring is satisfactory, the UN Committee must diversify its understanding of harmful traditional practices to adequately assess the realisation of the right to health (e.g. including male circumcision, as suggested by Tobin).⁵³⁷ This will enable it to develop a more comprehensive interpretation of Article 12 ICESCR.

The UN Committee also formulates recommendations when religious or cultural beliefs prevent a health service necessary to achieve the highest standard of health

⁵³⁶ UNCESCR, 'Concluding Observations Benin 2008' (n 256), para 47.

⁵³⁷ Tobin (n 19) 311–314.

attainable from being created. This can be observed through frequent expressions of concern regarding absolute bans on abortion. In such instances, the UN Committee recommends the legalisation of abortion for, at least, cases of rape, incest, and pregnancies threatening women's life. The UN Committee may wish to preserve a constructive dialogue with states and, thus, uses caution when dealing with strong cultural or religious oppositions to human rights standards. However, the availability of abortion services should not be limited to minimal conditions as a result. Let alone feminist arguments according to which women have the right to control their own bodies, unsafe abortions procedures have adverse effects on the health of women falling outside those three exceptions. Therefore, the UN Committee must ensure that its interpretation of Article 12 ICESCR promotes adequately an effective enjoyment of the right to health.

Finally, the UN Committee rarely recommends that traditional practices involving the health of community members but that are, in fact, harmless to human health, be respected. The UN Committee highlighted, for instance, the necessity for Argentina to protect natural resources necessary for indigenous peoples' '*way of life and subsistence*' under Article 12 ICESCR.⁵³⁸ It also recommended that Australia protected indigenous peoples' traditional knowledge and medicine through the creation of a specific intellectual property regime.⁵³⁹ However, these vague comments are the only examples in which the UN Committee recommended the state to make healthcare culturally acceptable, out of the sixty 2008-2012 Concluding Observations studied. Such lack of monitoring is problematic since the failure to meet the acceptability requirement can deter individuals from using institutional healthcare. This can be observed in the context of childbirth in Peru and Ecuador (both reviewed in the period studied but no issue was raised), as some patients refuse to use facility care culturally insensitive, resulting in maternal deaths.⁵⁴⁰

⁵³⁸ UNCESCR, 'Concluding Observations on Argentina's Third Periodic Report' (2011) UN Doc E/C12/ARG/CO/3, para 9.

⁵³⁹ UNCESCR, 'Concluding Observations Australia 2009' (n 221), para 33. However, here the UN Committee refers to Article 15 on the right to enjoy the benefits of scientific progress and its applications, not Article 12 on the right to health.

⁵⁴⁰ Gabrysch and others (n 202); La revolución Ciudadana Avanza, Care and Ministerio de Salud Pública, 'Culturally Appropriate Delivery Care' (n 209).

Considering the UN Committee monitors the implementation of the right to health in more than 160 states and in every region of the world, a context-sensitive approach to health is crucial. Not only to respect the diverse cultures of the States parties to the ICESCR, but also to increase the efficiency of health systems in states where cultural traditions have an important impact on individuals' health. Nevertheless, its review in this subject is irregular, which could be addressed by the use of thematic indicators, as suggested in Chapter 2.

The European Committee

Cultural or religious beliefs in Europe do not have the same impact on healthcare than they do in other regions of the world. The occurrence of harmful traditional practices and the prohibition of health services based on these considerations are rarer in Europe than they might be in African or in Latin American states, for instance. This may be the reason why the European Committee fails to monitor two of the three tests advocated by this thesis. However, this does not mean that cultural considerations do not come into play regarding health issues in Europe. Cultural or religious beliefs involving individuals' health are clearly present in European states, whether among nationals or among migrants. It is therefore important the European Committee remains aware of such issues when monitoring Article 11 ESC.

First, the European Committee does not require that States parties to the ESC respect traditional practices that are harmless to human health but important for the community in question (and, indirectly, benefiting the health of its members). Nevertheless, requesting that health services are culturally appropriate would improve the use of facility care by members of certain communities. For instance, 20% of childbirths still occur at home in Turkey, mainly to respect traditional practices which could easily be carried out by families in the hospital instead.⁵⁴¹ Therefore, such considerations should be incorporated in the European Committee's interpretation of Article 11 ESC.

⁵⁴¹ Duygu Yılmaz and others, 'Determination of the Use of Traditional Practices to Ease Labour among Turkish Women' (2013) 19 International Journal of Nursing Practice 65, 66.

Second, the European Committee does not review the issue of traditional practices harmful to health under Article 11 ESC. This is worrying for states in which such practices exist (e.g. tight swaddling of new-borns in Turkey),⁵⁴² but also for states in which traditional practices harmful to health have been imported by non-nationals. For instance, whilst FGM are illegal in Europe, hundreds of thousands women who have been subject to this procedure now live in European countries, or are at risk of being subject to such procedure during a trip to their parents' country of origin.⁵⁴³ The European Institute for Gender Equality deplores a lack of monitoring in that respect and suggests funding civil society organisations to organise awareness-raising, exchange good practices and advocate for the eradication of this practice.⁵⁴⁴ This could be easily encouraged through the reporting procedure of the European Committee and would enhance the quality of its interpretation of the right to health.

Third, the European Committee sometimes reviews the availability of health services facing cultural or religious opposition. For instance, it constantly monitors the existence of SRH education in schools through its reporting procedure, and sometimes through its complaint procedure.⁵⁴⁵ However, the availability of abortion services remains entirely unmonitored until recently. In its Merits Decision *IPPF v. Italy*, it found Italy in violation of the right to health for:

the failure of the competent authorities to adopt the necessary measures which are required to compensate for the deficiencies in service provision caused by health personnel choosing to exercise the right of conscientious objection, this constitutes a discrimination.⁵⁴⁶

⁵⁴² Geçkil, Şahin and Ege (n 533) 66 and 70.

⁵⁴³ European Institute for Gender Equality, 'Female Genital Mutilation in the European Union and Croatia' (European Union Publications Office 2013), pp. 25–26 <<http://eige.europa.eu/rdc/eige-publications/female-genital-mutilation-european-union-and-croatia-report>> [accessed 8 September 2015].

⁵⁴⁴ *ibid* 67–70.

⁵⁴⁵ E.g. *International Centre for the Legal Protection of Human Rights v Croatia* (ECSR) (n 368). The European Committee found a breach of Article 11 ESC on the basis that SRH in schools was inadequate.

⁵⁴⁶ *International Planned Parenthood Federation European Network (IPPF EN) v Italy* [2013] Complaint No. 87/2012, Decision on the Merits (ECSR) [189–194].

Such development is satisfactory but limited. The problem was not legalising abortion but providing sufficient access in practice, which the European Committee asked the state to do. Therefore, the European Committee has still not clarified whether a legal ban on abortion would breach Article 11 ESC. Tragic cases such as the unreported ‘Miss Y’ decision in Ireland (2014) highlight the importance for the European Committee to review the availability of abortion (and any health service giving rise to cultural or religious oppositions), in every reporting cycle. This will facilitate an interpretation of Article 11 ESC ensuring an effective enjoyment of the right to health.

To conclude, while the UN Committee seems willing to monitor the impact that cultural issues have on the realisation of the right to health (although not consistently enough), the European Committee has not integrated it yet in its interpretation. It is nonetheless essential that SNHRBs promote everyone’s effective enjoyment to the highest standard of health attainable when interpreting what the right to health entails in their monitoring procedures. This is true regardless of cultural differences between states, and regardless of individuals’ characteristics within the same state.

4.3 The right to a health system accessible to all (the scope of protection)

Whilst the scope of interests and, to a lesser extent, the scope of application of the right to health bear uncertainties, its scope of protection seems more definite at first glance. Human rights law being grounded in universalism and cosmopolitanism, all human rights instruments, whether international or regional, recognise that ‘everyone’ is entitled to a right to health. However, this raises a controversial question, particularly in the context of the economic crisis: do non-nationals benefit from the same right to health than nationals? It is nonetheless crucial to clarify what the scope of protection of the right to health should entail in supranational monitoring, in order to enable SNHRBs to optimise their interpretation accordingly. After having studied relevant literature and compared the two frameworks examined in this thesis, i.e. the UN and the CoE, I make three observations. Firstly (4.3.1), human rights treaties tend to restrict non-nationals’ right to health to minimum

levels, impeding the ability of SNHRBs to interpret adequately its scope of protection. Secondly (4.3.2), such restrictions, however, constitute disproportionate differential treatments and should be considered as such by SNHRBs. Thirdly (4.3.3), to accommodate this framework, SNHRBs must thus dismiss political considerations when monitoring non-nationals access to health, which the UN and the European Committees seem to do.

4.3.1 Restrictive right to health for non-nationals in human rights instruments

States have witnessed a considerable rise of migration flux over the past decades, as the global migrant stock increased from 92 million to 165 million from 1960 to 2000,⁵⁴⁷ and up to 232 million in 2013.⁵⁴⁸ However, the ‘receiving’ states often fear that the arrival of non-nationals jeopardise their cultural unity, economic markets, and environmental capacities. As a result, they have developed policies and legislations to control immigration, whether through international agreements or convergent domestic measures.⁵⁴⁹ More particularly, limiting migrants’ access to public services such as healthcare is one of the means often used to deter their intentions to stay or arrive.⁵⁵⁰ It is in this light that provisions restricting non-nationals’ right to health came to existence in human rights law.

At first glance, human rights treaties clearly reflect the universalist and cosmopolitan values in which human rights law is grounded.⁵⁵¹ Article 12 ICESCR,⁵⁵² Article 11

⁵⁴⁷ Çağlar Özden and others, ‘Where on Earth Is Everybody? The Evolution of Global Bilateral Migration 1960–2000’ (2011) 25 *The World Bank Economic Review* 12, 15.

⁵⁴⁸ UNPD, Department of Economic and Social Affairs, ‘International Migration Report 2013’ (2013) UN Doc. ST/ESA/SER.A/346 1 <http://www.un.org/en/development/desa/population/publications/pdf/migration/migrationreport2013/Full_Document_final.pdf#zoom=100> [accessed 8 September 2015].

⁵⁴⁹ Valsamis Mitsilegas, ‘Immigration Control in an Era of Globalization: Deflecting Foreigners, Weakening Citizens, Strengthening the State’ (2012) 19 *Indiana Journal of Global Legal Studies* 3.

⁵⁵⁰ Anna Błuś, ‘Beyond the Walls of Paper. Undocumented Migrants, the Border and Human Rights’ (2013) 15 *European Journal of Migration and Law* 413, 422–423.

⁵⁵¹ In the universalist approach, individuals receive rights by virtue of being ‘human beings’; and in the cosmopolitan approach, individuals receive rights by virtue of being ‘citizens of the world’ (deriving from a Kantian concept, although such concept was developed in the context of international conflicts). See Kant (n 36).

ESC,⁵⁵³ Article 16 of the African Charter,⁵⁵⁴ Article 10 of the Protocol of San Salvador,⁵⁵⁵ and Article 39 of the Arab Charter,⁵⁵⁶ all declare that ‘everyone’ is entitled to the highest standard of health attainable. However, some treaties provide grounds for a restrictive interpretation of non-nationals’ right to health, creating confusion. At the international level, two legally binding provisions are problematic. Article 28 ICMW explicitly restricts the right to health of migrant workers’ to emergency care;⁵⁵⁷ and Article 2(3) ICESCR allows developing countries to determine to what extent they wish to guarantee *economic* rights to non-nationals.⁵⁵⁸ The latter provision, however, does not affect the application of the right to health, which is a *social* right. Nevertheless, it highlights that a distinction can be made between nationals and non-nationals in human rights law. At the regional level, all instruments but the Protocol of San Salvador can be read as restricting the scope of the right to health.⁵⁵⁹ The Appendix of the ESC explicitly excludes from its scope of protection nationals from State not parties to the Charter, as well as Europeans illegally working or residing within other States parties.⁵⁶⁰ The African Charter is more implicit. Article 16 declares that state must ensure the health of ‘their people’ and Article 13(2), that every ‘citizen’ has the right of equal access to the public services of the country.⁵⁶¹ Finally, it is worth noting that Article 39 of the Arab Charter recognises that ‘citizens’ have a right to free basic healthcare and to access

⁵⁵² ICESCR (n 4), Art 12: ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’.

⁵⁵³ ESC 1961 (n 92), Part I (11); ESC 1996 (n 92), Part I (11): ‘Everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable’.

⁵⁵⁴ African Charter (n 92), Art 16: ‘Every individual shall have the right to enjoy the best attainable state of physical and mental health’.

⁵⁵⁵ Protocol of San Salvador (n 92), Art 10: ‘*Everyone shall have the right to health*’.

⁵⁵⁶ Arab Charter (n 92), Art 38: ‘Every person has the right to an adequate standard of living for himself and his family’.

⁵⁵⁷ ICMW (n 93), Art 28.

⁵⁵⁸ ICESCR (n 4), Art 2(3).

⁵⁵⁹ Protocol of San Salvador (n 92), Preamble.

⁵⁶⁰ ESC 1961 (n 92), Art 11 and Appendix; ESC 1996 (n 92), Art 11 and Appendix.

⁵⁶¹ African Charter (n 92), Art 13(2) and 16.

medical facilities without discrimination.⁵⁶² I will thus examine the confusion such provisions create for SNHRBs, through the examples of the ICESCR and the ESC, reflecting the two frameworks examined in this thesis.

International framework: conflict between the ICESCR and the ICMW

The ICESCR declares that ‘everyone’ has a right to health, which it understands in its Preamble as ‘all members of the human family’.⁵⁶³ This universal approach to human rights law in general, and to the right to health more particularly, derives from the moral belief that dignity is inherent to every human being. It is recognised in all UN human rights treaties and in founding texts such as the UDHR or the UN Charter.⁵⁶⁴ Whilst the universal approach entitles all human beings to a right to health, it is unclear whether everyone has a right to *similar* type of healthcare in the UN framework.

The UN recently adopted documents that differentiate the type of healthcare individuals are entitled to, according to their nationality and migration status. In 1985, the UN adopted the Declaration on the Human Rights of Individuals Who are not Nationals of the Country in which They Live.⁵⁶⁵ Its Article 8 recognises the existence of a right to health for non-nationals, but under strict conditions. It declares that non-nationals can only benefit from a right to health protection and medical care if they lawfully reside on the territory and respect participation regulations. Furthermore, it only grants non-nationals a right to health if states’ resources are not experiencing ‘undue strain’, which could be interpreted broadly.⁵⁶⁶ This instrument, however, is not legally binding. In 1990, the legally binding International

⁵⁶² Arab Charter (n 92), Art 39.

⁵⁶³ ICESCR (n 4), Preamble and Art 12

⁵⁶⁴ UDHR (n 3), Art 1: ‘All human beings are born free and equal in dignity and rights’; UN Charter (n 25), Art 1(3): ‘The purposes of the United Nations are [...] promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction as to race, sex, language, or religion’.

⁵⁶⁵ UNGA, ‘Declaration on the Human Rights of Individuals Who Are Not Nationals of the Country in Which They Live’ (1985) UN Doc. A/RES/40/144 <<http://www.un.org/documents/ga/res/40/a40r144.htm>> [accessed 8 September 2015].

⁵⁶⁶ *ibid*, Art 8(1)(c).

Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (ICMW) was adopted nonetheless, and came into force in 2003. Its Article 28 declares that migrant workers and members of their families, whether in a regular or irregular situation, have a right to health. However, it restricts this right to emergency care.⁵⁶⁷ Therefore, several issues arise when reading this provision altogether with Article 12 ICESCR.

First, Article 28 ICMW and Article 12 ICESCR are contradictory. On one hand, both the ICESCR and the ICMW prohibit discrimination based on national origin or on ‘any other status’, which could be understood as migration status.⁵⁶⁸ On the other hand, Article 12 ICESCR entitles everyone to the *highest* standard of health while Article 28 ICMW only guarantees emergency care to migrants. It is thus unclear how the conflict of norms between the ICESCR and the ICMW should be addressed.

Second, according to the principles *lex specialis derogat legi generali* and *lex posterior derogat priori*, the ICMW should prevail over the ICESCR. The ICMW provides for the right to health of a particular group of individuals rather than for all human beings, and was adopted more recently than the ICESCR. Nevertheless, reducing the scope of protection of the right to health based on the nationality and migration status of individuals could go against the principle of non-discrimination, pillar of human rights law and core obligation in GC14.⁵⁶⁹

Third, the ICMW only covers migrant workers. Therefore, unemployed migrants (whether in a regular or irregular situation) would benefit from the protection of the ICESCR instead. This means that states should guarantee the ‘highest standard of health attainable’ to unemployed migrants, but should limit access to emergency services for those who are working. Whilst working does not entitle to a human right to access better healthcare, it would be illogical if unemployment did, considering states’ efforts to deter migration.

⁵⁶⁷ ICMW (n 93), Art 28.

⁵⁶⁸ ICESCR (n 4), Art 2(2); ICMW (n 93), Preamble (reference to ICESCR).

⁵⁶⁹ UNCESCR, ‘GC14’ (n 21), para 43(a).

Contrarily to Article 12 ICESCR, Article 11 ESC bears restrictions as to who is entitled to benefit from healthcare. The Appendix of the Charter specifies that Article 11 protects refugees, stateless persons, nationals and '*foreigners only in so far as they are nationals of other Parties lawfully resident or working regularly within the territory of the Party concerned*'.⁵⁷⁰ The scope of Article 11, therefore, does not apply to regular migrants from non-States parties who are neither refugees nor stateless, and does not apply to irregular migrants in general.

However, the text of the Charter is confusing. Its Article E prohibits discrimination on the grounds of national extraction, national minority, birth or 'other status', which could be interpreted as migration status. Therefore, this provision should protect both regular migrants whose birth or national extraction is not located in Europe and individuals with irregular migration status, from health discrimination. Furthermore, Part I of the ESC describes Article 11 as the right of *everyone* to benefit from the highest standard of health attainable.⁵⁷¹

The Travaux Préparatoires of the ESC explicitly point at the drafters' intention to assign the scope of this instrument to European nationals.⁵⁷² Nevertheless, it is not clear whether drafters intended to exclude non-nationals from the scope of the Charter as a result.⁵⁷³ What is clear, however, is their desire to promote freedom of movement among Europeans, by protecting States parties' nationals against discrimination based on nationality grounds.⁵⁷⁴ It is thus perhaps more appropriate to study the restricted scope of the ESC and its Appendix through an historical

⁵⁷⁰ ESC 1961 (n 92), Appendix; ESC 1996 (n 92), Appendix.

⁵⁷¹ ESC 1961 (n 92), Part I (11).

⁵⁷² CoE, 'Collected Travaux Préparatoires of the European Social Charter, Volume III' (1956); CoE, 'Collected Travaux Préparatoires of the European Social Charter, Volume V' (1958).

⁵⁷³ CoE, 'Collected Travaux Préparatoires ESC, Volume I' (n 328): 'The aim of the social policy of the Member Governments should therefore be the continuous improvement of the standard of living of all members of society [...].'

⁵⁷⁴ Ibid, p 5 (Memorandum by the Secretariat-General, 16 April 1953), para 14: states parties are willing to 'abolish discrimination on grounds of nationality between nationals of the Members of the Council in relation to social rights.'

perspective. The Charter was drafted in the 1950s, a period in which migration movements raised different challenges in Europe than they do today. The first common labour market areas were created, the new borders resulting from World War II led millions of individuals to resettle, and many left for the Americas.⁵⁷⁵ Migration of non-European nationals towards Europe was not an important trend at the time, and the absence of protection provided by the ESC in that regard may thus result from an omission.⁵⁷⁶ However, migration trends have changed dramatically since. Mikkola, former Member and Chairman of the European Committee (1995-2006), declared: *‘Europe used to be the point of departure, now it is both the point of departure and the point of arrival’*.⁵⁷⁷ When the Charter was amended in 1996, States parties could have addressed the issue of migrants’ rights but decided to leave it untouched. This might reflect a more conscious desire to differentiate nationals from non-nationals, when providing for a right to health.

As a result, it is unclear when reading the ESC whether ‘everyone’ is entitled to healthcare, as recognised by Article 11; or whether certain migrants are excluded from its scope of protection, as stated by the Appendix. Moreover, reducing the scope of protection of the right to health according to individuals’ nationality or migration status could constitute a discrimination, ‘core’ substance of this right.⁵⁷⁸

To conclude, the uncertainty present in the UN and the CoE frameworks impede the ability of SNHRBs such as the UN and the European Committees to develop an adequate interpretation of the right to health. That is, one which promotes everyone’s effective enjoyment of the highest standard of health attainable, and that meets the requirement of principled consistency. Therefore, how should SNHRBs interpret such provisions?

⁵⁷⁵ Mikkola (n 319) 32–34.

⁵⁷⁶ Özden and others (n 547) 15: ‘In 1960, except for migration within the Soviet Union, the majority of migrants were born in Europe and South Asia’.

⁵⁷⁷ Mikkola (n 319) 33.

⁵⁷⁸ UNCESCR, ‘GC14’ (n 21), para 43(a).

4.3.2 *Restrictions to healthcare: a disproportionate measure?*

Restricting the scope of protection of the right to health based on right-holders' nationality goes against the very foundation of human rights law, i.e. equal dignity for all human beings (regardless of their nationality or status). As contended by Weiler, two main arguments should be made against the provision of human rights according to state affiliation.⁵⁷⁹ Firstly, it undervalues the common humanity of individuals and can thus feed xenophobia. Secondly, an approach based on economic considerations (i.e. the perceived costs of immigration) views aliens in utilitarian terms, which is undesirable in a human rights context. Furthermore, various authors have disputed the notion of citizenship as a simple legal status. Mantouvalou argues:

In the heart of the role of rights for citizenship lies the belief that only when a person enjoys the full range of rights can she or he be full member of a community. A community is not a synonym to the state, though, and the importance of belonging is not limited to state nationals.⁵⁸⁰

Human rights law, nevertheless, allows differential treatments based on citizenship if these pursue an objective and reasonable purpose, and if the measures taken are proportionate to that purpose.⁵⁸¹ In theory, it is objective and reasonable for states to avoid 'overspending' in the health sector, if they wish to realise other rights and do not have sufficient resources to do so. However, no evidence shows that in practice, restricting non-nationals' access to healthcare enables states to meet this objective.

On the contrary, authors have argued that restricting non-nationals' right to health is an inadequate immigration control strategy. Firstly, it is based on the false assumption that migrants will incur an economic loss to sovereign states. This does

⁵⁷⁹ Joseph HH Weiler, 'Thou Shalt Not Oppress a Stranger:* On the Judicial Protection of the Human Rights of Non-EC Nationals - A Critique' (1992) 3 *European Journal of International Law* 65, 65–69.

⁵⁸⁰ Virginia Mantouvalou, 'Workers without Rights as Citizens at the Margins' (2013) 16 *Critical Review of International Social and Political Philosophy* 366, 369. Further discussion on citizenship and (social) rights can be found on pp. 367–370, although focusing on labour rights.

⁵⁸¹ UNCESCR, 'General Comment No. 20: Non-Discrimination in Economic, Social and Cultural Rights (Art 2, Para 2)' (2009), paras 13 and 14.

not take into consideration the economic contributions made by migrant workers. Regular migrant workers pay taxes (some of which fund the health system), and some may create employment. Irregular migrant workers are often used as cheap labour,⁵⁸² and are sometimes overqualified if they failed to obtain equivalence of diplomas. Moreover, this strategy does not acknowledge the low usage of health facilities by irregular migrants, who fear to be identified by state authorities and deported.⁵⁸³ Secondly, deterring migration by restricting non-nationals' access to healthcare does not seem particularly efficient in the context of irregular migrants. Engbersen and Broeders argue that traditional border policies have been recently supplemented with internal migration control and expulsion measures to discourage individuals who managed to cross the borders.⁵⁸⁴ However, they contend that such measures are both costly (e.g. deportations, detention centres, enforcement personnel, etc.) and ineffective. Irregular migrants tend to develop inventive strategies and informal systems enabling them to stay within the borders (e.g. informal work, criminal activities, becoming unidentifiable).⁵⁸⁵ As a result, restricting migrants' access to healthcare seems to be disproportionate to the aim sought and therefore constitutive of *de jure* health discrimination. SNHRBs should thus abstain from interpreting the right to health in such manner.

However, the international community (including SNHRBs) tends to allow certain differential treatments based on nationality grounds, likely for political reasons since treatment of aliens are traditionally attached to states' sovereignty. It is nonetheless important that such leniency does not impede migrants' inherent dignity as human beings, including their ability to access an adequate health system (e.g. emergency care, primary care). Furthermore, differential treatments based on nationality grounds fail to represent a sustainable solution to immigration, provided there should be one.

⁵⁸² Gregor Noll, 'Why Human Rights Fail to Protect Undocumented Migrants' (2010) 12 European Journal of Migration and Law 241, 259; Sylvie Da Lomba, 'Immigration Status and Basic Social Rights: A Comparative Study of Irregular Migrants' Right to Health Care in France, the UK and Canada' (2010) 28 Netherlands Quarterly of Human Rights 6, 34–35.

⁵⁸³ Da Lomba (n 582) 34–35.

⁵⁸⁴ Godfried Engbersen and Dennis Broeders, 'The State versus the Alien: Immigration Control and Strategies of Irregular Immigrants' (2009) 32 West European Politics 867, 870–874.

⁵⁸⁵ *ibid* 874–881: it is worth noting that the article focuses on the Netherlands.

A question remains nonetheless: can the application of the right to health interrupt deportation procedures of irregular migrants in need of lifesaving treatments? Health rationing in lifesaving treatments is a particularly contentious issue in health economics, particularly in the context of non-nationals. International human rights law, nonetheless, widely and explicitly requires that minimum levels of health be guaranteed to all human beings.⁵⁸⁶ This thesis challenges the existence of minimum core obligations, but contends that lifesaving measures should be prioritised as much as possible, regardless of the nationality and migration status of individuals. Furthermore, human rights law prohibits the extradition of individuals at risk of cruel and inhuman treatment in their home countries (not solely torture), including an absence of lifesaving treatments.⁵⁸⁷ As a result, SNHRBs should explore at least four questions when deciding whether states should provide healthcare to irregular migrants about to be deported, given the treatment is lifesaving, safe and efficient. Any positive answer to the following generates an obligation to that effect. First, should the treatment be urgently administered? Second, is the treatment available in the receiving country but not the home country? Third, is the treatment short-term? Fourth, has the treatment begun? Such test points at the inaccurate rationale of decisions such as *N v the United Kingdom*.⁵⁸⁸ In this case, the European Court of Human Rights had rejected a claim brought by an irregular migrant who alleged that the state's decision to expulse her and to subsequently interrupt her antiretroviral treatment, amounted to inhuman treatment. The Court, however, only based its decision on the 50% likelihood for the claimant to get lifesaving treatment in her home country, leaving the other 50% to fate.⁵⁸⁹

To conclude, while SNHRBs have to deal with incoherent right to health provisions when it comes to non-nationals, they should consider immigration policies permanently restricting access to healthcare for non-nationals, disproportionate. It is

⁵⁸⁶ Declaration of Alma-Ata (n 255); UNCESCR, 'General Comment 3' (n 211), para 10; UNCESCR, 'GC14' (n 21), paras 43 and 44; ICMW (n 93).

⁵⁸⁷ *D v United Kingdom* [1997] Chamber, Application No. 30240/96, Judgment of 2 May 1997 (ECtHR).

⁵⁸⁸ *N v United Kingdom* [2008] Grand Chamber, Application No. 26565/05, Judgment of 27 May 2008 (ECtHR).

⁵⁸⁹ *ibid* [44 to 51].

nonetheless worth examining whether the approach adopted in their monitoring procedures accommodates these suggestions.

4.3.3 Comprehensive right to health for non-nationals in SNHRBs' jurisprudence

This thesis contends that in order for SNHRBs to optimise their interpretation of the scope of protection of the right to health, not only must they rely on a framework clarifying adequately its substance, they must also monitor non-nationals' access to health appropriately. Since this thesis focuses on the UN and the European Committees, I will assess whether the approach adopted in their monitoring procedures accommodates the suggestions developed in subsections 4.3.1 and 4.3.2.

Protection of migrants' health at the UN level

Article 28 ICMW on migrants' health has a more restricted scope of protection than Article 12 ICESCR, and applies to fewer states. Only 47 states are parties to the ICMW and almost no European or Northern American states have ratified it (except Albania, Azerbaijan and Turkey).⁵⁹⁰ This means that among the 10 countries receiving the largest number of international migrants (i.e. USA, Russia, Germany, Saudi Arabia, UAE, UK, France, Canada, Australia, Spain),⁵⁹¹ none is bound by the Convention. As Noll declared: '*the treaty clearly was and is the South's project.*'⁵⁹² Furthermore, the ICMW does not protect refugees, stateless persons, and migrants who are not workers or members of the worker's family. Therefore, non-nationals' right to health is better protected by the UN Committee (on Economic, Social and Cultural Rights) than by the UN Committee on Migrant Workers.

The UN Committee frequently highlights health discrimination committed against migrants (whether in regular situation or undocumented); asylum-seekers; refugees;

⁵⁹⁰ UN Treaty Collection, 'Status of the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families' <https://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-13&chapter=4&lang=en> [accessed 8 September 2015].

⁵⁹¹ UNPD, 'International Migration Report 2013' (n 548), p 5.

⁵⁹² Noll (n 582) 255.

or stateless persons. In the sixty Concluding Observations studied, it reviewed their situation fifteen times under Article 12 ICESCR, targeting both *de jure* and *de facto* discrimination.

Firstly, the UN Committee sometimes points *de jure* discrimination. These can directly affect non-nationals, for instance when a new legislation curtailed the rights of irregular migrants to access public health services in Spain.⁵⁹³ However, *de jure* discrimination can also indirectly affect non-nationals, by imposing conditions they cannot reach. This was the case for instance of Israel, who required that individuals had a permanent residence permit to access healthcare, excluding in practice Palestinians with temporary residence permits, migrant workers, and refugees.⁵⁹⁴ Furthermore, the UN Committee also expresses its concern when states' legislations only provide migrants with access to emergency healthcare. This was the case of Belgium, with irregular migrants,⁵⁹⁵ and of Russia, with persons having a temporary asylum status.⁵⁹⁶

Secondly, the UN Committee sometimes criticises states for allowing *de facto* discrimination. For example, it observed that poor awareness, complex administrative formalities and language barriers, impeded access to healthcare of asylum-seekers and undocumented migrant workers in France.⁵⁹⁷ Finally, the UN Committee often urges states to provide medical assistance to migrants who are victims of trafficking, exploitation, abuse and violence.⁵⁹⁸

Such interpretation fits with the recommendations formulated in subsection 4.3.2. However, since the UN Committee does not use thematic indicators and has no

⁵⁹³ UNCESCR, 'Concluding Observations Spain 2012' (n 301), para 19.

⁵⁹⁴ UNCESCR, 'Concluding Observations on Israel's Third Periodic Report' (2011) UN Doc E/C12/ISR/CO/3, para 31.

⁵⁹⁵ UNCESCR, 'Concluding Observations on Belgium's Third Periodic Report' (2008) UN Doc E/C12/BEL/CO/3, paras 21 and 35.

⁵⁹⁶ UNCESCR, 'Concluding Observations Russia 2011' (n 221), para 21.

⁵⁹⁷ UNCESCR, 'Concluding Observations France 2008' (n 287), para 26.

⁵⁹⁸ UNCESCR, 'Concluding Observations Philippines 2008' (n 220), para 21.

methodology in its reporting procedure, it does not systematically review migrants' access to health in its monitoring and interpretation of Article 12 ICESCR.

The extensive interpretation of the European Committee

The European Committee recently started to widen the scope of protection of the right to health in its monitoring procedures, despite the restrictions of the ESC regarding non- nationals.

In its collective complaint procedure, the European Committee reached two decisions on migrants' right to health. These led to different findings, whether Article 13 ESC on the right to medical assistance, or Article 11 on the right to health protection, was under review.⁵⁹⁹ First, in its Merits Decision *FIDH v France*, the European Committee recognised that Article 13 entitled irregular migrants to access emergency healthcare.⁶⁰⁰ It recognised that their children should access healthcare on the same basis as the rest of the population, but based its decision on Article 17 ESC on children's right to social protection.⁶⁰¹ The European Committee then used the principle of good faith in the Vienna Convention of the Law of Treaties,⁶⁰² to assert that the Charter was based on the values of dignity, autonomy, equality and solidarity.⁶⁰³ It declared that since healthcare was necessary to preserve human dignity, irregular migrants were entitled to a form of medical assistance, which entailed emergency care.⁶⁰⁴ However, emergency healthcare does not include basic aspects of primary care such as treatment for common diseases and injuries (e.g. GP consultations).⁶⁰⁵ Such system, therefore, fails to meet requirements the UN

⁵⁹⁹ ESC 1961 (n 92), Art 11 and 13; ESC 1996 (n 92), Art 11 and 13.

⁶⁰⁰ *International Federation of Human Rights Leagues (FIDH) v France* [2004] Complaint No. 14/2003, Decision on the Merits (ECSR) [26 to 34].

⁶⁰¹ *ibid* [35 to 37].

⁶⁰² Vienna Convention on the Law of Treaties 1969 (VCLT), Art 31(1).

⁶⁰³ *International Federation of Human Rights Leagues v France* (ECSR) (n 600) [26 to 32].

⁶⁰⁴ *ibid* [31 to 34].

⁶⁰⁵ Declaration of Alma-Ata (n 255).

framework considers to be ‘minimum’ (which this thesis interprets as ‘to be prioritised’).⁶⁰⁶

Second, in its Merits Decision *Médecins du Monde International v France*, the European Committee recognised that Article 11 ESC entitled migrants to enjoy adequate access to health, beyond emergency care and regardless of their residence status.⁶⁰⁷ It considered that the unhealthy living conditions and the difficult access to healthcare experienced by Roma migrants breached their right to health. The European Committee declared, thus, that the emergency care fund for irregular migrants residing in France for less than three months was insufficient.⁶⁰⁸ It requested that France took preventive measures such as free consultations and screening to pregnant women and children; measures preventing infectious diseases or domestic accidents; and immunisation. As a result, irregular migrants’ right to health is better protected when monitored under Article 11 ESC than under Article 13. However, it is still unsure whether the European Committee will interpret them as requiring that non-nationals be guaranteed access to healthcare on the same basis as citizens.

Similarly to its complaint procedure, the European Committee reviews migrants’ right to health expansively in its reporting procedure, whether regarding Article 13 ESC (right to medical assistance) or Article 11 (right to health protection).⁶⁰⁹ Its Conclusions usually recognise a right to emergency healthcare for irregular migrants under Article 13 ESC, and it holds violations when such services are not provided. Until 2013, however, its Conclusions did not recognise irregular migrants’ right to access general healthcare under Article 11 ESC, and no violation had been found in that respect.⁶¹⁰ This changed recently, as the European Committee applied the

⁶⁰⁶ UNCESCR, ‘GC14’ (n 21), paras 43 and 44; UNCESCR, ‘General Comment 3’ (n 211), para 10.

⁶⁰⁷ *Médecins du Monde v France* (ECSR) (n 399) [134–164].

⁶⁰⁸ *ibid* [163].

⁶⁰⁹ ESC 1961 (n 92), Art 11 and 13; ESC 1996 (n 92), Art 11 and 13.

⁶¹⁰ ECSR, ‘Conclusions 2009’, France pp. 299–300: The European Committee declared that ‘*The system makes it possible to cover the healthcare costs of illegal immigrants*’, and asked France whether access to healthcare was equally guaranteed between French citizens and foreigners.

jurisprudence developed in *Médecins du Monde International v France* to its 2013 Conclusions on Spain. In this document, it threatened to reach a finding of non-conformity to Article 11 against Spain, on the basis it had amended its legislation to restrict irregular migrants' access to healthcare to emergency services.⁶¹¹ It referred to *Médecins du Monde International v France*, declaring that States parties to the ESC had positive obligations towards irregular migrants' health 'whatever their status'. It also specified that the health system had to be accessible to the entire population (including migrants), and referred to the universality of Article 12 ICESCR.⁶¹² This confirms the European Committee is starting to extend the scope of the right to health to every individual, regardless of her nationality or migration status, by recognising *de jure* and *de facto* health discrimination. Such interpretation is in line with the recommendations formulated in subsection 4.3.2.

To conclude, the monitoring and adjudication of non-nationals' right to health in SNHRBs such as the UN and the European Committees, reflect their attempts to accommodate an issue traditionally attached to states' sovereignty, while promoting a universalist approach, a pillar of human rights law. It is thus essential that SNHRBs such as the UN and the European Committees review this issue more systematically, to verify that states do not restrict migrants' access to healthcare disproportionately. Furthermore, since irregular migrants may avoid using complaint procedures by fear of being identified and consequently deported, such procedures should remain open to NGOs and allow anonymity.

Conclusion

In this Chapter, I clarified how the normative scope of the right to health should be interpreted in supranational monitoring by addressing three key questions left unanswered in Part I. What is the highest standard of health attainable; do cultural considerations affect its content; and can everyone benefit from it? I thus used the relevant doctrine and analysed comparatively the UN and the European Committees'

⁶¹¹ ECSR, 'Conclusions XX-2 (2013)', Spain pp. 12-14.

⁶¹² *ibid*, Spain p 13.

interpretations, in order to develop a theoretical account based on the principles of interpretation advocated by this thesis, enabling SNHRBs to optimise their interpretation. In Section 4.1, I suggested that the scope of interests of the right to health should be understood as a right to an adequate health system. I highlighted the need for SNHRBs to interpret the requirement to achieve the highest standard of health attainable as a requirement to set up adequate health systems, due to the excessive vagueness of the WHO Constitution and human rights instruments. I also argued that such a requirement could be materialised into clear legal standards and obligations, and that SNHRBs had to monitor it comprehensively and methodically to rationalise its content coherently. In Section 4.2, I highlighted that the scope of application of the right to health meant that it had to be responsive to the cultural environment in which it was implemented. I thus discussed how, on one hand, cultural relativist arguments could threaten the implementation of the right to health and how, on the other hand, SNHRBs should take into consideration cultures to promote an effective enjoyment of this right. I then assessed whether the UN and the European Committee's monitoring accommodated these suggestions. In Section 4.3, I analysed the scope of protection of the right to health by focusing on non-nationals. I outlined that human rights instruments tended to formulate migrants' right to health in restrictive terms, including in the UN and the CoE. However, I argued that permanent restrictions on non-nationals' right to health could represent disproportionate differential treatments; and that SNHRBs should monitor those accordingly. Such approach has been successfully adopted by SNHRBs such as the UN and the European Committees.

Chapter 5 Clarifying states' obligations to realise the right to health in supranational monitoring

Introduction

As outlined in the introduction of my thesis, an adequate interpretation of the right to health should ensure an effective enjoyment of this right, set reasonable expectations upon states, offer context sensitivity through its implementation and overall, it should guarantee principled consistency. However, one can legitimately wonder how SNHRBs can make these principles coexist when defining states' obligations to realise the right to health through their monitoring procedures. The monitoring procedures of the UN and the European Committees highlight interesting findings in this concern, but fundamental conceptual issues remain unaddressed. What does 'progressively' realising the right to health entail; and are states obliged to fulfil certain minimum core obligations regardless of constraints weighing upon them?

It is fundamental such questions be clarified, since excessive vagueness can threaten the realisation of the right to health. Chapter 5 will thus offer a theoretical account assisting SNHRBs in interpreting states' obligations to realise the right to health adequately, based on a comparative analysis of the UN and the European Committees' interpretation, and on a study of the relevant doctrine.

Legal scholarship has written profusely about the obligation to progressively realise ESCR and about minimum core obligations.⁶¹³ While arguments have slightly shifted from whether ESCR produce legal obligations to how these can be monitored, confusion remains on how duty-bearers must implement the right to health. As a result, it is fundamental to clarify the nature of states' obligations in that respect. However, it is worth noting that this chapter will not rely on the tripartite typology of obligations to respect, protect and fulfil the right to health, yet widely used in human rights scholarship, for it does not contribute adequately to clarifying the legal content of the right to health. As argued by Koch, the tripartite typology is problematic in

⁶¹³ E.g. Felner (n 125); Gauthier De Beco, 'The Interplay between Human Rights and Development the Other Way Round: The Emerging Use of Quantitative Tools for Measuring the Progressive Realisation of Economic, Social and Cultural Rights' (2010) 4 Human Rights and International Legal Discourse 265; Chapman and Russell (n 234).

practice (and in the context of this thesis, in supranational monitoring), as the categories it creates eventually merge between each other, and recent developments highlight the need to adopt additional categories.⁶¹⁴ For instance, what differentiates the obligation to respect (usually described as an obligation to refrain from interfering with the enjoyment of rights) from the obligation to provide, when states are required to adopt measures combating *de facto* discrimination in access to healthcare? To avoid ‘interfering’ with the enjoyment of the right to health (obligation to respect), states must ensure that groups vulnerable to discrimination benefit from the same healthcare than the rest of the population, by providing measures adapted to their vulnerability (obligation to fulfil). Therefore, it is unclear what distinguishes one obligation from the other, and how such distinction may assist SHRB in interpreting states’ obligations through monitoring as it may crystallise the latter inadequately.

This Chapter will thus explore the nature of states’ obligations to realise the right to health by focusing on the timeframe in which they have to be fulfilled, guided by the

⁶¹⁴ Ida Elisabeth Koch, ‘Dichotomies, Trichotomies or Waves of Duties’ (2005) 5 Human Rights Law Review 81. It is worth noting that the tripartite typology stems from Shue’s writings: Henry Shue, *Basic Rights: Subsistence, Affluence, and U.S. Foreign Policy* (Princeton University Press 1980). In this book, Shue specifically recognises the obligations to ‘avoid depriving’, to ‘protect from deprivation’, and to ‘aid the deprived’ (in the revised edition: Henry Shue, *Basic Rights: Subsistence, Affluence, and U.S. Foreign Policy* (2nd edition, Princeton University Press 1996), 52). In 1987, Eide proposed a typology deriving from Shue’s writings, but using the terminology now recognised as the obligations to respect, protect and fulfil (Special Rapporteur on the right to food, Mr. Asbjørn Eide, ‘Final Report on the Right to Adequate Food as a Human Right’ (1987) UN Doc. E/CN.4/Sub.2/1987/23). However, scholars such as Van Hoof suggest that the obligation to fulfil includes an obligation to promote (Van Hoof ‘The Legal Nature of Economic, Social and Cultural Rights: A Rebuttal of Some Traditional Views’, in Philip Alston and Katerina Tomaševski, *The Right to Food* (Martinus Nijhoff Publishers 1984), 106). Steiner and Alston even advocate for a quintuple typology, including obligations (1) to respect the rights of others; (2) to create institutional machinery essential to the realisation of rights; (3) to protect rights/prevent violations; (4) to provide goods and services to satisfy rights; and (5) to promote rights (Steiner and Alston, *International Human Rights in Context* (2nd edition, Oxford University Press 2000), 182). See further information on the evolution of the tripartite typology in Sepúlveda (n 152) 157-164. It is worth highlighting that in 2000, the UN Committee recognised that the obligation to fulfil the right to health encompassed obligations to facilitate, provide and promote (UNCESCR, ‘GC14’ (n 21), para 37). However, the negative wording used for the obligation to respect (see UNCESCR, ‘GC14’ (n 21), paras 33 and 34) is particularly confusing, as ‘refrain[ing] from interfering directly or indirectly with the enjoyment of the right to health’ often requires that states ‘provide’ or ‘facilitate’ access to such right, yet part of the obligation to fulfil.

established principle of progressive realisation in supranational monitoring. Section 5.1 will examine how SNHRBs should interpret the obligation to progressively realise the right to health. It will analyse the requirement to progressively improve this right in human rights law; how such progress must be monitored by SNHRBs; and what they must prohibit to give meaning to its substance. Section 5.2 will then explore the notion of minimum core obligations in the context of healthcare. It will discuss how minimum core obligations are recognised in human rights law, and will challenge how their legal content is determined. Finally, it will conclude they cannot be clearly defined and SNHRBs must thus understand them through the test of reasonableness, as measures to be prioritised, although they may heuristically facilitate findings of non-conformity against particular states.

5.1 The obligation to progressively realise the right to health

The obligation to progressively realise ESCR is a cornerstone of human rights law and has received considerable attention in the literature. However, it is still unclear what such requirement precisely obliges or prohibits states to do; and it is often criticised for not guaranteeing an effective enjoyment of ESCR, including the right to health. In an attempt to clarify states' obligation to progressively realise the right to health to enable SNHRBs to optimise their interpretation, this section will suggest that whilst the concern to set reasonable expectations upon states is legitimate, the importance of giving substance to this obligation must not be forgotten. Firstly (5.1.1), I will observe that progressive realisation requires that states improve individuals' enjoyment of their right to health, but that this is contingent upon the availability of resources. Secondly (5.1.2), I will argue that in order to interpret this right adequately, SNHRBs must monitor it adequately, i.e. by evaluating resource availability and by using health indicators. Thirdly (5.1.3), I will contend that to materialise states' obligation to progressively realise the right to health adequately, SNHRBs must review it through two findings of violations: insufficient progress, or retrogression of health standards.

5.1.1 Progress towards a better realisation of the right to health

In order to comply with their obligations under human rights law, states must ‘progressively realise’ the right to health. The nature of such progress, however, is insufficiently clarified in human rights law. This subsection thus suggests that two elements be taken into account. Firstly (5.1.1.1), states’ progress must attest an improvement in individuals’ enjoyment of their right to health. Secondly (5.1.1.2), whilst progress is understood through a long-term approach, being contingent upon resource availability, it requires that states take steps immediately.

5.1.1.1 The requirement to improve individuals’ enjoyment of their right to health

Both human rights instruments and SNHRBs, when interpreting them, clearly recognise the importance for states’ progressive realisation of the right to health to attest an improvement in individuals’ enjoyment of this right.

Recognition by human rights instruments

As mentioned in subsection 1.2.1.1, the legal requirement to progressively realise and improve the enjoyment of ESCR, including the right to health, is explicitly enshrined in Article 2(1) ICESCR, which reads:

Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.⁶¹⁵

When drafting this provision in the early 1950s, states’ representatives disagreed on the necessity to take into consideration resource availability by including the word ‘*progressively*’.⁶¹⁶ Some advocated that this formulation clarified what was already

⁶¹⁵ ICESCR (n 4), Art 2(1).

⁶¹⁶ Alston and Quinn (n 126) 174–177.

implicit in the Covenant,⁶¹⁷ and that transforming objectives into an express obligation strengthened the legal force of the ICESCR.⁶¹⁸ Others, however, declared that the word *progressively* did not add any substance to the Covenant but, rather, provided an excuse for not implementing it;⁶¹⁹ and that it dealt inappropriately with low-income countries.⁶²⁰ This formulation, nonetheless, was adopted by 11 votes against 5.⁶²¹ The UN Committee issued various General Comments since, clarifying the content of this obligation while highlighting the need to take into account practical difficulties states can face when implementing the Covenant.⁶²² However, the expectation weighing upon states is clearly to ‘improve’ the enjoyment of the right to health, to reach towards its ‘full realisation’.⁶²³

Regional human rights instruments also require that states progressively realise and thus improve the enjoyment of ESCR (including the right to health), although less explicitly than the ICESCR. The drafters of the ESC, second focus of this thesis, clearly recognised the need to incorporate the notion of progressivity. The Rapporteur to the Committee on Social Questions mentioned in his first report that the harmonisation and coordination of social policies between Member States would necessitate flexibility, and a long-term approach to be carried out ‘*progressively*’.⁶²⁴

⁶¹⁷ ECOSOC Commission on Human Rights, ‘Summary Record of the 271st Meeting’ (1952) UN Doc. E/CN.4/SR.271, p 12 (Mrs. Roosevelt, USA).

⁶¹⁸ ECOSOC Commission on Human Rights, ‘Summary Record of the 233rd Meeting’ (1951) UN Doc. E/CN.4/SR.233, p 8 (Mr. Azmi Bey, Egypt; and Mr. Cassin, France).

⁶¹⁹ Commission on Human Rights, ‘271st Meeting 1952’ (n 617), pp. 5 and 11 (Mr. Azkoul, Lebanon).

⁶²⁰ ECOSOC Commission on Human Rights, ‘Summary Record of the 273rd Meeting’ (1952) UN Doc. E/CN.4/SR.273, p 7 (Mr Morozov, USSR) and p 14 (Mr Jevremovic, Yugoslavia).

⁶²¹ Commission on Human Rights, ‘Report to the Economic and Social Council on the Seventh Session of the Commission, Held at the Palais Des Nations, Geneva, from 16 April to 19 May 1951’, para 54 <http://www.un.org/ga/search/view_doc.asp?symbol=E/1992> [accessed 8 September 2015].

⁶²² E.g. UNCESCR, ‘General Comment 3’ (n 211), para 9: ‘It is on the one hand a necessary flexibility device, reflecting the realities of the real world and the difficulties involved for any country in ensuring full realization of economic, social and cultural rights’.

⁶²³ UNCESCR, ‘GC14’ (n 21), paras 30 to 32.

⁶²⁴ CoE, ‘Collected Travaux Préparatoires ESC, Volume I’ (n 328), Report Presented by Mr Heyman on behalf of the Committee on Social Questions on the request made by the

Whilst the ESC has no equivalent to Article 2(1) ICESCR, its preamble declares that the CoE aims at facilitating the economic and social ‘*progress*’ of its States parties, who must strive to ‘*further*’ realise human rights. It also asserts that States parties are bound to ‘*improve*’ the standards of living of their populations.⁶²⁵ Finally, Article 11 requires that States parties provide the ‘*highest possible standard of health attainable*’, by removing and preventing diseases ‘*as far as possible*’.⁶²⁶ Nevertheless, no interpretative guidelines have been published regarding the requirement to ‘*improve*’ such standard. It is worth noting that the Inter-American and the African systems have also embraced the notion of progressivity and improvement in the realisation of ESCR. The African Charter provides for the ‘*best attainable*’ standard of health,⁶²⁷ and Article 1 of the Protocol of San Salvador reads:

The States Parties to this Additional Protocol to the American Convention on Human Rights undertake to adopt the necessary measures, both domestically and through international cooperation, especially economic and technical, to the extent allowed by their available resources, and taking into account their degree of development, for the purpose of achieving *progressively* and pursuant to their internal legislations, the full observance of the rights recognized in this Protocol.⁶²⁸

Recognition by SNHRBs: focus on the UN and the European Committees

While human rights instruments clearly require that states progressively improve individuals’ enjoyment of their right to health, it is worth asking whether SNHRBs also recognise this requirement in their jurisprudence. The examples of the UN and the European Committees will respond positively to this question.

Out of the sixty Concluding Observations examined in the 2008-2012 sample, the UN Committee only urged states three times to comply with their obligation to

Committee of Ministers for an opinion on the memorandum by the Secretariat General (18 September 1953), Document 188, p 17.

⁶²⁵ ESC 1961 (n 92), Preamble; ESC 1996 (n 92), Preamble.

⁶²⁶ ESC 1961 (n 92), Art 11; ESC 1996 (n 92), Art 11.

⁶²⁷ African Charter (n 92), Art 16.

⁶²⁸ Protocol of San Salvador (n 92), Art 1.

progressively realise the right to health by referring expressly to Article 2(1) ICESCR. In these instances, states were prompted to increase their healthcare expenditure on the basis such figures had decreased or stagnated, while the overall, resource availability had improved.⁶²⁹ Nevertheless, the UN Committee clearly expects states to ‘progress’ in the field of healthcare, through its reporting procedure. Firstly, it often asks states to submit data demonstrating their progress in the health sector.⁶³⁰ Secondly, it regularly expresses satisfaction when this data shows an improvement.⁶³¹ Thirdly, when the information provided does not demonstrate sufficient progress or when no information is provided, the UN Committee can require that further measures be undertaken.⁶³² Furthermore, Chapter 2 demonstrated that the UN Committee attempted to carry out follow-ups from one reporting cycle to the next. This follow-up, however, lacks greatly in coherency and transparency, and has not led to the development of any norms with regard to the improvement of states’ performance in health.

In contrast, the European Committee often refers to the notion of ‘progress’ to assess states’ conformity to Article 11 ESC in its reporting procedure,⁶³³ and applies a much stricter follow-up than the UN Committee. For this purpose, it reviews the evolution of states’ legislation, regulations and measures in public health by using the same thematic health indicators in each reporting cycle.⁶³⁴ Furthermore, the European

⁶²⁹ UNCESCR, ‘Concluding Observations DRC 2009’ (n 61), para 16; UNCESCR, ‘Concluding Observations Cambodia 2009’ (n 219), para 27; UNCESCR, ‘Concluding Observations Philippines 2008’ (n 220), para 17.

⁶³⁰ E.g. UNCESCR, ‘Concluding Observations Ecuador 2012’ (n 216), para 30: ‘The Committee requests the State party to provide information on the progress made in the field of mental and psychosocial health in its next periodic report’.

⁶³¹ E.g. UNCESCR, ‘Concluding Observations Sri Lanka 2010’ (n 187), para 5: the UN Committee commended Sri Lanka for ‘its significant progress towards the achievement of the Millennium Development Goals, especially in the field of health’.

⁶³² UNCESCR, ‘Concluding Observations Kenya 2008’ (n 218), para 20: the UN Committee asked Kenya to progressively extend the scope of its health insurance in order to reimburse hospitalisation fees and to cover the entirety of workers and unemployed persons.

⁶³³ For the first time in ECSR, ‘Conclusions III (1973)’, Cyprus.

⁶³⁴ Such review is also applied in the complaint procedure, as the Committee explicitly declares that it ‘assesses the efforts made by states with reference to their national legislation and regulations and undertakings entered into with regard to the European Union and the United Nations’, in *Marangopoulos Foundation for Human Rights v Greece (ECSR)* (n 372) [204] (referring inaccurately to Conclusions XV-2, Italy, Article 11§3, pp. 307-312).

Committee has held states several times in breach of Article 11 ESC for not having improved sufficiently their performance in the health sector,⁶³⁵ for having let such performance declined,⁶³⁶ or for not having demonstrated any progress.⁶³⁷ It nonetheless usually encourages states to improve the realisation of the right to health if they have made considerable efforts, even if such performance remains low compared to other States parties.

In its collective complaint procedure, the European Committee refers even more explicitly to states' obligation to progressively realise the right to health. In its Merits Decisions *FIDH v Greece* and *Marangopoulos v Greece*, the European Committee found the state in breach of Article 11 ESC for not having taken timely measures against the health hazards caused by river pollution and by lignite mining.⁶³⁸ To reach these decisions, it expressly referred to two standards specific to the progressive realisation of the Charter, developed in previous case law. Firstly, the European Committee declares that when a right is particularly complex and expensive to realise, states should take measures that aim at achieving the objectives set by the ESC '*within a reasonable time, with measurable progress and to an extent consistent with the maximum use of available resources.*'⁶³⁹ Secondly, it affirms that in order to ensure constant progress towards the objectives set in the ESC, states should not only change their laws, they should also make resources available and take the measures necessary to give full effect to this instrument.⁶⁴⁰

⁶³⁵ E.g. ECSR, 'Conclusions XIX-2 (2009)', Latvia: finding of non-conformity to Article 11(1) for insufficient efforts to address mortality rate and life expectancy; ECSR, 'Conclusions 2009', Turkey: finding of non-conformity to Article 11(1) for insufficient efforts to address maternal and infant mortality.

⁶³⁶ ECSR, 'Conclusions XV-2 (2001)', Belgium: finding of non-conformity to Article 11(3) for having let immunisation coverage decline.

⁶³⁷ E.g. ECSR, 'Conclusions 2009', Ireland: finding of non-conformity to Article 11(3) for absence of evidence showing progress to prevent accidents.

⁶³⁸ International Federation for Human Rights International Federation for Human Rights (FIDH) v Greece [2013] Complaint No. 72/2011, Decision on the Merits (ECSR); Marangopoulos Foundation for Human Rights v Greece (ECSR) (n 372).

⁶³⁹ *International Association Autism-Europe (IAAE) v France* [2003] Complaint No. 13/2002, Decision on the Merits (ECSR) [53].

⁶⁴⁰ *International Movement ATD Fourth World v France* [2008] Complaint No. 33/2006, Decision on the Merits (ECSR) [61].

To conclude, while the UN Committee benefits from a clearer textual basis than the European Committee to assert states' obligation to progressively realise the right to health, its monitoring methods are weaker and its follow-up is insufficient. The high number of States parties to the ICESCR and the low level of resources available to the UN Committee can partially explain this situation. This has impeded the development of international legal standards. The role of regional systems in monitoring states' obligation to progress in healthcare and interpreting its substance is thus crucial. The precision of the European Committee's follow-up and jurisprudence regarding states' obligation to progressively realise Article 11 ESC can be used as an example of success in that regard, since they enabled the refinement of the legal content of the right to health in the CoE.

5.1.1.2 The contingency of progress upon resources

The extent to which states can guarantee the enjoyment of the right to health effectively depends on resource availability. This means that the realisation of the right to health may take time and is likely to be 'progressive' as a result. Such contingency upon resources appears in Article 2(1) ICESCR and in GC14, as both documents mention states' obligation to meet the standards set by the Covenant to the 'maximum of their available resources'.⁶⁴¹ It also appears in regional instruments.

Whilst the text of the ESC does not mention the importance of resource availability, its Travaux Préparatoires explicitly do so:

'[...] the standard of living depends on the sum of available resources, which again is conditioned by economic factors'.⁶⁴²

Furthermore, the Protocol of San Salvador declares that states must guarantee rights '*to the extent allowed by their available resources*',⁶⁴³ and the African Commission

⁶⁴¹ ICESCR (n 4), Art 2(1); UNCESCR, 'GC14' (n 21).

⁶⁴² CoE, 'Collected Travaux Préparatoires ESC, Volume I' (n 328), Memorandum by the Secretariat General of the Council of Europe on the role of the Council of Europe on the social field (16 April 1953) Doc SG (53)1, para 6 p 5.

⁶⁴³ Protocol of San Salvador (n 92), Art 1.

affirms that the notion of progressive realisation must be understood ‘*within the resources available*’ to states.⁶⁴⁴

Such contingency upon resources and a long-term approach have often been heavily criticised for not sufficiently guaranteeing an effective enjoyment of individuals’ rights, including the right to health. During the drafting of the ICESCR, various states’ representatives were already concerned that the notion of progressive realisation could become an excuse for non-compliance,⁶⁴⁵ and make the work of the UN Committee meaningless.⁶⁴⁶ Many academics have also warned against the vagueness of this obligation, arguing it tarnished the legal force of ESCR. When defending core obligations, Chapman declares that the notion of progressive realisation complicates both the conceptualisation of those rights and their monitoring.⁶⁴⁷ Moreover, Felner argues that NGOs are reluctant to deal with states’ obligation to progressively realise ESCR. He outlines that they do not have adequate tools to assess compliance in that regard and fear states may use it as an excuse for breaching human rights law. As a result, NGOs presumably focus on immediate obligations instead, to counter critiques that ESCR are not ‘real’ rights, and be more efficient in their primary work of ‘naming and shaming’.⁶⁴⁸

While such criticisms reflect some degree of truth, three arguments should be made. Firstly, saying that states’ obligation to progressively realise the right to health is impossible to monitor, is unhelpful. The adequacy of the law is not solely based on its simplicity. As outlined in this thesis, in order to interpret the right to health adequately, SNHRBs must: (1) ensure an effective enjoyment of this right; (2) set reasonable expectations upon states; (3) be sensitive to the context in which it will be implemented; and overall (4), guarantee principled consistency. Not taking into

⁶⁴⁴ African Commission on Human and Peoples’ Rights, ‘Principles and Guidelines on the Implementation of Economic, Social and Cultural Rights in the African Charter on Human and Peoples’ Rights’ (2011), paras 13 to 15.

⁶⁴⁵ Commission on Human Rights, ‘271st Meeting 1952’ (n 617), p 11 (Mr Azkoul, Lebanon).

⁶⁴⁶ *ibid*, p 8 (Mr Morozov, USSR) (it was called the ‘Commission’ at the time).

⁶⁴⁷ Chapman and Russell (n 234) 7–8.

⁶⁴⁸ Felner (n 125) 405–408.

account the resources available to the state would fail to meet the second and fourth principle of interpretation. Furthermore, monitoring this obligation may be complex but not impossible. The ICESCR, the ESC and the comparative analysis of their monitoring procedures, point at two fundamental stages in that regard. The first stage requires that SNHRBs evaluate both the resources available to the state and its progress towards realising fully the right to health. The second stage requires that they materialise the notion of progressive realisation through two findings of violation: either based on insufficient improvement, or on decline of states' performance under the right to health. However, human rights literature and jurisprudence remain hesitant on these issues and little material clarifies what either stage entails.

Secondly, and as argued by Alston, the word 'progressively' should not be understood out of context. SNHRBs should read it in conjunction with the requirements that first, states use the maximum level of resources available and second, aim to fully realise the right to health.⁶⁴⁹ Such requirements appear explicitly in Article 2(1) ICESCR,⁶⁵⁰ and are reaffirmed by the UN Committee in General Comment 3.⁶⁵¹ They can also be read in the ESC or the Protocol of San Salvador, and represent guidelines of implementation for the African Charter.⁶⁵² Moreover, GC14 specifies that states must realise the right to health '*as expeditiously and effectively as possible*' and that retrogressive measures constitute a prima facie violation of the Covenant.⁶⁵³

Finally, the notion of progress is not solely restricted to a long-term approach, since states' obligation to progressively realise the right to health also embraces immediate obligations. According to the UN Committee in GC14, such obligations include: taking steps towards the realisation of the right to health; and guaranteeing the

⁶⁴⁹ Alston and Quinn (n 126) 172–173.

⁶⁵⁰ ICESCR (n 4), Art 2(1).

⁶⁵¹ UNCESCR, 'General Comment 3' (n 211), para 9.

⁶⁵² ESC 1961 (n 92); ESC 1996 (n 92); Protocol of San Salvador (n 92), Art 1; African Commission, 'Principles and Guidelines on the Implementation of ESCR' (n 644), paras 13 to 15, and 20.

⁶⁵³ UNCESCR, 'GC14' (n 21), paras 31 and 32.

principle of non-discrimination in its enjoyment.⁶⁵⁴ The African and the Inter-American Commissions consider minimum core obligations to be of an immediate nature, in which case they would depart from the obligation to *progressively* realise the right to health.⁶⁵⁵ This thesis, however, will refute this argument in section 5.2.

To conclude, SNHRBs should and have interpreted the obligation to progressively realise the right to health as requiring that states improve their performance in healthcare, depending on the availability of their resources. However, it is still uncertain how they ought to approach the elements of progress and resources in their monitoring procedures. This should thus be clarified to optimise their interpretation of the nature of states' obligations to realise the right to health.

5.1.2 Monitoring the obligation to progressively realise the right to health

Whilst states' obligation to improve individuals' enjoyment of their right to health is well recognised in human rights law, it is still unclear how this requirement should be implemented and, thus, monitored. This thesis contends that in order for SNHRBs to optimise their interpretation of states' obligation to progressively realise the right to health, they must evaluate the progress of states' performance in health adequately. Therefore, two methods are indispensable. These include: an assessment of states' use of resources to realise the right to health, and the use of thematic health indicators.

5.1.2.1 Evaluating states' resources to monitor potential

Evaluating states' resources to monitor their potential to realise the right to health involves two questions. First, what are the resources to be evaluated; and second,

⁶⁵⁴ *ibid*, para 30.

⁶⁵⁵ Inter-American Commission on Human Rights, 'Guidelines for Preparation of Progress Indicators in the Area of Economic, Social and Cultural Rights' (2008) OEA/Ser.L/V/II.132 Doc. 14 Rev. 1, para 67: '*significant dimensions of social rights are immediately enforceable before the domestic courts*'; African Commission, 'Principles and Guidelines on the Implementation of ESCR' (n 644), para 16: '*[Immediate] obligations include but are not limited to the obligation to take steps, the prohibition of retrogressive steps, minimum core obligations and the obligation to prevent discrimination in the enjoyment of economic, social and cultural rights*'.

how should they be evaluated in order to monitor adequately the realisation of the right to health?

What are the resources to be evaluated?

It is widely recognised amongst human rights lawyers that the notion of ‘resources’ should be interpreted comprehensively, and should not be restricted to budgetary considerations.⁶⁵⁶ This view was also expressed by states’ representatives during the drafting of the ICESCR.⁶⁵⁷ Although it is futile to list every single resource necessary to realise the right to health, main categories may be listed for clarity purposes. As highlighted by Robertson, ESCR require: financial, human, technological, information, and natural resources (to which should also be added logistical resources).⁶⁵⁸ In the context of health, these can be translated into: a budget allocated to health (financial resources); as well as health personnel and researchers in the field of health (human resources). Resources also include: medical equipment, facilities, and services (technological and logistical resources); health-related information; and any natural resources essential to health (e.g. food, water, and air of good quality).

Furthermore, such resources can be sourced either nationally or internationally. The importance of international cooperation and international aid are recognised at the international and regional levels: in the ICESCR, the ESC, the African Charter, and the Protocol of San Salvador.⁶⁵⁹ However, international assistance and cooperation

⁶⁵⁶ The International Commission of Jurists, the Urban Morgan Institute on Human Rights and the Centre for Human Rights of the Faculty of Law of Maastricht University, ‘Maastricht Guidelines on Violations of Economic, Social and Cultural Rights’ (1997), para 10: ‘[the] full realization of the rights may depend upon the availability of adequate financial and material resources’; See also Sigrun Skogly, ‘The Requirement of Using the “Maximum of Available Resources” for Human Rights Realisation: A Question of Quality as Well as Quantity?’ (2012) 12 Human Rights Law Review 393, 398–404.

⁶⁵⁷ Commission on Human Rights, ‘271st Meeting 1952’ (n 617), p 5 (Mr Azkoul, Lebanon) and p 6 (Mr Cassin, France): ‘The resources of a state should be interpreted broadly to include budgetary appropriations and also technical assistance, international co-operation and other elements’.

⁶⁵⁸ Robert E Robertson, ‘Measuring State Compliance with the Obligation to Devote the “Maximum Available Resources” to Realizing Economic, Social, and Cultural Rights’ (1994) 16 Human Rights Quarterly 693, 703–713.

⁶⁵⁹ ICESCR (n 4), Art 2(1); ESC 1961 (n 92), Part I; ESC 1996 (n 92), Part I: ‘The Parties accept as the aim of their policy, to be pursued by all appropriate means both national and

do not represent a legal obligation *per se*. As a result, only resources that have been offered by sovereign states, international organisations or private donors, and that are under the control of the receiving state, can be assessed. It is important to note that the resources transferred through foreign aid can be of similar nature than those deployed by the state itself: health funds, health personnel, medical facilities, medical goods, etc.

Lack of expertise, as well as time and financial constraints prevent SNHRBs from carrying out in-depth reviews of each type of resources each state can access to realise the right to health.⁶⁶⁰ However, SNHRBs often work alongside agencies that have the capacity to conduct such assessment. This includes, for instance, the WHO and the World Bank in the UN; or Eurostat (although affiliated with the European Union) and the Commissioner for Human Rights in the CoE. Interestingly, the UN Committee relies on ‘Core documents forming part of the reports of States parties’, common to all treaty bodies, to contextualise the environment in which the right to health is implemented. These documents could facilitate a review of the availability of resources by welcoming contributions from expert agencies. Core documents, nonetheless, are prepared by states (reliable data is thus not guaranteed) and do not provide a detailed account of their available resources. It is worth noting that the European Committee sometimes uses data published by expert agencies, but more to evaluate states’ efforts under Article 11 ESC than to examine resource availability.

In the light of the above, I contend that SNHRBs should rely more often on the expertise of supranational agencies to contextualise resource availability. Accessing reliable data produced by expert agencies would improve supranational monitoring, since it promotes a more effective enjoyment of the right to health and sets more

international in character’; African Charter (n 92), Preamble; African Commission, ‘Principles and Guidelines on the Implementation of ESCR’ (n 644), para 13; Protocol of San Salvador (n 92), Art 1.

⁶⁶⁰ Such constraints are clearly outlined in the literature, e.g.: Evatt ‘Ensuring effective supervisory procedures: the need for resources’ in Alston and Crawford (n 144); Suzanne Egan, ‘Strengthening the United Nations Human Rights Treaty Body System’ (2013) 13 Human Rights Law Review 209. See also OHCHR, ‘Resources in Support of the Human Rights Treaty Body System -Human Rights Programme’ (2012) <<http://www.ohchr.org/Documents/HRBodies/TB/HRTD/NY/HRTDBudgetPaper310112.pdf>> [accessed 8 September 2015].

reasonable reporting expectations upon states. For that purpose, it would be helpful if SNHRBs could access short summaries on the main categories of resources available in each state (financial, human, technological, information, natural, and logistical). Those summaries should focus on the resources necessary to realise the various ESCR recognised by human rights law, including the right to health. Themes examined would thus include: work and trade unions; social security; food; water and sanitation; housing; health; education; and cultural life. Furthermore, those summaries should be regularly updated by the relevant supranational agencies on an online database, which could be managed at an international level and receive regional inputs. This suggestion is especially relevant when Committee members, whether in the UN or in regional systems, work on a voluntary basis and often have full-time professional commitments elsewhere.⁶⁶¹

Evaluating the availability of resources: practical difficulties

Considering human rights law obliges states to use the *maximum* of their available resources to realise ESCR,⁶⁶² monitoring the obligation to progressively realise the right to health seems, at first glance, to imply an evaluation in three stages. Firstly, SNHRBs would assess the resources potentially available to the state. Secondly, they would evaluate the resources effectively invested towards the realisation of this right. Thirdly, SNHRBs would conclude whether this is sufficient to be able to comply with the right to health. In this third stage, they would justify their decisions of non-compliance by specifying which resources should have been obtained (if unavailable) or unblocked (if available), to avoid arbitrary rulings. This subsection will however demonstrate, through the examples of the UN and the European Committees, that SNHRBs fail to respect these three steps when monitoring the right to health, due to problems inherent to such evaluation.

⁶⁶¹ Issue picked up during Interviews UN Committee members (n 190).

⁶⁶² ICESCR (n 4), Art 2(1). The European Committee first established this standard in *International Association Autism-Europe v France* (n 639) (ECSR) [53]: ‘When the achievement of one of the rights in question is exceptionally complex and particularly expensive to resolve, a State Party must take measures that allows it to achieve the objectives of the Charter within a reasonable time, with measurable progress and to an extent consistent with the maximum use of available resources’.

The European Committee usually skips the first and the third stages in its comments, i.e. assessing the resources available, and concluding whether those used to realise the right to health are sufficient for compliance. Instead, it provides an in-depth evaluation of the second stage (resources effectively deployed in health), thanks to the indicators developed in its reporting procedure on Article 11 ESC. It often examines the use of financial resources, by looking at the proportion of GDP spent on healthcare, and the proportion of public and private funding in the health sector, through the indicator ‘access to healthcare’. It regularly assesses the human resources deployed to realise the right to health, by reviewing the number of general practitioners, specialists, dentists, and pharmacists per 1,000 inhabitants, under the indicator ‘healthcare professionals’. The European Committee also evaluates the logistical resources used in the health sector, by reviewing the legislation, monitoring systems, and equipment in place, through most indicators. It examines the informational resources deployed to implement Article 11 ESC by assessing the provision of health education in schools and the organisation of awareness-raising campaigns within the population, under the corresponding indicators. Finally, it evaluates the appropriateness of natural resources crucial to health under the indicators ‘Air pollution’, ‘Water pollution’, ‘Asbestos’, ‘Ionising radiation’, ‘Noise pollution’, and ‘Food safety’. However, the European Committee fails to review resource availability. Therefore, when it holds a breach of Article 11 ESC, it rarely comments on what resources the state should have used to prevent such violation, or what resources the state should use to remedy the situation (third stage). Its comments are limited to declaring that the resources deployed in public health are insufficient, and to briefly asking for improvement in the next report. For instance, in its 2009 Conclusions, the European Committee observed that the proportion of Azerbaijan’s GDP devoted to healthcare was the lowest in Europe, and held a breach of Article 11 ESC.⁶⁶³ No comment was made as to what unused resources were available to the state, or as to what health budget it should aim for. The European Committee, nonetheless, does carry out further analysis in some instances. When it reviews the maternal and infant mortality of a population, for example, it takes into consideration states’ level of income by explicitly setting higher standards for the

⁶⁶³ ECSR, ‘Conclusions 2009’, Azerbaijan pp. 98–101; see also ECSR, ‘Conclusions 2013’, Azerbaijan pp. 5–7.

wealthier ones. It requires that states take measures bringing maternal and infant deaths down to zero risk,⁶⁶⁴ especially those with highly developed healthcare systems.⁶⁶⁵ The European Committee has subsequently warned several ‘wealthy’ states against unacceptably high maternal mortality rates. However, it decided to defer its conclusions rather than hold a violation of Article 11 ESC.⁶⁶⁶

The UN Committee, unlike the European Committee, often goes through the three stages prompted by the obligation to use the maximum resources available to realise the right to health in its comments, but superficially so. Firstly, it is not clear how thoroughly the UN Committee assesses the resources available to each state. Common Core Documents are limited,⁶⁶⁷ and Concluding Observations do not explicitly recognise resources constraints as being relevant factors or difficulties impeding the implementation of the ICESCR. Interviews conducted with a few Committee members highlight that they carry out individual research through reliable sources, but this is neither guaranteed nor transparent. Secondly, the UN Committee usually tries to assess the resources deployed by states in health, by asking questions to the government prior to drafting its Concluding Observations. This is reflected in lists of issues, replies to lists of issues, and summary records of its sessions.⁶⁶⁸ However, those findings do not always appear in Concluding Observations. Thirdly, the UN Committee sometimes declares that the levels of resources deployed are insufficient to comply with the right to health. Nevertheless, its rationales are unclear. Comments are often limited to declaring that the objectives set by Article 12 ICESCR are not met, without providing any technical support on how to obtain or unblock the resources needed to remedy such situation. This is

⁶⁶⁴ First established in ECSR, ‘Conclusions XV-2 (2001)’, Belgium p 94.

⁶⁶⁵ First established in ECSR, ‘Conclusions 2003’, France p 147 (standard reiterated in more ‘formal’ terms, in cycles XIX-2 (2009) and 2009).

⁶⁶⁶ ECSR, ‘Conclusions XV-2 (2001), Addendum 1’, Luxembourg pp. 77-80; ECSR, ‘Conclusions XVII-2 (2005)’, Netherlands pp. 594-596.

⁶⁶⁷ E.g. UN International Human Rights Instruments, ‘Common Core Document Forming Part of the Reports of States Parties: United Republic of Tanzania’ (2012) UN Doc. HRI/CORE/TZA/2012, para 7: financial resources are summarised in only eight lines.

⁶⁶⁸ All documents relating to the reporting procedure of the UN Committee can be found online:

<http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/SessionsList.aspx?Treaty=CESCR> [accessed 8 September 2015].

surprising for a SNHRB that usually prioritises constructive dialogue. It is worth noting that the Concluding Observations of the UN Committee sometimes engage systemically with resource availability or resource allocation, but not consistently enough. Until 2010, the Concluding Observations of the UN Committee often included a section entitled ‘Factors and difficulties impeding the implementation of the Covenant’, but the latter tended to review armed conflicts, and not even systematically.⁶⁶⁹ In its 2015 reporting cycle, the UN Committee integrated a paragraph on ‘Maximum available resources’ in each Concluding Observations, but it is uncertain whether this will continue.⁶⁷⁰

To conclude, the UN and the European Committees sometimes express concern or reach findings of violation when they consider that the resources effectively devoted to the realisation of the right to health are insufficient. Nevertheless, they often fail to assess the resources available to the state. This leads to two observations. First, the Committees cannot conclude with precision whether sufficient resources have been invested to implement the right to health, since they have not investigated what resources were available beforehand. As a result, they rarely outline which resources should have been used to avoid such situations, or how to unblock them in the future. Second, the Committees tend to focus on whether the standards set by the right to health have been achieved, regardless of states’ resources. This review fails to acknowledge states must use their *maximum* available resources, a requirement recognised by both the UN and the CoE.⁶⁷¹ However, such minimum core approach can set unreasonable expectations, as I will argue in section 5.2.

⁶⁶⁹ E.g. UNCESCR, ‘Concluding Observations DRC 2009’ (n 254), paras 6 and 34: the UN Committee acknowledges the challenge that the conflict represents to obtain the resources needed to realise ESCR, but criticises the state for mismanaging the resources that are already accessible (e.g. foreign aid and composition of the budget), urging an allocation of 15% of its budget to build a sustainable health system.

⁶⁷⁰ All documents relating to the reporting procedure of the UN Committee can be found online:
 <http://tbinternet.ohchr.org/_layouts/TreatyBodyExternal/SessionsList.aspx?Treaty=CESCR
 > [accessed 8 September 2015].

⁶⁷¹ UNCESCR, ‘General Comment 3’ (n 211), paras 9 and 10; *International Association Autism-Europe v France* (ECSR) (n 639) [53].

It is crucial to understand why both Committees fail to evaluate whether states use the maximum resources available, as this problem may be relevant to other SNHRBs. First, the UN and the European Committees may be reluctant to interfere in resource allocation, a matter intricately connected to states' sovereignty. This thesis, however, does not pretend to address this issue for it represents another research project. Second, the UN and European Committees may consider the evaluation of states' resources as a complex and daunting exercise that impedes their ability to promptly decide whether the targets set by the right to health are met. It is therefore fundamental that this thesis clarifies how such evaluation should be carried out.

The problem of an analysis focusing primarily on the availability of resources in order to evaluate whether their use is maximum, is twofold. Firstly, such analysis fails to provide a standardised model, as it works entirely on an ad hoc basis, reviewing the situation of each country disjointedly from one other. Secondly, such analysis tends to view resources as needing to be deployed in order to realise the right to health. Whilst this is true on various accounts, it is certainly not automatic. The United States, for instance, is one of the countries spending the most money on healthcare worldwide.⁶⁷² However, 14.7% of its population (45.5 million persons) cannot afford any health insurance, representing 40% of poor American adults.⁶⁷³ Therefore, injecting more money does not necessarily ensure an equal access to appropriate care for everyone, as required by the right to health. Money can be easily spent on items that do not benefit potential or existing patients, namely right-holders (e.g. excessively high salary for physicians).⁶⁷⁴

⁶⁷² World Bank, 'Health Expenditure' (n 174); WHO, 'Interactive Chart on Health Financing (per Capita Total Expenditure on Health at Average Exchange Rate in US\$: 2012)' <http://gamapserver.who.int/gho/interactive_charts/health_financing/atlas.html?indicator=i3&date=2012> [accessed 8 September 2015]. In 2012, the United States spent 17.9% of its GDP on healthcare and \$8,895 per capita. Both figures amount to the highest in the world (except Norway who spends \$9,055 per capita but its healthcare expenditure represents 9% of its GDP). However, access to (private) health system remains expensive and unequal.

⁶⁷³ U.S. Centers for Disease Control and Prevention, National Center for Health Statistics, 'Health Insurance Coverage' (n 111).

⁶⁷⁴ U.S. Bureau of Labor Statistics, 'Physicians and Surgeons: Pay (Occupational Outlook Handbook)' <<http://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm#tab-5>> [accessed 8 September 2015].

This thesis does not pretend to advise how resources should be deployed in healthcare. This question should be left to experts in medicine, public health, health economics, and ethics. However, I argue that the obligation to progressively realise the right to health clearly imposes two duties in terms of resources, as interpreted by the African Commission.⁶⁷⁵

The first of those duties is to mobilise resources to fund an adequate health system without excluding vulnerable sections of the population from accessing it, whether directly or indirectly. This can be done, for instance, by establishing an effective and fair taxation system to collect the financial resources necessary to realise the right to health. The Special Rapporteur on Extreme Poverty and Human Rights recently published a report in which she outlines the key role of fiscal policies in the realisation of ESCR.⁶⁷⁶ She specifies that tax structures that have a disproportionate impact on the poorest sections of the population, as well as untaxed exploitation of natural resources, can indicate a failure to mobilise adequate resources. Therefore, such policies may constitute a breach of states' obligation to progressively realise ESCR, including the right to health.⁶⁷⁷ Such view is also reflected in the work of various academics, and more particularly Nolan, O'Connell and Harvey.⁶⁷⁸ SNHRBs can monitor this obligation relatively easily, by asking states' officials and independent experts (e.g. academics) to describe the health insurance coverage for vulnerable groups, or the proportion of public funding to the health sector. It is worth noting that these elements are often monitored by the European or the UN Committees, but not consistently.

⁶⁷⁵ African Commission, 'Principles and Guidelines on the Implementation of ESCR' (n 644), para 15.

⁶⁷⁶ Special Rapporteur on extreme poverty and human rights, Magdalena Sepúlveda Carmona, 'Report to the Human Rights Council (Main Focus: Taxation and Human Rights)' (2014) UN Doc. A/HRC/26/28.

⁶⁷⁷ *ibid*, paras 5 and 72.

⁶⁷⁸ Saiz 'Resourcing Rights: Combating Tax Injustice from a Human Rights Perspective', in Aoife Nolan, Rory O'Connell and Colin Harvey (eds), *Human Rights and Public Finance: Budgets and the Promotion of Economic and Social Rights* (Hart 2013); Rory O'Connell, Aoife Nolan, Colin Harvey, Mira Dutschke, Eoin Rooney (eds), *Applying an International Human Rights Framework to State Budget Allocations: Rights and Resources* (Routledge 2014); Aoife Nolan (ed), *Economic and Social Rights after the Global Financial Crisis* (Cambridge University Press 2014).

The second duty deriving from states' obligation to progressively realise the right to health (in the context of resources' evaluation), is to give this right due consideration in the distribution of resources, through the budgeting process.⁶⁷⁹ The UN and the European Committees often review the percentage of states' GDP devoted to the health sector. Whilst it is a good indicator of whether states prioritise the realisation of the right to health or not in their budget allocation, it remains a very general tool. What if a state spends an adequate percentage of its GDP to healthcare but overfunds one service to the detriment of others? The approach developed by Anderson and Foresti is particularly helpful for monitoring this. Instead of asking what resources are available and whether they are sufficiently deployed towards healthcare, which this thesis demonstrates is unhelpful, their approach asks questions the other way around. What must be done? How much does it cost? Is it affordable?⁶⁸⁰ Therefore, this model coincides better with states' obligation to identify the health needs of their population (developed in Chapter 4), than an analysis based primarily on resource availability. Furthermore, it places the burden of proof on states, enabling SNHRBs to focus on procedural questions regarding the allocation of resources rather than to examine the vast issue of their availability. Four steps should lead this evaluation.

First, SNHRBs should assess whether states have identified the health needs of their populations. This argument was developed in Chapter 4 and requires that states collect data regarding various aspects of health, which can be translated into thematic indicators. If states did not identify such needs, SNHRBs may find a violation of their obligation to realise the highest standard of health.

Second, if states have identified the health needs of their populations, SNHRBs should verify whether they have subsequently evaluated the measures necessary to meet those needs in order to improve the realisation of the right to health. It is worth noting that states need econometrics and public health expertise to detect what goods or services are necessary to meet the health needs of their populations, and what

⁶⁷⁹ African Commission, 'Principles and Guidelines on the Implementation of ESCR' (n 644), para 15.

⁶⁸⁰ Edward Anderson and Marta Foresti, 'Assessing Compliance: The Challenges for Economic and Social Rights' (2009) 1 *Journal of Human Rights Practice* 469, 471–475.

factors restrict access to the latter.⁶⁸¹ If states did not carry out such analysis, SNHRBs may find them in violation of their obligation to progressively realise the right to health.

Third, if states have evaluated the measures necessary to meet the health needs of their populations, SNHRBs should assess whether they have appraised how much such measures would cost. This means states should have determined the health goods and services to be purchased, their prices once purchased, and their prices once user-fees have been subtracted.⁶⁸² If states did not undertake such costing exercise, SNHRBs may find them in breach of their obligation to progressively realise the right to health.

Fourth, if states have calculated the costs of the measures deemed necessary to meet the health needs of their populations, SNHRBs should verify whether they have subsequently determined whether such costs were affordable. It requires that states follow what Anderson and Foresti call an assessment on ‘rules of thumb’.⁶⁸³ This involves measuring whether the direct effects of a measure initially aimed at improving the realisation of the right to health, are superior to the indirect effects arising from having to raise the necessary revenue. If the positive and direct effects are superior, the measure is considered affordable, and the state cannot justify its inaction by an unavailability of resources. If states did not carry out this analysis, SNHRBs may find them in violation of the obligation to progressively realise the right to health. Finally, if states did carry out this analysis, they must prove why such measure was unaffordable, shifting the process-orientated aspect of such monitoring to a merits-based decision.

Several shortcomings arise from this monitoring nonetheless. Firstly, it is inexistent. Neither the UN nor the European Committees verifies such budgeting process; and the African or the Inter-American systems do not seem familiar with it either. Secondly, this cost-benefit analysis is based on an economic approach, inadequate

⁶⁸¹ *ibid* 471–472.

⁶⁸² *ibid* 472–473.

⁶⁸³ *ibid* 471–475.

and insufficient to measure the realisation of human rights. Certain health services must be guaranteed, regardless of the income they eventually generate (e.g. primary healthcare for detainees). The right to health cannot rely on a utilitarian approach since it primarily aims at protecting human dignity. Such monitoring, however, does not pretend to address the issue of minimum core or healthcare prioritisation (discussed later in this chapter), but that of affordability. Thirdly, Anderson and Foresti's approach focuses on the affordability of a specific measure but fails to consider the possibility for resources to be spent on other measures, or on other considerations than ESCR. It is realistically impossible to evaluate the costs of each measure necessary to realise each ESCR in every country. However, it is possible for SNHRBs to point at clearly insufficient allocation of resources to social sectors, and more precisely, at excessively low healthcare budgets.⁶⁸⁴ Both the UN and the European Committees can express their concern or hold states in violation of the right to health for excessively low health expenditures.⁶⁸⁵ This should not lead to comparing the level of resources allocated to healthcare with that allocated to other sectors, as implicitly suggested by Robertson.

Robertson claims that the realisation of human rights takes priority over all other considerations and that this should be reflected in resources allocation.⁶⁸⁶ Such argument is nonetheless over-simplistic and impractical for three reasons. First, Robertson does not take into account the occurrence of conflict of rights, as realising one right might contravene another. For instance, the right to health obliges states to promote SRH among teenagers, while the right to freedom of religion may require that states protect catholic schools' right to promote SRH themselves (and possibly, abstinence). Second, Robertson fails to acknowledge that (certain) states are unlikely to be able to fully realise every human right they are bound to while having resources left to run the rest of their duties (e.g. foreign affairs, legislature etc.). For instance, a high defence budget might be essential to protect civilians in times of armed conflict and may not be the only reason why the state devoted insufficient resources to

⁶⁸⁴ E.g. UNCESCR, 'Concluding Observations on Gambia's Initial Report' (2015) UN Doc E/C12/GMB/CO/1, paras 10 and 27.

⁶⁸⁵ E.g. ECSR, 'Conclusions 2013', Azerbaijan pp. 5-7; UNCESCR, 'Concluding Observations DRC 2009' (n 61), para 16.

⁶⁸⁶ Robertson (n 658) 700.

health.⁶⁸⁷ Third, Robertson dismisses the need for states to deploy resources in other areas that represent a source of taxation financing the realisation of human rights (e.g. business start-up grants).

To conclude, measuring states' use of resources to realise the right to health is a complex exercise but the obligation to progressively realise this right cannot be monitored fairly without engaging with it. Furthermore, the (quasi) judicial function of SNHRBs transfers upon them the duty to reach decisions that are justified with a transparent rationale. The burden of proof, however, lies upon states. SNHRBs can thus focus on the procedural aspect of the budgeting process but request expertise from states' representatives, local NGOs, relevant agencies and independent experts, if and when reviewing merits. While fairness and transparency are fundamental to monitor the right to health through principled consistency, one of the principles of interpretation advocated by this thesis, consistency is also of utmost importance.

5.1.2.2 Using health indicators to monitor progress

In order to respond to the concerns expressed against progressive realisation and to provide a framework in which states' resources to realise the right to health can be evaluated consistently, SNHRBs must use indicators and benchmarks. Such argument is well supported in the human rights community, including by Hunt in both his academic and (former) UN capacity.⁶⁸⁸ This thesis, however, will not outline which indicators states must perform adequately against to comply with the right to health. Whilst certain indicators are clearly essential to the realisation of this right (e.g. the proportion of births attended by skilled health personnel),⁶⁸⁹ listing them all

⁶⁸⁷ E.g. UNCESCR, 'Concluding Observations DRC 2009' (n 254), para 16: 'The Committee is also concerned about the continuous decrease over the past decade of the resources allocated to social sectors, notably health and social protection, whereas budgetary allocations to defence and public security have increased considerably to reach 30 per cent of State expenditures'.

⁶⁸⁸ Hunt and McNaughton (n 226) 308: 'there is no alternative but to use indicators to measure and monitor the progressive realization of the right to the highest attainable standard of health'; Special Rapporteur of the right to health, 'Annual Report 2003' (n 225); Special Rapporteur on the right to health, 'Annual Report 2006' (n 227).

⁶⁸⁹ Special Rapporteur on the right to health, 'Annual Report 2006' (n 227), paras 39–47.

falls beyond the scope and expertise of my thesis,⁶⁹⁰ and would freeze the content of this right. As argued in Chapter 4, indicators must be designed and updated through the guidance of medical and public health experts, in order to reflect the scope of interests of the right to health adequately. Therefore, what I recommend is the use of *thematic* indicators by SNHRBs, pointing at areas in which states must demonstrate their efforts (e.g. maternal mortality). Health indicators present numerous advantages, as highlighted by Welling and when comparing the reporting procedures of the European and the UN Committees.⁶⁹¹

Firstly, thematic indicators enable SNHRBs to monitor the obligation to progressively realise the right to health more adequately. As demonstrated by Chapters 2 and 3, the European Committee follows up relatively well states' progress under Article 11 ESC, thanks to the consistent use of the same indicators in each reporting cycle. The UN Committee, however, never uses any indicators and its monitoring of Article 12 ICESCR is erratic. The information reviewed by the European Committee is more comprehensive, of better quality, and easier to compare between different periods of time or between different states. Furthermore, the use of indicators facilitates a systematic methodology, which contributes to the creation of norms, thus strengthening the legal content of the right to health. These enabled the European Committee to develop a precise jurisprudence on Article 11 ESC and to clarify its legal content. The absence of thematic health indicators from the Concluding Observations of the UN Committee, however, is associated with a dearth of jurisprudence and a vague legal content of Article 12 ICESCR.

Secondly, thematic health indicators reinforce transparency and legal certainty for States parties to ESCR treaties, by clarifying what they must report on and what they must achieve, to fulfil their obligation to progress. They also reflect more accurately states' efforts to comply, enable them to denounce illegitimate expectations, and can help them in improving the realisation of the right to health. Once again, the comparison between the UN and the European Committees explicitly points this out.

⁶⁹⁰ Hunt and MacNaughton (n 226), 304–330: this model is sixteen pages long for SRH alone.

⁶⁹¹ Welling (n 204) 940–947.

Thanks to the indicators used by the European Committee, Article 11 ESC benefits from a precise jurisprudence, which states can access to through various documents. These include: reporting guidelines,⁶⁹² a Case law Digest,⁶⁹³ and a factsheet on the right to health.⁶⁹⁴ States are thus aware of the data they must submit and the objectives they must meet under this provision. The UN Committee, nevertheless, does not offer any precise guidelines on Article 12 ICESCR to States parties.

Thirdly, the use of health indicators clarify the legal content of the right to health by enabling SNHRBs to develop norms or set thresholds, and thus reach findings of non-conformity. As a result, they materialise the notion of progressive realisation into a violation approach benefiting both NGOs and individuals, as it facilitates the recognition of victims and the possibility of redress in parallel complaint procedures. This statement is confirmed when comparing the monitoring procedures of the European and the UN Committees. From 1969 to 2000, before it had started using any health indicators, the European Committee reached only one decision of non-conformity to Article 11 ESC through its reporting procedure. Since it started using health indicators in 2001, the European Committee has held nearly fifty findings of violation through this procedure. The UN Committee refuses to explicitly adopt a violation approach, but expresses its dissatisfaction when standards deriving from the right to health are unmet. By facilitating a more comprehensive monitoring of Article 12 ICESCR than what is currently left to chance, health indicators would contribute to identifying more efficiently victims of situations where standards are ‘unmet’.

Finally, the use of disaggregated data under certain indicators enables SNHRBs to identify victims of a breach of the right to health based on discrimination. The UN Committee monitors the realisation of the right to health for numerous vulnerable groups, by using data disaggregated on multiple grounds. Nevertheless, it does not do so consistently as it does not use any indicators. Furthermore, to date, the

⁶⁹² CoE Committee of Ministers, ‘Form for the Reports to Be Submitted in Pursuance of the European Social Charter (revised) (2008)’, pp. 26–27 <http://www.coe.int/t/dghl/monitoring/socialcharter/ReportForms/FormIndex_en.asp> [accessed 8 September 2015].

⁶⁹³ ECSR, ‘Case Law Digest 2008’ (n 353).

⁶⁹⁴ ESC Secretariat, ‘The right to health and the ESC’ (n 323).

Conclusions of the European Committee only scrutinise women, children, persons living in rural areas, and (more rarely) Roma people's health. Further disaggregated data is thus needed in both systems to identify appropriately potential victims of health discrimination, through the use of indicators.

Despite its benefits, the use of indicators also presents challenges in human rights monitoring, as argued by Barsh and Green,⁶⁹⁵ and as observed in the reporting procedure of the European Committee on Article 11 ESC, studied in Chapter 3. These issues must be addressed in order to evaluate adequately the obligation to progressively realise the right to health. Problems such as unclear definitions, unreliable sources of data, or inappropriate aggregation of information,⁶⁹⁶ can sometimes arise in the monitoring of Article 11 ESC. The reporting guidelines and the jurisprudence developed under the indicator 'access to healthcare', for instance, do not specify what information states must submit in their reports.⁶⁹⁷ Moreover, nothing guarantees that data is accurately collected, or accurately disaggregated according to the relevant vulnerable groups existing in each state. Other issues such as the risk for indicators to favour quantitative information, or to measure states' compliance more than individuals' enjoyment of their right to health, were also identified. The European Committee, nevertheless, uses both quantitative and qualitative data comprehensively in its Conclusions. Furthermore, while this tool may emphasise states' obligations more than individuals' rights, the inherent purpose of the reporting procedure is to assess states' compliance with Article 11 ESC, not to provide remedies. Certain questions remain unanswered nonetheless: are eighteen thematic health indicators too few or too many to follow-up the progress of states in the field of healthcare? What distinguishes right to health indicators from development indicators?⁶⁹⁸ Finally, when discussing issues arising from monitoring ESCR, Anderson and Foresti declare that '*no real guidance has yet been offered on*

⁶⁹⁵ Russel Lawrence Barsh, 'Measuring Human Rights: Problems of Methodology and Purpose' (1993) 15 Human Rights Quarterly 87; Maria Green, 'What We Talk About When We Talk About Indicators: Current Approaches to Human Rights Measurement' (2001) 23 Human Rights Quarterly 1062

⁶⁹⁶ Barsh (n 695) 99–103.

⁶⁹⁷ CoE Committee of Ministers, 'Form for Reports' submission under the ESC' (n 692), pp. 26–27.

⁶⁹⁸ Green (n 418) 1084–1094.

how to judge whether the benchmarks set by governments are sufficiently challenging'.⁶⁹⁹ However, one could add that no real guidance has been provided on how to assess whether such targets are too challenging either.

To conclude, in order to monitor and interpret adequately states' obligation to progressively realise the right to health, SNHRBs ought to evaluate states' use of resources rather than availability, and they ought to use indicators to measure states' progress in healthcare. While it is important to understand the challenges inherent to both methods when applied to the right to health, so that SNHRBs can optimise their interpretation of the latter, it is equally important to remember what they aim at: for SNHRBs to highlight inadequate progress, and thus, to find violations.

5.1.3 Holding violations of the obligation to progressively realise the right to health

This thesis contends that in order for SNHRBs to optimise their interpretation of states' obligation to progressively realise the right to health, not only must they rely on a framework enabling them to clarify and monitor adequately its substance, they must also give it a meaning by holding violations when it is unfulfilled. Since states are obliged to progressively improve the realisation of the right to health (and to take steps immediately), two actions can constitute a violation of this obligation, following an adequate monitoring. These include: stagnation or excessively slow improvement; and retrogression in the realisation of this right.

5.1.3.1 Violations based on an insufficient improvement in the realisation of the right to health

While states must progressively realise the right to health, this does not mean that the timeframe in which such progress must be performed is indefinite, or that any progress can be considered sufficient. GC14 even declares that states must progress '*as expeditiously and effectively as possible towards the full realization of article 12 [ICESCR]*'.⁷⁰⁰ However, few human rights instruments on which SNHRBs may rely clarify this assertion. It is a comparative analysis between the monitoring of the UN

⁶⁹⁹ Anderson and Foresti (n 680) 471.

⁷⁰⁰ UNCESCR, 'GC14' (n 21), para 31.

and the European Committees, the focus of this thesis, that point towards frequent reprimands for stagnation or excessively slow improvement in the realisation of the right to health.

The UN Committee tends to criticise states for having insufficiently improved the realisation of the right to health on three accounts, implicitly pointing at an incompatibility with their obligation to progressively realise this right. Firstly, the UN Committee regularly declares that the measures taken by the state since the last report are inadequate to improve an existing health issue. For instance, it expressed concern over insufficient measures to improve the situation of elderly persons in nursing homes in Germany⁷⁰¹ (which was considered unsatisfactory in previous Concluding Observations).⁷⁰² Secondly, the UN Committee often observes that although the state has taken measures since its last review, the health situation remains inadequate. In its 2015 Concluding Observations on Paraguay, for example, it noted the progress achieved in access to healthcare through the introduction of services free of charge, but declared that the quality of healthcare, as well as financial and human resources devoted to it, remained insufficient.⁷⁰³ Finally, the UN Committee may also (more rarely) express its concern over a general absence of improvement regarding a health issue, i.e. stagnation. For instance, it highlighted that a high maternal mortality rate persisted in Dominican Republic, due to the overall poor standard of maternal care⁷⁰⁴ (referring implicitly to similar comments made in previous Concluding Observations).⁷⁰⁵

The European Committee, in contrast with the UN Committee, developed more precise legal standards regarding the timeframe in which states should progress towards the realisation of the right to health. In its Merits Decisions *International*

⁷⁰¹ UNCESCR, ‘Concluding Observations Germany 2011’ (n 205), para 27.

⁷⁰² UNCESCR, ‘Concluding Observations on Germany’s Fourth Periodic Report’ (2001) UN Doc E/C12/1/Add68, para 24.

⁷⁰³ UNCESCR, ‘Concluding Observations on Paraguay’s Fourth Periodic Report’ (2015) UN Doc E/C12/PRY/CO/4, para 28.

⁷⁰⁴ UNCESCR, ‘Concluding Observations Dominican Republic 2010’ (n 239), para 28.

⁷⁰⁵ UNCESCR, ‘Concluding Observations on Dominican Republic’s Second Periodic Report’ (1997) UN Doc E/C12/1/Add16, para 15.

Association Autism-Europe IAAE v France,⁷⁰⁶ and *International Movement ATD Fourth world v. France*,⁷⁰⁷ it set two general principles. Firstly, the European Committee recognises that the realisation of certain rights can be particularly complex and expensive. States parties, therefore, must take measures ‘*within a reasonable time, with measurable progress and to an extent consistent with the maximum use of available resources*’.⁷⁰⁸ Secondly, in order to ensure ‘*constant*’ progress towards the objectives set by the Charter, it requires that states change their laws, make resources available, and take the measures necessary to give full effect to this instrument.⁷⁰⁹ The European Committee has since applied those two principles to Article 11 ESC, in the context of environmental pollution.⁷¹⁰ In *Marangopoulos v Greece* and *FIDH v Greece*, it conceded that overcoming pollution could only be achieved gradually. However, it held the state in breach of the right to health in both cases, considering Greece had not improved the situation within a reasonable time.⁷¹¹ In *Marangopoulos v Greece*, Greece had granted a 40% rise of greenhouse gas emission from 2005 to 2010, while the Kyoto Protocol had set a target of 25% rise from 1990 to 2010.⁷¹² In *FIDH v Greece*, Greece had left health hazards resulting from river pollution unmanaged for 40 years.⁷¹³ Furthermore, the European Committee has started ruling on the first requests for immediate measures,⁷¹⁴ but not in the context of emergency medical care so far.

⁷⁰⁶ *International Association Autism-Europe v France* (ECSR) (n 639) [53].

⁷⁰⁷ *International Movement ATD Fourth World v. France* (ECSR) (n 640) [61].

⁷⁰⁸ *International Association Autism-Europe v. France* (ECSR) (n 639) [53].

⁷⁰⁹ *International Movement ATD Fourth World v France* (ECSR) (n 640) [61].

⁷¹⁰ *International Federation for Human Rights v Greece* (ECSR) (n 638) [129 and 133]; *Marangopoulos Foundation for Human Rights v Greece* (ECSR) (n 372) [204].

⁷¹¹ *Marangopoulos Foundation for Human Rights v. Greece* (ECSR) (n 372) [194–221]; *International Federation for Human Rights v Greece* (ECSR) (n 638) [131–154].

⁷¹² *Marangopoulos Foundation for Human Rights v Greece* (ECSR) (n 372) [204–207].

⁷¹³ *International Federation for Human Rights v Greece* (ECSR) (n 638) [127–130].

⁷¹⁴ ECSR, ‘Rules of the Committee (as of 9 September 2014)’, rule 36 <http://www.coe.int/t/dghl/monitoring/socialcharter/ESCRrules/Rules_rev_en.pdf> [accessed 8 September 2015]; ECSR, ‘Activity Report 2013’, p 6 and see Annex 5 <http://www.coe.int/t/dghl/monitoring/socialcharter/Presentation/ActivityReport2013_en.pdf> [accessed 8 September 2015].

The European Committee also reaches findings of violation through its reporting procedure, when states fail to improve the realisation of the right to health. The rationales used in this concern are similar to what the UN Committee expresses concern on. Firstly, the European Committee often finds states in violation of Article 11 ESC for not having taken sufficient measures to improve compliance with this provision since the last review. For instance, it declared that Bulgaria had failed to implement adequate measures to improve Roma communities' access to healthcare,⁷¹⁵ since a Merits Decision the year before.⁷¹⁶ Secondly, the European Committee may also (more rarely) reach a decision of non-conformity when a health situation is inadequate, regardless of the measures taken by the state. In its recent Conclusions on Azerbaijan, for example, it considered that although Azerbaijan had implemented measures to improve perinatal care, maternal and infant mortality rates were still too high. However, unlike the UN Committee, the European Committee justified its decision. It specified that while these rates were decreasing (e.g. 12.1 infant deaths per 1,000 live births in 2007, against 10.8 in 2011), they remained significantly above the European average (i.e. EU-27 rate in 2010 was 4.1 infant deaths per 1,000 live births).⁷¹⁷

To conclude, both the UN and the European Committees expect states to sufficiently improve the enjoyment of the right to health between each review. Nevertheless, the European Committee sets clearer limitations than the UN Committee. Its jurisprudence explicitly imposes time limits under the obligation to progressively realise the right to health. Moreover, thanks to its thematic health indicators, the European Committee identifies more easily insufficient progress, and places the burden of proving an improvement in the realisation of the right to health on states. When observing an insufficient improvement in the progressive realisation of the right to health, SNHRBs should thus find states in breach of their obligation to give meaning to the latter, and enhance their interpretation as a result. It is worth noting that both Committees sometimes reprimand inadequate performance in healthcare, regardless of the progress realised by the state. However, such minimum core

⁷¹⁵ ECSR, 'Conclusions 2009', Bulgaria pp. 160–162.

⁷¹⁶ European Roma Rights Centre European Roma Rights Centre v Bulgaria (ECSR) (n 399).

⁷¹⁷ ECSR, 'Conclusions 2013', Azerbaijan pp. 5-7.

approach diverges from the obligation to progressively realise the right to health, and does not rely on any transparent criteria (as will be discussed in Section 5.2).

5.1.3.2 Violations based on retrogression in the realisation of the right to health

Since the obligation to progressively realise the right to health requires that states sufficiently improve their health systems, it also prohibits a decrease in their performance. This is confirmed by GC14, which declares that ‘*there is a strong presumption that retrogressive measures taken in relation to the right to health are not permissible*’ in the context of progressive realisation.⁷¹⁸ This subsection will thus discuss states’ obligation to not retrogress in the realisation of the right to health; and the justifications they can exceptionally raise before SNHRBs to legitimise such measures.

The prohibition to retrogress in the field of healthcare

Until recently, states’ obligation to progressively realise ESCR was mainly discussed through the concepts of indicators and resources rather than retrogression. Legal scholars have started exploring this issue in response to austerity measures affecting access to social services worldwide,⁷¹⁹ but no clear guidelines exist as to how SNHRBs should address retrogression. A comparative analysis between the UN and the European Committee, however, contributes to delineating what retrogression entails, with regard to the realisation of the right to health.

Whilst the ICESCR is silent on the issue of retrogression, the UN Committee explicitly prohibits states from taking retrogressive measures in its General Comments. It declares that ‘*any deliberately retrogressive measures in that regard would require the most careful consideration [...]*’ in General Comment 3;⁷²⁰ and

⁷¹⁸ UNCESCR, ‘GC14’ (n 21), para 32.

⁷¹⁹ E.g. Nolan, Lusiani and Courtis, ‘Two steps forward, no steps back? Evolving criteria on the prohibition of retrogression in economic, social and cultural rights’, in Nolan (n 678) ; Academic Network on the European Social Charter and Social Rights, ‘Brussels’ Document: The Future of the Protection of Social Rights’ (2015) <http://www.coe.int/T/DGHL/Monitoring/SocialCharter/Doc_Bruxelles_version_EN_FR_DEF.pdf> [accessed 8 September 2015].

⁷²⁰ UNCESCR, ‘General Comment 3’ (n 211), para 9.

goes further in GC14 by affirming that such measures are strongly presumed to be impermissible.⁷²¹ Sepúlveda argues that the word '*deliberate*', used in those two General Comments,⁷²² imply that retrogressive measures must be intentional to be prohibited.⁷²³ This argument, however, is problematic for two reasons. First, only retrogressive measures lowering health standards intentionally are prohibited, not those creating a decline involuntarily. Therefore, inactions that could be understood as decisions not to act or as negligence are allowed. Second, the burden of proving states' intention thus relies on the UN Committee. Considering the nature of the obligation to progressively realise the right to health, i.e. improving health systems, and the complexity already embodied by the concept of resource availability, such limitations are undesirable.

In its reporting procedure, the UN Committee nonetheless interprets states' obligation to progressively realise the right to health as prohibiting both deliberate retrogressive measures as well as declines in health standards. This assertion relies on two observations. Firstly, the UN Committee sometimes criticises states that take deliberate retrogressive measures under Article 12 ICESCR. In such instances, it tends to express concern over cuts in health budgets and legislation curtailing access to healthcare. For example, the UN Committee expressed concern over budget cuts in healthcare in Iceland, which resulted in the closure of health facilities, the reduction of health staff, and a decrease in the quality and availability of health services.⁷²⁴ It also expressed dissatisfaction over the repeal by Nicaragua of a

⁷²¹ UNCESCR, 'GC14' (n 21), para 32. It is worth noting that the UN Committee recognises the negative impact of austerity measures but surprisingly, does not recognise that they represent a *prima facie* breach of the Covenant in: UNCESCR, 'Open Letter to States Parties on Economic, Social and Cultural Rights in the Context of the Economic and Financial Crisis' (2012) <<http://www2.ohchr.org/english/bodies/cescr/docs/LetterCESCRtoSP16.05.12.pdf>> [accessed 8 September 2015]; UNCESCR, 'Concluding Observations on Portugal's Fourth Periodic Report' (2014) UN Doc E/C12/PRT/CO/4, para 6.

⁷²² See also UNCESCR, 'General Comment 4' (n 492), para 11: 'a general decline in living and housing conditions, directly attributable to policy and legislative decisions by States parties, and in the absence of accompanying compensatory measures, would be inconsistent with the obligations under the Covenant'.

⁷²³ Sepúlveda (n 152) 323–324.

⁷²⁴ UNCESCR, 'Concluding Observations on Iceland's Fourth Periodic Report' (2012) UN Doc E/C12/ISL/CO/4, para 17.

legislation authorising therapeutic abortion in certain conditions, as it resulted in the death of pregnant women who underwent clandestine abortions.⁷²⁵ In both instances, the UN Committee failed to mention the prohibition to take retrogressive measures, as provided by GC14. Secondly, the UN Committee often criticises states whose performance under Article 12 ICESCR is decreasing, even if no deliberate measure is involved. For instance, it expressed concern against the Democratic Republic of Congo on the basis that the state had neglected to treat persons with preventable diseases during the conflict, leading to millions of deaths.⁷²⁶

Unlike in the UN, no human rights document explicitly prohibits states from taking retrogressive measures in the CoE. However, the European Committee clearly recognises such prohibition in its monitoring procedures on Article 11 ESC. Two observations are worth making in this regard.

Firstly, the systematic use of thematic indicators enables the European Committee to follow the evolution of health standards consistently, and to often criticise declines in states' performances. In such cases, and comparably to the UN framework, the 'deliberate' aspect of retrogression is irrelevant. For instance, in 2001 the European Committee found Portugal in breach of Article 11 on the ground that '*certain indicators reveal[ed] negative developments in the health care system*'. In this instance, the number of deaths due to AIDS had risen, the number of hospital beds had declined, and the proportion of beds in the private sector had increased (but the intention of the state was irrelevant).⁷²⁷

Secondly, the European Committee sometimes holds states in breach of Article 11 ESC on the basis a deliberate retrogressive measure has been taken, but this is rare. Prior to its 2013 Conclusions, most of its comments were limited to request information on the impact of health reforms.⁷²⁸ However, due to the recent increase

⁷²⁵ UNCESCR, 'Concluding Observations on Nicaragua's Second, Third and Fourth Periodic Reports' (2008) UN Doc E/C12/NIC/CO/4, para 26.

⁷²⁶ UNCESCR, 'Concluding Observations DRC 2009' (n 254), paras 16 and 34.

⁷²⁷ ECSR, 'Conclusions XV-2 (2001)', Portugal pp. 491–495.

⁷²⁸ *European Roma Rights Centre v Bulgaria* (ECSR) (n 399); ECSR, 'Conclusions 2009', Bulgaria pp. 160–162: up to its 2009 reporting cycle, the European Committee had only held

of austerity policies resulting in a restrictive access to healthcare, the European Committee has started taking a stronger stand. In its 2013 Conclusions, it held that if Spain had not repealed its new legislative amendment by the next reporting cycle, it would be found in violation of Article 11 ESC (the amendment reduced access to healthcare to emergency services for migrants in irregular situation).⁷²⁹ Its recent comments on Latvia are also worth noting. Latvia responded to the economic crisis by reforming its health system, substantially reducing the number of hospitals. Whilst the majority of the European Committee members asked for further information to be provided, two members declared, in a dissenting opinion, that a violation should have been found on the basis Latvia had taken ‘*measures that pose[d] a serious and direct threat to the effective fulfilment of Latvia’s obligations under Article 11*’.⁷³⁰

To conclude, the prohibition of retrogression is not explicitly recognised by the CoE, and is only recognised in the context of deliberate retrogressive measures in the UN. However, both the UN and the European Committees have interpreted states’ obligation to progressively realise the right to health as prohibiting: deliberate retrogressive measures and declines in states’ performances. Neither Committees explicitly prohibit retrogression but both seem to review it as a prima facie breach of the right to health. Future developments arising in response to austerity measures may clarify such assertion, and encourage such approach being adopted by other SNHRBs.

Justifying retrogression in the field of healthcare

A prima facie breach of the right to health allows states to bring forward justifications for their non-compliance before SNHRBs, and to subsequently decline

one violation in this regard (against Bulgaria, whose legislative amendment restricted access to health insurance for socially vulnerable persons).

⁷²⁹ ECSR, ‘Conclusions XX-2 (2013)’, Spain pp. 12–14: this legislative amendment occurred in 2012, outside the referencing period (2008-2011).

⁷³⁰ ECSR, ‘Conclusions XX-2 (2013)’, Latvia pp. 5-7 and 20-21.

their responsibility if these are found to be legitimate.⁷³¹ However, since there is no clear jurisprudence prohibiting the retrogression of health standards in human rights law, there is even less clarity on the circumstances that may justify it. Several comparative elements of the UN and the European Committees' interpretations, nonetheless, are worth mentioning.

At the international level, the UN Committee recognises that retrogressive measures represent a *prima facie* violation of the ICESCR and, as a result, reviews strictly their justifications. For instance, GC14 declares that in order to justify retrogressive measures, states must demonstrate that they have carefully considered all other alternatives and taken retrogressive measures at last resort, after having used the maximum of their available resources on realising all other ESCR.⁷³² It is unrealistic to expect states to prove the latter (and the UN Committee, to verify it), as argued in subsection 5.1.2.1. However, the UN Committee has clarified its position since, by setting criteria that could assist other SNHRBs.

In a 2007 Statement, the UN Committee listed six criteria which retrogressive measures should meet to be deemed justifiable by resources constraints.⁷³³ I have organised them chronologically for clarity purposes, following the conceptual framework developed in Chapter 5. The first criterion requires that the UN Committee consider the severity of the breach of the right to health caused by the retrogressive measure. Whilst such review is logical, it should not lead to GC14's suggestion according to which if the breach concerns a minimum core obligation, a violation will be found regardless of the resources constraints experienced by the state.⁷³⁴ As I will argue in section 5.2, this would fail to set reasonable expectations upon states. The second, third, and fourth criteria suggest that the UN Committee

⁷³¹ See International Law Commission, 'Responsibility of States for Internationally Wrongful Acts' (2001), Annex to General Assembly Resolution 56/83 (Corrected by Document A/56/49 (Vol. I)/Corr.4), Chap V on 'circumstances precluding wrongfulness'.

⁷³² UNCESCR, 'GC14' (n 21), para 32; see also UNCESCR, 'General Comment 3' (n 211), para 9.

⁷³³ UNCESCR, 'Statement: An Evaluation of the Obligations to Take Steps to the "Maximum of Available Resources"' under an Optional Protocol to the Covenant' (2007) UN Doc E/C12/2007/1, para 9.

⁷³⁴ UNCESCR, 'GC14' (n 21), para 48.

evaluate the resources available to the state in order to find whether a justification based on resources constraints applies. This includes evaluating the country's level of development; its current economic situation; and the existence of other serious claims justifying resources constraints (e.g. natural disaster, armed conflict). However, as discussed in subsection 5.1.2.1, SNHRBs should evaluate the *use* of resources rather than their availability, to monitor the right to health adequately. The affordability of a measure being inextricably related to resource availability, economic indicators such as GDP per capita, government debt as percentage of GDP etc. are relevant, but insufficient. This is where the fifth and sixth criteria interfere: the UN Committee must assess whether the retrogressive measure has been taken at last resort. It must verify whether the state has attempted to identify low-cost options (fifth criterion). It must also verify whether the state has tried to obtain, or at least has accepted, international cooperation and assistance aimed at realising the right to health (sixth criterion).⁷³⁵ Such review sets reasonable expectations upon states, promotes an effective enjoyment of the right to health, and is applicable to supranational monitoring. Nevertheless, it relies on states' willingness to provide accurate data.

In an Open Letter to States parties to the ICESCR, the UN Committee establishes that in times of economic crisis, retrogressive measures are only permissible if they respect four cumulative criteria. First, the measure must be temporary; second, it must be necessary and proportionate; third, it must be non-discriminatory and thus must not affect the most vulnerable; and fourth, it must not impede the core content of the right.⁷³⁶ Whilst the latter element is problematic, as argued in section 5.2, these guidelines simplify even further the process described in the 2007 Statement, which could inspire other SNHRBs.

At the regional level, the European Committee does not recognise the prohibition of retrogression as clearly as the UN Committee. As a result, its interpretation of what can justify retrogressive measures is imprecise. To date, the European Committee has never explicitly accepted any justification to retrogression under Article 11 ESC,

⁷³⁵ UNCESCR, 'Statement on Maximum Available Resources 2007' (n 733), para 9.

⁷³⁶ UNCESCR, 'Open letter on ESCR in Financial Crisis 2012' (n 721).

whether in its Conclusions or Merits Decisions. However, two aspects of its jurisprudence regarding Articles 11 and 12(3), on the right to health and social security, delineate what justifications it may accept to consider.

Firstly, in its reporting procedure on Article 11 ESC, the European Committee expects states to justify why their performance is declining but fails to set criteria in that respect. For instance, in its 2009 Conclusions, the European Committee asked Andorra to explain the decline of its immunisation coverage rates, and deferred its decision until the next reporting cycle.⁷³⁷ In 2013, it took note of the updated information (presumably, an increase of the coverage rates) and found the situation acceptable.⁷³⁸ Such comments, however, do not set light on what instigated a decline in the first place and whether it is excusable. Instead, they highlight the flexibility of the European Committee, in allowing states to remedy a decline of health standards from one reporting cycle to the next without holding a breach of Article 11.

Secondly, the European Committee has developed a specific jurisprudence on retrogression under Article 12(3) ESC. This provision obliges states to ‘*raise progressively the system of social security to a higher level*’,⁷³⁹ and requires *inter alia* that they progressively improve health insurance and sickness benefits. The European Committee has clearly interpreted Article 12(3) as prohibiting retrogression in the General Introduction to its 1998 Conclusions.⁷⁴⁰ However, in that same statement, it allows states to make certain alterations to their social security systems. It allows retrogressive measures to be justified by the need to ‘*consolidate public finances in times of economic crisis, in order to ensure the maintenance and sustainability of the existing social security system*’.⁷⁴¹ Such comments, nevertheless, are specific to the right to social security, although declines in health insurance and in sickness benefits are related to the affordability of healthcare. Furthermore, such

⁷³⁷ ECSR, ‘Conclusions 2009’, Andorra p 55.

⁷³⁸ ECSR, ‘Conclusions 2013’, Andorra pp. 21–22.

⁷³⁹ ESC 1961 (n 92), Art 12(3); ESC 1996 (n 92), Art 12(3).

⁷⁴⁰ ECSR, ‘Conclusions XIV-1 (1998), General Introduction’, p 47 (para 39).

⁷⁴¹ General Federation of employees of the national electric power corporation (GENOP-DEI) / Confederation of Greek Civil Servants’ Trade Unions (ADEDY) v Greece [2012] Complaint No. 66/2011, Decision on the Merits (ECSR) [46 and 47].

comments are too vague to represent adequate guidelines. The criteria set by the UN Committee are, therefore, more helpful and could be easily transposed to regional frameworks such as the CoE, where no precise interpretation has been developed in that regard.

Limits to what can justify retrogressive measures

It is worth noting that both Committees agree on the fact that no justification may be brought in the event of a retrogression affecting the ‘essence’ of the right to health.

In GC14, the UN Committee stresses that states cannot justify deliberate retrogressive measures affecting the minimum core of this right, since such measures automatically violate Article 12 ICESCR.⁷⁴² This view was reiterated in the 2012 Open Letter, in which the UN Committee declares that austerity measures should guarantee ‘*the protection of this core content [of the ICESCR] at all times*’;⁷⁴³ and in recent Concluding Observations.⁷⁴⁴ The UN Committee, nonetheless, refuses to adopt a violation approach in its reporting procedure, and has not held any decision yet on retrogression or on Article 12 through its communications procedure. It is thus uncertain which justifications the UN Committee refuses to review.

Interestingly, the jurisprudence of the European Committee on Article 11 and Article 12(3) ESC points at a similar approach to GC14, i.e. the impossibility for states to justify retrogressive measures affecting minimum levels of healthcare. Two observations should be made.

Firstly, the European Committee recently declared in its reporting procedure on Article 11 ESC that ‘*the economic crisis cannot serve as a pretext for a restriction or denial of access to health care that affects the very substance of the said right*’.⁷⁴⁵ In

⁷⁴² UNCESCR, ‘GC14’ (n 21), para 48.

⁷⁴³ UNCESCR, ‘Open letter on ESCR in Financial Crisis 2012’ (n 721).

⁷⁴⁴ UNCESCR, ‘Concluding Observations Portugal 2014’ (n 721), para 6; UNCESCR, ‘Concluding Observations on Ukraine’s Sixth Periodic Report’ (2014) UN Doc E/C12/UKR/CO/6, para 5.

⁷⁴⁵ ECSR, ‘Conclusions XX-2 (2013)’, Spain pp. 12–14.

this case, Spain had reduced access to healthcare for migrants in irregular situation, to emergency care, maternal care, and healthcare for minors. It is too early to tell whether this nascent jurisprudence prohibits justifications based on financial restraints when the right of everyone to access basic primary healthcare is at stake. However, such statement clearly contradicts *FIDH v France* (2004).⁷⁴⁶ In this Merits Decision, the European Committee found that France was complying with Article 13 on the right to medical assistance because although its legislative amendment restricted irregular migrants' access to healthcare, it retained emergency care.

Secondly, in the General Introduction to its 1998 Conclusions, the European Committee sets two limitations to the alterations states are allowed to make to their social security systems under Article 12(3) ESC.⁷⁴⁷ It declares that states should not progressively restrict their social security to a system of minimum assistance, and should not reduce individuals' protection against social and economic risks.⁷⁴⁸ Such limitations have since become part of the jurisprudence of the European Committee on Article 12(3). They have been used to hold states in breach of their obligation to improve their social security systems in both the reporting,⁷⁴⁹ and the complaint procedures.⁷⁵⁰ In the Merits Decision *GENOP-DEI and ADEDY v. Greece* (2012), the European Committee even expressly referred to the concept 'retrogressive measures' for the first time.⁷⁵¹ In this case, the complainant alleged that the new legislation introducing special apprenticeship contracts between employers and young individuals restricted considerably social security coverage, as it excluded sickness allowances and the reimbursement of prescription charges.⁷⁵² Greece argued

⁷⁴⁶ International Federation of Human Rights Leagues v France (ECSR) (n 600).

⁷⁴⁷ ECSR, 'Conclusions XIV-1 (1998), General Introduction', p 47 (para 39).

⁷⁴⁸ *ibid.*

⁷⁴⁹ E.g. ECSR, 'Conclusions XVIII-1 (2006)', Netherlands pp. 557–559: the Committee found the Netherlands in violation of Article 12 ESC and of its obligation to progressively improve the system of social security, on the basis that it had abolished a legislation providing for sickness benefits to self-employed persons, resulting in an absence of health protection for this group of individuals. The European Committee held that it had restricted 'the personal scope of the social security system'.

⁷⁵⁰ *GENOP-DEI and ADEDY v Greece* (ECSR) (n 741) [45].

⁷⁵¹ *ibid* [47].

⁷⁵² General Federation of employees of the national electric power corporation (*GENOP-DEI*) / Confederation of Greek Civil Servants' Trade Unions (*ADEDY*) v Greece [2011]

that its new legislation was excluding these allowances in order to address the structural problems of its social security, public health, and welfare systems. It declared that this retrogression was resulting from the reduction of contributions, caused by the high level of unemployment and the demographic crisis of the country.⁷⁵³ The European Committee, nonetheless, held that such retrogressive measure failed to meet the minima required under Article 12(3): a core framework and a protection against serious economic and social risks. It concluded that this constituted a ‘*deterioration*’ of the social security scheme, and found Greece in violation of Article 12(3).⁷⁵⁴ This case highlights that retrogressive measures limiting access to healthcare constitute a violation of the ESC when they fail to respect a minimum. Two elements in this case are yet worth noting. First, Greece did not specifically refer to Article 12(3) in its submissions; it is thus unclear whether its comments correspond to a formal justification under this provision.⁷⁵⁵ Second, if such retrogressive measure was prohibited because it infringed the ‘core content’ of Article 12(3), why did the European Committee asked for more information regarding the necessity of this measure and the results obtained through its implementation?⁷⁵⁶ In light of these elements, it is difficult to assert the recognition of a ‘core content’ of the right to health against which no alterations can be justifiable (here, the affordability of basic occupational health).

To conclude, the UN Committee prohibits unconditionally deliberate retrogressive measures that breach the core content of the right to health in GC14, but such approach is not explicitly reflected by its reporting procedure. The European Committee, on the contrary, does not automatically prohibit retrogression when minimum levels of healthcare are at stake but rather, reviews such retrogression strictly. However, recent developments under Article 11 ESC and limits set under

Complaint No. 66/2011, Case document No. 1, Complaint (ECSR) [4]; GENOP-DEI and ADEDY v. Greece (ECSR) (n 741) [43].

⁷⁵³ General Federation of employees of the national electric power corporation (GENOP-DEI) / Confederation of Greek Civil Servants’ Trade Unions (ADEDY) v Greece [2011] Complaint No. 66/2011, Case document No. 5: Submissions of the Government on the merits (ECSR), p 3.

⁷⁵⁴ *GENOP-DEI and ADEDY v. Greece* (ECSR) (n 741) [45 to 49].

⁷⁵⁵ *ibid* [44].

⁷⁵⁶ *ibid* [46].

Article 12(3) seem to point at similar approach than GC14. Is it desirable that SNHRBs adopt such approach when interpreting what states' obligation to realise the right to health entails?

5.2 Minimum core obligations to realise the right to health and reasonableness test

Whilst states' obligation to progressively realise the right to health is limited to resource availability, the idea that states must realise a 'minimum core content' regardless of available resources has triggered debates amongst human rights lawyers. SNHRBs such as the UN and the European Committees have embraced this approach in order to strike a fairer balance between their desire to avoid setting unreasonable expectations upon states, and promote an effective enjoyment of the right to health. However, the minimum core approach raises legitimate concerns, which must be reviewed against the principles of interpretation developed by this thesis. Firstly (5.2.1), I assert the recognition of minimum core obligations to realise the right to health in both the UN and the CoE. Secondly (5.2.2), I argue that such obligations are not and cannot be determined by criteria meeting the principles of interpretation set by this thesis. Thirdly (5.2.3), I suggest that SNHRBs interpret and monitor the right to health through a test of reasonableness instead, in order to set reasonable expectations upon states. I however concede that a core approach may (heuristically) facilitate its monitoring in Europe.

5.2.1 *The notion of minimum core*

The concept of minimum core obligations, i.e. obligations to realise the minimum levels of a specific right, does not appear in any legally binding human rights instrument. It emerged instead in the literature on ESCR in the 1980s.⁷⁵⁷ However, certain SNHRBs have started embracing this notion in their monitoring procedures, whether implicitly or explicitly. When examining how the right to health is interpreted through their monitoring procedures, a comparative analysis between the

⁷⁵⁷ Chapman and Russell (n 234) 8.

UN and the European Committees highlights that both have adopted a minimum core approach, but to a different degree and through different means. Whilst the UN Committee explicitly attributes a core content to Article 12 ICESCR on paper, it is uncertain whether such concept is monitored in practice. The European Committee, on the contrary, does not recognise the existence of a core content under Article 11 ESC, but its monitoring procedures implicitly reflect minimum core obligations.

The UN Committee mentioned the notion of minimum core obligations for the first time in 1990, in its General Comment 3 on the nature of States' obligations under Article 2(1) ICESCR. In this document, it describes them as ensuring '*at the very least, minimum essential levels of each of the rights*' and representing the '*raison d'être*' of the Covenant.⁷⁵⁸ It also specifies that in the context of health, such minima correspond to '*essential primary health care*'.⁷⁵⁹ Ten years later, in GC14 on the right to health, the UN Committee goes further. It declares that minimum core obligations are non-derogable and therefore, nothing can justify breaching them.⁷⁶⁰ It also interprets minimum core obligations expansively, through the following non-exhaustive list:

- The prevention, treatment and control of epidemic and endemic diseases;
- The provision of essential medicines (as defined by WHO guidelines);
- The provision of basic levels of food, water, shelter, housing, and sanitation;
- The implementation of a national health strategy;
- The provision of reproductive, maternal and child healthcare;
- The provision of immunisation programmes against major infectious diseases;
- The organisation of health promotion campaigns on main health problems; and
- The training of health personnel.⁷⁶¹

⁷⁵⁸ UNCESCR, 'General Comment 3' (n 211), para 10.

⁷⁵⁹ *ibid.*

⁷⁶⁰ UNCESCR, 'GC14' (n 21), para 47.

⁷⁶¹ *ibid.*, paras 43 and 44.

This list, however, can be and has been challenged on various accounts. First, it can be criticised for inflating the content of minimum core obligations and, thus, for being unachievable for states with very low income.⁷⁶² Second, it can be criticised for neglecting complex theoretical questions and, as a result, for merging moral and practical considerations without any rationale.⁷⁶³ Thirdly, and subsequently to the latter point, this list can also be criticised for not including crucial aspects of healthcare, e.g. essential surgical care.⁷⁶⁴ Finally, what is the most surprising is that it is almost never used in practice.

In recent guidelines specific to its communications procedure, the UN Committee outlined how it intended to monitor minimum core obligations.⁷⁶⁵ This, however, remains to be seen since the Optional Protocol establishing this procedure has recently come into force and no decision involving a breach of Article 12 ICESCR has been reached yet.⁷⁶⁶ Furthermore, in its reporting procedure on Article 12 ICESCR, the UN Committee rarely refers to the notion of minimum core content. From 2008 to 2014, the UN Committee only mentioned this term a couple of times, and only once under Article 12. In the latter instance, it urged the Netherlands to ‘*meet its core obligations*’ by providing undocumented migrants with minimum essential levels of healthcare.⁷⁶⁷ Nevertheless, when commenting on situations incompatible with what GC14 happens to list as ‘core obligations’, the UN Committee urges states to act ‘*immediately*’ or ‘*without delay*’ in its Concluding Observations (as discussed in Chapter 2). Although it does not explicitly recognise that such situations represent a ‘breach’ of ‘core obligations’, one could argue that the UN Committee interprets the core content of the right to health as requiring immediate implementation. This remains uncertain, since Concluding Observations

⁷⁶² Tobin (n 19) 240.

⁷⁶³ Young (n 139) 152, 155–156.

⁷⁶⁴ Paul E Farmer and Jim Y Kim, ‘Surgery and Global Health: A View from Beyond the OR’ (2008) 32 *World Journal of Surgery* 533: the authors characterise surgery as ‘*the neglected stepchild of global public health*’ in low-income countries. See also WHO Global Initiative for Emergency and Essential Surgical Care, launched in 2005 to address this issue.

⁷⁶⁵ UNCESCR, ‘Statement on Maximum Available Resources 2007’ (n 733), paras 6 and 10(b).

⁷⁶⁶ OP to ICESCR (n 101).

⁷⁶⁷ UNCESCR, ‘Concluding Observations Netherlands 2010’ (n 205), para 25(b).

avoid using legal terminology, do not lead to findings of non-conformity, and are often worded vaguely.

In the CoE, minimum core obligations are not as clearly recognised as in the UN, although the Commissioner on Human Rights recently referred to their existence in the context of austerity.⁷⁶⁸ However, the European Committee implicitly adopts a minimum core approach in its monitoring procedures on the right to health. Such a statement is based on three observations. Firstly, the European Committee consents to the general idea that states should meet minimum thresholds when realising the ESC. This can be established by the use of indicators such as poverty thresholds, minimum levels of social assistance, and minimum wages or pensions in its Conclusions on Articles 12, 13, 23, and 30 ESC.⁷⁶⁹ Secondly, and as argued in Chapter 3, the European Committee formulates and reviews the obligation to reduce maternal and infant mortality rates more strictly than other standards developed under Article 11 ESC. In its reporting procedure, it declares that maternal and mortality rates are a decisive factor when determining states' compliance with the right to health.⁷⁷⁰ Moreover, the number of violations found under this standard is by far the highest out of the eighteen indicators developed under Article 11 (i.e. 21 decisions of non-conformity out of a total of 93).⁷⁷¹ One could thus presume that the obligation to reduce maternal and infant mortality represents a core obligation to realise the right to health. Thirdly, the European Committee recently prohibited retrogressive measures that affect '*the very substance*' of the right to health. In this case, it identified such '*substance*' as everyone's right to access healthcare (beyond

⁷⁶⁸ CoE Commissioner for Human Rights, 'Safeguarding Human Rights in Times of Economic Crisis' (2013) <<https://wcd.coe.int/com.instranet.InstraServlet?command=com.instranet.CmdBlobGet&InstranetImage=2664103&SecMode=1&DocId=2215366&Usage=2>> [accessed 8 September 2015].

⁷⁶⁹ ESC 1961 (n 92), Art 12 and 13; ESC 1996 (n 92), Art 12, 13, 23, 30.

⁷⁷⁰ First established in ECSR, 'Conclusions XV-2 (2001)', Belgium p 94.

⁷⁷¹ Figure based on all Conclusions drafted from 1969 to 2013 inclusive, and based on all Merits Decisions up to Complaint 90/2013.

emergency services), including irregular migrants.⁷⁷² This nascent jurisprudence clearly embraces the existence of non-derogable minimum levels of health.

To conclude, the approach developed by the UN and the European Committees (whether explicit or implicit) does not justify what should constitute the core content of the right to health. What criteria does the UN Committee use to list certain aspects of health as core and not others, in GC14? Why does the European Committee consider that states' compliance with standards on maternal and infant mortality is decisive, and not compliance with immunisation standards? What is the right balance between recognising too many core obligations and too few? Such issues remain unclear in human rights law and literature, threatening the requirement of principled consistency in SNHRBs' interpretation. It is thus crucial to explore what criteria should determine the core content of the right to health to assist SNHRBs in optimising their interpretation in this respect.

5.2.2 Determining the minimum core content of the right to health

Whilst it is clear that core obligations to realise the right to health aim at guaranteeing minimum levels,⁷⁷³ how can SNHRBs determine what such levels are? The issue of basic or minimal human rights has been widely discussed by legal philosophers but no principled argument has answered this question, at least in the context of healthcare. This thesis will thus examine the adequacy of the two criteria most often suggested by the literature, for supranational monitoring purposes. These include: (5.2.2.1) survival; as well as (5.2.2.2) low cost and wide-scale measures.

5.2.2.1 Life-saving healthcare

Determining minimum core obligations through survival?

In GC14, the UN Committee does not justify why certain aspects of health ought to represent core obligations and not others. It simply declares that the core content of the right to health corresponds to minimum levels, '*including essential primary*

⁷⁷² ECSR, 'Conclusions XX-2 (2013)', Spain p 14.

⁷⁷³ UNCESCR, 'General Comment 3' (n 211), para 10; UNCESCR, 'GC14' (n 21), para 43.

health care'.⁷⁷⁴ Therefore, when deriving a list of core obligations from Article 12 ICESCR, the UN Committee fails to provide any rationale explaining its selection (although GC14 draws inspiration from the Declaration of Alma-Ata on International Primary Health Care).⁷⁷⁵ Instead, it refers to basic primary care (essential drugs, maternal and child care, immunisation programmes, care against epidemic or endemic diseases); and basic health policies (e.g. training of health personnel, health education).⁷⁷⁶ One could argue that the UN Committee associates the core content of the right to health with care that primarily aims at protecting individuals' survival, rather than at improving their wellbeing. However, nothing explains why, for instance, emergency services do not appear on this list since they serve a similar purpose;⁷⁷⁷ or why health education, on the contrary, is included.

The legitimisation of healthcare prioritisation through human survival or through the right to life finds more explicit support in the literature, as outlined by Young.⁷⁷⁸ Bilchitz, prominent in this discourse, justifies the progressive realisation/minimum core dichotomy by suggesting a distinction between 'minimal interests', i.e. survival, and 'maximal interests', i.e. flourishing.⁷⁷⁹

His first threshold corresponds to individuals' freedom from general threats to survival, and represents a starting point without which no human right can be effectively enjoyed. Bilchitz argues that states should thus prioritise realising entirely those minimum conditions first, which he considers 'unconditional obligations'.⁷⁸⁰

⁷⁷⁴ UNCESCR, 'GC14' (n 21), para 43; UNCESCR, 'General Comment 3' (n 211), para 10. This formulation is peculiar since the WHO already defines primary healthcare as 'essential', see Declaration of Alma-Ata (n 255), item VI.

⁷⁷⁵ Declaration of Alma-Ata (n 255), item VII (3).

⁷⁷⁶ UNCESCR, 'GC14' (n 21), paras 43 and 44.

⁷⁷⁷ Wim Van Damme, Wim Van Lerberghe and Marleen Boelaert, 'Primary Health Care vs. Emergency Medical Assistance: A Conceptual Framework' (2002) 17 Health Policy and Planning 49.

⁷⁷⁸ Young (n 139) 128–133. See also James L Cavallaro and Emily J Schaffer, 'Less as More: Rethinking Supranational Litigation of Economic and Social Rights in the Americas' (2004) 56 Hastings Law Journal 217, 278–279.

⁷⁷⁹ David Bilchitz, *Poverty and Fundamental Rights: The Justification and Enforcement of Socio-Economic Rights* (Oxford University Press 2008) 187–189.

⁷⁸⁰ *ibid* 187–189, see also Chap 3.

The first threshold could potentially justify the existence of a right to minimum health conditions without which human life cannot be sustained, when applied to the right to health. His second threshold corresponds to individuals' right to live in adequate conditions in order to 'flourish' and achieve their goals, once their survival is not threatened anymore. Logically, such threshold can only be met once states have achieved the first, i.e. guaranteeing human survival, but since it is not confined to such 'minimum', it has a broader scope. Bilchitz thus contends that states should meet these conditions as much as possible, but not necessarily entirely.⁷⁸¹ The second threshold could potentially justify the existence of an obligation of progressive realisation, when applied to the right to health.

Bilchitz' argument embodies well suggestions according to which human survival should be used as a criterion to determine the content of minimum core obligations to realise ESCR, including the right to health. However, these thresholds can be criticised on several accounts, making them inadequate for supranational monitoring purposes.

Challenging the 'survival' threshold

Firstly, King argues with good reason that Bilchitz dismisses the reasonableness test too swiftly and thus fails to address the potential consequences of an 'aggressive' judicial review.⁷⁸² If courts ordered remedies for every minimum core obligation violated, following potential SNHRBs' recommendations, they would run the risk of allocating resources to the well-off who can access justice systems more easily, depriving others from similar needs. Additionally, it is unreasonable to expect states to provide essential levels of health to everyone without delay.⁷⁸³ This, however, does not prevent courts (and SNHRBs) from holding findings of non-conformity, as long as they design remedies accordingly to states' capability.

⁷⁸¹ *ibid* 189–191.

⁷⁸² Jeff King, 'Poverty and Fundamental Rights: The Justification and Enforcement of Socio-Economic Rights (Publication Review)' (2008) (Winter) Public Law 820, 823–824.

⁷⁸³ Ferraz (n 18).

Secondly, one can wonder whether states with very low-income can realistically realise every core obligation of every ESCR (including the right to health), whenever human survival is at stake, as Bilchitz seems to suggest. For instance, what should SNHRBs expect from Eritrea, who had a GDP per capita of \$544 and spent 3% of its GDP on health in 2013; while France had a GDP per capita of \$42,560 and spent 11.7% of its GDP on health that year.⁷⁸⁴ How tangible is the core substance of an obligation that cannot be realised? At the same time, how tangible is the core substance of a right that is dictated by resources?

Thirdly, it is unclear how SNHRBs should understand the notion of survival defended by Bilchitz to define core obligations in health. Should it correspond to healthcare that directly or indirectly prevents death? How likely must the occurrence of death be and in what timeframe? Such distinctions are unclear, even in the realm of biological survival.⁷⁸⁵ I will demonstrate this through the example of water contamination due to river pollution.

Essential medicines can be easily considered as a direct means to physically avoid the potentially deadly consequences of water contamination, e.g. antimicrobials treating diarrhoea. However, what about information notifying individuals of river pollution and of its dangers to human health? Such information may be unhelpful in cases where contamination has occurred but it directly prevents its occurrence and, thus, the occurrence of a water-related disease and its lethal effects. This, nonetheless, quickly becomes a slippery slope: a better monitoring of water quality would have also prevented the occurrence of river pollution and thus, human deaths. Should the latter be considered as a core obligation to realise the right to health? If not, why? Should minimum healthcare only aim at saving human lives that are already endangered, not those likely to be threatened?

Even if the answer was positive, SNHRBs would face other questions unanswered: how likely must be the death of an individual who has been contaminated, and after

⁷⁸⁴ World Bank, 'GDP per Capita (current US\$) 2010-2014' <<http://data.worldbank.org/indicator/NY.GDP.PCAP.CD>> [accessed 8 September 2015]; World Bank, 'Health Expenditure' (n 174).

⁷⁸⁵ Young (n 139) 131.

how long must it occur, for the provision of healthcare to be considered a core obligation? The likelihood for an individual to die from water-related diseases such as diarrhoea or cancer depends on a multitude of factors requiring medical expertise, public health statistics, as well as an insight into the social conditions of the patient. It is therefore difficult to evaluate precisely the causal link between the provision of healthcare and the prevention of human deaths. This does not mean that every health service protects biological survival in similar efficiency and numbers. Immunisation programmes can obviously not be compared to ophthalmology consultations. What it means is that listing health services that protect human survival at a similarly high degree in every country and for everyone, is an extremely difficult task, which does not offer any significant benefits against an ad hoc review for SNHRBs. Moreover, the timeframe in which death occurs after contamination can greatly affect the length and, thus, the cost of treatment. Water contaminated by human or animal faeces often causes diarrhoea which, when untreated, can kill within a few days (e.g. cholera); whereas water contaminated by chemicals such as arsenic or chlorine can cause longer-term deadly diseases (e.g. cancer).⁷⁸⁶ Should SNHRBs compare long and costly life-saving treatments with short and non-expensive care, when determining the core content of the right to health?

Finally, how many lives must be at stake to consider the provision of a specific health service, a minimum core obligation? This issue has been widely discussed in the context of healthcare rationalisation by medical experts, economists, philosophers, and, particularly following the *Soobramoney* case, (human rights) lawyers.⁷⁸⁷ This thesis does not pretend to answer this question, but rather, to point at the lack of potential consensus on this issue, as illustrated by the absence of guidelines in the human rights law of the UN and the CoE. It is not desirable that SNHRBs specify how many lives must be at stake for states to be obliged to provide essential levels of healthcare. This could grant states the right to neglect a certain number of human lives when resources are lacking.

⁷⁸⁶ RD Morris, 'Drinking Water and Cancer' (1995) 103 *Environmental Health Perspectives* 225.

⁷⁸⁷ *Soobramoney v Minister of Health (Kwazulu-Natal)* [1998] 1998 1 SA 765 CC 1997 12 BCLR 1696 CC (Constitutional Court South Africa).

To conclude, using the criterion of human survival to delineate the existence of a minimum core obligation to realise the right to health is an excessively complex and controversial exercise. SNHRBs should thus abstain from doing so. Literature, however, highlights another criterion, which deserves to be discussed: low-cost and wide-scale (life-saving) healthcare.

5.2.2.2 Low-cost, wide-scale, non-discriminatory (and life-saving) healthcare

No such thing as free healthcare

Reflecting mainstream human rights scholarship, Chapman and Russell declare that:

‘[S]ince the obligation to respect is fundamental and apparently cost-free, it is a short step to assign the respect-bound obligations to the category of minimum State obligations.’⁷⁸⁸

This argument, however, fails to verify whether the obligation to respect is effectively cost-free (which this thesis refutes), and to justify its assignment to a minimum core content. According to GC14, the obligation to respect prohibits states from directly or indirectly impeding equal access to preventive, curative, and palliative health.⁷⁸⁹ It even elevates the principle of non-discrimination to the core content of the right to health.⁷⁹⁰ However, assuming that this obligation is cost-free assumes that everyone has similar access to health services in the first place, which is obviously inaccurate. Whilst vulnerable groups may be entitled to access healthcare on the same basis as the rest of the population *de jure*, it is not always the case *de facto*. This is outlined by the UN and the European Committees, who have repeatedly expressed concern over *de facto* discrimination in their monitoring procedures. Their comments clearly point to the need for states to provide additional care to vulnerable communities suffering from *de facto* health inequalities, in order to comply with their obligation to respect everyone’s right to equal access to

⁷⁸⁸ Chapman and Russell (n 234) 11.

⁷⁸⁹ UNCESCR, ‘GC14’ (n 21), paras 33 and 34.

⁷⁹⁰ *ibid*, para 43(a).

health.⁷⁹¹ Therefore, there is no such thing as a cost-free obligation to respect in health.

Some measures, nevertheless, are certainly less costly than others. For instance, in low- and middle-income countries, health promotion campaigns that use mass media to encourage better diet and physical activity cost less than US\$0.10 per person; while screening performed through primary healthcare to detect risks of cardiovascular disease among persons over 40 years old, costs between US\$3 to US\$4.⁷⁹² However, the cost of a measure does not necessarily determine the urgency with which it must be undertaken. Implementing awareness campaigns on contraception is cheaper than providing trained obstetric staff for every childbirth, but the latter is evidently subject to a tighter timeframe. While the notion of urgency morally demands that priority is given to health services that are particularly lifesaving, how can SNHRBs avoid Bilchitz' shortcomings? I considered that it was inadequate for SNHRBs to use the criterion of survival alone to delineate the core content of the right to health, as it set unreasonable expectations upon states. However, this criterion could be useful if SNHRBs were to associate it with other criteria. Following a costs-benefits analysis in the context of resources constraints, lifesaving measures should logically have two features. They should be as wide-scale as possible, in order to benefit a maximum number of patients;⁷⁹³ and as low-cost as possible, in order to take into consideration the state's capability.

⁷⁹¹ E.g. *Médecins du Monde v France* (ECSR) (n 399) [163]: 'The particular situation of migrant Roma requires the Government to take specific measures in order to address their particular problems. Treating the migrant Roma in the same manner as the rest of the population when they are in a different situation constitutes discrimination'. UNCESCR, 'Concluding Observations on Romania's Third to Fifth Periodic Reports' (2014) UN Doc E/C12/ROU/CO/3-5, para 21: 'The number of community nurses and Roma Health Mediators should be increased and all cases of discrimination and segregation of patients should be severely punished'.

⁷⁹² WHO, 'Scaling up Action against Non-communicable Diseases: How Much Will It Cost?' (2011), pp. 20–22 and 26–27 <http://www.who.int/nmh/publications/cost_of_inaction/en/index.html> [accessed 8 September 2015].

⁷⁹³ This also fits the definition of primary care given in Declaration of Alma-Ata (n 255), item VII(2): '[primary care] addresses the main health problems in the community'.

Whose lives do we save?

The exercise of health prioritisation and budgeting raises other issues in supranational monitoring. The following examples are simplified, but illustrate the types of discrimination that healthcare rationing inevitably results in, by prioritising certain health services or patients over others. Should a state prioritise providing penicillin to 1,000 ill children or to 1,000 ill elderly persons, by considering their remaining years of life? Should it choose to provide penicillin to 1,000 adults with pneumonia or to 1,000 adults with pneumonia and strong diabetes, by considering their subsequent quality of life? Should a state prioritise providing penicillin to 1,000 ill adults or providing maternal healthcare to 100 pregnant women, by considering their vulnerability? Who or what should SNHRBs consider as having to be prioritised?

Firstly, rationing by patients involves either favouring persons who will benefit the most from the care provided, or giving the same ‘healthcare package’ to everyone.⁷⁹⁴ Favouring patients who will benefit the most from the care provided discriminates against persons with fewer years of life ahead (e.g. older persons), or persons with a lower quality of life following the treatment (e.g. persons with diabetes). However, giving the same healthcare package to everyone discriminates against persons with chronic diseases and disabilities, in need of more regular care. Since such type of rationing corresponds to a direct discrimination, contrary to the cornerstone principle of equality in human rights law, it should be considered at last resort, when states experience general shortages of resources (e.g. natural disaster, war).

Secondly, rationing healthcare often implies prioritising the provision of certain services over others.⁷⁹⁵ For instance, states may allocate more funds to emergency medicine than to ophthalmology, as the former directly protects everyone’s biological survival. Nevertheless, rationing by services can discriminate against individuals to the same extent as rationing by patients, when it affects health services

⁷⁹⁴ David Orentlicher, ‘Deconstructing Disability: Rationing of Health Care and Unfair Discrimination against the Sick’ (1996) 31 *Harvard Civil Rights-Civil Liberties Law Review* 49, 52–53.

⁷⁹⁵ *ibid.*

explicitly targeting specific groups of individuals. For example, underfunding paediatrics, geriatrics, obstetric, or oncology can lead to health discrimination based on age, gender, or health status. Discrimination can also occur when rationing health services that *implicitly* target certain groups of individuals. For instance, women use family planning centres more often than men since most contraceptives are designed for women. Underfunding such services could thus lead to health discrimination based on gender. Rationing per services should thus focus on the lifesaving aspect of the care provided; and when it involves a direct discrimination, it should be considered at last resort, based on a general shortage of resources.

Finally, healthcare prioritisation and rationing is an incredibly complex exercise, which human rights law cannot and should not address alone.⁷⁹⁶ Expertise in medicine, ethics, public health, and health economics is crucial. SNHRBs, however, can contribute to interpreting and monitoring such process in three ways. First, they can verify that rationing measures are taken at last resort, following requirements set by the principle of non-retrogression (see subsection 5.1.3.2). Second, SNHRBs can verify that rationing measures are as non-discriminatory as possible. Third, they can verify that the decision-making process in healthcare prioritisation is principled, evidence-based, consultative, transparent, and evaluative, as suggested by Tobin;⁷⁹⁷ and that it produces measures guaranteeing an effective enjoyment of the right to health, reasonable expectations upon states, context-sensitivity, and principled consistency. As suggested by this thesis, this would entail for SNHRBs giving priority to measures that are the most lifesaving, low-cost and wide-scale, and the least discriminatory (which I will call ‘core measures’ for matters of clarity). However, no list of what such measures might represent can be drawn up. Therefore, their review can only be ad hoc and cannot operate through a non-derogable approach.

⁷⁹⁶ Tobin (n 19) 71–73: the author highlights the concerns raised by Griffin, O’Neill and Daniels through his analysis of the macro/micro resource allocation dilemma. The literature on healthcare prioritisation is rich, e.g. Keith Syrett, *Law, Legitimacy and the Rationing of Health Care: A Contextual and Comparative Perspective* (Cambridge University Press 2007); Norman Daniels and James E Sabin, *Setting Limits Fairly: Learning to Share Resources for Health* (Oxford University Press 2008).

⁷⁹⁷ Tobin (n 19) 71–73.

To conclude, the criteria on which SNHRBs could potentially rely to determine what constitute the core content of the right to health, cannot generate a list of measures that states would have to implement, regardless of any constraints they may face. Therefore, it is desirable that SNHRBs interpret what this thesis calls ‘core measures’ (measures that are life-saving, low cost, wide-scale, and non-discriminatory), through a reasonableness test instead.

5.2.3 The reasonableness test

Determining a universal minimum core content of the right to health presents insurmountable dilemmas, especially when setting non-derogable obligations. I thus suggest SNHRBs interpret and monitor ‘core measures’ through a reasonableness test, enabling a fairer process while guaranteeing strict scrutiny (5.2.3.1). However, this thesis concedes that minimum core obligations can represent a heuristic tool for SNHRBs monitoring states with high levels of income and with more or less akin features, such as European states (5.2.3.2).

5.2.3.1 Reasonableness over minimum core

If a measure was lifesaving, low-cost, wide-scale, and non-discriminatory, one could argue that states would be at a loss for valid reasons explaining why they did not implement it; and therefore, they should not be able to derogate from it. However, two issues arise in the light of supranational monitoring. Firstly, and as outlined in subsection 5.2.2, those four criteria are rarely gathered all at once. Translating them into a list of non-derogable measures common to all states is unrealistic. Secondly, what if states experience a general shortage of resources due to a force majeure event, i.e. natural disaster or war? While external, unpredictable, and ‘irresistible’ circumstances do not automatically justify inaction, it would be unfair and detrimental to the credibility of the right to health to dismiss them when reviewing states’ compliance.⁷⁹⁸ Therefore, SNHRBs must follow a case-by-case analysis and allow derogations, even if reviewed strictly, when deciding whether states should implement such measures. As outlined by Quinot and Liebenberg, reviewing social rights through a test of reasonableness promotes transparency, justification, fairness,

⁷⁹⁸ See criticism of absolutist approach in Quinot and Liebenberg (n 32).

and contributes to delineating their content.⁷⁹⁹ Those advantages suitably embody the purpose of this thesis, i.e. clarifying the right to health through supranational monitoring, and the principles set in its introduction. Four observations however should be made.

First, if SNHRBs review failures to implement lifesaving, low-cost, wide-scale, and non-discriminatory measures through the reasonableness test, they are likely to reach similar decisions than if they had reviewed them through the non-derogable core approach. Realistically, states are unlikely to be found complying with the right to health if they fail to implement ‘core measures’, as very few arguments may justify it in practice. However, the reasonableness test respects a fairer procedure, as it considers the occurrence of force majeure events causing general shortages of resources. It thus avoids setting non-derogable obligations that are impossible to fulfil.

Second, the reasonableness test enables SNHRBs to understand ‘minimum core obligations’ through the conceptual framework of progressive realisation, thus enabling them to set more realistic expectations in terms of time and resources. Vaccines against major serious diseases affecting the community, for instance, are clearly lifesaving, low-cost, wide-scale and non-discriminatory. However, it would be unrealistic for SNHRBs to expect the poorest states to immediately provide such vaccines regardless of other imperative needs, whether in healthcare (e.g. providing basic maternal care) or in other sectors (e.g. civilians’ protection in the midst of conflict). Whilst states must prioritise such measures through resources (rationing process) and through time (expeditious process),⁸⁰⁰ they cannot implement them overnight. Understanding ‘core measures’ through the prism of progressive realisation enable SNHRBs to set achievable standards for all states, not simply those with a higher income.⁸⁰¹ However, this means that once low-income countries have

⁷⁹⁹ *ibid* 641.

⁸⁰⁰ UNCESCR, ‘General Comment 3’ (n 211), para 10 mentions the notion of priority in relation with minimum core obligations ‘it [a state] must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations’.

⁸⁰¹ Craven (n 152) 143–144.

funded such measures, they may have very little left to fund specialised and expensive treatments.⁸⁰² This approach accepts the distinction between ‘infringements’ of the right to health (when it has not been fulfilled for legitimate reasons); and ‘violations’ (when it has not been fulfilled for illegitimate reasons).⁸⁰³

Third, applying a reasonableness test to ‘core measures’ in supranational monitoring enables the prioritisation process to be principled (e.g. giving priority to lifesaving, low-cost, wide-scale, and non-discriminatory healthcare). Such an outcome is well supported by the literature, which suggests that healthcare prioritisation must follow a fair decision-making process. In their ‘accountability for reasonableness’ framework, for instance, Daniels and Sabin contend that such process should be based on justifiable reasons; that grounds for decisions should be made public; that decisions should be revisable in light of new evidence and arguments; and that respect of procedures should be guaranteed.⁸⁰⁴ This also enables SNHRBs’ interpretation to reach the requirement of principled consistency and to clarify the legal content of the right to health. Nevertheless, as Quinot and Liebenberg reminds us when discussing the South African model, it is important to avoid falling in an excessively procedural and thus, meaningless administrative process when human rights are at stake.⁸⁰⁵ A right balance should be struck by SNHRBs, since excessively substantive models can also fail to set realistic and principled obligations (e.g. GC14). In the event where ‘core measures’ are not implemented, SNHRBs should thus verify that the prioritisation process is adequately principled and aims at guaranteeing an effective enjoyment of the right to health.

Fourth and finally, SNHRBs should apply the reasonableness test with stricter scrutiny when ‘core measures’ are at stake, since their lifesaving, low-cost, wide-scale, and non-discriminatory aspects require for them to be prioritised. This thesis

⁸⁰² A comparison can be drawn with the *Soobramoney case* (n 787).

⁸⁰³ A.M. Viens, ‘Interdependence, Human Rights and Global Health’ Health Care Analysis (2015, forthcoming). However, this distinction is initially made by Judith Jarvis Thomson, *The Realm of Rights* (Harvard University Press 1990); and by Joel Feinberg, ‘Voluntary Euthanasia and the Inalienable Right to Life’ (1978) 7 *Philosophy & Public Affairs* 93.

⁸⁰⁴ Daniels and Sabin (n 796), Chapter 4.

⁸⁰⁵ Quinot and Liebenberg (n 32): see the shift of the South African jurisprudence towards a more substantive conception of review, following criticisms against its procedural focus.

thus suggests SNHRBs adopt a *prima facie* approach, according to which states ought to prove that they have implemented such measures and if they have failed to do so, can bring very few excuses to justify their non-compliance. Whilst such approach is endorsed by the European Committee, it is still absent from the monitoring procedures of the UN Committee. However, obligations to realise Article 12 ICESCR cannot be materialised and victims, identified, without a violation approach.⁸⁰⁶

It is worth noting that these comments are specific to the concept of minimum core as developed by GC14: a *non-derogable* aspect of the right to health.⁸⁰⁷ In later General Comments, the UN Committee avoided endorsing such approach,⁸⁰⁸ perhaps due to criticisms following GC14. However, it declares in these documents that such obligations are immediate, which is also problematic. As argued above, ‘core measures’ must be prioritised in time, but they cannot be implemented overnight. As a result, it is not desirable that SNHRBs interpret the nature of states’ obligation as being non-derogable or immediate when reviewing ‘core measures’. Instead, they should review such measures through the prism of progressive realisation and healthcare prioritisation, by applying a test of reasonableness.

5.2.3.2 Minimum core obligations: a heuristic tool in Europe?

As discussed, SNHRBs would interpret and monitor states’ obligations to provide ‘core measures’ in health more adequately by applying a reasonable approach than a non-derogable core approach. However, the latter may represent a useful tool in practice, which this thesis acknowledges through the European model.

The interpretation of the European Committee regarding Article 11 ESC implicitly highlights the adoption of a non-derogable core approach, as discussed in Chapter 3. Such an approach seems to rely on the presumption that European states all have

⁸⁰⁶ Leckie (n 212) 95–96.

⁸⁰⁷ UNCESCR, ‘GC14’ (n 21), para 47: ‘It should be stressed, however, that a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations set out in paragraph 43 above, which are non-derogable.’

⁸⁰⁸ Except in UNCESCR, ‘General Comment 15’ (n 492).

access to a certain degree of resources enabling the fulfilment of minimum standards in health systems. In subsection 5.2.1, I criticised the European Committee for using opaque or incoherent criteria to determine the core content of the right to health. However, non-derogable standards have also enabled it to sharpen its jurisprudence and thus, to clarify the legal content of the right to health to a certain extent. The European Committee systematically finds states in violation of Article 11 ESC when their performance in healthcare falls far behind the European average; or when these report significantly poor maternal and infant mortality,⁸⁰⁹ or health discrimination.⁸¹⁰ By having to justify such findings of non-conformity, the European Committee has thus delineated ‘thresholds’ or standards under which states are not allowed to perform, clarifying subsequently the legal content of the right to health. For instance, it recently prohibited retrogressive measures that affected ‘the very substance’ of the right to health, understood as everyone’s right to access healthcare beyond emergency services, including irregular migrants.⁸¹¹

Nevertheless, three observations should be made. Firstly, the non-derogable core approach raises issues of principled consistency in SNHRBs’ interpretation, including in Europe. It remains heavily criticised in the literature, has no textual support in the CoE, and receives mitigated endorsement from the UN Committee (whether in recent General Comments or in Concluding Observations). Furthermore, the European Committee has not yet explicitly recognised the adoption of a non-derogable core approach under Article 11 ESC and even less so, justified it. As a result, its application in Europe lacks transparency and presents no clear rationales. Secondly, the reason why the European Committee has been able to develop a precise interpretation of Article 11 ESC primarily lies in the use of indicators, not the

⁸⁰⁹ See the standard ‘States must undertake measures to bring maternal and infant deaths down to zero risk, especially countries with highly developed healthcare systems’ (and its implicit recognition as being non-derogable), first established in ECSR, ‘Conclusions XV-2 (2001)’, Belgium p 94; and in ECSR, ‘Conclusions 2003’, France p 147.

⁸¹⁰ See the standard ‘Healthcare systems must be accessible to everyone, and potential restrictions on the application of Article 11 must not impede access to healthcare for disadvantaged groups’, first established in ECSR, ‘Conclusions XV-2 (2001)’, Cyprus p 25; in ECSR, ‘Conclusions XVII-2 (2005)’, Statement of interpretation on Article 11, para 5; and in ECSR, ‘Conclusions 2005’, Statement of interpretation on Article 11, para 5. See also ESC 1996 (n 92), Art E (non-discrimination clause).

⁸¹¹ ECSR, ‘Conclusions XX-2 (2013)’, Spain p 14.

use of European averages, or the strict wording and review of maternal mortality standards. The ability of thematic health indicators to clarify the legal content of the right to health and the need for SNHRBs to use them in order to optimise their interpretation, have been highlighted multiple times in this thesis, based on the positive example set by the European Committee. Thirdly, a non-derogable core approach may be helpful for SNHRBs monitoring states with high income and relatively harmonious features, as is the case in Europe, but this may not be successful in other regions. What non-derogable minimum standards should be set for states with very low-incomes such as the sub-Saharan Africa region, where 550 women die for every 100,000 live births?⁸¹² What non-derogable minimum standards should be set for continents displaying great disparity such as Africa, where 46 women die for every 100,000 live births in Tunisia, while 1,100 die in Sierra Leone?⁸¹³ States' failures to provide basic healthcare should thus be reviewed primarily through a reasonableness test, although applied with strict scrutiny.

To conclude, SNHRBs ought to review 'core measures' through a reasonableness test in order to ensure a fairer process; and while the non-derogable approach may present (heuristic) benefits in Europe, it is not sufficiently decisive to be encouraged.

Conclusion

In this Chapter, I clarified how the nature of states' obligations to realise the right to health should be interpreted in supranational monitoring, by focusing on the timeframe in which states must implement this right. This key and complex question remained unanswered in Part I. For this purpose, I used the relevant doctrine and analysed comparatively the UN and the European Committee's interpretations, in order to develop a theoretical framework based on the principles of interpretation this thesis advocates, and to enable SNHRBs to optimise their interpretation. In Section 5.1, I explored how the obligation to progressively realise the right to health should be interpreted in supranational monitoring. Firstly, I demonstrated that this obligation

⁸¹² WHO, 'Trends in Maternal Mortality: 1990 to 2013' (n 476), p 25.

⁸¹³ *ibid*, pp. 31–35.

should be and had been interpreted by SNHRBs such as the UN or the European Committees, as requiring that states improved their performance in healthcare, depending on their available resources. Secondly, I argued that SNHRBs should monitor this obligation by evaluating adequately states' use of resources, and using health indicators. Thirdly, I asserted that to give substance to the obligation to progressively realise the right to health, SNHRBs had to hold violations when states insufficiently improved the standards of their health systems, or when the latter retrogressed. Section 5.2 then analysed how SNHRBs should approach the notion of minimum core obligations to realise the right to health. First, I demonstrated that this concept was explicitly recognised in the UN but not in the CoE, and implicitly endorsed by SNHRBs such as the UN and the European Committee. Second, I however challenged the possibility for SNHRBs to delineate the legal content of non-derogable core obligations. For this purpose, I challenged the possibility for potential criteria such as lifesaving, wide-scale, low-cost and non-discriminatory measures, to generate a clear list of measures constituting the core content of the right to health. Third, I thus concluded that SNHRBs ought to review the implementation of such measures through a test of reasonableness instead, to ensure their interpretation meet the requirements of principled consistency and fairness. Finally, whilst I acknowledged that a non-derogable approach might represent a heuristic tool in Europe, I found its benefits insufficiently convincing.

Chapter 6 Concluding remarks: key challenges to conceptual clarity across SNHRBs

Introduction

As demonstrated by Chapters 4 and 5, the normative scope of the right to health and states' obligations to realise it can be clarified in a manner enabling SNHRBs to interpret adequately the legal content of this right. This involves following the principles of interpretation developed in this thesis, i.e. SNHRBs should promote an effective enjoyment of the right to health; set reasonable expectations upon states; offer context sensitivity through its implementation; and overall, guarantee principled consistency. However, various elements challenge the conceptual clarity of the legal content of the right to health, as delineated by my theoretical framework (i.e. through supranational monitoring), which can in turn affect its implementation. How can SNHRBs coherently and, thus, effectively interpret a universal right subject to different human rights regimes, and different quasi-judicial monitoring avenues? To what extent can SNHRBs align theory with practice if they cannot bring the legal content of the right to health to life through enforcement procedures?

It is fundamental that such questions be clarified, or at least that the challenges they represent be acknowledged, in order to optimise SNHRBs' interpretation of the right to health and ensure principled consistency at each level of protection. Such consistency is essential for two reasons, both related to an adequate implementation of the right to health. First, by constructing their interpretation in a principled manner, SNHRBs justify their decisions through states' consent and through moral considerations of equality and dignity, cornerstones of human rights law. Second, by constructing their interpretation consistently, SNHRBs ensure a reasonable degree of legal certainty, pillar of the rule of law. Therefore, Chapter 6 will explore how the conceptual framework developed in Chapters 4 and 5 can operate coherently across all levels of supranational monitoring. It will examine how the international and regional interpretations of the right to health should interact with each other to promote an adequate and effective realisation of this right.

Numerous legal philosophers have discussed the role of coherence in legal reasoning,⁸¹⁴ its desirability,⁸¹⁵ and its limits.⁸¹⁶ While it is not the purpose of this thesis to discuss such vast issues, the increasing number of instruments, jurisprudences, procedures, and political contexts through which the right to health is interpreted, incontestably challenge the ability of international human rights law and particularly, SNHRBs, to promote coherently an effective enjoyment of this right worldwide. Various legal scholars have written about the substance and the monitoring of the right to health in international systems,⁸¹⁷ or (fewer) in regional systems.⁸¹⁸ However, little to no research discusses the coexistence of such aspects across both frameworks, and the role of SNHRBs in this respect.⁸¹⁹ Tobin, however, developed a comprehensive definition of what he calls the ‘principle of coherence’, supposed to ensure consistency when interpreting the right to health.⁸²⁰ Nevertheless, his *in abstracto* analysis does not shed light on the issues identified as being particularly problematic through the empirical research conducted in Chapters 2 and 3, or through the comparison carried out in Chapters 4 and 5.

Chapter 6 will thus discuss the key challenges that enhancing the conceptual clarity of the right to health across different levels of supranational monitoring represent, to assess whether and how SNHRBs can optimise their interpretations as a result. In Section 6.1, I will argue that in response to the fragmentation of human rights law, SNHRBs should harmonise the normative scope of the right to health in order to

⁸¹⁴ E.g. Dworkin 1986 (n 27).

⁸¹⁵ E.g. Barbara Baum Levenbook, ‘The Role of Coherence in Legal Reasoning’ (1984) 3 *Law and Philosophy* 355.

⁸¹⁶ E.g. Joseph Raz, ‘The Relevance of Coherence’ (1992) 72 *Boston University Law Review* 273.

⁸¹⁷ E.g. Toebe 1999a (n 1).

⁸¹⁸ E.g. Roscam Abbing (n 320).

⁸¹⁹ The few existing publications focus on CPR: Monica Pinto, ‘Fragmentation or Unification among International Institutions: Human Rights Tribunals’ (1998) 31 *New York University Journal of International Law and Politics* 833; Vassilis P Tzevelekos, ‘The Use of Article 31(3)(C) of the VCLT in the Case Law of the ECtHR: An Effective Anti-Fragmentation Tool or a Selective Loophole for the Reinforcement of Human Rights Teleology - Between Evolution and Systemic Integration’ (2009) 31 *Michigan Journal of International Law* 621; Marjan Ajevski (ed), *Fragmentation in International Human Rights Law: Beyond Conflict of Laws* (Routledge 2015).

⁸²⁰ Tobin (n 19) 100–110.

guarantee they all interpret and thus monitor an effective enjoyment of this right. I will examine how international law can encourage SNHRBs to interpret comprehensively what adequate health systems entail, and to reconcile conflicts of norms affecting the protection of non-nationals' right to health. This section will thus assess whether the conceptual framework developed in Chapter 4 can operate coherently across all SNHRBs. In Section 6.2, I will contend that in the light of diverse quasi-judicial avenues through which the right to health is monitored, SNHRBs should maintain some flexibility to set realistic expectations upon states under review. I will therefore discuss the importance for SNHRBs to balance the individual and collective dimensions of the right to health according to the monitoring procedure at stake; and to adapt their compliance approach to the level of monitoring they represent. This section will thus assess whether the conceptual framework developed in Chapter 5 can operate coherently across all SNHRBs. Finally, in Section 6.3, I will highlight SNHRBs' limited ability to bring their own interpretation to life through enforcement procedures, and to coherently align theory with practice as a result.

6.1 Fragmentation of human rights law and harmonising the normative scope of the right to health

As discussed in Chapter 4, SNHRBs should understand the right to health as a right for everyone to access an adequate health system that is responsive to the needs of the population and to the culture in which it is to be implemented. However, the increasing number of international and regional treaties recognising a right to health increases the likelihood for different interpretations to be developed, threatening the coherence of its substance (and subsequently, of its implementation). In the light of such fragmentation of human rights law,⁸²¹ it is fundamental that SNHRBs promote an effective enjoyment of the right to health across all systems of human rights protection. Furthermore, harmonising the normative scope of the right to health

⁸²¹ Formulation first used by the Study Group of the International Law Commission chaired by Martti Koskenniemi. The fragmentation of human rights law and its impact on ESCR has generated little research; as mentioned in footnote 819, the few existing publications focus on CPR..

across SNHRBs guarantees principled consistency for states members of both international and regional frameworks, and for right-holders living in such states. Subsection 6.1.1 will thus highlight the compatibility of supranational interpretations of the highest standard of health attainable; but will suggest that SNHRBs use the principle of external system coherence to ensure a comprehensive scope of interests. Subsection 6.1.2 will then study the conflict of norms arising between supranational human rights instruments regarding the recognition of non-nationals' right to health; and will offer a framework enabling SNHRBs to reconcile such scope of protection.

6.1.1 Towards a common interpretation of the highest standard of health attainable: the right to an adequate health system

Subsection 6.1.1 aims at examining whether the meaning given to the '*highest standard of health attainable*' at the international and regional levels of human rights protection, is compatible. Firstly (6.1.1.1), I will highlight similarities between the international and regional systems, whether in right to health provisions or their interpretation by relevant SNHRBs. Secondly (6.1.1.2), I will suggest that SNHRBs use the principle of external system coherence to fill the potential or existing gaps in their jurisprudences, in order to ensure a more comprehensive interpretation.

6.1.1.1 Similarities between international and regional frameworks

Definition

The scope of interests of the right to health is defined in similar terms in both international and regional human rights instruments, as briefly mentioned in subsection 4.1.1.2. These instruments all require that states achieve the '*highest standard of health attainable*' and, more specifically, provide adequate health systems through appropriate medical assistance. At the international level, Article 12 ICESCR requests that states achieve '*the highest attainable standard of physical and mental health*' and provide medical assistance in the event of diseases or sickness.⁸²² It is worth noting that 164 states are bound to this provision.⁸²³ At the regional level,

⁸²² ICESCR (n 4), Art 12.

⁸²³ UN Treaty Collection, 'Status of OP to ICESCR' (n 101).

similar requirements can be found in the European, African and Inter-American systems of human rights protection. Articles 11 and 13 ESC urge states to remove ‘*as far as possible*’ the causes of ill-health and to guarantee the right to adequate medical assistance.⁸²⁴ The African Charter refers to a right to enjoy ‘*the best attainable state of physical and mental health*’ and to benefit from medical attention, in its concise Article 16.⁸²⁵ Finally, Article 10 of the Protocol of San Salvador recognises the right to ‘*the highest level of physical, mental and social well-being*’, and the right to measures ensuring appropriate healthcare.⁸²⁶ It is also worth noting that 43 states are parties to the ESC,⁸²⁷ 53 to the African Charter,⁸²⁸ and 16 to the Protocol of San Salvador.⁸²⁹ Such numbers highlight a strong consensus amongst states regarding the scope of interests of the right to health. Finally, it is worth noting that similar requirements can be found in human rights instruments of the League of Arab States and ASEAN. Article 39 of the Arab Charter, ratified by 14 states,⁸³⁰ embraces a right to ‘*the highest attainable standard of physical and mental health*’ and to access medical services and facilities.⁸³¹ As for Article 29(1) of the ASEAN Human Rights Declaration, it recognises that everyone has a right to ‘*the highest attainable standard of physical, mental and reproductive health*’, as well as to access affordable healthcare and facilities.⁸³² However, these instruments do not have the same importance as those present in the European, African and American systems. The Arab Charter has been criticised for deviating from international human rights

⁸²⁴ ESC 1961 (n 92), Art 11 and 13; ESC 1996 (n 92), Art 11 and 13.

⁸²⁵ African Charter (n 92), Art 16.

⁸²⁶ Protocol of San Salvador (n 92), Art 10.

⁸²⁷ CoE, ‘Table of Accepted Provisions of the ESC’ (n 337).

⁸²⁸ African Commission, ‘Ratification Table: African Charter on Human and Peoples’ Rights’ (n 99).

⁸²⁹ OAS, ‘Signatories and Ratifications of the Protocol of San Salvador’ <<http://www.oas.org/juridico/english/sigs/a-52.html>> [accessed 8 September 2015].

⁸³⁰ Mattar (n 97) 94. No further information can be found on the website of the League of Arab States.

⁸³¹ Arab Charter (n 92), Art 39.

⁸³² ASEAN, ‘Human Rights Declaration’ (2012) <<http://aichr.org/documents/>> [accessed 8 September 2015].

standards;⁸³³ and its Human Rights Committee, for its lack of transparency.⁸³⁴ As for the ASEAN Declaration, it has been criticised for not being legally binding; and its Intergovernmental Commission on Human Rights, for being a window-dressing institution lacking independence.⁸³⁵ Moreover, neither ASEAN nor the League of Arab States benefit from human rights monitoring procedures at present, as showed in subsection 1.1.3.2. As a result, this chapter will not examine these systems.

Interpretation

International and regional human rights instruments define the scope of interests of the right to health in similar terms. However, the compatibility of their interpretations remains to be determined for most frameworks, as few SNHRBs monitor this right at the regional level. Only the European and the African systems have had the opportunity to develop a regional jurisprudence on the right to health. Therefore, it is fundamental to examine whether their interpretations of what constitutes an adequate health system are compatible with international standards.

As demonstrated in Chapter 4, both the UN and the European Committees understand the right to health as entitling individuals to adequate health systems, which standards must be as high as possible, depending on states' resources. Few differences can be noted and when these arise, they correspond to areas monitored by one Committee and not the other, rather than a conflict between both interpretations. For instance, the UN Committee clearly considers that mental health as well as SRH are essential to adequate health systems, since it regularly and comprehensively assesses them in its Concluding Observations on Article 12 ICESCR. Such a review does not appear in the Conclusions of the European Committee on Article 11 ESC.

⁸³³ UN Press Release, 'Statement by UN High Commissioner for Human Rights on the Entry into Force of the Arab Charter on Human Rights' (2008) <<http://www.unhchr.ch/huricane/huricane.nsf/view01/6C211162E43235FAC12573E00056E19D?opendocument>> [accessed 8 September 2015]: the Commissioner raised concerns regarding death penalty for children, women's and non-citizens' rights, and the equation of Zionism with racism.

⁸³⁴ Rishmawi (n 97).

⁸³⁵ Briefly summarised by John D Ciorciari, 'Institutionalizing Human Rights in Southeast Asia' (2012) 34 Human Rights Quarterly 695.

Nevertheless, this does not suggest the European Committee considers mental health and SRH should not belong to the normative content of the right to health. On the contrary, it has recently recognised children's right to SRH education in its complaint procedure; as well as women's right to access abortion services that have been legalised.⁸³⁶ Furthermore, the European Committee sometimes cites Article 12 ICESCR and GC14 as '*relevant law*' in Merits Decisions involving Article 11 ESC, pointing towards compatibility.⁸³⁷ Since SRH is only partially monitored and mental health remains largely unmonitored, this cross-fertilisation process might encourage the European Committee to recognise more explicitly their importance in health systems and subsequently, states' duty to guarantee them under Article 11 ESC.

Examining thoroughly how the African Commission delineates the legal content of the right to health in its reporting and complaint procedures falls outside the scope of this chapter. This thesis focuses on the European system for a valid reason: it is the only regional framework that offers a rich jurisprudence on the right to health. However, the interpretation of what constitutes an adequate health system under Article 16 of the African Charter, suggests a compatibility with the UN framework on two accounts. Firstly, the format of the Concluding Observations of the African Commission is entirely inspired from that of the Concluding Observations of the UN Committee and, therefore, unlikely to produce legal standards which could subsequently clash. It expresses concern when facing poor health standards; expresses satisfaction when observing progress; and (sometimes) formulates recommendations for improvements. Its comments are usually vague, not driven by a clear legal reasoning or terminology, and rely on an ad hoc approach. For instance, in 2012 the African Commission praised Togo for doubling its medical personnel within 6 years,⁸³⁸ which is significant in a country with a GDP per capita of \$359-

⁸³⁶ International Centre for the Legal Protection of Human Rights v Croatia (ECSR) (n 368); International Planned Parenthood Federation European Network v Italy (ECSR) (n 546).

⁸³⁷ Marangopoulos Foundation for Human Rights v Greece (ECSR) (n 372) [196]; International Federation for Human Rights v Greece (ECSR) (n 638) [13 and 14]; International Planned Parenthood Federation European Network v Italy (ECSR) (n 546) [37 and 38].

⁸³⁸ African Commission on Human and Peoples' Rights, 'Concluding Observations on the Republic of Togo's Combined Third, Fourth and Fifth Periodic Report on Implementation of the ACHPR' (2012), paras 19 and 69; All the Concluding Observations of the African

\$503 at the time.⁸³⁹ The Commission nonetheless declared this insufficient, without specifying what number of physicians per 1,000 inhabitants Togo should aim for.⁸⁴⁰ Since the African Commission fails to set standards on what the highest standard of health attainable means, logically its interpretation is unlikely to be restrictive and to clash with international standards. Secondly, the interpretation of the African Commission of what the normative scope of the right to health entails suggests a compatibility with the international framework, because its Merits Decisions on Article 16 of the African Charter systematically refer to UN standards. (This assertion is based on decisions reached post 2001, as the Commission only started to effectively delineate the normative content of the right to health that year.)⁸⁴¹ In *Social and Economic Rights Action Center and Center for Economic and Social Rights v. Nigeria*, for instance, the African Commission used Article 12 ICESCR to declare that the right to health obliged states to take steps to secure a healthy environment.⁸⁴² In *Purohit and Moore v The Gambia*, it referred to the UN Principles for the Protection of Persons with Mental Illness and Improvement of Mental Health Care to contend that the right to health of mental health patients included special treatment enabling them to reach independence.⁸⁴³ In *Sudan Human Rights Organisation & Centre on Housing Rights and Evictions v Sudan*, the African

Commission can be found online on <<http://www.achpr.org/states/reports-and-concluding-observations/>> [accessed 8 September 2015].

⁸³⁹ World Bank, 'GDP per Capita' (n 784): see Togo in 2004-2008 (to put such figures into perspectives, in 2010 the GDP per capita in the United Kingdom amounted to \$36,425).

⁸⁴⁰ WHO, 'Interactive Chart on the Density of Physicians (total Number per 1000 Population): Latest Available Year' <http://gamapserver.who.int/gho/interactive_charts/health_workforce/PhysiciansDensity_Total/atlas.html> [accessed 8 September 2015]. As of 2008, Togo only had 0.053 physicians per 1,000 persons, and was thus one of the 15 states with the least doctors per inhabitants on the planet (while the United Kingdom, for instance, had 2.809 in 2013).

⁸⁴¹ Mbazira (n 121) 342–357; Ssenyonjo (n 121) 367–370 and 375–377. This is true for all Merits Decisions post-2001, except *Democratic Republic of Congo v Burundi, Rwanda, Uganda* [2003] Communication No. 227/99, Decision on the Merits (African Commission on Human and Peoples' Rights) [88]. In this case, the Commission simply declared a violation of the right to health.

⁸⁴² *Social and Economic Rights Action Center (SERAC) and Center for Economic and Social Rights (CESR) v Nigeria* [2001] Communication No. 155/96, Decision on the Merits (African Commission on Human and Peoples' Rights) [50–53].

⁸⁴³ *Purohit and Moore v The Gambia* [2003] Communication No. 241/01, Decision on the Merits (African Commission on Human and Peoples' Rights) [77–85].

Commission referred to GC14 to assert that the right to health included underlying determinants of health.⁸⁴⁴ Finally, in *Egyptian Initiative for Personal Rights and INTERIGHTS v Egypt*, it used Article 25 UDHR and GC14 to highlight states' obligation to provide medical attention to victims of sexual violence.⁸⁴⁵

It is also worth noting that whilst the right to health cannot be litigated in the Inter-American system, the Inter-American Commission recently declared that the ICESCR and UN General Comment 3 could be used as sources of interpretation in decisions involving ESCR matters.⁸⁴⁶ Following this, the Court reviewed retrogressive measures (i.e. reduction of pensions) '*in the same line of thought*' than the UN Committee, by referring to its General Comment 3 and to its 2007 Statement.⁸⁴⁷ A compatibility with UN standards can therefore be highlighted.

To conclude, it is clear that regional human rights bodies all delineate the scope of interests of the right to health by referring to the interpretation of the UN Committee, at least partially. Such cross-fertilisation process mitigates the possibility for incompatibilities to arise and thus protect the coherence of the right. However, it is uncertain whether ASEAN and the League of Arab States will perpetuate such practices through their relevant bodies, if and when they start monitoring the right to health efficiently. Furthermore, while the absence of clash enables SNHRBs' interpretation to meet the requirement of principled consistency more easily, it does not guarantee that they will promote comprehensively the enjoyment of this right.

⁸⁴⁴ *Sudan Human Rights Organisation & Centre on Housing Rights and Evictions (COHRE) v Sudan* [2009] Communication No. 279/03-296/05, Decision on the Merits (African Commission on Human and Peoples' Rights) [208–212]; UNCESCR, 'GC14' (n 21).

⁸⁴⁵ *Egyptian Initiative for Personal Rights and INTERIGHTS v Egypt* [2013] Communication No. 323/06, Decision on the Merits (African Commission on Human and Peoples' Rights) [257–267].

⁸⁴⁶ *National Association of Ex-employees of the Peruvian Social Security Institute et al v Peru* [2009] Case No. 12.670, Decision on Admissibility and the Merits (Inter-American Commission of Human Rights) [70, 135, 136]; UNCESCR, 'General Comment 3' (n 211).

⁸⁴⁷ *Case of Acevedo Buendía et al ('Discharged and Retired Employees of the Comptroller')* v Peru [2009] Series C No. 198, Decision on the Merits (Inter-American Court of Human Rights) [20, 102, 103]; UNCESCR, 'General Comment 3' (n 211); UNCESCR, 'Statement on Maximum Available Resources 2007' (n 733).

6.1.1.2 Mind the gap: the principle of external system coherence

Subsection 6.1.1 highlights that conflicts of norms are almost non-existent at the supranational level, when it comes to understanding what health systems states should ideally guarantee under the right to health. What arise more frequently, however, are the gaps generated by interpretations that are more comprehensive than others. In order for such gaps to be filled and, thus, to enable a more protective jurisprudence of the right to health, it is desirable SNHRBs apply the principle of external system coherence.

According to this principle, called ‘external system coherence’ by Tobin,⁸⁴⁸ and ‘systemic integration’ by the International Law Commission,⁸⁴⁹ SNHRBs should interpret the right to health by examining international human rights law holistically. This principle derives from the rules of treaty interpretation set in Article 31 of the Vienna Convention on the Law of Treaties.⁸⁵⁰ Article 31(1) and (2) requires that a treaty be interpreted according to the context in which it was signed; and that instruments formally connected to this treaty be examined. However, Article 31(3) goes further by stating that the system to which the treaty pertains must also be considered (i.e. agreements, practices and relevant rules of international law).⁸⁵¹ This was reaffirmed by the International Court of Justice in *Legal Consequences for States of the Continued Presence of South Africa in Namibia*.⁸⁵² In this case, the Court declared that international instruments should be interpreted and applied ‘*within the framework of the entire legal system prevailing at the time of the interpretation*’.⁸⁵³ The principle of external system coherence thus guarantees the right to health is adequately protected during the cross-fertilisation process, as it

⁸⁴⁸ Tobin (n 19) 104–110.

⁸⁴⁹ Study Group of the International Law Commission, ‘Fragmentation of International Law: Difficulties Arising from the Diversification and Expansion of International Law (finalised by Martti Koskenniemi) (long version)’ (2006) UN Doc. A/CN.4/L.682, Section F.

⁸⁵⁰ VCLT (n 602), Art 31.

⁸⁵¹ *ibid*, Art 31(1), (2), and (3).

⁸⁵² *Legal Consequences for States of the Continued Presence of South Africa in Namibia (South West Africa) notwithstanding Security Council Resolution 276 (1970)* [1971] ICJ Reports 1971, p 16, Advisory Opinion (International Court of Justice).

⁸⁵³ *ibid* [53].

enables SNHRBs to interpret this right in the light of more comprehensive interpretations, developed in other human rights systems.

When SNHRBs interpret the right to health, they must consider the principle of external system coherence altogether with that of *lex specialis derogat legi generali*, cornerstone in treaty interpretation.⁸⁵⁴ This logically includes three steps. First, SNHRBs must use the right to health provision they are mandated to supervise. Second, they may also use other instruments, either formally connected to this provision, or drafted within the framework to which this provision pertains. Third, if this is insufficient, SNHRBs can interpret the right to health by examining provisions of other frameworks to which the state belongs. It is at this third stage that the principle of external system coherence and the process of cross-fertilisation become relevant.

For instance, if the European Committee received a complaint alleging that the Irish ban on abortion breached women's right to health, based on the dangers of clandestine abortion procedures, it should follow three steps. First, it should use the wording of Article 11 ESC and its own jurisprudence on this provision.⁸⁵⁵ Second, it should also use CoE Resolution 1607 (2008), which recognises that bans on abortion lead to clandestine procedures and to a rise of maternal mortality.⁸⁵⁶ Finally, if the European Committee considered that Article 11 ESC and Resolution 1607 were insufficient to reach a decision, it should refer to Article 12 ICESCR to cast light on the broader context in which this provision should be understood, as Ireland ratified this treaty. It could subsequently refer to the numerous Concluding Observations of the UN Committee, which interpret Article 12 ICESCR as imposing an obligation to reduce maternal mortality and, thus, as prohibiting general bans on abortion. This would enable the European Committee to develop a more protective jurisprudence

⁸⁵⁴ Early recognition in *Ambatielos case (jurisdiction)* [1952] ICJ Reports 1952, p 28, Judgment of 1 July 1952 (International Court of Justice), Dissenting Opinion of Judge Hsu Mo p 88: '*It is a well-recognized principle of interpretation that a specific provision prevails over a general provision*'; International Law Commission, 'Draft Articles on Responsibility of States for Internationally Wrongful Acts, with Commentaries' (2001) UN Doc. A/56/10, Art 55.

⁸⁵⁵ ESC 1961 (n 92), Art 11; ESC 1996 (n 92), Art 11.

⁸⁵⁶ CoE Parliamentary Assembly, 'Resolution 1607' (n 394), para 4.

on SRH. However, thanks to its precise jurisprudence on Article 11 ESC, the European Committee is less likely to need the principle of external system coherence to optimise its interpretation, than other SNHRBs.

The African system applies the principle of external system coherence in its nascent jurisprudence on the right to health, since its Merits Decisions often refer to UN standards (see subsection 6.1.1.1). This practice ensures legal certainty for States parties to both the African Charter and UN treaties, and a reinforced monitoring for right-holders. However, this should not impede the development of regional instruments on health and human rights issues within the African system. Such instruments may cast light on issues specific to African countries (e.g. Ebola virus disease), with more expertise and speediness than the UN. Moreover, it would be unhelpful for the African Commission to follow the jurisprudence of the UN Committee on the right to health, since the latter avoids developing precise standards in this concern. Chapter 2 and interviews with the members of the UN Committee highlight that its approach focuses on a constructive dialogue with states instead, due to the international nature of this forum. Therefore, regional tools developed within the African system are fundamental to a better monitoring and adjudication of the right to health, provided these do not deviate from international human rights law.

The principle of external system coherence could be particularly helpful to the Inter-American system, as its jurisprudence on the right to health is limited. Most ESCR enshrined in the Protocol of San Salvador, including the right to health, cannot be subject to complaints before the Inter-American Commission of Human Rights;⁸⁵⁷ and cannot be brought to the Inter-American Court of Human Rights at a later stage.⁸⁵⁸ As a result, the right to health tends to be adjudicated through an integrated approach using two provisions of the American Convention on Human Rights: Articles 4 and 26.⁸⁵⁹ Two comments should be made regarding the importance of applying the principle of external system coherence in this regard.

⁸⁵⁷ Protocol of San Salvador (n 92), Art 19.

⁸⁵⁸ American Convention on Human Rights 1969, Art 44, 51, 61.

⁸⁵⁹ *ibid*, Art 4 and 26.

Firstly, Article 4 of the American Convention on Human Rights on the right to life has enabled the Inter-American Court to rule in favour of victims of right to health violations.⁸⁶⁰ After recognising that the right to life encompassed the right to a dignified existence in the *Street Children* case,⁸⁶¹ the Court considered that inadequate access to health could constitute a breach of the right to life.⁸⁶² Whilst such an integrated approach protects certain elements of the right to health, it leaves non-life threatening issues unmonitored, e.g. promotion of SRH in schools. However, this limitation cannot be overcome by applying the principle of external system coherence since the competence of the Court is restricted to CPR in theory.

Secondly, Article 26 of the American Convention on Human Rights sets a different light on this issue. It requires that states fully realise ‘*the rights implicit in the economic, social, educational, scientific, and cultural standards set forth in the Charter of the Organization of American States*’.⁸⁶³ This provision is enforceable and is often used in adjudication involving ESCR.⁸⁶⁴ Furthermore, Article 26 has not been the object of any reservation nor denunciation, contrarily to Article 4.⁸⁶⁵ Research shows nonetheless that in most cases, the textual basis of Article 26 is insufficient to offer an appropriate legal content for each ESCR, and that UN sources are often used instead.⁸⁶⁶ Such application of the principle of external system

⁸⁶⁰ *ibid*, Art 4; Steven R Keener and Javier Vasquez, ‘A Life Worth Living: Enforcement of the Right to Health through the Right to Life in the Inter-American Court of Human Rights’ (2008) 40 *Columbia Human Rights Law Review* 595.

⁸⁶¹ *Case of the ‘Street Children’ (Villagran-Morales et al) v Guatemala* [1999] Series C No. 63, Decision on the Merits (Inter-American Court of Human Rights).

⁸⁶² *Case of the Yakyé Axa Indigenous Community v Paraguay* [2005] Series C No. 125, Decision on the Merits (Inter-American Court of Human Rights); *Case of the Sawhoyamaya Indigenous Community v Paraguay* [2006] Series C No. 146, Decision on Merits (Inter-American Court of Human Rights); *Case of Ximenes-Lopes v Brazil* [2006] Series C No. 149, Decision on the Merits (Inter-American Court of Human Rights).

⁸⁶³ American Convention on Human Rights (n 858), Art 26.

⁸⁶⁴ *ibid*, Art 26; Oswaldo R Ruiz-Chiriboga, ‘The American Convention and the Protocol of San Salvador: Two Intertwined Treaties - Non-Enforceability of Economic, Social and Cultural Rights in the Inter-American System’ (2013) 31 *Netherlands Quarterly of Human Rights* 159.

⁸⁶⁵ OAS, ‘American Convention on Human Rights, Signatories and Ratifications’ <http://www.oas.org/dil/treaties_B-32_American_Convention_on_Human_Rights_sign.htm> [accessed 8 September 2015].

⁸⁶⁶ Ruiz-Chiriboga (n 864) 171.

coherence can be beneficial. It assists the Inter-American Court in interpreting the right to health in accordance with international standards, i.e. protection of the highest standard of health attainable; and it ensures legal certainty for both duty-bearers and right-holders. However, three conditions must be respected. First, the Court must ensure that it does not develop a jurisprudence differing from that of the Inter-American Commission, who monitors Article 10 of the Protocol of San Salvador on the right to health. Second, the application of the principle of external system coherence must not prevent the design of health and human rights instruments by the Organisation of American States. As explained in the context of the African system, regional tools can be highly beneficial to the monitoring and adjudication of the right to health as they deal with health issues specific to the region. Third, it would be unhelpful for the Court to try following the jurisprudence of the UN Committee regarding the right to health, as the latter does not offer any precise standards, as explained above.

To conclude, the scope of interests of the right to health is defined similarly across human rights instruments and no specific clash seems to arise amongst SNHRBs with regard to its interpretation. However, to avoid the adverse effects of fragmentation on the coherence of this right, SNHRBs should fill the gaps of their incomplete jurisprudences by using the principle of external system coherence. What is nonetheless more problematic in this harmonisation exercise, aimed at optimising SNHRBs' interpretation of the right to health, is the task of reconciling its scope of protection.

6.1.2 Reconciling the scope of protection of the right to health: non-nationals

As suggested by Tobin, the principle of external system coherence highlights tools that SNHRBs can use to interpret what the right to health means, when the provision they supervise the application of is not sufficiently precise.⁸⁶⁷ However, this principle presumes that no conflict of norms arises with respect to the right to health in international human rights law. This is true in most cases, as supranational human rights instruments define its scope of interests in similar terms. Nevertheless, as

⁸⁶⁷ Tobin (n 19) 104–110.

outlined in Chapter 4, supranational human rights instruments define right-holders differently, to the extent that incompatible frameworks coexist. It is therefore fundamental that SNHRBs harmonise this question, to ensure that duty-bearers benefit from a better legal certainty, and right-holders, from a better protection. Firstly (6.1.2.1), I will highlight the tensions between the international and regional systems in that regard. Secondly (6.1.2.2), I will suggest how SNHRBs can resolve this conflict of norms to optimise their interpretation.

6.1.2.1 Tensions between international and regional frameworks

Divergences of definitions

The UN and the Inter-American systems both recognise a universal right to health. Their preambles and their right to health provisions declare that everyone is entitled to this right on the basis of their inherent attributes as human beings.⁸⁶⁸ This wording reflects the universalist approach inherent to human rights law and advocated by this thesis, as discussed in Chapter 4.

However, divergences exist within the UN, the European and the African frameworks, as mentioned in subsection 4.3.1. Article 2(3) ICESCR allows developing countries to provide a restricted protection to non-nationals;⁸⁶⁹ and Article 28 ICMW only recognises a right to emergency healthcare for migrants.⁸⁷⁰ Furthermore, the European and the African systems authorise States parties to restrict the application of the right to health to their nationals. The ESC excludes explicitly foreigners residing or working illegally in Europe, from the scope of protection of Article 11.

⁸⁶⁸ ICESCR (n 4), Preamble, Art 2 and Art 12; Protocol of San Salvador (n 92), Preamble, Art 3 and Art 10.

⁸⁶⁹ ICESCR (n 4), Art 2(3).

⁸⁷⁰ ICMW (n 93), Art 28.

Its Appendix declares:

[the persons covered by Article 11] include foreigners only in so far as they are nationals of other Parties lawfully resident or working regularly within the territory of the Party concerned.⁸⁷¹

The African Charter is less definite but could potentially be interpreted restrictively. Whilst its Article 16 declares that every individual should enjoy the highest standard of health attainable, it obliges States parties to protect the health of ‘*their people*’, and declares that every ‘*citizen*’ has the right of equal access to the public services of her country.⁸⁷²

In theory, these formulations allow states to deny migrants, stateless persons and asylum-seekers the right to access adequate healthcare without having to justify why. Nevertheless, both *de jure* and *de facto* discrimination based on nationality are incompatible with the universalist premise of human rights law, and health discrimination are prohibited at all supranational levels of ESCR protection.⁸⁷³ Moreover, Chapter 4 demonstrated that whilst human rights law may allow states to differentiate nationals from non-nationals, excluding the latter from the scope of protection of the right to health is not based on an objective justification and is indefinite in time. Therefore, the scope of the ICMW, the ESC and the African Charter is highly problematic, and the restrictions they allow seem disproportionate.

It is worth noting that a restrictive scope of protection is particularly problematic in the context of regional human rights bodies for three reasons. Firstly, they set standards over numerous States parties (47 States parties to the ESC and 53 to the African Charter).⁸⁷⁴ Secondly, such standards are susceptible to having a greater impact on the application of the right to health than those developed in UN

⁸⁷¹ ESC 1961 (n 92), Appendix; ESC 1996 (n 92), Appendix.

⁸⁷² African Charter (n 92), Art 13(2) and 16.

⁸⁷³ ICESCR (n 4), Art 2(2); ESC 1961 (n 92), Preamble; ESC 1996 (n 92), Art E; African Charter (n 92), Art 2; Protocol of San Salvador (n 92), Art 3.

⁸⁷⁴ CoE, ‘Signatures and Ratifications of the ESC and Its Protocols’ (n 100): Switzerland, however, has only signed the ESC; African Commission, ‘Ratification Table: African Charter on Human and Peoples’ Rights’ (n 99).

institutions. Regional human rights bodies often have stronger enforcement mechanisms and closer ties with States parties, due to the fact they share more similar features than within an international forum. Moreover, under the *lex specialis* principle, regional instruments such as the ESC or the African Charter would logically take precedence over the ICESCR. Thirdly, regional human rights bodies have an impact on the broader international human rights community. The interviews conducted with the members of the UN Committee show that its Concluding Observations on Article 12 ICESCR are increasingly inspired by various external sources, including regional human rights standards. Therefore, it is fundamental that the wording of Article 11 ESC and Article 16 of the African Charter is interpreted more comprehensively in order to provide a more adequate scope of protection and promote everyone's effective enjoyment of this right.

Efforts to reconcile jurisprudences

The European Committee has greatly mitigated the conflicts arising between the scope of protection of Article 12 ICESCR and that of Article 11 ESC, through its jurisprudence on migrants' health. This was discussed in depth in Chapter 4. In *International Federation of Human Rights Leagues v. France*, it recognised that irregular migrants had the right to minimal medical assistance, and that their children had the right to access healthcare on a similar basis as the rest of the population.⁸⁷⁵ It grounded this decision on the principle of good faith, set in the Vienna Convention on the Law of Treaties,⁸⁷⁶ by declaring that the ESC was based on the values of dignity, autonomy, equality and solidarity; and that '*health care [wa]s a prerequisite for the preservation of human dignity*'.⁸⁷⁷ In *Médecins du Monde International v France*,⁸⁷⁸ and in its 2013 Conclusions on Spain,⁸⁷⁹ the European Committee further extended the scope of protection of Article 11. It recognised that adult migrants, whether in regular or irregular situation, had the right to access adequate healthcare

⁸⁷⁵ *International Federation of Human Rights Leagues v. France* (ECSR) (n 600).

⁸⁷⁶ VCLT (n 602), Art 31(1).

⁸⁷⁷ *International Federation of Human Rights Leagues v. France* (ECSR) (n 600) [26 to 32].

⁸⁷⁸ *Médecins du Monde v France* (n 399).

⁸⁷⁹ ECSR, 'Conclusions XX-2 (2013)', Spain pp. 12-14.

and that this was not limited to emergency services. As a result, Article 11 ESC (the right to protection of health) and Article 13 ESC (the right to medical assistance) now apply to irregular migrants.⁸⁸⁰

Contrarily to the European Committee, it is unclear whether the African Commission interprets the right to health as entitling non-nationals to access healthcare on the same basis as nationals. None of the five Merits Decisions involving Article 16 of the African Charter concerns issues of migrants' access to healthcare. Moreover, no research has been carried out with regard to the protection of non-nationals by the African Charter, except in the context of mass expulsions.⁸⁸¹ However, two Merits Decisions on Article 16 recognise the right to health as that of the '*citizens*' of the state, although presumably to describe the litigants' status.⁸⁸² Such formulation is more restrictive than the text of Article 16, which requires that States parties protect the health of their '*people*', not their '*citizens*'.⁸⁸³ These decisions do not necessarily mean that the African Commission wishes to exclude non-nationals from the scope of protection of the right to health. In *Institute for Human Rights and Development in Africa v Angola*, the latter held that the absence of medical attention to migrants in detention camps constituted a cruel, inhuman and degrading treatment.⁸⁸⁴ Nevertheless, nothing was said regarding their right to health. It is therefore desirable that the African Commission clarifies the scope of the right to health in its jurisprudence by expanding it to non-nationals, similarly to the European Committee.

Finally, at the international level, the UN Committee has clearly interpreted the scope of protection of Article 12 ICESCR as being universal, subsequently

⁸⁸⁰ ESC 1961 (n 92), Art 13(1) and (4); ESC 1996 (n 92), Art 13(1) and (4).

⁸⁸¹ Prohibited by the African Charter (n 92), Art 12(5). See Gina Bekker, 'Mass Expulsion of Foreign Nationals: A Special Violation of Human Rights - Communication 292/2004 Institute for Human Rights and Development in Africa v. Republic of Angola' (2009) 9 African Human Rights Law Journal 262.

⁸⁸² Egyptian Initiative for Personal Rights and INTERIGHTS v Egypt (African Commission) (n 845) [258 and 264]; Social and Economic Rights Action Center and Center for Economic and Social Rights v Nigeria (African Commission) (n 842) [52].

⁸⁸³ African Charter (n 92), Art 16.

⁸⁸⁴ *Institute for Human Rights and Development in Africa (on behalf of Esmaila Connateh & 13 others) v Angola* [2008] Communication No. 292/04, Decision on the Merits (African Commission on Human and Peoples' Rights) [51 and 87].

disregarding Article 2(3) ICESCR and Article 28 ICMW. In fact, the UN Committee frequently highlights health discrimination committed against non-nationals in its reporting procedure, may they be migrants in regular situation, undocumented migrants, asylum-seekers, refugees, or stateless persons. Out of the sixty Concluding Observations examined, it reviewed their situation fifteen times under Article 12 ICESCR. However, since the UN Committee does not use any thematic indicators and has no methodology in its reporting procedure, it does not systematically review non-nationals' access to health.

6.1.2.2 Resolving conflict of norms

Conflicts of norms regarding the scope of protection of the right to health can arise between regional and international instruments (i.e. between the UN and the European or African systems), or within the same framework (i.e. the UN). However, as discussed in Chapter 4 or as declared by the European and the UN Committees, denying non-nationals their right to health violates human rights law. Therefore, it is important to study which principles of interpretation SNHRBs should apply to ensure their interpretation conform to the universal scope of the right to health.

Two customary principles of international law are commonly applied to resolve conflict of norms at a supranational level: *lex specialis* and *lex posterior*. In the first instance, if a conflict of norms opposes a general provision and a specific provision, the specific provision prevails (*lex specialis*).⁸⁸⁵ As a result, a regional provision specifying the scope of the right to health (i.e. Article 11 ESC or Article 16 African Charter) should prevail over an international provision not specifying its scope (Article 12 ICESCR). In the second instance, if a conflict of norms opposes two provisions within the same framework, the most recent provision prevails (*lex posterior*).⁸⁸⁶ As a result, recent right to health provisions in the UN (Article 28 ICMW, adopted in 1990) should prevail over older ones (Article 12 ICESCR, adopted in 1966). However, the ESC, the African Charter and the ICMW, which

⁸⁸⁵ *Ambatielos case (jurisdiction)* (ICJ) (n 854), Dissenting Opinion of Judge Hsu Mo p 88; ILC, 'Draft Articles on Responsibility of States with Commentaries' (n 854), Art 55.

⁸⁸⁶ VCLT (n 602), Art 30; derived from UN Charter (n 25), Art 103.

these principles give prevalence to, fail to protect non-nationals' right to health, contrarily to the ICESCR. Therefore, the principles *lex specialis* and *lex posterior* are inadequate to address conflict of norms arising from the fragmentation of international human rights law, since they can reduce its scope of protection and thus impact negatively on individuals' enjoyment of their right to health.⁸⁸⁷ Moreover, they do not address instances where two provisions clash within the same instrument, i.e. Art 2(3) and Art 12 ICESCR.

When a conflict of norms arises between various right to health provisions, and the application of the principles *lex specialis* or *lex posterior* narrows the scope of protection of the right to health, two alternatives should be considered. These alternatives are suggested by the 2006 Fragmentation Report of the International Law Commission,⁸⁸⁸ and reflect the doctrine of external system coherence studied in subsection 6.1.1.2.

The first alternative requires that the general law rules out the special law, or that the old law rules out the recent law, if '*third party beneficiaries may be negatively affected*' by *lex specialis* or *lex posterior*.⁸⁸⁹ In the European and the African frameworks, irregular migrants are clearly affected by the special law (the ESC and the African Charter), since it does not protect them. Therefore, the general law (the ICESCR) should rule it out. Furthermore in the UN framework, regular migrants are clearly affected by the recent law (the ICMW), since it restricts their right to health. As a result, the older law (the ICESCR) should prevail.

The second alternative offered by this report, which also provides a rationale to the first, is to preclude the application of the special law or the recent law if it '*might*

⁸⁸⁷ Anja Lindroos, 'Addressing Norm Conflicts in a Fragmented Legal System: The Doctrine of Lex Specialis' (2005) 74 Nordic Journal of International Law 27: in this article, the author shows that the *lex specialis* principle is not suitable for all conflict of norms, due to the fragmentation of the international legal system.

⁸⁸⁸ Study Group of the ILC, 'Fragmentation Report (long version)' (n 849); Study Group of the International Law Commission, 'Fragmentation of International Law: Difficulties Arising from the Diversification and Expansion of International Law (short version)' (2006) UN Doc. A/CN.4/L.702.

⁸⁸⁹ Study Group of the ILC, 'Fragmentation Report (short version)' (n 888), conclusions 10 and 27 (para 14).

frustrate the purpose of the general law'.⁸⁹⁰ Since human rights law aims at protecting individuals based on their inherent quality of human beings,⁸⁹¹ human rights are universal *per se*. Individuals' migration status should thus not interfere with the exercise of their right to health in theory.

This thesis suggests that SNHRBs use the alternatives proposed by the Fragmentation Report if a conflict of norms arises and that the subsequent application of the *lex specialis* or *lex posterior* principles restricts the scope of protection of the right to health. Finally, for cases that neither alternative addresses, the International Law Commission is of the general view that '*[i]n regard to conflicts between human rights norms, [...] the one that is more favourable to the protected interest is usually held overriding*'.⁸⁹² Therefore, this would give precedence to Article 12 ICESCR over Article 2(3) ICESCR.

To conclude, the scope of protection of the right to health is defined differently across human rights instruments, although various SNHRBs have attempted to reconcile those divergences in their monitoring procedures. Nevertheless, to prevent the adverse effects of fragmentation on the coherence of this right, SNHRBs should resolve those conflicts of norms by using the alternatives offered in the Fragmentation Report. This, nonetheless, is not to say that the legal content of the right to health should be crystallised. On the contrary, in the light of the diverse quasi-judicial avenues through which the right to health can be monitored, SNHRBs must ensure that they adapt their review of states' obligations to the context in which they are set, to ensure coherence between theory and practice.

⁸⁹⁰ *ibid*, conclusions 10 and 27 (para 14); See also Study Group of the ILC, 'Fragmentation Report (long version)' (n 849), part C, section 5 on regionalism.

⁸⁹¹ E.g. UDHR (n 3), Preamble: 'recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family'.

⁸⁹² Study Group of the ILC, 'Fragmentation Report (long version)' (n 849), para 108.

6.2 Diversity of quasi-judicial monitoring avenues and adapting the review of states' obligations to practical realities

As discussed in Chapter 5, to interpret the obligation to progressively realise the right to health adequately, SNHRBs must carry out particular monitoring, reach specific findings of non-conformity, and apply a reasonableness test. However, the diversity of quasi-judicial avenues through which the right to health can be monitored and that of states monitored, increase the likelihood for different interpretations to be developed (and subsequently, for different expectations to be set). In the light of such diverse reviews, it is essential SNHRBs promote an effective enjoyment of the right to health worldwide, while being able to adapt their approach to the practical realities of their monitoring. Such flexibility is fundamental to transcend the substance of the right to health into practical standards for SNHRBs, and reasonable expectations for states. Subsection 6.2.1 will thus contend that SNHRBs should balance the individual and collective dimensions of the right to health differently, depending on the procedure at stake (i.e. reporting or complaint procedure). Subsection 6.2.2 will then argue that SNHRBs should adapt their compliance approach to the level of monitoring they represent (i.e. regional or international).

6.2.1 Adapting the dimension of the right to health to the monitoring procedure

SNHRBs monitor the realisation of the right to health through various procedures, outlined in subsection 1.1.3.2. It has however become apparent in this thesis that the dimension of the right to health changes according to the procedure used to review it. Reporting procedures inevitably embrace a more collective dimension, focusing on population's health; while complaint procedures inevitably embrace a more individual dimension, focusing on petitioners' health. It is nevertheless important that SNHRBs balance the two dimensions adequately in each procedure, as neglecting one dimension can adversely impact the coherence of the right to health. Such a statement acknowledges criticisms formulated against the programmatic aspect of this right,⁸⁹³ or against the misuse of resources in litigation (e.g. in

⁸⁹³ Dennis and Stewart (n 11).

Brazil).⁸⁹⁴ Subsection 6.2.1.1 thus argues that while reporting procedures primarily measure states' compliance with their obligations, SNHRBs must also measure individuals' enjoyment of their right to health. Subsection 6.2.1.2 then argues that while complaint procedures primarily focus on petitioners, SNHRBs must also consider broader public health interests, especially in the context of healthcare prioritisation.

6.2.1.1 Reporting procedures: focus on duty-bearers of the right to health

Reporting procedures require that states periodically report to SNHRBs on the implementation of the right to health (e.g. every 5 years for the ICESCR; every 4 years for the ESC). To review the overall realisation of this right within each country, SNHRBs use states' reports as well as other sources (e.g. NGOs' shadow reports) before formulating comments, recommendations or sometimes, holding findings of non-conformity. However, due to the collective dimension of this process focusing on populations' health, SNHRBs can fail to recognise the notion of victim. The research carried out in previous Chapters highlights the difficulty for both the UN and the European Committees to define right-holders precisely when interpreting the right to health in reporting procedures. Various factors contribute to this situation. Firstly, reporting procedures do not involve petitioners and do not provide remedies. In certain cases, SNHRBs do not even reach findings of non-conformity (e.g. UN Committee, African Commission). As a result, the notion of victim becomes diluted when breaches of the right to health arise. Secondly, the data states must submit under right to health provisions and the indicators SNHRBs use, if any, focus on population's health overall. For instance, the European and the UN Committees often assess life expectancies or maternal mortality rates. Such review, however, can translate human rights monitoring into summaries of countries' general levels of development if not combined with access and availability issues, as those highlight more explicitly violations of individuals' right to health. Thirdly, the involvement of civil society, and more particularly NGOs representing individuals' health rights, can be limited in reporting procedures. For example, neither the European Committee nor the UN Committee receive a high number of NGOs'

⁸⁹⁴ Octavio Luiz Motta Ferraz, 'The Right to Health in the Courts of Brazil: Worsening Health Inequities' (2009) 11 Health and Human Rights 33; Ferraz 2010 (n 18).

shadow reports regarding health issues. Therefore, violations of the right to health might be left unmonitored.

While it is the nature of reporting procedures to focus on states' compliance with their obligations rather than to provide victims with remedies, their purpose remains to identify violations of the right to health. Identifying violations, however, necessarily involves identifying victims. In order for the notion of victim to avoid being excessively diluted through reporting procedures, this thesis recommends that SNHRBs design indicators by using a human rights-based approach to health.⁸⁹⁵ As demonstrated in previous chapters, general indicators are acceptable as long as accessibility or availability indicators are used in parallel, to highlight potential impediment of individuals' right to health. For instance, it is insufficient to review maternal mortality rate, SNHRBs must also evaluate whether maternal care exists and whether it is affordable. This thesis also recommends a greater involvement of the civil society in the reporting process. This entails: for SNHRBs, to raise awareness about their procedures amongst NGOs; and for states, to respect and work alongside local and international NGOs. Finally, while this procedure is not a forum where remedies can be provided, stronger enforcement mechanisms should be set up to bring to life the substance given to this right in the course of quasi-judicial monitoring procedures.

6.2.1.2 Complaint procedures: conflict between the collective and the individual dimensions of the right to health

Complaint procedures enable individuals (or NGOs representing their interests) to bring complaints before SNHRBs if they believe the state has breached their right to health. SNHRBs review facts and laws relevant to the situation denounced in the complaint and invite states to respond. They then reach a decision by holding a finding of conformity or non-conformity and, sometimes, provide recommendations to the state and remedies to the victims. Therefore, due to the individual dimension of this process focusing on petitioners' health, complaint procedures recognise the notion of victim more clearly than reporting procedures. While the UN Committee has not reviewed any communication involving Article 12 ICESCR yet, the research

⁸⁹⁵ Welling (n 204); Hunt and McNaughton (n 226).

carried out in Chapter 3 on the European Committee confirms a better identification of victims when interpreting the right to health through the complaint procedure.

However, litigation initiated by individuals can fail to integrate the collective component of the right to health and can subsequently impede access to healthcare for the rest of the population. Ferraz and Wang highlight two pitfalls in particular, when discussing right to health litigation before Brazilian courts. Firstly, petitioners in right to health litigation tend to have a level of education and wealth enabling them to access judicial procedures. As a result, requesting that states provide remedies to such petitioners while basic healthcare remains unavailable for poorer sections of the population can increase health inequalities. Secondly, petitioners in right to health litigation can sometimes ask for expensive treatments benefiting a minority of patients. Therefore, ordering states to provide such treatments for free can take away resources for inexpensive treatments benefiting the majority.⁸⁹⁶

Such pitfalls have been nuanced by authors such as Yamin, Gloppen, Gauri and Brinks, who highlight in detail the positive contributions that right to health litigation can represent for individuals in their edited collections.⁸⁹⁷ However, it is important that SNHRBs avoid reproducing the issues highlighted by Ferraz and Wang at the international or regional level when interpreting the right to health, as the latter protects *everyone's* right to the highest standard of health attainable. First, by guaranteeing that their procedures are accessible to everyone (e.g. publication of clear online guidelines, links to NGOs providing legal support etc.). Second, by reviewing health prioritisation matters through a reasonableness test focusing primarily on the decision-making process, based on resource availability within states, and taking into account vulnerable groups to health discrimination. Following the example of Brazil, this can involve public hearings with relevant experts to establish criteria under which states must fund certain treatments (e.g. effectiveness, safety, necessity, costs).⁸⁹⁸ Issues of compliance remain nonetheless. Once SNHRBs

⁸⁹⁶ Ferraz 2010 (n 18); Wang and Ferraz (n 18); Wang (n 443) 77–78 (the case referred to is: Brazilian Federal Supreme Court, AgRg No. RE 271286).

⁸⁹⁷ Yamin and Gloppen (n 133); Gauri and Brinks (n 18).

⁸⁹⁸ Wang (n 443) 81–90.

reach a decision, follow-ups are neither well documented nor subject to an enforcement mechanism, affecting the strength of their complaint procedures.⁸⁹⁹

To conclude, SNHRBs must preserve some degree of flexibility when monitoring the right to health, in order to adapt its content to practical realities such as the limits of their procedures, and optimise their interpretation. Reporting procedures inevitably focus on the individual dimension of this right while complaint procedures inevitably focus on its collective dimension. However, SNHRBs must strike a right balance between both dimensions to preserve the coherence of what this right intends to protect. Such flexibility should nonetheless also consider the coherence of this right with practical realities such as the context in which its review takes place, affecting SNHRBs' compliance approach to states' obligations.

6.2.2 Adapting the compliance approach to the level of monitoring of the right to health

SNHRBs monitor the realisation of the right to health at different levels: international and regional. It has however become clear in this thesis that the approach adopted by SNHRBs varies according to the level of monitoring they operate at. International bodies such as the UN Committee are drawn towards a more lenient approach to states' compliance than regional bodies such as the European Committee, which may develop a stricter approach. It is nonetheless essential to discuss the reasons for such differentiation as well as its consequences, since these can affect either adversely or positively the interpretation of the right to health. Section 6.2.2.1 will thus explore what approach to compliance may be adopted by international bodies, while section 6.2.2.2 will explore what approach may be adopted by regional bodies.

⁸⁹⁹ See Frans Viljoen and Lirette Louw, 'State Compliance with the Recommendations of the African Commission on Human and Peoples' Rights, 1994-2004' (2007) 101 *American Journal of International Law* 1, 24.

6.2.2.1 Compliance at the international level

A weak approach to compliance

When it reviews states' obligations to realise the right to health, the UN Committee rarely uses legal terminology such as 'obligation', 'violation' or 'compensation'.⁹⁰⁰ Instead, it expresses concern over issues relevant to Article 12 ICESCR, and formulates recommendations to remedy the situation. Chapter 2 demonstrates that the UN Committee refuses to endorse a judicial function, and the interviews conducted with four of its members highlight the desire to preserve a constructive dialogue with States parties to the Covenant. Such weak approach to states' compliance, nonetheless, impedes the development of a jurisprudence on the right to health and subsequently prevents delineating its legal content with precision.

But all is not lost. Considering the practical realities to which the UN Committee is confronted, prioritising a constructive dialogue with states can be a heuristic approach to states' compliance in international monitoring procedures, for two reasons. First, the diversity of States parties to the ICESCR does not favour a strict approach to compliance. 164 states have ratified the Covenant, among which many of the worst human rights offenders and many of the poorest worldwide. It would be unfair and pointless to evaluate the realisation of the right to health in Eritrea on the same basis as in France, considering their GDP per capita is, respectively, \$540 and \$42,560.⁹⁰¹ Second, the absence of an enforcement mechanism within the UN framework (frequent in ESCR monitoring, as observed in subsection 1.1.3.2) does not allow for a strict approach to compliance. What is the use of holding a state in violation of the right to health, if the state is under no obligation to take measures to redress the situation?

⁹⁰⁰ Whilst the word 'obligation' is sometimes used, little terminology reflects the intention to seek legal compliance. It is interesting to note that all four members of the UN Committee whom I interviewed believed they were using a legal terminology.

⁹⁰¹ World Bank, 'GDP per Capita' (n 784) (see figures of the year 2013); World Bank, 'Health Expenditure' (n 174) (their health expenditure varied between 3% and 11.7% of their GDP that same year).

I suggest throughout Chapters 4 and 5 that SNHRBs adopt what this Chapter will call a *flexible legal approach* to monitor the realisation of the right to health. This approach enables SNHRBs such as the UN Committee to assess whether the health needs of the population have been evaluated, and whether the maximum level of available resources has been used to guarantee them, depending on the state under review. Such interpretation enables an ad hoc and flexible approach to states' compliance, particularly valuable for international bodies such as the UN Committee, who faces a greater diversity of abilities or desires to cooperate amongst states. However, a flexible *legal* approach also requires that the UN Committee reach findings of non-conformity when states fail to perform adequately. Clarifying what can or cannot justify the non-fulfilment of right to health standards is essential to interpret and monitor it as a legal right. Furthermore, as demonstrated by Chapters 4 and 5, the obligation to progressively guarantee adequate health systems can be applied to all states, regardless of their levels of income. For instance, it is possible for states with very low income to comply with the right to health, as long as they demonstrate sufficient efforts to obtain international support and an appropriate use of such support. Therefore, the main issue does not lie in the theoretical framework itself. It lies instead in the practical aspect of identifying the health needs of the population, reviewing the obligation to progressively realise the right to health, and being confronted to states in which the realisation of the right proves to be difficult.

Theoretical framework and practical considerations

In practice, states with low or very low income are more likely to lack the resources needed to develop strong governance structures.⁹⁰² As a result, they are more prone to be affected by corruption issues, and less so to identify adequately the health needs of their populations or to fund appropriately the health sector.⁹⁰³ This, nonetheless, potentially represents a failure to fulfil the obligation to progressively guarantee adequate health systems. Therefore, SNHRBs may find my theoretical

⁹⁰² C Raj Kumar, 'Corruption, Human Rights, and Development: Sovereignty and State Capacity to Promote Good Governance' (2005) 99 Proceedings of the Annual Meeting (American Society of International Law) 416.

⁹⁰³ The literature on health, human rights and governance is dense, see for instance the arguments laid out by Friedman and Gostin 'Pillars for progress on the right to health', in Zuniga, Marks and Gostin (n 131).

framework unhelpful on two aspects, when reviewing the realisation of the right to health in such states.

Firstly, it may be difficult for SNHRBs to evaluate health needs and resource availability in states with very low income and/or affected by corruption. Such exercises require that accurate data be collected, necessitating resources and transparency from state agencies. However, both resources and transparency tend to be adversely affected by corruption. Furthermore, whilst I argue that the UN Committee should use data collected by UN agencies, states may be unwilling to cooperate, and time or money constraints within the UN may be insufficient.

Secondly, the benefits of reaching findings of non-conformity against states with very low income and/or affected by corruption can be limited for SNHRBs. It takes time for states to build governance structure and to thus eventually comply with the right to health. Systematically holding a state in breach of its obligations does not ensure better governance or better compliance with human rights law. This is especially relevant considering the absence of enforcement mechanism within the UN Committee. Therefore, prioritising a constructive dialogue may be preferable to endorsing a judicial role. It enables the UN Committee to explore the sources of the problem, by providing states with the technical support necessary to combat corruption and increase health expenditure. Nevertheless, to justify the absence of a legal approach to states' compliance, constructive dialogue and technical support on health matters must be appropriate.

This thesis does not pretend to assess the adequacy of the UN technical support in health, as this would necessitate expertise in public health, health economics, medicine, etc. However, it argues that the dialogue established between the UN Committee and key actors is insufficient to monitor and, subsequently, interpret adequately the right to health. Constructive dialogue demands an appropriate degree of communication between the UN Committee, relevant UN agencies or treaty bodies, state authorities, civil society, and National Human Rights Institutions (NHRIs). Whilst the interviews conducted with UN Committee members highlight positive interactions with key actors, they also highlight deficiencies. Three points should thus be made, highlighting the failure of the UN Committee to develop a

constructive dialogue that offsets the absence of legal approach, and that generates monitoring tools facilitating an adequate interpretation of the right to health.

First, the UN Committee should review the implementation of the right to health more holistically, by collaborating with relevant UN agencies and UN treaty bodies who have the expertise required.⁹⁰⁴ This would contribute to promoting an effective enjoyment of the right to health. For instance, when assessing children's health, the UN Committee should use the expertise of WHO, UNICEF, and the Committee on the Rights of the Child. The interviews I conducted highlight a regular dialogue between UN institutions, mainly orchestrated by the Office of the High Commissioner for Human Rights. However, interviewees also reported a lack of coordination and coherence with other treaty bodies, as well as time constraints playing against it since members work on a voluntary basis. Moreover, according to one interviewee, WHO is rarely involved in the reporting procedure, although it is involved in drafting General Comments. UN agencies and treaty bodies cannot be omnipresent, considering the time and financial constraints weighing on the UN. A minimum degree of collaboration, nonetheless, is fundamental to enable SNHRBs to optimise their interpretation of the right to health, especially at the international level. Consultation with agencies such as WHO or UNDP; and collaboration with other treaty bodies, are necessary to drafting reporting guidelines, designing thematic health indicators, and identifying health priorities, on which the interpretation of the UN Committee inevitably builds upon. This requires time to be set aside for periodic meetings; shared databases classifying general human rights-related information per country to be created; etc.⁹⁰⁵

Second, interactions between the UN Committee and states' authorities are indispensable to understand the health issues specific to the country under review

⁹⁰⁴ It is worth noting that internal collaborations are also explicitly encouraged in the Inter-American system. Protocol of San Salvador (n 92), Art 19(4): '*The specialized organizations of the inter-American system may submit reports to the Inter-American Economic and Social Council and the Inter-American Council for Education, Science and Culture relative to compliance with the provisions of the present Protocol in their fields of activity*'.

⁹⁰⁵ See early recommendations in the seminal article: Anne F Bayefsky, 'The UN Human Rights Treaties: Facing the Implementation Crisis' (1996) 15 Windsor Yearbook of Access to Justice 189, 251–255.

and the measures taken to address them. This enables realistic expectations to be set, and context-sensitivity to be considered in the implementation of the right to health. States' representatives are systematically invited to present their reports and to answer questions asked by members of the UN Committee,⁹⁰⁶ as recorded in the summary records of each session.⁹⁰⁷ Interviews confirmed the regularity of such interactions during the reporting procedure (i.e. through reports, lists of issues, replies, dialogue). However, they also highlighted that constructive dialogue could only occur if states' delegations attended sessions, as the UN Committee does not rely on simple statements. This is not always the case. Furthermore, since such meetings are systematically held in Geneva, it may privilege states with a certain level of income and a certain geographic proximity.

Third, contributions from civil society and NHRIs are fundamental to develop an adequate monitoring and thus, interpretation of the right to health. As pointed by Gallagher, they can draw attention to violations of the right to health states may attempt to hide, and help translating universal principles into measures that are context sensitive, thanks to their work on the ground.⁹⁰⁸ However, their contributions can be mixed. The members of the UN Committee whom I interviewed recognised unanimously the importance of NGOs' participation in the reporting procedure; but highlighted two problems. Firstly, the level of dialogue with NGOs tends to be irregular, considering they may find it difficult to travel to Geneva for geographic or financial reasons. Interviewees reported that the UN Committee often dealt with the same NGOs, primarily (but not exhaustively) those based in Geneva. Reporting procedures should thus accommodate a more representative portion of civil society to monitor the right to health adequately (e.g. introducing video conferences).⁹⁰⁹

⁹⁰⁶ UNCESCR, 'Rules of Procedure 1993' (n 98), rule 62.

⁹⁰⁷ E.g. UNCESCR, 'Summary Record of the 32nd Meeting: Consideration of Reports Submitted by the United Republic of Tanzania' (2013) UN Doc E/C.12/2012/SR.32, see paras 11 to 31 recounting the discussions held between UN Committee members and state representatives on Articles 10 to 12.

⁹⁰⁸ Gallagher, 'Making Human Rights Treaty Obligations a Reality: Working with New Actors and Partners', in Alston and Crawford (n 144).

⁹⁰⁹ OHCHR, 'Annual Report' (2013), p 98 <http://www2.ohchr.org/english/OHCHRReport2013/WEB_version/allegati/downloads/1_The_whole_Report_2013.pdf> [accessed 8 September 2015].

Secondly, the other problem interviewees pointed at was the potential subjectivity of NGOs' shadow reports. The issues brought to light, ignored, or the angle they are presented in, can vary according to the quality of the research, the agenda of the organisation, the funding received, etc. Therefore, it is essential the UN Committee maintain a high degree of impartiality when dealing with NGOs. This is also true regarding NHRIs, although interactions remain insufficient in supranational monitoring.⁹¹⁰ Some interviewees stressed that despite the Paris Principles,⁹¹¹ NHRIs were not always independent,⁹¹² and were subsequently viewed as states' agencies. However, their contributions to optimising the interpretation of the UN Committee should not be underestimated. They can facilitate communication between the UN Committee and states' representatives, and can assist in states in reporting on the adequacy of their health systems.

To conclude, one can be sympathetic of the time and financial constraints weighing on UN treaty bodies such as the UN Committee, but the promise of a constructive dialogue does not effectively offset the absence of a legal approach in its reporting procedure. In order for such dialogue to encourage a coherent monitoring and interpretation of what the right to health entails, key actors must be actively involved. This is not always the case. The complaint procedure may, in the future, enable the UN Committee to adopt a flexible legal approach while maintaining the dialogue facilitated by the reporting procedure. This remains to be seen.

⁹¹⁰ See Gallagher (n 908).

⁹¹¹ UNGA, 'Principles Relating to the Status of National Institutions' (1993) UN Doc. A/RES/48/134, Annex.

⁹¹² See discussions on the degree of political pressure put on these institutions and the difference between independence de jure and de facto (e.g. through appointment procedures or resources allocation) in Colm O'Cinneide and Neil Crowther, 'Bridging the Divide? Integrating the Functions of National Equality Bodies and National Human Rights Institutions in the European Union' (Nuffield Foundation 2013), pp. 50–53 <<http://www.edf.org.uk/blog/?p=29767>> [accessed 8 September 2015].

6.2.2.2 Compliance at the regional level

A strong approach to compliance

SNHRBs have a greater ability to adopt a strong approach to compliance when reviewing states' obligations to realise the right to health at a regional level, for various reasons adequately summarised by Sarkin.

Consensus is easier to achieve because regions are often relatively homogenous. As far as their processes are concerned, regional systems for many reasons are more accessible, cheaper for litigants, and more effective in the work they do than international courts. They are more likely to achieve greater enforceability of their decisions partly because of the political will, at least in some regions, to do so by the regional system itself.⁹¹³

As recognised by Helfer and Slaughter, the cultural and political homogeneity is stronger in regional monitoring than it is in international monitoring, thus facilitating the definition (and enforcement) of shared objectives.⁹¹⁴ However, similar questions arise: how can right to health standards be coherently defined and interpreted when applying to states with different levels of income, political regimes and cultural perceptions of health?

As studied in Chapter 3, the European Committee interprets precisely the right to health thanks to tools promoting an adequate compliance approach: thematic indicators, averages (although this is debatable), and findings of non-conformity. The European Committee systematically uses the same eighteen indicators in its reporting procedure, i.e. in each reporting cycle and for each State party. Such repetition has assisted the formulation of precise standards (now used in both reporting and complaint procedures), resulting in the adoption of a violation approach. Thematic indicators also enable a rigorous follow-up of states' obligation to progressively

⁹¹³ Jeremy Sarkin, 'The Role of Regional Systems in Enforcing State Human Rights Compliance: Evaluating the African Commission on Human and People's Rights and the New African Court of Justice and Human Rights with Comparative Lessons from the Council of Europe and the Organization of American States' (2008) 1 *Inter-American and European Human Rights Journal* 199, 209–210.

⁹¹⁴ Laurence R Helfer and Anne-Marie Slaughter, 'Toward a Theory of Effective Supranational Adjudication' (1997) 107 *Yale Law Journal* 273, 335–336.

guarantee adequate health systems. The European Committee rarely fails to monitor problematic health issues from one reporting cycle to the next. Furthermore, when a state repeatedly fails to provide the information required, the European Committee frequently defers its decision and reaches a finding of non-conformity if it persists. Findings of non-conformity are also facilitated by the use of European averages, which are used to identify and analyse the worst performances in Europe rather than to simply point at states falling below the average. Moreover, the European Committee sometimes uses averages according to the level of income of the states assessed, to compare progress in healthcare and request they achieve the highest standard possible. These tools, therefore, do not set definite standards. Instead, they focus on states' compliance with their obligations to progressively guarantee adequate health systems and to report on such progress.

Similar obligations exist in the Inter-American, the African (and the Arab) systems. However, their SNHRBs have adopted a weak approach to states' compliance (if any) and, subsequently, have developed weak jurisprudences on the right to health. This is not necessarily justified considering the relative homogenous context in which states' obligations are to be reviewed. Therefore, these bodies may wish to adopt similar tools than those used by the European Committee, in order to achieve further coherence and conceptual clarity when interpreting the right to health. However, certain conditions must be met.

Theoretical framework and exporting monitoring tools

Firstly, this thesis recommends that regional bodies use thematic health indicators corresponding to areas in which states must demonstrate appropriate performances. The indicators used by the European Committee are sufficiently general to be exported to other regional systems of human rights protection, although perhaps restricted to reporting procedures. Chapter 3, however, highlights two themes missing: SRH and mental health. The need to access contraception, abortion, counselling or psychiatric services is universal and should thus be monitored in every

region (including Europe).⁹¹⁵ Saying that mental health, SRH, or other types of healthcare are universal, nevertheless, does not mean that needs for such services are the same everywhere, as discussed in Chapter 4. For instance, the numbers of unsafe abortions registered in Africa and Asia are considerably higher than in Europe or North America.⁹¹⁶ The measures needed to redress the SRH situation in these regions are thus greater. However, as mentioned in Chapter 5, thematic indicators aim at avoiding listing measures states ought to take to comply with the right to health. Such box-ticking exercise freezes its legal content and falls beyond the scope of my thesis. Instead, thematic indicators point towards areas in which states must take adequate measures, according to the health needs of their populations and their available resources. Therefore, thematic health indicators are mainly beneficial on two accounts. First, they give substantive meaning to the procedural obligation to report. By forcing states to collect data on specific aspects of their health systems, SNHRBs enable them to identify the health needs of their populations, as discussed in Chapters 3 and 4. Second, they give life to the obligation to progressively realise the right to health. By setting benchmarks against which progress should be evaluated, SNHRBs engage coherently with the content of the right, as discussed in Chapter 5.

Secondly, this thesis recommends that regional bodies use (sub)regional averages as a heuristic tool, provided these apply to states with comparable resources and do not result in a non-derogable core approach, which Chapter 5 considered inappropriate. As shown in Chapter 3, the use of regional averages enables the European Committee to enforce states' obligation to progressively realise the right to health. However, it is unsure whether this monitoring tool would be as beneficial in other regions. The first reason why averages may not be beneficial in non-European regions is because they tend to reflect a minimum core approach. In Chapter 5, I challenged this approach on the ground that what constitutes minimum levels of

⁹¹⁵ E.g. WHO Regional Office for Europe, 'Policies and Practices for Mental Health in Europe: Meeting the Challenges' (2008), p 1 <<http://www.euro.who.int/en/health-topics/noncommunicable-diseases/mental-health/publications/2008/policies-and-practices-for-mental-health-in-europe.-meeting-the-challenges>> [accessed 8 September 2015]. This document highlights that in Europe, suicide rates are high and neuropsychiatric disorders rank as the first cause of years lived with disability.

⁹¹⁶ WHO, 'Unsafe Abortion' (n 534), p 19 (table 5).

health worldwide cannot be determined, and their non-derogable aspect disregards force majeure events. This is especially relevant for non-European countries, which are more likely to be confronted to general shortages of resources and thus entail a reasonableness test instead. The second reason why regional averages may not be beneficial in regions outside Europe is because greater differences exist among States parties to the Organisation of American States or the African Union, than among States parties to the CoE. For example, discrepancies of revenues and health expenditure are much wider in Africa and in the Americas than in Europe, when comparing states with the highest and the lowest figures in each region. The GDP per capita of Azerbaijan is 18% that of France, and its percentage of GDP spent on health is half of France's. However, the GDP per capita of Eritrea is only 8% that of South Africa, and its percentage of GDP spent on health is a third of South Africa's; with similar gaps observed between Bolivia and the United States for instance.⁹¹⁷ Therefore, regional averages may be insufficiently precise for European countries, but even more for African or American countries. The African and the Inter-American Commissions should thus consider using sub-averages for states with comparable income (as well as the European Committee).

Thirdly, this thesis recommends that regional human rights bodies use findings of non-conformity in both reporting and complaint procedures, to strengthen the legal force of the right to health. Findings of non-conformity belong to four main categories, as suggested in Chapters 4 and 5, and are limited by resource availability. First, regional bodies should reach findings of non-conformity when states fail to *identify the health needs* of their populations. Similarly, they should also reach findings of non-conformity when states fail to submit data requested, since collecting data is essential to identifying such needs. Second, regional bodies should hold violations of the right to health when states fail to *address the health needs* of their populations. Such failure can be observed when their health systems are not responsive, context-sensitive, or accessible to everyone. These two suggestions were made in Chapter 4. Third, regional bodies should reach findings of non-conformity when states have *not sufficiently improved* their performance under the right to

⁹¹⁷ World Bank, 'GDP per Capita' (n 784); World Bank, 'Health Expenditure' (n 174) (based on 2013 figures).

health. This can include stagnation or excessively slow progress. Fourth, regional bodies should hold violations of the right to health when states have taken retrogressive measures in its implementation. These should be particularly strictly reviewed. These two suggestions were made in Chapter 5. However, whether such approach will encourage states' compliance and cooperation in implementing the right to health remains uncertain.

To conclude, it is important SNHRBs preserve some flexibility when monitoring the right to health, in order to adapt its content to practical realities such as the context in which they review states' obligations, and thus optimise their interpretation. Whilst the weak approach to compliance developed by the UN Committee could be hypothetically justified by the desire to maintain dialogue with a wide range of states, the constructive dialogue carried out with key actors must be reinforced to offset the absence of a legal approach. Regional bodies, however, represent further potential for consensus and homogeneity, and should thus adopt a stronger approach to compliance, based on the example of the European Committee. However, conceptual clarity and coherence in SNHRBs' interpretation of the right to health can seem pointless if its legal content cannot be brought to life through enforcement.

6.3 Enforcement and SNHRBs' limits in giving life to their own interpretation

SNHRBs do not benefit of sufficient enforcement procedures, particularly when dealing with ESCR. This phenomenon has been widely discussed and acknowledged in legal scholarship.⁹¹⁸ Enforcement, however, is crucial to give life to SNHRBs' interpretation of what the right to health should entail, and to strengthen the legal force of its content through implementation. States can often refuse to redress human rights violations in supranational monitoring, and domestic courts might refuse to apply international human rights law in their proceedings.⁹¹⁹ Several limits to the

⁹¹⁸ Numerous academics have expressed concern in this regard, e.g. Alston and Crawford (n 144); Gauthier de Beco (ed), *Human Rights Monitoring Mechanisms of the Council of Europe* (Routledge 2013).

⁹¹⁹ See for instance *McGeoch (AP) (Appellant) v The Lord President of the Council and another (Respondents) (Scotland)* (2013) UKSC 63 (UK Supreme Court). In this case, the

capacity of SNHRBs in building a substantive meaning of the right to health that is enforceable in practice can be highlighted.

At the international level, two main factors contribute to such a situation. Firstly, the UN Committee has not processed any communications involving the right to health yet, due to the recent entry into force of the Optional Protocol to the ICESCR.⁹²⁰ Furthermore, this complaint procedure does not benefit from any enforcement mechanism. If the UN Committee observes a violation of the right to health, it can only send suggestions to the state. Such suggestions simply require a written response from the state within six months and no mechanism obliges the state to enforce them.⁹²¹ Secondly, the reporting procedure is not particularly satisfactory either. Not only does the UN Committee adopt a weak legal terminology in its Concluding Observations, for the sake of preserving a ‘constructive dialogue’ with states; it also fails to use any methodology guiding its review. Moreover, no procedure guarantees that the recommendations formulated in Concluding Observations will be enforced.⁹²²

At the regional level, similar factors impede SNHRBs’ capacity to give life to the interpretation of the right to health they developed, by ways of enforcement procedures. Two main points should be made. Firstly, complaint procedures do not generate sufficient findings. In theory, the right to health can be adjudicated through complaint procedures in the European and African systems. However, such procedures were either established too recently (1995 in Europe), or only started clarifying the normative content of this right in recent years (2001 in Africa), for SNHRBs to have produced substantive jurisprudence.⁹²³ Furthermore, those

UK Supreme Court considered not applying the jurisprudence of the European Court of Human Rights on prisoners’ right to vote.

⁹²⁰ OP to ICESCR (n 101).

⁹²¹ *ibid*, Art 9: the UN Committee may follow up progress on the implementation of Article 12 through the reporting procedure but the procedure goes in circles since there is no enforcement mechanism for the complaints procedure either.

⁹²² Research shows that Concluding Observations tend to be ignored, here through the example of the Netherlands, New Zealand and Finland: Jasper Krommendijk, ‘The (In)effectiveness of UN Human Rights Treaty Body Recommendations’ (2015) 33 *Netherlands Quarterly of Human Rights* 194.

⁹²³ Ssenyonjo (n 121).

procedures do not benefit from any enforcement mechanisms and as outlined in subsection 1.1.3.2, the Inter-American system does not review communications involving alleged violations of the right to health.⁹²⁴ Secondly, reporting procedures are not always satisfactory. The style of the Concluding Observations of the African Commission being very alike that of the UN Committee's, similar criticisms can be raised (i.e. weak approach to states' compliance). As for the comments of the Inter-American Commission on Human Rights through this procedure, they tend to focus on CPR.⁹²⁵ Finally, none of those three systems benefit from an enforcement mechanism. For instance, when the European Committee finds a state in violation of the right to health in its Conclusions, it has to wait for the Committee of Ministers to consult with the Consultative Assembly and to make 'suggestions' to the state.⁹²⁶ Moreover, nothing guarantees the state will respect these suggestions.

It is also important to note that out of the existing 198 states, only 112 are parties to 'functional' regional systems of human rights protecting the right to health,⁹²⁷ i.e. mainly African, American and European countries. Therefore, 86 states cannot access any adequate regional protection of the right to health, and more than 20 of those are in geographical areas that are not attached to any regional frameworks.⁹²⁸ The latter include states or territories from Southern Asia, Eastern Asia, Central Asia, as well as Oceania.⁹²⁹ Moreover, among the 20 states not governed by any regional framework, many are inhabited by exceptionally high populations (e.g. China, India). As a result, the only supranational definition and safeguard of the right

⁹²⁴ Except through the integrated approach or, more rarely, through Article 26 of the American Convention on Human Rights (n 858).

⁹²⁵ See the reports of the Inter-American Commission on <<http://www.oas.org/en/iachr/reports/country.asp>> [accessed 8 September 2015].

⁹²⁶ ESC 1961 (n 92), Art 29; ESC 1996 (n 92), Art C.

⁹²⁷ ESC: 43 ratifications; Protocol of San Salvador: 16 ratifications; African Charter: 53 ratifications.

⁹²⁸ Forty-four when including small islands, see UN Statistics Division, 'Composition of Macro Geographical (continental) Regions, Geographical Sub-Regions, and Selected Economic and Other Groupings, Revised 31 October 2013' <<https://unstats.un.org/unsd/methods/m49/m49regin.htm>> [accessed 8 September 2015].

⁹²⁹ *ibid.*

to health in these areas derive from a weak UN framework and do not benefit from the double regional-international protection.

Finally, regardless of SNHRBs' interpretation and procedures through which the latter takes place, the right to health is a social right that embraces complex ethical, economic and legal issues. As a result, building its substance is bound to be an extremely difficult exercise, especially since it ought to apply to different states. Expertise is thus required beyond that of SNHRBs to assess parameters such as populations' health needs, cultural environments, or resource availability. These parameters, specific to each state, have been shown in this thesis to be paramount to an adequate interpretation of the right to health. Such interpretation should ensure: an effective enjoyment of the right to health; reasonable expectations upon states to realise it; context sensitivity in its implementation; and overall, principled consistency in its content. Therefore, not only is it essential that the right to health be protected in domestic adjudication, the role of national courts in appreciating specific parameters and in building content is significant. Furthermore, special mechanisms and non-judicial institutions in the field of human rights, such as the Special Rapporteur on the right to health at the UN level; the Commissioner for Human Rights in the CoE; the Working Group on Economic, Social and Cultural Rights in the African Union; or the Unit on Economic, Social and Cultural Rights in the Organisation of American States; can also bring to life SNHRBs' interpretation. Not only can they assist SNHRBs in evaluating the parameters specific to the state under review and thus enable the legal content of the right to health to be adequately delineated, they can also encourage its enforcement amongst reluctant states.

Conclusion

In this Chapter, I outlined how the conceptual framework developed in Chapters 4 and 5 could operate coherently across all SNHRBs, in order to ensure the right to health is interpreted (and later, realised) adequately at both international and regional levels. Therefore, I argued that the normative scope of the right to health should be interpreted harmoniously across all frameworks, but that SNHRBs should retain

sufficient flexibility to review states' obligations adequately in the light of practical realities in monitoring. In Section 6.1, I explored the importance for SNHRBs to harmonise the normative scope of the right to health across different levels of monitoring, in response to the fragmentation of human rights law. I argued that the scope of interests of the right to health was defined in compatible terms in both international and regional systems, but that SNHRBs should use the principle of external system coherence to enhance the comprehensiveness of their interpretation. I then studied the conflict of norms arising from supranational human rights instruments regarding the scope of protection of the right to health for non-nationals. I suggested as a result that SNHRBs use the alternatives highlighted by the Fragmentation Report of the International Law Commission. In Section 6.2, I outlined the importance for SNHRBs to retain a degree of flexibility when monitoring states' obligations to realise the right to health, in the light of practical realities. I thus argued that SNHRBs should adapt their interpretation in two ways. First, they should balance the individual and collective dimensions of the right to health according to the monitoring procedure at stake; and second, they may adapt their approach to states' compliance according to the level of monitoring they represent. Finally, I highlighted the limits of SNHRBs to bring to life their own interpretation through enforcement, and thus highlighted the importance of national adjudication and supranational non-judicial human rights institutions to that effect.

PART II:

CONCLUDING REMARKS

This thesis seeks to clarify the legal content of the right to health through supranational monitoring, in order to attempt remedying its conceptual vagueness. In Part I, this thesis explored how SNHRBs could effectively contribute to clarifying the legal content of the right to health in the course of their quasi-judicial monitoring procedures. In Part II, this thesis studied how SNHRBs' interpretation could be optimised for that purpose.

Based on the methodology and findings of my thesis, and based on the principles of interpretation it advocates, I thus developed a theoretical framework enabling SNHRBs to develop a clear and enhanced interpretation of the right to health. I argue hereupon that the legal content of the right to health should be understood through first, its normative scope and second, the nature of the obligations it creates, while acknowledging key challenges that seeking conceptual clarity through supranational monitoring, represents.

In order for SNHRBs to delineate more precisely the normative scope of the right to health, Chapter 4 recommends they translate the requirement to achieve the highest standard of health attainable into a requirement to set up adequate health systems, which obliges states to identify the health needs of their populations. It also suggests SNHRBs adopt a context-sensitive approach when dealing with cultural issues, and that they protect the right to health of non-nationals. In order for SNHRBs to delineate more precisely states' obligations to realise the right to health, Chapter 5 then recommends they use indicators to monitor the progressive realisation of this right and recognise specific violations when this obligation is not met. Furthermore, it suggests SNHRBs use the reasonableness test instead of minimum core obligations, as these cannot be clearly defined. Finally, Chapter 6 emphasises that attempting to clarify the legal content of the right to health through supranational monitoring represents key challenges. In order for SNHRBs to preserve its principled consistency across different human rights frameworks, it suggests they interpret the normative scope of the right to health harmoniously, while leaving room for practical

realities of monitoring. However, such exercise is limited by the lack of enforcement procedures available to SNHRBs, necessary to bring to life their interpretation.

CONCLUSION

The need to remedy the lack of conceptual clarity surrounding the legal content of the right to health is highlighted by criticisms regularly raised by legal scholars, and confirmed by the excessive vagueness of its substance in human rights law. Such vagueness, nonetheless, can affect key actors in its realisation and hinder its implementation: how can states, SNHRBs and NGOs contribute towards realising a right the meaning of which they are unaware? It is thus fundamental to look for further conceptual clarity. However, legal scholarship has failed to provide or at least agree on a comprehensive framework clarifying what the right to health entails, and has widely ignored the potential of SNHRBs to that effect, as well as the authority of their interpretation.

Therefore, this thesis assesses how SNHRBs can contribute to clarifying the legal content of the right to health in the course of their quasi-judicial monitoring procedures, and how their interpretation can be optimised for that purpose. While these two questions are intertwined to a certain extent, I divided them in two parts for the sake of clarity. Part I examines the potential that SNHRBs represent in furthering conceptual clarity; and Part II suggests how this potential can be maximised. Throughout six chapters, thus, I evaluate how two particular SNHRBs (i.e. the UN and the European Committees) interpret the right to health, and I suggest a theoretical framework aimed at optimising SNHRBs' interpretation during monitoring procedures. My arguments are based on four principles of interpretation, encouraging SNHRBs to seek conceptual clarity while: (1) promoting an effective enjoyment of this right; (2) setting reasonable expectations upon states; (3) offering context sensitivity through its implementation; and overall, (4) guaranteeing principled consistency.

Part I, therefore, provides a critical overview of how the right to health is currently recognised and interpreted in international human rights law, by seeking potential conceptual clarity amongst SNHRBs, through their monitoring of this right

In Chapter 1, I contextualise the recognition of the right to health in international law, since it is essential to understand where this right comes from and what

challenges it currently faces, before arguing how SNHRBs can and should define its legal content. I first discuss the historical relevance of the right to health in international human rights law. I demonstrate that millennia of states' involvement in public health paved the way for the recognition of a right to health in the WHO Constitution (1946) and later, in human rights instruments. However, I then highlight that the right to health is not defined with sufficient conceptual clarity. I argue that excessive vagueness currently surrounds its legal content in human rights law and hinders its realisation as a result; and that legal scholarship has failed to engage thoroughly with its substance, as few authors attempted to clarify it and to explore the potential of SNHRBs in this concern. This Chapter concludes that it is thus necessary to turn towards SNHRBs and assess their contribution to clarifying the right to health, since they represent its most authoritative interpretation and provide an 'adjudicatory' platform through their quasi-judicial monitoring procedures.

In Chapter 2, I explore whether and how the UN Committee on Economic, Social and Cultural Rights clarifies the right to health when interpreting Article 12 ICESCR through its monitoring procedures, for it represents the most authoritative international interpretation of this right. After having briefly described this provision and the procedures through which it can be monitored (so far, limited to the reporting procedure), I argue that the UN Committee does not delineate the normative scope of the right to health precisely. The topics that it reviews tend to be randomly monitored, and while the AAAQ framework could potentially clarify the legal content of the right to health, it fails to do so in practice. I then contend that the UN Committee defines the nature of states' obligations to realise the right to health slightly more clearly. Whilst it does not always explicitly recognise the obligation to progressively realise the right to health and minimum core obligations in its reporting procedure, it follows up states' progress and urges them to fulfil 'immediate' obligations. This Chapter concludes that the lack of methodology characterising the Concluding Observations of the UN Committee weakens its interpretation of the right to health and fails to echo the principles this thesis advocates, but that it leaves a degree of flexibility beneficial for constructive engagement purposes. However it is necessary to examine how the right to health is interpreted at the regional level, to

identify whether international and regional standards are compatible, and to highlight ‘best practice’.

In Chapter 3, I examine the interpretation of the right to health in a region with high levels of income and strong human rights record, and assess whether and how the European Committee of Social Rights clarifies it when monitoring Article 11 ESC. After having briefly described this provision and the procedures used to monitor it (i.e. reporting and complaint procedures), I argue that the European Committee delineates clearly the normative scope of the right to health. The use of thematic indicators enables the European Committee to develop express standards under Article 11, and the use of findings of non-compliance, to draw their boundaries. Furthermore, I contend that the methodology used by the European Committee in its reporting procedure implicitly highlights an obligation for states to collect data and to perform comparably with European averages. Both point towards the adoption of progressive realisation and minimum core approaches. I conclude this Chapter by discussing how the indicators and express standards used by the European Committee, as well as the (sometimes) defective evaluation of Article 11 ESC, affect its interpretation of the right to health. However, the legal content of this right as developed by the European Committee is more precise and substantial than that developed by the UN Committee, and it attempts more successfully to meet the principles this thesis advocates.

Part II, therefore, builds upon the shortcomings identified in Part I, to produce a theoretical framework bringing further conceptual clarity on how the legal content of the right to health should be read in monitoring procedures, in order to optimise SNHRBs’ interpretation.

In Chapter 4, I develop a theoretical account assisting SNHRBs in clarifying what the normative scope of the right to health consists of when monitoring it, based on the principles of interpretation underlying this thesis. For that purpose, I identify three key questions that yet remain unanswered in previous chapters: what is the highest standard of health; does it mean the same regardless of the cultural environment in which it ought to be implemented; and who can benefit from it? Firstly, I outline the unrealistic or incoherent standards defining the ‘highest standard

of health attainable', suggesting that SNHRBs understand the scope of interests of the right to health as a right to an adequate health system instead. I argue that SNHRBs should translate the latter into legal requirements by inviting expertise, by creating an obligation to identify (and address) health needs, and by understanding social determinants of health through the principle of the interdependence of rights. I then use this framework to assess how SNHRBs such as the UN and the European Committees conceptualise health, highlighting the comprehensiveness of one interpretation and the clarity of the other. Secondly, I discuss how SNHRBs ought to interpret the scope of application of the right to health by exploring its interactions with cultural considerations. I demonstrate that on one hand, cultural environments cannot be used to justify a breach of this right, but on the other, they can enhance its implementation. I eventually conclude that the monitoring of the UN Committee accommodates the adoption of such a context-sensitive approach, but not that of the European Committee. Thirdly, I outline that it is unclear in human rights law to what extent non-nationals are entitled to benefit from the right to health, reflecting tensions between universalism and states' sovereignty in its scope of protection. I highlight that restricting migrants' right to health can be a disproportionate measure to control migration flux, in the light of human rights law, and that SNHRBs such as the European and the UN Committees should (and have) expanded their protection.

In Chapter 5, I continue my theoretical account but this time to assist SNHRBs in clarifying the nature of states' obligations to realise the right to health, a well-established notion in human rights law which content yet remains unclear from the reading of previous chapters. Using again the principles of interpretation underlying this thesis, I focus on the timeframe in which obligations must be implemented, for it avoids crystallising inadequately the content of these obligations. I thus start by examining what the obligation to progressively realise the right to health means, and discuss its recognition by human rights instruments and SNHRBs. However, since this obligation is often criticised for its contingency upon resources, I argue that SNHRBs must inject substance through monitoring. I suggest such monitoring includes an evaluation of states' resources based on their use rather than their availability; as well as indicators measuring states' progress, following the example of the European Committee. Furthermore, I suggest SNHRBs translate the obligation

to progressively realise the right to health into specific legal requirements, through findings of non-conformity based on insufficient improvement or retrogression. Such findings remain too rare in the interpretation of the UN and the European Committees. I then discuss the notion of non-derogable minimum core obligations, and its recognition by the ICESCR and the ESC. I argue that it is impossible to determine a core content of the right to health, as all potential criteria for doing so embody insurmountable dilemmas. Instead, I contend that SNHRBs should understand the core content of this right through the prisms of healthcare prioritisation and progressive realisation, and review it through the test of reasonableness (although a core approach may represent a heuristic tool for the European Committee).

In Chapter 6, I discuss the key challenges that enhancing the conceptual clarity of the right to health through supranational monitoring represent, in order to enable SNHRBs to guarantee principled consistency at both regional and international levels, through my theoretical framework. Firstly, and to avoid the adverse effects of the fragmentation of human rights law, I suggest that SNHRBs harmonise their interpretation of what the normative scope of the right to health entails. Whilst I highlight that SNHRBs tend to interpret the scope of interests of the right to health similarly, they should fill the gaps of their jurisprudences by using the principle of external system coherence. I argue, however, that in human rights law, the scope of protection of the right to health is inconsistent regarding non-nationals, and contend that SNHRBs can reconcile these tensions through the alternatives offered by the Fragmentation Report of the International Law Commission. Secondly, I suggest that to ensure coherence despite the diverse quasi-judicial avenues used to monitor the right to health, SNHRBs adapt their review of states' obligations to the practical realities they encounter. I outline the importance for SNHRBs to balance adequately the individual and collective dimensions of the right to health, depending on what monitoring procedure is at stake. I also outline the importance for SNHRBs to adapt their approach to states' compliance, depending on what level of monitoring they represent. Finally, I highlight that despite such suggestions, the powers of quasi-judicial collegial SNHRBs to bring to life their own interpretation of what the right to health entails, are limited. They do not benefit from any enforcement mechanism,

and the right to health being inherently complex, interpreting it remains an extremely difficult task. However, national courts, as well as other international or regional human rights mechanisms and institutions, can also contribute to delineating what this right means, and bring to life SNHRBs' interpretation by encouraging reluctant states to realise it.

This thesis demonstrates that SNHRBs can contribute to clarifying the legal content of economic, social and cultural rights, and it assisted them in optimising their interpretation for that purpose, through the example of the right to health. However, the lack of literature attempting to clarify what those rights entail represents both a cause and a symptom of the criticisms they are subject to. Therefore, it is essential researchers exploit the potential offered by SNHRBs, and develop conceptual frameworks clarifying the legal content of economic, social and cultural rights to assist their monitoring. This will enable us, as human rights lawyers, to assist key actors such as SNHRBs, judges, or NGOs in realising these rights, and to promote a more effective enjoyment of human rights standards amongst individuals.

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APPENDIX

List of questions asked to members of the UN Committee on Economic, Social and Cultural Rights during the interviews held in Geneva on 26-28 May 2015

I. Scope of the right to health

1. My research shows that when the CESCR Committee reviews the implementation of Article 12 ICESCR in its Concluding Observations, it reviews certain aspects more often than others; do you know why?

(Example: sexual and reproductive health and mental health are mentioned in respectively 75% and 50%, while vaccination and life expectancy are only mentioned in 3 and 6% of the Concluding Observations studied)

2. What influence do NGOs' shadow reports have, if any, on the issues brought to light –or ignored– by the CESCR Committee, in its reporting procedure on Article 12?
3. How helpful do you find the Availability Accessibility Acceptability Quality framework when evaluating the implementation of the right to health?
4. Under which right(s) do you consider issues related to inadequate food, water, hygiene, housing should be reviewed?
5. Is the right to health the same for everyone: 1) within the same country; and 2) between different countries?

II. Progressive realisation/minimum core

6. How do you follow up states' progress in healthcare, according to their obligation to progressively realise the right to health? Would you consider using health indicators?
7. Do you evaluate states' available resources? If yes, how?
8. Do you consider that a retrogression of health standards (e.g. increase of maternal mortality) is a breach of the right to health to the same extent than deliberate retrogressive steps (e.g. closing maternal wards)?

9. What justifications would you accept to consider in presence of retrogressive measures, if any?
10. What do you think about minimum core obligations?
11. Why do Concluding Observations rarely refer to ‘core obligations’ (at least in the context of Article 12)? Do requests to take ‘immediate steps’ to redress a health crisis indicate the existence of a minimum core obligation?

III. Legal approach/constructive engagement

12. How important is states’ obligation to report on their implementation of the right to health?
13. Why does the CESCR Committee avoid using a legal terminology (e.g. ‘obligation’, ‘violation’ etc.) and avoid reaching decisions of non-conformity?
14. What can you say about the constructive engagement approach of the CESCR Committee?
15. During the reporting procedure, how often do you consider that the CESCR Committee collaborate with the following actors:
 - UN agencies:
 - State authorities:
 - Civil society:
 - National Human Rights Institutions:
 - UN/regional human rights bodies:
 - Others:
16. Do you believe it is possible for the UN Committee to adopt a more legal approach while keeping similar levels of constructive dialogue with states?

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