Solidarity and the right to health in the era of healthcare commercialization

Solidariteit en het recht op gezondheid in een tijdperk van commercialisering van de gezondheidszorg

(met een samenvatting in het Nederlands)

Proefschrift

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ABBREVIATIONS

AAAQ	Availability, accessibility, acceptability and quality
ANC	African National Congress
AUGE-GES	*Régimen de Garantías en Salud*
Bangalore Declaration	Bangalore Declaration and Plan of Action
CESR	Center for Economic and Social Rights
ECDC	European Centre for Disease Prevention and Control
ECtHR	European Court of Human Rights
ECLAC	The Economic Commission for Latin America and the Caribbean
ECOSOC	United Nations Economic and Social Council
FONASA	*Fondo Nacional de Salud*
IACHR	Inter-American Commission on Human Rights
IACtHR	Inter-American Court of Human Rights
ICCPR	International Covenant on Civil and Political Rights
ICESCR/Covenant	International Covenant on Economic, Social and Cultural Rights
ICJ	International Commission of Jurists
ILO	International Labour Organization
ISAPRES	*Instituciones de Salud Previsional*
Maastricht Guidelines	The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights
Maastricht Principles	Maastricht Principles on Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights
NGO	Non-governmental organisation
NHS	National Health Service
NZa	Health Care Authority
OAS	Organization of American States
OHCHR	Office of the United Nations High Commissioner for Human Rights
PHM	The People's Health Movement
SNS	*Serviço Nacional de Saúde*

UNCESCR/Committee	United Nations Committee on Economic, Social and Cultural Rights
UNCHR/Commission	United Nations Commission on Human Rights
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
UNGA	United Nations General Assembly
UNHRC	United Nations Human Rights Committee
UNHRCL	United Nations Human Rights Council
WHO	World Health Organization
WTZi	Health Facilities Admission Act (*Wet Toelating Zorginstellingen)*

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Universal Declaration of Human Rights

Vienna Convention on the Law of Treaties

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Venezuela
Constitution 1999

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Constitution 2013

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Constitution of the World Health Organization

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Declaration on the Right to Development (1986)

Declaration on Social Progress and Development (1969)

EU Racial Equality Directive

Guiding Principles on Business and Human Rights

Guiding Principles on Extreme Poverty and Human Rights

Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights (ICJ)

Maastricht Guidelines on Violations of Economic, Social and Cultural Rights (ICJ)

Maastricht Principles on the Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights

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Dedicado a María Isabel y Mario, mis amados padres, y a mi pequeña Eloise, con el deseo de que vivas en un mundo donde la salud llegue a ser un derecho humano de verdad, es decir, igual para todos.

The way that leads forward seems to lead backward
Lao Tzu
Tao te ching, XLI

INTRODUCTION

The impact of the 2008 financial crisis has resonated far beyond its initial economic consequences. I began writing my PhD in 2012, a year when the implications of the crisis were not expected on the political plane and central countries in the West remained connected to a liberal political centre reigning uncontested from the end of the Cold War. Although Spain and the United States had registered unrest in what was known as the *Indignados* and the *Occupy Wall Street* social movements, these did not lead to any immediate electoral shifts. Political elites did not imagine then that things could get out of hand. While their projections proved wrong, these emergent popular movements' thirst for change remains unfulfilled. Like in other grim times in history, the far-right gains from these crises.

In Spain, although the emergence of the new force *Podemos* altered the two-party system ruling the country since 1978, the political establishment preferred its declared adversaries rather than governing in alliance with *Podemos*. In Greece, after the once unthinkable triumph of *Syriza* in 2014, its initial anti-austerity agenda was swiftly cracked down by the dictates of the financial and European elites in the July 2015 negotiations. In the United Kingdom, Jeremy Corbyn surprised in September 2015 when he became the leader of the Labour Party. But the surprise of his election was shy by comparison to the 52% majority that voted to leave the EU in June 2016. In the United States, when Bernie Sanders announced his candidacy to the Democratic Party's presidential nomination in April 2015, few gave him any hope. The polls registered a 40% gap against the front-runner Hillary Clinton. Yet, by the time Sanders endorsed Clinton's candidacy in June 2016, he managed to almost catch up in a spectacular campaign unprecedented in contemporary US politics. The Sanders campaign had not only raised the exorbitant amount of US$ 229 million, mostly from individual contributions,[1] but it had also produced a discursive shift that obliged the other candidates to react and eventually include aspects of his agenda and rhetoric. Sanders not only did not shy away from his credentials as a democratic socialist but he also boldly blamed Wall Street for the financial crisis. A proposal for a renewed clean economy came hand in hand with the promise of cancelling the negotiations of the Trans-Pacific Partnership (TPP) while at the same time an important element of his campaign consisted in shifting Obama Care into the establishment of a single-payer healthcare

[1] 'Which Presidential Candidates are Winning the Money Race' *The New York Times* (New York, 22 June 2016) <www.nytimes.com/interactive/2016/us/elections/election-2016-campaign-money-race.html> accessed 23 June 2017.

system. The past presidential campaign in the United States is perhaps the most ominous image of the present time. In what could once be regarded only as a bad joke it was Donald Trump who with his obnoxious personality and inflammatory rhetoric defeated the establishment. The election of Trump appears a change of era: from the rampant cosmopolitanism of the 1990s to a post-democratic Westphalianism. The liberal hegemony has certainly been shaken.

The role of human rights is critical in this constellation. Human rights law and the human rights movement are at a crossroads. If they keep on failing to address the challenges of the 'world-system European / Euro-North American, Christian-centred, modern / colonial, capitalist / patriarchal', borrowing from Grosfoguell's expression, their contribution as a transformative project of emancipation will remain dubious.[2] This thesis deals with one of these emancipatory avenues: the human right to health, a right that as much as other social rights depends on a shared vision of what human dignity prescribes. Namely, a construct that cannot be envisioned separated from politics.

Someone can fairly ask: why defend welfare in the era of globalization? Why a renewed hope in the State? It was Tony Judt who shortly before his death warned against those who so easily fell enchanted by a cosmopolitanism that would do without the State.[3] Grounded in the present nature of globalization, which remains fundamentally the globalization of capital, I believe that the State must be recovered. Not so much for what it makes possible but for what cannot be made without it. The State may be far from demarcating sustainable horizons of emancipation, but any attempt of attaining them cannot be envisioned in its absence. There is nothing further removed from the truth than the idea that neoliberalism is opposed to the State. The forces of financial globalized capitalism have successfully put the State at the service of its agenda. This is why Samir Amin questions the common place assumption that today's management is run by the market. The 'real management of capitalism requires "market plus state"'.[4] It is for this reason that recovering classical welfare functions of the State makes double sense: not just in order to reorient it towards the humanistic goal of realizing human rights, but also in order to disempower the elites' governing predatory forms of globalization that cannot be reconciled with human rights.

Popular culture is suited to remind us of how true it is that rights (as much as non-rights) depend on the contours of our political imagination. A good example can be found in the 1997 romantic comedy 'As Good as It Gets' with Jack Nicholson (Melvin) and Helen Hunt (Carol). She, the mother of a chronically asthmatic child (Spencer), is a waitress at a popular restaurant

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2 Angélica Montes Montoya and Hugo Busso, 'Entrevista a Ramón Grosfoguel' (2007) 18 Polis Revista Latinoamericana <http://polis.revues.org/4040> accessed 17 April 2017.

3 As he put it, 'When banks fail, when unemployment rises dramatically, when large-scale corrective action is called for, there is no "corporatist market state". There is just the state as we have known it since the 18th century. That is all we have'. Tony Judt, *Ill Fares the Land* (Penguin Books 2010) 195.

4 Samir Amin, *Capitalism in the Age of Globalization: The Management of Contemporary Society* (2nd edn, Zed Books 2014) 39.

in Manhattan but lives with her mother and child in the suburbs of Brooklyn. Melvin is a successful writer of romantic novels. Quite far from the characters he gives life to, he is an antisocial misanthrope suffering from obsessive-compulsive disorder. An important part of the film concerns the relation between Melvin and Carol. At some point, Carol fails to go to work as a consequence of a severe asthma episode affecting her child. Melvin, in his obsession for being served only by Carol, manages to obtain her address in Brooklyn. Melvin visits Carol at her house telling her that he is very hungry, as she has failed to attend at work. Carol, after recovering from Melvin's shockingly neurotic excuse to visit her, reveals that the reason for her absence is her son's sickness. After the visit, Melvin decides to fully cover a private medical treatment for Spencer, so that Carol can get back to work (and, apparently, he can get back to eat...).

Melvin's gesture leaves Carol in an exposed position. While she is grateful with her life, she remains unconvinced about Melvin's real intentions. Carol's uncomfortable situation is sadly believable thanks to a realistic framework: a polity where access to healthcare is not a right but a private commodity dependent on ability to pay. What is at stake is a vision of human dignity, a notion that in the United States (and in many other corners of the world that are prone to following its examples) includes the equal enjoyment of various liberties but which falls short of treating people equally when it comes to accessing healthcare.

In its progressive human rights version, this problem is addressed by focusing on the specific needs of vulnerable persons. Yet, this emphasis does not go far enough as to upgrade healthcare from the private to the public sphere. Admittedly, the effect of this vision is to take one step away from the 'naked' market. Not by granting equal access to healthcare but by providing a minimum level of healthcare to those unable to buy social rights by themselves. Such a focus does not deal with our concern; in fact, it reproduces it. As the film aptly shows, Spencer was entitled to a sub-standard access to healthcare before Melvin's intervention. And while contemporary voices would claim that the only challenge left consists in improving Spencer's entitlement, such a stand insists in confining collective action on healthcare as a subsidiary form of State involvement. The question that human rights law scholars should ask to themselves is what happens to the fundamentality of human rights when one of the right to health's most crucial components becomes operationalized under a private logic, and what does that say about the alleged indivisibility and protection on an equal foot of all human rights.

In the words of the theologian of liberation Leonardo Boff, the point at stake involves 'not the law of Darwin, and his idea of the survival of the fittest, ... but the idea of collaboration, of solidarity of everyone with everyone because we are all interdependent'.[5] As a perspective applied to the right to health, solidarity entails a communitarian justification of the duties we owe to one another. This indeed reflects in equal treatment − arguably a human rights promise − but also in the extent a community shares its scarcities. Solidarity means not just equal access to

[5] Leonardo Boff, 'Derechos de la Tierra y Teología de la Liberación' in Edgardo Rodríguez Gómez (ed), *Aportación de la Teología de la Liberación a los Derechos Humanos* (Dykinson 2008) 201.

rights, but it also means that rather than confining scarcity to the shoulders of the poor, they are justly distributed among all members of society. In this way, Melvin's wealth and Carol's poverty should be irrelevant by the time of defining priorities in access to healthcare (in the film Melvin gets swift access to mental care while Carol struggles for basic healthcare for her child). This, however, requires human rights law to take a more advanced stand against the commodification of healthcare. Its failure to do so amidst its flirtation with the world of businesses is in my view one of the most important reasons to explain the advances from the far-right at the expense of human rights.

This thesis defends that the duties and institutions that support the right to health ought to be justified differently than mainstream human rights law interpretations. I maintain that if what one seeks is equal treatment, a human right of access to healthcare should demand something different than a legal right for those at disadvantage. It is disingenuous to defend that the framework of individual legal rights will ever lead to health equity. Unsurprisingly, those that most strongly defend such a stand are often the ones with the economic guarantee of resorting to private healthcare should they really need it.[6]

The methodological justification to undertake a different conceptualization of social rights comes from the fact that I do not think that the hegemony of the predominant interpretation of this human right is based on political neutrality. This thesis is therefore dedicated to studying the inconsistencies of this central human rights interpretation, and to exploring the question of whether there would be grounds for conceiving this human right differently.

I wrote this work to defend social rights from two different but equally testing adversaries: the cultured liberal voices that zealously defend human rights as long as the adversary is the State and not the market, and the vociferous ones that do not want to know anything about human rights.

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[6] 'It has become commonplace to assert that we all want the same thing, we just have slightly different ways of going about it. But this is simply false. The rich do not want the same thing as the poor. Those who depend on their job for their livelihood do not want the same thing as those who live off investments and dividends. Those who do not need public services − because they can purchase private transport, education and protection − do not seek the same things as those who depend exclusively on the public sector.' Judt (n 3) 168.

CHAPTER ONE
RESEARCH DESIGN

1. RIGHTS AND NEW CONSTITUTIONALISM

Contemporary societies are shaped by the notion of rights.[1] Although the legal tradition of rights is far from exclusive in Western legal thinking,[2] practically all contemporary justice theories have aligned to the discursive and institutional framework of rights.[3]

The legal nature of rights consists of something that must be either given or not taken away from the legal subject.[4] In the context of the history of human rights, it is still controversial to argue that the operation of rights is only successful when a duty-bearer is identified.[5] Yet, a

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1 Unless stated otherwise, the expression 'rights' is intended to mean individual legal rights.

2 Christian moral reasoning, for instance, is critical of the self-assertiveness and individualism inherent in rights, an anthropocentrism that may end up obscuring the importance of the community and other aspects of the creation such as animals or the environment, as well as critical concepts such as duties, Isabella Bunn, *The Right to Development and International Economic Law. Legal and Moral Dimensions* (Hart Publishing 2012) 83-84.

3 Except for the Communitarian and the Marxist tradition, most of Western contemporary political philosophy does not conflict with rights. In distinguishing his justice-as-fairness theory from utilitarianism, John Rawls established a framework compatible with the idea of rights, John Rawls, *A Theory of Justice* (originally published 1971, reprint, HUP) 31.

4 As stated by Costas Douzinas, legal subjectivity does not consist in a natural entity but in a legal construct. Costas Douzinas, *The End of Human Rights: Critical Legal Thought at the Turn of the Century* (Hart Publishing 2000) 233. The legal subject of human rights can include one or more individuals as in the case of group rights. In opposition to the traditional legal subjectivity of human rights constructed in the second half of the twentieth century (eg Thomas Buergenthal, 'To Respect and to Ensure: State Obligations and Permissible Derogations' in Louis Henkin (ed), *The International Bill of Rights. The Covenant on Civil and Political Rights* (Columbia University Press 1981) 72, 73), recent jurisprudential developments appear to be extending this legal subjectivity to non-persons such as corporations. In *Citizens United v Federal Election Commission*, the United States Supreme Court held that the government's restriction on corporations from making independent expenditures for political campaigns was contrary to the First Amendment, Appeal from the United States district court for the district of Columbia, 21 January, No 08-205, 558 U S 310.

5 This may be linked to the decisive influence of Rawlsian philosophy, which maintained that the idea of the

dichotomy between rights and duties is odd given that the most widespread theoretical classification − Hohfeld's − admits that the fulfilment of rights *depends* on the accomplishment of legal duties.[6]

The point of departure of this thesis is that it is useless to speak of rights without clearly identifying duties, something that seems even truer in the context of social rights.[7] Hence, one of the main goals of this thesis is to assess whether contemporary interpretational developments of the social right to health, which emphasize their judicial enforceability, help in identifying the duties without which this right cannot truly exist.

This problem appears necessarily linked with the wider development of the legal doctrines of *neoconstitutionalism*[8] and *transformative constitutionalism.*[9] While these doctrines each have their emphases, they share a set of fundamental standpoints in connection with the jurisprudential development of rights. Not only law appears closely linked to morality in these

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right held precedence over the idea of the good. Rawls, *Justice* (n 3) 31; International Council on Human Rights Policy, *Taking Duties Seriously: Individual Duties in International Human Rights Law. A Commentary* (Versoix 1999) 1-2.

6 In this sense, the emphasis on rights to the detriment of duties should be regarded an oddity also from a Western legal perspective. See eg Wesley Hohfeld, *Fundamental Legal Conceptions. As Applied in Judicial Reasonin*g (originally published 1919, Greenwood Press 1978) 38; Kelsen emphasized the importance of the duty bearer by stating that '"the subject" ... is the only obligated individual − the one who can violate or fulfill the obligation by his behavior; the "entitled" individual − the one toward whom the behavior is to take place − is only the object of the behavior which, because corresponding to the obligated behavior, is codetermined by the latter'. Hans Kelsen, *Pure Theory of Law* (first published 1967, University of California Press 1970) 127.

7 As Atria notes in his reading of T H Marshall, 'the incentive that operates in the free contract system of the open market is the incentive of personal gain. The incentive that corresponds to social rights is that of public duty'; see Fernando Atria, '¿Existen los Derechos Sociales?' (2004) 4 Discusiones: Derechos Sociales 15, 18[9]; Samuel Moyn, 'Rights versus Duties: Reclaiming the History and Language of Human Obligations' ABC Religion and Ethics 26 April 2017 <www.abc.net.au/religion/articles/2017/04/26/4659114.htm> accessed 17 June 2017.

8 Ronald Dworkin, *Taking Rights Seriously* (first published 1977, HUP 1978) 147; Robert Alexy, 'On Necessary Relations Between Law and Morality' (1989) 2 (2) Ratio Juris; Ronald Dworkin, 'The Moral Reading of the Constitution' (1996) 43 (5) The New York Review of Books 6ff; Wilfrid Waluchow, *Una Teoría del Control Judicial de Constitucionalidad Basada en el Common Law. Un Árbol vivo* (Marcial Pons 2009); Gustavo Zagrebelsky, 'Realismo y Concreción en el Control de Constitucionalidad. El Caso de Italia' in Miguel Carbonell and Leonardo García Jaramillo (eds), *El Cánon Neoconstitucional* (Trotta 2010) 438.

9 The expression *transformative constitutionalism* became popular after its use by Kaarl Klare in an article on the role of judicial adjudication in transitional democratic societies such as South Africa, Karl Klaare (1998) 'Legal Culture and Transformative Constitutionalism' (South African Journal on Human Rights, 14) 146-188; a more balanced approach based on the formula: 'litigation was more effective as a shield than a sword', can be found in Richard Abel, 'Legality Without a Constitution: South Africa in the 1980s' in David Dyzenhaus (ed), *Recrafting the Rule of Law: The Limits of Legal Order* (Hart Publishing 1999) 71, 79; somehow overstating the role of liberal lawyers and courts as a root to the end of apartheid, David Dyzenhaus, *Hard Cases in Wicked Legal Systems. Pathologies of Legality* (OUP 2010) 163, 166, 260, 262.

theories; judges appear generally bestowed with an epistemologically privileged access when it comes to declaring what is legally the *truth*.[10]

Neoconstitutionalism affirms that human rights are in a space of legal − as opposed to political − incumbency.[11] Something similar is done by transformative constitutionalism. With the argument that 'legal constraint is culturally constructed',[12] a conflation between law and politics is justified. Despite the truth involved in the assertion that 'judge's political and moral values ... play a routine, normal, and ineradicable role in adjudication',[13] if such a claim is taken to the extent of reducing democratically enacted rules to little more than optional guidelines judges may or may not adopt, elected representatives necessarily become less responsible for the failure or success of social justice efforts, understood as how much inequality every society considers acceptable.[14]

The effect is the trivialization and downgrading of the importance of democratic deliberation and popular sovereignty.[15] As Chantal Mouffe comments, today's dominant tendency consists in 'envisaging democracy in such a way that it is almost exclusively identified with the *Rechtsstaat* and the defence of human rights, leaving aside the element of popular sovereignty, which is deemed to be obsolete'.[16]

Although contrary to the intention of the theorists and the self-proclaimed goals of neoconstitutionalism and transformative constitutionalism, the development experimented by these doctrinal trends has ended up amalgamating with the liberal constitutionalism promoted by Friedrich Hayek. At the core of Hayek's legal thought lies the distinction between law and legislation. Law was to be understood as a perennial category while legislation was presented as a more accidental phenomenon that could or could not align with the permanent principles of the

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10 Luigi Ferrajoli, *Democracia y Garantismo* (2nd edn, Trotta 2010) 68-69.

11 ibid 81.

12 Klare, *Transformative* (n 9) 161.

13 ibid 163.

14 WHO, *The World Health Report. Health Systems Financing. The Path to Universal Coverage* (WHO 2010) 14; another more historical approach of social justice emphasizes the links of this notion with the goals of the social democratic state. According to Ignacio Sotelo, while the goal of the democratic state was to guarantee formal liberties − all citizens are equal before the law, including equal political rights − the social democratic welfare state sought everyone to enjoy of a real liberty. In doing so, it attempted not only not to suppress formal liberties, but also not to weaken them. Besides equal rights, there should be equality of opportunity to exercise them. This requires starting off from a similar material welfare, reducing the great social gaps and extending the same education. Constitutive of this model was also national redistribution, state education and other social services important to improve life conditions. Ignacio Sotelo, *El Estado Social: Antecedentes, Origen, Desarrollo y Declive* (Trotta 2010) 285.

15 Aharon Barak, *Judicial Discretion* (Yale University Press 1989) 109, 232; Pius Langa, 'Transformative Constitutionalism' (prestige lecture, Stellenbosch, 9 October 2006) <www.msu.ac.zw/elearning/material/1238154663Pius%20Langa%20Speech.pdf> accessed 15 May 2017.

16 Chantal Mouffe, *The Democratic Paradox* (Verso 2009) 3-4.

law.[17] For legislation to be in line with these permanent ends, it had to guarantee property, a fundamental requirement of liberty.[18] Hayek envisioned this regime not only at the domestic level but also at the planetary level.[19]

The development of Hayek's liberal constitutionalism has been impressive. Writing in 1990, the political scientist Stephen Gill stated that the decay of the Post-War *international* economic order based on economically sovereign states, would transit into the hegemony of a *transnational liberal economic order*, where 'capital flows and interpenetrating investments are fusing the world political economy into a more integrated whole'.[20]

A global constitutionalism is today a reality. Not in the way envisioned by prominent neoconstitutionalists like Luigi Ferrajoli, who expected the law to take control of the economic domain,[21] but exactly in the way that they feared: what today governs is the more or less *de facto* constitutionalization of the rules protecting the property of capital owners.[22] The late sociologist Zigmunt Baumann characterizes our present state of affairs as the *political economy of uncertainty*, namely:

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17 F A Hayek, *Law, Legislation and Liberty* (Routledge 2013) 91.

18 ibid 102-103.

19 Rachel Turner, 'Neo-Liberal Constitutionalism: Ideology, Government and the Rule of Law' (2008) 1 (2) Journal of Politics and Law, 47, 54; Rachel Turner, *Neo-Liberal Ideology: History, Concepts and Policies* (2nd edn, Edinburgh University Press 2011) 187-188.

20 Stephen Gill, *American Hegemony and the Trilateral Commission* (CUP 1990) 88.

21 Ferrajoli (n 10) 59.

22 According to Stephen Gill, new-constitutionalism helps the owners of capital to 'constitute and enlarge the world market and within it their freedom to acquire, exchange or move property. These freedoms also involve constitutional guarantees against expropriation of their assets of property. New constitutionalism also imposes what are theoretically binding constraints on states' macroeconomic, trade, investment and industrial policies. For example, devaluation or inflation may affect the capital value of an asset or investment; state industrial strategies may imply that domestic capital gains preferential treatment over foreign capital; national laws may have the same effect'. Stephen Gill, 'Market Civilization, New Constitutionalism and World Order' in Stephen Gill and Claire Cutler, *New Constitutionalism and World Order* (CUP 2014) 37; it is interesting to note that the first action of the so-called anti-globalization movement − later known as alter-globalization movement − would consist in their opposition to a Summit of the G7 in Seattle in 1999. The demonstrations took place in the wake of the exposure of the secretive Organisation for Economic Cooperation and Development negotiations to constitutionalize investors' rights through a Multilateral Agreement on Investment. The demonstrations had the effect of aborting the agreement, Leo Panitch and Sam Gindin, *The Making of Global Capitalism. The Political Economy of American Empire* (Verso 2012) 425[106]; under a set of secretive negotiations a new set of free trade agreements emerged during the Obama administration (the Trade in Services Agreement, the Transatlantic Trade and Investment Partnership, and the Trans-Pacific Partnership). The agreements excluded China and the BRICS countries. The little that was known about them was made available through Wikileaks. Wikileaks, 'Trade in Services Agreement − Press Release', 3 December 2015, <https://wikileaks.org/tisa/press.html> accessed 23 June 2017.

> [T]he set of "rules to end all rules" imposed by the extraterritorial financial, capital, and trade powers upon local political authorities … The principles are simple, since they are mostly negative; they are not meant to establish a new order, only to take apart the existent ones; and to prevent state governments of the day from replacing the dismantled regulations with new ones.[23]

The mistake of neoconstitutionalism lies in its overestimation of the ability of the law to control capitalism. The jurisdictional function and the agents revolving around it no doubt play an important role. Yet, some scholars presented this area as the one where the most crucial decisions were to be decided.[24] This entailed to effectively de-mobilize the political and social arenas, a prolific source of opposition against social injustice. A legal and political culture obsessed with legalizing everything has ended up suffocating the political. At least from 1993, Chantal Mouffe has been accurately predicting the dangerous effects of this trend in terms of how much it opens a window for the far right.[25] Brexit and the election of Donald Trump appear to confirm her analysis.

The collapse of the Berlin Wall not only marked the end of the Communist era; it also accelerated the decay of social democracy. Understanding social rights as 'the standards with which a community specifies the distribution of wealth and opportunities necessary for the satisfaction of everyone's needs of social assistance, education and labour',[26] was a typical way of furthering social democratic ideals. However, given that the proportion of the areas that are today under commercialization has radically increased, social rights in Europe are in retreat as much as social democracy, at least since the 1980s.[27]

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[23] Zygmunt Bauman, *In Search of Politics* (Stanford University Press 1999) 173.

[24] Ferrajoli envisions both a domestic and a planetary democratic constitutionalism. Both are ruled by his distinction between institutions of government and institutions of guarantee. The earlier concern decisions of political and discretional nature. These decisions must at all times align with the second sphere that Ferrajoli calls the sphere of the unspeakable. This sphere is comprised of the jurisdictional institutions in charge of applying the law, namely, the decisions that must not be adopted (the ones that encroach on the rights of liberty) and the decisions that must be adopted (the ones that guarantee social rights). Ferrajoli (n 10) 102-103, 319-320.

[25] Chantal Mouffe, *The Return of the Political* (Verso 1993) 4; Mouffe, *Paradox* (n 16) 7; Chantal Mouffe, *On the Political* (Routledge 2005) 64-72.

[26] Ricardo García Manrique, *La Libertad de Todos: Una Defensa de los Derechos Sociales* (El Viejo Topo 2013) 34.

[27] Wolfgang Streeck lists the following areas where social rights are in retreat: 'politically guaranteed full employment, collective society-wide wage formation negotiated with free trade unions, worker participation at workplace and enterprise level, state control of key industries, a broad public sector with secure employment as a model for the private sector, universal social rights protected from competition, tax and income policies that kept inequality within tight limits, and government cyclical and industrial policies to secure steady growth'. Wolfgang Streeck, *Buying Time: The Delayed Crisis of Democratic Capitalism* (Verso 2014) 28.

Today's understanding of social rights leads to paying almost exclusive attention to these rights' adjudication by the judiciary. The scope social rights have over the economy − including multilateral trade and investment agreements − is a challenge that predominant interpretations of social rights have not satisfactorily tackled. This challenge is all the more urgent because the current political economy affects critical aspects of this human right such as the provision of healthcare services, which are today exposed to increasing commercialization.[28]

The reasons for situating a study on the human right to health within these general coordinates are linked to the view that the dynamics where this right is placed cannot be properly disentangled without looking at this larger picture. Not doing so risks maintaining the vicious circle where social rights have been confined during the last years. Although I focus on the question of *who* adjudicates, I claim that an accurate analysis of the questions posed by social rights cannot skip *what can be* adjudicated. Such a debate cannot be severed from the way in which our political economy has developed, and the role human rights law plays in this respect.

We can group together the doctrinal developments of neoconstitutionalism, transformative constitutionalism and Hayek's liberal constitutionalism under the label of new constitutionalism (Stephen Gill). I do so with awareness of the fact that although analytically separable, transformative constitutionalism and neoconstitutionalism, with its accent on the rule of law, its dismissal of politics and its exaggerated account of the ability of courts to bring social justice, have ended up serving Hayek's liberal constitutionalism.

On its route to becoming today's legal and political hegemon, new constitutionalism appeared as a seductive doctrine to the political elites of several countries. The reasons are varied:

- Economic agents discovered the tremendous potential of doing business in connection with fundamental social needs;
- Because of the former, public officials saw their accountability burden significantly lightened as they appeared less linked to the process of expanding the amount, quality and scope of essential public services;
- Civil society was also given a place; non-governmental legal organizations and other philanthropic entities saw an opportunity to play a role in connecting individual interests with the public interest of access to justice; in the vocabulary of neoconstitutionalism, *strategic litigation* became the most appropriate and effective means of addressing social justice concerns;

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[28] Laura Turiano and Lanny Smith, 'The Catalytic Synergy of Health and Human Rights: The People's Health Movement and the Right to Health and Health Care Campaign' (2008) 10 (1) Health and Human Rights 137, 138; Paul O'Connell, 'The Human Right to Health in an Age of Market Hegemony' in John Harrington and Maria Stuttaford (eds), *Global Health and Human Rights: Legal and Philosophical Perspectives* (Routledge 2010) 200.

- The system's production of legitimacy earned a new *deliverable*: the increased responsibility of judges was welcomed with general sympathy as a further instantiation of a culture of justification in constant expansion.[29]

Looking at South Africa, a country whose racist political regime symbolized the ultimate form of wickedness until its fall in the 1990s,[30] can be illustrative. South Africa saw its democratic re-foundation by the hand of Nelson Mandela and his party, the African National Congress (ANC). The 1996 Constitution enshrined a multifaceted set of rights. The judgments issued by its Constitutional Court in the field of social rights have been the object of extensive legal analysis. Yet, if the degree of frustration produced by a broken promise is proportional to its generated expectations, new constitutionalism is perhaps one of the greatest legal disillusions of our time. In countries like South Africa − and for the same matter Colombia, India or Brazil − this legal trend has massively failed in materializing one of its main promises: the idea that human rights could bring social justice.[31] The promise involved that for a country to attain social justice, the focus was to be put on fundamental social rights through courts involvement and including extended use of judicial review.[32]

The sophisticated jurisprudential developments of the last two decades have not impeded South Africa from holding the record of being one of today's most unequal countries in the globe, even when comparing its present situation to the apartheid era.[33] This development occurred in spite of the intentions of the ANC's political program, which was not only about opposing the apartheid regime, but which also consisted in tackling social justice in the terms set by the Freedom Charter. [34] The 1990-1994 economic negotiations held between the

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[29] Michael Langford, 'The Justiciability of Social Rights: From Practice to Theory' in Michael Langford (ed), *Social Rights Jurisprudence. Emerging Trends in International and Comparative Law* (CUP 2008) 33; on the other hand, scholars like Samuel Moyn cast doubt on this prospect, Samuel Moyn, *Human Rights and the Uses of History* (Verso 2014) 144.

[30] Even to the extent of being expressly condemned in the Right to Development Declaration, UNGA, Declaration on the right to development, 97th Plenary meeting, 4 December 1986, 41/28, art 5.

[31] A recent justification of this possibility can be found in Dan Chong, 'How Human Rights Can Address Socioeconomic Inequality?' in Doutje Lettinga and Lars Van Troost (eds), *Can Human Rights Bring Social Justice?* (Amnesty International Netherlands 2015) 19, 24.

[32] Victor Dankwa, Cees Flinterman and Scott Leckie, 'Commentary to the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights' (1998) 20 (3) Human Rights Quarterly 705, 712; Sandra Liebenberg, 'Needs, Rights and Transformation: Adjudicating Social Rights' (2006) 17 (1) Stellenbosch Law Review 5, 36; Samantha Besson, 'European Human Rights, Supranational Judicial Review and Democracy' in Patricia Popelier, Catherine Van de Heyning and Piet Van Nuffel (eds), *Human Rights Protection in the European Legal Order: The Interaction Between the European and the National Courts* (Intersentia 2011); George Katrougalos and Paul O'Connell, 'Fundamental and Social Rights' in Mark Tushnet, Thomas Fleiner-Gerster, Cheryl Saunders, *Routledge Handbook of Constitutional Law* (Routledge 2015).

[33] Oxfam International, 'Even It Up. Time to End Extreme Inequality' (Oxfam International 2014) 7.

[34] Naomi Klein, *The Shock Doctrine: The Rise of Disaster Capitalism* (Penguin Books 2007) 196; the Freedom Charter was officially adopted on 26 June 1955 at the Congress of the People, held in Kliptown. The main

representatives of the National Party and the ANC are an important cause of this problem.[35] In practice, the negotiations entailed that the ANC gave up crucial elements of its social agenda. A strong constitutional protection of property,[36] the abandoning of land redistribution,[37] the annulling of banks and mines nationalization,[38] the cancelling of employment policies[39] and the new regulations on intellectual property[40] are examples of this. Furthermore, social (constitutional) rights found their institutional materialization through the involvement of the private sector in public services.[41] All these factors have been relevant in hindering *black economic empowerment*.[42] This has all contributed to perpetuate the marginalization of the black majority as well as increasing social and economic inequality.

South Africa shows that new constitutionalism, by defining social rights as a phenomenon primarily associated with the development of legal jurisprudence, has not led to democratizing the economy. Unsurprisingly, the intrinsic dynamics of the law and the judiciary found themselves more at ease with tools often used to neutralize rather than to promote social justice: the rule of law has not catapulted social justice;[43] judges remain fundamentally devoted to the protection of property rights rather than civil and political rights (let alone economic, social and cultural rights).[44] Worse, in the cases that these rights have received attention, the result has not led towards the socialization of the public goods promised by social rights.

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elements of the Charter included popular sovereignty, equality before the law and equality of rights, redistribution of all wealth including the land and minerals, recognition of social, economic and cultural rights such as the right to form trade unions, the right and duty to work, equal pay and national minimum wage, the right to education, the right to housing, the right to food, the right to a preventive health scheme run by the state, the right to free medical care and hospitalization for all, with special care for mothers and young children, the right to rest, the right to security and the right to self-determination. A photograph of an original copy of the Charter can be found at <www.historicalpapers.wits.ac.za/inventories/inv_pdfo/AD1137/AD1137-Ea6-1-001-jpeg.pdf> accessed 23 June 2017.

35 Klein, *Shock* (n 34) 199.

36 ibid 203.

37 ibid.

38 ibid 206.

39 ibid 203.

40 ibid.

41 ibid 203-204; Isabel Masanque 'Progressive Realization Without the ICESCR: The Viability of South Africa's Socioeconomic Rights Framework, and its Success in the Right to Access Health Care' (2012-2013) 43 California Western International Law Journal 461, 483.

42 Klein, *Shock* (n 34) 195.

43 Turner, *Constitutionalism* (n 19) 50; Turner, *Ideology* (n 19) 163.

44 Joseph Stiglitz, *Freefall: Free Markets and the Sinking of the Global Economy* (Penguin Books 2010) 287; Rolf Künnemann, 'How Are Social Justice and Human Rights Related? Four Traps to Avoid' in Doutje Lettinga and Lars Van Troost (eds), *Can Human Rights Bring Social Justice?* (Amnesty International Netherlands 2015) 65, 68-69.

The South African experience is an example of the scant value of a purely judicial understanding of social rights – a development that fails to connect social rights with the democratization of the fundamental economic structure of a country (this includes at least the legal regime concerning labour and the organization and property of the means of production,[45] intellectual property,[46] the basic rules regulating the financial sector,[47] the regulation of capital, services, trade and investment, and the nature of taxation[48]). It is a narrow view to think of human rights essentially as a negative force that only counters, weakens or contests state sovereignty.[49] To be sure, human rights do and must keep on doing that to deliver protection from the often-

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[45] It is not a coincidence that in the so-called Second Bill of Rights, Franklin Delano Roosevelt included 'the right to a useful and remunerative job in the industries or shops or farms or mines of the Nation', 'the right of every farmer to raise and sell his products at a return which will give him and his family a decent living', 'the right of every businessman, large and small, to trade in an atmosphere of freedom from unfair competition and domination by monopolies at home or abroad'. In his State of the Union message to Congress (otherwise known as *the Four Freedoms speech*), Franklin Delano Roosevelt referred to the need of sharing 'equitably the burdens of taxation', as well as taxing 'unreasonable profit'. Franklin D Roosevelt, 'State of the Union Message to Congress: 11 January, 1944' (Franklin D. Roosevelt: Presidential Library and Museum) <www.fdrlibrary.marist.edu/archives/address_text.html> accessed 23 June 2017; in the context of the discussion of the right to work, the Chilean delegate to the drafting of the Universal Declaration of Human Rights, Mr Hernán Santa Cruz, made reference to President Roosevelt's speech. Santa Cruz considered that within this right the right to employment should be embedded or, in the expression of President Roosevelt, the right to useful and remunerative work, see Summary Record of the Fourteenth Meeting [of the Drafting Committee of the Commission on Human Rights], UN Doc E/CN.4/AC.1/SR.14, 23 June 1947.

[46] Leslie London, 'What Is a Human Rights-Based Approach to Health and Does it Matter?' (2008) 10 (1) Health and Human Rights 65, 72.

[47] Gorik Ooms and Rachel Hammonds, 'Taking Up Daniels' Challenge: The Case for Global Health Justice' (2010) 12 (1) Health and Human Rights 29, 31.

[48] Taking a critical focus on the marginalization of taxation from human rights, see Katarina Tomaševski, 'Economic Costs of Human Rights' in Peter Baehr, Cees Flinterman and Mignon Senders (eds), *Innovation and Inspiration: Fifty Years of the Universal Declaration of Human Rights* (Royal Netherlands Academy of Arts and Sciences 1999) 67-69; Joseph Stiglitz, *The Price of Inequality* (Penguin Books 2013) 39, 47; International Bar Association, *Tax Abuses, Poverty and Human Rights* (International Bar Association 2013) 113; although not speaking about 'progressive' taxes and purely against 'regressive' taxation, the Lima Declaration is an example of the growing attention of this issue within the human rights movement, Center for Economic and Social Rights (CESR) and others, 'Lima Declaration on Tax Justice and Human Rights' (CESR 19 June 2015) <www.cesr.org/sites/default/files/Lima_Declaration_Tax_Justice_Human_Rights.pdf> accessed 23 June 2017.

[49] In his Laudato, Si': On Care for Our Common Home encyclical letter, Pope Francis has cautioned about the danger posed by transnational corporations on the sovereignty of individual nations. The letter claims that the activities of these corporations may be window dressing of their economic interests with the protection of rights or nature, Pope Francis, 'Laudato Si' (Vatican Press 2015) <http://w2.vatican.va/content/dam/francesco/pdf/encyclicals/documents/papa-francesco_20150524_enciclica-laudato-si_en.pdf> accessed 23 June 2017, 38.

invasive power of the State. Yet, there is abundant evidence to be suspicious of any call for limited sovereignty on behalf of liberalization, privatization and de-regulation, especially when the first candidates of those limitations are the countries of the Global South. Furthermore, there is no strong legal reason why the exploration of social rights' content must be kept confined to a minimum declared by the judiciary.

These various insights have inspired my quest for finding out if there is room to conceive human rights law in a counterhegemonic way.[50] Inspired by Costas Douzinas, who argues that 'in law and politics ... the task is not so much to discard "wrong" ideological concepts, like human rights, but to re-define them against whatever conservative connotations they may have acquired, adjust them to the project of popular politics and build around them a "hegemonic" bloc'.[51] I understand this challenge in a two-fold way. On the one hand, by avoiding the absorption of the democratic and communitarian elements of politics, a dimension without which social rights would not be intelligible. On the other, by addressing social rights without misrepresenting its foundational components: the values and principles they pose − social justice and solidarity − as well as the duties and institutions that make them possible.

In my analysis, I have noted that new constitutionalism has not been the only legal insight of recent emergence. New perspectives linked to *popular, weak*, or *political* constitutionalism, critical of the structural limitations of social rights advocacy in court, have also emerged.[52] These perspectives do not deny the merit of new constitutionalism in having brought social rights to the centre of legal discussions. What these perspectives are critical of is new constitutionalism's overstated claim that judicialization leads *per se* towards the universal and egalitarian access to social rights,[53] and to an effective reduction of income inequality.[54] For

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[50] For Boaventura de Sousa Santos, this depends on the ability of human rights discourse to 'radically [distance] itself from hegemonic neoliberalism and on being part of a broader strategy for social and global transformation'. This process could open the way to 'an intercultural, post-imperial [conception] of human rights'. Within this new conception 'the right to a solidarity-oriented transformation of the right to property' is included. Boaventura de Sousa Santos, *Toward a New Legal Common Sense: Law, Globalization, And Emancipation* (2nd edn, Butterworths 2002) 467; José-Manuel Barreto, 'Epistemologies of the South and Human Rights: Santos and the Quest for Global and Cognitive Justice' (2014) 21 (2) Indiana Journal of Global Legal Studies 395, 415, 421-422.

[51] Douzinas (n 4) 169.

[52] Jeremy Waldron, 'A Right's-Based Critique of Constitutional Rights', Oxford Journal of Legal Studies (1993) 13 (1) 18; Jeremy Waldron, *Law and Disagreement* (OUP 1999); Larry Kramer, *The People Themselves. Popular Constitutionalism and Judicial Review* (OUP 2004); Richard Bellamy, *Political Constitutionalism: A Republican Defence of the Constitutionality of Democracy* (CUP 2007); Ran Hirschl, *Towards Juristocracy: The Origins and Consequences of the New Constitutionalism* (HUP 2007); Mark Tushnet, *Weak Courts, Strong Rights: Judicial Review and Social Welfare Rights in Comparative Constitutional Law* (Princeton University Press 2008); Joel Colón-Ríos, *Weak Constitutionalism: Democratic Legitimacy and the Question of Constituent Power* (Routledge 2012); Fernando Atria, *La Forma del Derecho* (Marcial Pons 2016).

[53] Atria, *Existen* (n 7) 45-49.

[54] Jacob Mchangama and Christian Bjørnskov, 'Do Social Rights Affect Social Outcomes?' (2013) Aarhus

example, in Ran Hirschl's perceptive study of judicial review, the justiciability of legal rights appears inspired by less elevated reasons than those often articulated behind their *strong* justification. On the basis of an analysis on Israel, Canada, New Zealand and South Africa, Hirschl's research suggests that recourse to judicial activism may have to do more with ruling political elites' interest in entrenching their power and political agenda in light of electoral shifts, than to provide efficacious means towards rights protection.[55] However that may be, it is a fact that the extensive use of judicial review in several countries has so far been compatible with the widespread perpetuation of social and economic inequalities.[56]

Another account is that of Gerald Rosenberg who, contrasting the United States Supreme Court's jurisprudence with its social effects, concludes that the role of courts in bringing social change is limited unless backed by the action of the other branches of power, legislatures in particular.[57] Furthermore, Jeremy Waldron's understanding of the rule of law as a notion compatible with the action of legislatures[58] provides a different point of departure than Hayek's notion.[59]

With these different insights, this study critically looks at the arena where social rights are battled. I aim to look back at the original questions social rights were supposed to confront us with. I think that these questions need to be re-evaluated by the human rights academia for social rights to be truly protected.

University Economic Working Papers 18/2013, 18 <http://econ.au.dk/fileadmin/site_files/filer_oekonomi/Working_Papers/Economics/2013/wp13_18.pdf> accessed 12 May 2017; Fernando Atria, *Derechos Sociales y Educación: Un Nuevo Paradigma de lo Público* (Lom 2014) 115-116; Aeyal Gross, 'Is There a Human Right to Private Health Care?' (2013) Journal of Law Medicine and Ethics 138, 139-140.

55 Hirschl (n 52) 60-65, 77, 83-85, 92, 97, 164-168, 249[122].

56 Limiting the World Bank Gini index data to the income share of the richest 10% for the period 1981-2011, the following data emerges: Brazil (1981: 45,88 - 2011: 41,89), Colombia (1988: 41,21 - 2013: 41,94), India (1983: 25,72 - 2011: 29,98); South Africa (1993: 46,66 - 2011: 51,26) World Bank, 'World Bank Open Data' <http://data.worldbank.org/indicator/SI.POV.GINI?view=chart> accessed 23 June 2017.

57 Gerald Rosenberg, *The Hollow Hope: Can Courts Bring About Social Change?* (2nd edn, The University of Chicago Press 2008) 49, 52-55, 106.

58 Jeremy Waldron, 'Legislation and the Rule of Law' (2007) 1 (1) Legisprudence 91, 121-123; Jeremy Waldron, 'The Rule of Law and the Importance of Procedure' (2010) Public Law and Legal Theory Research Paper Series 10/73, 23-25 <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1688491> accessed 23 June 2017; Jeremy Waldron, *The Hamlyn Lectures: The Rule of Law and the Measure of Property* (CUP 2012) 106.

59 F A Hayek, *The Constitution of Liberty* (first published 1960, Routledge 1976) 231-232.

2. RESEARCH QUESTION

This thesis is placed in the intersection between three central themes: law and politics, social justice and human rights law, and the effort to combatting two distinct problems: poverty and inequality.[60] Social rights are at the core of these intersections. While it would be incorrect to argue that social rights are the only instruments tasked with bringing social justice, it seems even more mistaken to argue that there is no connection between social rights and social justice.[61]

The struggle against poverty is not to be confused with the struggle against inequality. Even ultra-libertarian views claim to struggle against destitution.[62] The real challenge consists in determining in what cases the law is confronting inequality. Let us begin by providing context. It seems fair to suggest that democracy and human rights lose legitimacy in a background of excessive inequalities. And the present state of affairs has them in plenty: as never before, 62 persons possess the same wealth as 3.6 billion people who constitute the poorest half of the planet.[63] This reality appears to validate the Marxian critique that democracy under capitalism represents no more than a bourgeois form of liberty unavailable to the proletarian classes.[64] At

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60 As acknowledged by Hayek, who thinks that the crisis of social security is 'a consequence of the fact that an apparatus designed for the relief of poverty has been turned into an instrument for the redistribution of income', ibid 302.

61 As argued by Hayek, for whom social justice was either 'pseudo-ethics' (Hayek, *Law* (n 17) 468), or 'some non-existing principle' (Hayek, *Liberty* (n 59) 302).

62 Milton Friedman, *Capitalism and Freedom* (first published 1962, University of Chicago Press 2002) 191; not long ago the World Bank announced that 2015 would be the first year in which less than 10% of the world population would be below the poverty line, World Bank, 'World Bank Forecasts Global Poverty to Fall Below 10% for First Time; Major Hurdles Remain in Goal to End Poverty by 2030' (World Bank, 4 October 2015) <www.worldbank.org/en/news/press-release/2015/10/04/world-bank-forecasts-global-poverty-to-fall-below-10-for-first-time-major-hurdles-remain-in-goal-to-end-poverty-by-2030> accessed 23 June 2017. To arrive at that conclusion the World Bank operated on the basis of its metric of US$ 1.90 per day. Yet, tackling the problem from the perspective of elementary capabilities (such as the ability to be adequately nourished) and including other estimates going beyond income poverty (such as under-nutrition, infant mortality, access to health services and other indicators), scholars have casted doubt on both the World Bank's figure and methodology, concluding it is altogether inappropriate for a definition of deprivation, Sanjay Reddy and Thomas Pogge, 'How Not To Count the Poor' (29 October 2005) <https://papers.ssrn.com/sol3/papers.cfm?abstract_id=893159> accessed 23 June 2017; Amartya Sen, Development as Freedom (OUP 1999) 20, 24-25.

63 Oxfam International, 'An Economy for the 1%' (18 January 2016) 210 Oxfam Briefing Paper, 2 <www.oxfam.org/en/research/economy-1> accessed 23 June 2017.

64 In the Communist Manifesto, Marx and Engels stated that under capitalism, the working man was left in a position where 'instead of rising with the progress of industry, [he] sinks deeper and deeper below the conditions of existence of his own class. He becomes a pauper, and pauperism develops more rapidly than population and wealth', see Karl Marx and Friedrich Engels, *The Communist Manifesto. From an 1888 Edition* (electronic resource, first published 1848, The Floating Press 2008) 26; this predicament appears

the very least, there is a contradiction between societies shaped by the notion of rights in a background characterized by these disparities.[65] Yet, in what way more exactly are social inequalities the *stuff* of human rights law? To what extent is greater inequality a signal of social rights' failure?

The present study critically looks at these problems from the perspective of one single human right: the right to the highest attainable standard of health − from now onwards the right to health − under international human rights law. More specifically, this thesis refers only to access to health and within that, access to healthcare.

I take T H Marshall's point that social rights contribute to diminishing the gap of inequality of condition.[66] Yet, as he also stated, social rights' main contribution consists not in ensuring an equal material reality, but in guaranteeing an equality of *status*.[67] I understand this as the equal possibility for people to freely realize their personality.[68] This view is consistent with the formulation of Article 22 of the Universal Declaration of Human Rights in the sense that the object of social rights is to guarantee 'the dignity and free development of the personality'. Finally, the idea that social rights pursue equality of status should not be used to disregard the importance of equality of outcome. Paraphrasing Anne Phillips, equality of outcome remains an unavoidable mechanism for measuring how real equality of opportunity was.[69]

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linked to the Marxist critique of representative democracy. The contradiction between democracy and capitalism, according to Brian Roper, appears linked to the 'undemocratic nature of capitalist relations of production. The generalized commodification of labour power disguises the authoritarian nature of social relations in the sphere of production (workplaces are generally organized hierarchically and undemocratically), and also the undemocratic nature of resource allocation by market mechanisms. In other words, the relations of production that are constitutive of the capitalist mode of production are necessarily undemocratic precisely because they rest on the systematic exclusion of the immediate producers from exercising effective control over the means of production labour-power and resource allocation'. Brian Roper, *The History of Democracy: A Marxist Interpretation* (Pluto Press 2013) 238.

65 As has been recognized in UN declarations: Declaration on Social Progress and Development, UNGA Res 2542 (XXIV) 11 December 1969, preamble, art 2; Declaration on the Establishment of a New International Economic Order, UNGA Res 3201 (S-VI), 1 May 1974, 4(b); Rio Declaration on Environment and Development (1992) UN Doc A/CONF.151/26 (vol. I), 31 ILM 874, principle 5; OHCHR, 'Report of the Independent Expert on Human Rights and International Solidarity, Virgina Dandan', UN Doc A/HRC/26/34, 1 April 2014, Annex, para 4(2)(a).

66 T H Marshall, *Citizenship and Social Class and Other Essays* (CUP 1950) 56.

67 ibid.

68 Johannes Morsink, *The Universal Declaration of Human Rights: Origins, Drafting, and Intent* (University of Pennsylvania Press 1999) 88; Ricardo García and Víctor de-Currea-Lugo emphasize its connection with liberty, (García (n 26) 34; Víctor de-Currea-Lugo, *Cuadernos Deusto de Derechos Humanos. La Salud Como Derecho Humano: 15 Requisitos y una Mirada a las Reformas* (Universidad de Deusto 2005) 23).

69 Addressing the problem of discrimination against women, Phillips puts the argument in this way: 'The crucial move is the claim that equality of opportunity is a chimera if it has not generated equality of outcome in these fields. If the result of all our disparate choices and opportunities is that men nonetheless congregate in

Looking at the right to health from the perspective of international human rights law, I take the view that the *lex lata* element of this right is based on Article 12 of the International Covenant on Economic, Social and Cultural Rights besides the important provision of its Article 2(1).[70] In the borderline between what the right to health *is* and what the right to health *should be*, lie a series of interpretations.[71] I call the one on which I focus *the predominant interpretation of the right to health*. This interpretation fundamentally comprises the contributions of two UN bodies: the Committee on Economic, Social and Cultural Rights − consisting specifically of this Committee's General Comments and Concluding Observations − and the reports of the Special Rapporteur for the Right to the Highest Attainable Standard of Health. Yet, what this study also does − and hence its title − is to dig for another interpretation. The perspective I defend is based on what I consider to be a philosophically coherent standpoint that permeates social rights in general, and the right to health in particular: the principle of solidarity.

Solidarity's added value lies in the idea that liberty in social rights is delimited by equality. No other principle involves this idea with the same normative specificity and distinctiveness. Put differently, what solidarity does when defining the scope of social rights is to oppose an unequal liberty.[72] This is reflected in the maxim popularized by Marx: *from each*

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the higher echelons of the economy, predominate in positions of political influence, sweep up all the literary prizes, and never collect the children from school, the presumption must be that the opportunities were not so equal. We can judge, that is, the extent of the equality by checking on the results, and should be reluctant to credit an initial equality of opportunity if the outcomes prove so dissimilar'. Anne Phillips, 'Defending Equality of Outcome' (2004) 12 The Journal of Political Philosophy 1, 6.

70 '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', International Covenant on Economic, Social and Cultural Rights (adopted on 16 December 1966) 993 UNTS 3, art 2(1).

71 The Limburg Principles corroborate that the principles themselves and the Concluding Observations of the United Nations Committee on Economic Social and Cultural Rights are a set of 'recommendations' that 'should be taken into account', see UNCHR, 'Note Verbale Dated 5 December 1986 from the Permanent Mission of the Netherlands to the United Nations Office at Geneva Addressed to the Centre for Human Rights ("Limburg Principles")' (8 January 1987) E/CN.4/1987/17, paras 5, 83; OHCHR, 'Economic, Social and Cultural Rights: Handbook for National Human Rights Institutions' (Professional Training Series 12, United Nations, 2005) 6; Eibe Riedel, 'The Human Right to Health: Conceptual Foundations' in Mary Robinson and Andrew Clapham (eds), *Realizing The Human Right to Health* (3 Rüffer and Rub 2009); Brigit Toebes, 'Human Rights and Health Sector Corruption' in John Harrington and Maria Stuttaford (eds), *Global Health and Human Rights: Legal and Philosophical Perspectives* (Routledge 2010).

72 This is in line with Gerald Cohen's observation that in a market society 'money and its lack, imply relations of freedom and unfreedom' and that the protest against poverty is a plea 'against the extreme unfreedom of the poor in capitalist society, and in favour of a much more equal distribution of freedom'. Michael Otsuka (ed), *On the Currency of Egalitarian Justice, and Other Essays on Political Philosophy* (Princeton University Press 2011) 184-186.

according to his ability, to each according to his needs.[73] My goal is to explore whether solidarity can teach us something about the limitations, challenges and contradictions involved in an individualized understanding of the right to health while at the same time exploring what it means to link solidarity with the duties and institutions that make the right to health possible. In this way, the study's research question can be formulated as follows: *How does the principle of solidarity inform the right to health?*

3. HYPOTHESIS

Considering that the avoidance of armed conflict, access to water and sewage, environmental protection or in general, action on the social determinants of health can have a greater impact on human health and inequality,[74] focusing on healthcare may seem an arbitrary choice. I hope to be able to show that the reasons for limiting the study to access to healthcare contribute to the explanation of why the right to health − and social rights more in general − are in fact human rights and not mere rhetorical devices destined to invigorate social policy. While doing this, I hope to be able to make sense of the reasons behind the research question of this study.

One may wonder whether healthcare could not be approached under a purely utilitarian rationale only. As a matter of fact, this perspective carries weight: in the field of social rights resources are particularly scarce while the list of human needs they serve is long, multifaceted and urgent. Therefore, when stating that what fundamentally galvanizes the human right to health is not utilitarian calculation, this should not be understood to mean that planning or cost-effective considerations are unimportant. In line with the Alma-Ata Declaration,[75] I regard the most efficient use of these scarce resources as an issue of an importance so pivotal that the interpretation I put forward in chapter four is greatly driven by this concern. Yet, if this were so, would not then a utilitarian approach − understood as the greatest impact for the greatest number – be the approach that fits this study better? The most immediate reason why that is not the case lies in positive law: Article 12(2)(d) of the International Covenant on Economic, Social and Cultural Rights makes clear that the right to health is not just about the most cost-effective policy, but it involves the integration of several actions, one of which is indeed healthcare.[76]

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[73] Karl Marx, *Critique of the Gotha Programme* (first published 1875, The Electric Book Company 2001) 20.

[74] Octavio Ferraz and Fabiola Vieira 'Direito à Saúde, Recursos Escassos e Equidade: Os Riscos da Interpretação Judicial Dominante' (2009) 52 (1) DADOS – Revista de Ciências Sociais Rio de Janeiro 223, 225.

[75] WHO, 'Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR' (6-12 September 1978), para VII (5).

[76] Ooms (n 47) 35.

However, in my view, the deepest reason why healthcare must be incorporated in any definition of the right to health is of an ethical nature.[77] When Dr Martin Luther King Jr stated that 'out of all disparities health inequities are the most shocking and inhumane',[78] he was providing a justification for the right to health as a social right. The public and social dimensions intertwined in Dr King's statement provide the distinctive ethical argument behind the right to health. Namely, that no one in a community should be deprived of an effort and techniques so critical to embody the fine line between death and life. Secondly, that the necessarily social and comparative nature of inequities means that healthcare is fundamentally a problem of justice to be collectively decided. And, as such, the focus as a human right should not be put on the individual interest to get healthcare, but on a community's decision of considering healthcare as something too important not to be addressed collectively. It is therefore wrong to connect the right to health to the right of a person or a group of persons. Speaking of the right to health means speaking about *a people's* right to health.

Hence, the thesis' research problem consists in identifying the legal nature of the right to health. In this respect, the hypothesis of the study is that it is solidarity and not the extension of legal rights that gives this social right its distinctiveness. This is because it is the content of the right to health − not other human rights − what needs to become protected and enforced. Solidarity entails that the entitlements of the right cannot be distributed in accordance to a private and unequal logic (ability to pay), but in accordance to a public logic based on principles of distributive justice (citizenship and medical need). When this is so, the result of interpreting the duties of this right in accordance to solidarity means that all members of the community – not just the poor – will share the limitations derived from the scarcity of the goods and services social rights involve. In this way, the role of social rights shifts into guaranteeing an equality of status by rendering access to healthcare a public common good. When informed by solidarity, the right to health becomes not a legal right but fundamentally a non-marketed right to access a public healthcare service. I believe that this interpretation is what more properly answers the dilemma set by the Human Rights World Conference held in Vienna in 1993. The outcome of this reunion was that all human rights were interrelated, indivisible and had to be protected on an equal footing.[79] As I show further on in this thesis, rather than protecting what is distinctive in social rights, the specific elements of social rights have been collapsed in the technique of legal rights. Since equal protection cannot exist when the basic components of one set of rights transmute

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[77] The former Special Rapporteur for the Right to Health, Paul Hunt defines it as a core social institution, UNCHR, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Paul Hunt', UN Doc E/CN.4/2006/48, 3 March 2006, para 20.

[78] Dr Martin Luther King Jr, 25 March 1966, 2nd National Convention of the Medical Committee for Human Rights.

[79] OHCHR, 'Vienna Declaration and Programme of Action' (12 July 1993) Un Doc A/CONF.157/23, para 5; Brigit Toebes, *The Right to Health as a Human Right in International Law* (Intersentia 1999) 307[81].

into those of another, I will therefore explore whether solidarity allows to protect the right to health in a way where its specific content is protected, rather than absorbed.

This perspective coincides with criticisms that in other contexts have been formulated against the overreliance on rights as a project of emancipation. As Makau Mutua has put it in the context of South Africa's transition, the exaggeration of the logic of legal rights has led to a *technification* of social justice:

> [W]ithout doubt, rights discourse was indispensable as a strategy for energizing the anti-apartheid movement. But rights rhetoric cannot and should not be the primary, and in this case the only, instrument for the transformation of apartheid's legacies. At the very least, rights discourse must be one of several tools, policies and approaches deployed to alter the institutional features of the apartheid state.[80]

The thesis will show that when informed by solidarity, the right to health entails two main duties. The first of these duties takes place in the international arena and relates to Article 28 of the Universal Declaration of Human Rights. The right to health, as much as all the human rights contained in the Universal Declaration, must be understood in the larger context of assisting the right of an equitable international order.[81] In this sense, the most intense impairment against the right to an equitable international order takes place by offending another right – the right to self-determination. Armed conflict, apartheid and colonialism are among the starkest forms of disregard of the right to health and the right to self-determination.[82] For this reason the right to

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[80] Makau Mutua, *Human Rights: A Political and Cultural Critique* (University of Pennsylvania Press 2002) 152.

[81] Contrary to this view, Hayek dismissed Franklin Delano Roosevelt's Four Freedoms speech and rights, such as the one of Article 28 of the Universal Declaration of Human Rights as 'an irresponsible game', see Hayek, *Law* (n 17) 263-265.

[82] According to a report from the UN Millennium Project Task Force on Child Health and Maternal Health 'more than 40 countries, 90 percent of them low-income nations, are dealing with armed conflict', see Lynn Freedman and others, 'Who's Got the Power? Transforming Health Systems for Women and Children' (United Nations Millennium Project Task Force on Child Health and Maternal Health 2005) 77; according to the Europe-Third World Centre, 'there is no doubt that the armaments industry ... is the most dangerous sector, not only for health but for the right to life', see Melik Özden, 'The Right to Health: A Fundamental Human Right Affirmed by the United Nations and Recognized in Regional Treaties and Numerous National Constitutions' (Europe-Third World Centre (CETIM) 2006) 20; Upendra Baxi, 'The Place of the Human Right to Health and Contemporary Approaches to Global Justice: Some Impertinent Interrogations' in John Harrington and Maria Stuttaford (eds), *Global Health and Human Rights: Legal and Philosophical Perspectives* (Routledge 2010) 13-14; the Turkish Medical Association states that 'as one of the two leading phenomena threatening human life throughout the history, war is the priority public health problem that must be fought against and eliminated', see Turkish Medical Association, 'Rapid Assessment of Health Services in Eastern and South-Eastern Anatolia Regions in the Period of Conflict Starting From 20 July 2015' (Turkish Medical Association Publications 2015) 22; Donna Perry, Christian Guillermet and David Fernández, 'The Right to Life in Peace: An Essential Condition for Realizing the Right to Health' (2015) 17 (1) Health and

self-determination, one of the few provisions common to both international covenants, is often a pre-requisite of the right to an equitable international order. The right to self-determination should not be understood only in tension with human rights,[83] but also in alliance with human rights, such as the right to health. The right to health should never be disconnected from obligations in the international arena. The implications of this duty, however, are not the focus of this thesis.

The second most critical duty to guaranteeing the right to health under solidarity, requires protecting the distinctive attributes of this social right. I claim that that is not a goal as simple as to merely extend justiciability to social rights. Without prejudice to the fact that courts may be important to secure non-discrimination, this element or individual justiciability of the right to health are not the defining elements of social rights' protection. As this study shows, the overemphasis on access to court has distracted attention from what really is at stake in the right to health. As I argue in the second half of chapter four, the right to health calls for an interpretation in line with what I regard as social rights' inherent elements: their democratic pedigree, the principles of distributive justice that these rights uphold, the trade-offs that describe these rights' background and the collective nature of the remedies that best address their social nature. Protecting the right to health from the perspective of solidarity means adopting a *logic* of increasingly socializing access to healthcare.

The 2008 financial crisis represents the beginning of the end of the triumphalist neoliberal, cosmopolitan and new constitutionalist expectations that succeeded the falling of the Berlin Wall.[84] I am sceptic of understandings of social rights that circumvent the crucial role of the State. Not because the State unequivocally leads to emancipation but rather, on the assumption that if the State is not put at the service of the emancipatory ends, the human rights project will remain flawed. For this reason, I take the view that the duties behind the right to health refer to an obligation that must be fulfilled primordially by the State and of which all human beings are *prima facie* recipients.[85] Citizens no doubt belong to these recipients.[86] Yet, I claim that all individuals subject to the State's jurisdiction are beneficiaries in the same terms as

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Human Rights Journal 148, 149.

83 Steven Ratner, *The Thin Justice of International Law: A Moral Reckoning of the Law of Nations* (OUP 2015) 272-273.

84 An example can be found in Ferrajoli (n 10) 38; an example of a reaction against the economic triumphalism of the 1990s can be found in Joseph Stiglitz who, already in 2009, stated that 'the first decade of the twenty-first century is already being written down as a lost decade. For most Americans, income at the end of the decade was lower than at the beginning. Europe began the decade with a bold new experiment, the euro – an experiment that may now be faltering. On both sides of the Atlantic, the optimism of the beginning of the decade has been replaced with a new gloom. As the weeks of the downturn − the New Malaise − stretch into months, and the months become years, a new gray pallor casts its shadows'. Stiglitz, *Freefall* (n 44) 343.

85 Dyzenhaus (n 9) 288; García Manrique (n 26) 34-36; Ratner (n 83) 270.

86 Ratner (n 83) 269-270.

citizens.[87] Even further: in line with Article 28 of the Universal Declaration, the State obligation should be understood to reach every human being. Practical reasons and respect for the right to self-determination put the State in a position to comply with this obligation indirectly, via international cooperation.

Unlike this view, the predominant interpretation of the right to health understands the right to health as a legal right, namely, as an individual or group entitlement.[88] This entitlement refers either to a specific healthcare treatment or a minimum healthcare provision over which the right holder would possess a right to property.[89] I shall argue how this view is largely unable to identify the duties necessary for everyone to access equal healthcare. Moreover, I will show how, despite its targeted focus on the vulnerable, the legal rights approach has difficulties when focusing on the poor. This is because the predominant interpretation of the right to health, unlike what is the case with classical rights, recognizes the poor only to have partial rights in the field of social rights. This derives from this interpretation's acquiescence in allowing the commercial logic of the healthcare industry permeate the provision of the goods and services protected by human rights.

My goal is not to argue that the actual references to solidarity that can be found in various legal instruments generate legal obligations different from those envisioned by the

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87 ibid 269.

88 Iain Byrne considers that while states are free to decide the means to realize the ICESCR, the arrangements they choose must be effective, namely, 'appropriate means of redress, or remedies, must be available to any aggrieved individual or group, and appropriate means of ensuring governmental accountability must be put in place'. Iain Byrne, 'Enforcing the Right to Health: Innovative Lessons From Domestic Courts' in Mary Robinson and Andrew Clapham (eds), *Realizing the Human Right to Health* (3 Rüffer and Rub 2009) 525; Benjamin Mason and Ashley Fox complain that the individual right to health needs to be complemented with a framework of collective rights, Benjamin Mason and Ashley Fox, 'International Obligations Through Collective Rights: Moving From Foreign Health Assistance to Global Health Governance' (2010) 12 (1) Health and Human Rights Journal 61, 62; according to David Landau 'courts are likely to enforce social rights either by issuing negative injunctions or by giving individualized remedies to individual plaintiffs', see David Landau, 'The Reality of Social Rights Enforcement' (2012) 53 (1) Harvard International Law Journal 402, 408; Alicia Yamin states that 'the civil law, or mixed civil-common law jurisdictions in Latin America, where thresholds for standing and bringing claims are extremely low, produce high levels of individual litigation for treatments and services, which as a general matter exploit the system but do not attempt to transform it'. Alicia Yamin, 'Editorial: Promoting Equity in Health: What Role for Courts?' (2014) 16 (2) Health and Human Rights 1.

89 One can observe a parallel with elements that derive from social rights such as the right to social security but due to *rationae materiae* limitations they have been addressed through individual rights. Janneke Gerards has observed this development as elaborated by the European Court of Human Rights in the field of social benefits, where they would have been understood as 'possessions'. Gerards notes that the property construct (finally consolidated in the *Stec* case), together with the reasoning by analogy and case-based argumentation mechanisms of the Court, stimulate individuals 'acting out of self-interest' to bring their different interests to the Court. Janneke Gerards, 'The Prism of Fundamental Rights' (2012) 8 (2) European Constitutional Review 173, 182.

predominant interpretation of the right to health. Showing that solidarity, although a formally foundational principle in human rights law, has remained largely unexplored, the study's general research goal consists in inquiring whether there is both theoretical and normative ground to widening the legal horizons of the right to health. This task is carried out with the view that only a new vision on the duties of the right to health can help human rights re-encounter its social justice roots. Currently, the right to health can do little to drive the question of access away from individual ability to pay. At the dawn of this twenty-first century, the rent-seeking characteristics of the businesses run by the healthcare industry allow describing the health sector as the era of commercialization.[90] The challenge for the right to health means to shift from that and transform the financing and provision of healthcare into a public service conditional on citizenship and medical need.

Furthermore, using the perspective of solidarity in the context of this study is not grounded in a claim of impartiality. Solidarity does not fit the idea of legal, let alone scientific neutrality. But the same can be said of any other legal notion that appears neutral today. Take the idea of equality. At the beginning of the European eighteenth century, when most people lived under the rule of absolute monarchs claiming to exercise their power by direct authorization from God, equality was certainly contested. And the same thing can be said about democracy and the human right to vote in the context of the European nineteenth and twentieth centuries and pretty much about every other legal notion. None of these notions are neutral and obtain their persuasiveness and legitimation from historical events and historical contexts. By the same token, today's exceptions to the rule − monarchies in the twenty-first century, for example − are the starkest expression not only that principles are not neutral but also that the most conspicuous advocates of the rule of law, democracy and human rights, by focusing on the challenges to democracy 'far away', also are not. This corroboration, rather than leading to sceptic cynicism, should reinvigorate and help legitimize the efforts of legal scholars that understand human rights research as an emancipatory project at the service of the oppressed majorities of our world. As stated by José Mujica, President of Uruguay between 2010 and 2015 before the United Nations General Assembly:

> Las Repúblicas nacidas para afirmar que los hombres somos iguales, que nadie es más que nadie, que sus gobiernos deberían representar el bien común, la justicia y la equidad muchas veces se deforman y caen en el olvido de la gente corriente. No fueron, Las Repúblicas, construidas para vegetar encima de la Grey, sino por el contrario son parte funcional de la misma y se deben por lo tanto a las mayorías.[91]

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[90] David Harvey, *The Enigma of Capital and the Crises of Capitalism* (Profile Books 2011) 220; John Lister, *Health Policy Reform. Global Health Versus Private Profit* (Libri Publishing 2013) 211; Stiglitz, *Inequality* (n 48) xxxi-xxxii, 121.

[91] 'The Republics, which were born to affirm that all men are equal, that no one is worth more than any other, that governments should represent the common good, justice and equity, often fall deformed and forgot ordinary people. Yet, the Republics were not created to vegetate over the multitude. On the contrary, they are

The law does not work with aseptic materials. By putting forward the notion of solidarity I am not attempting to convince the reader about the impartiality of this notion. More humbly, my effort consists in providing arguments that will hopefully be persuasive about the ability of the legal construct of solidarity to provide a more consistent explanation of social rights such as the right to health.

4. STRUCTURE

The plan towards answering the research question of the study is as follows. Chapter two begins by looking at the predominant interpretation of the right to health. Generally, a more descriptive kind of analysis, this point of departure is essential to our purposes as it allows to contrast the present state of affairs of social rights with the notion of solidarity that will be presented further on. This transition to solidarity takes place by the end of the chapter, where a few problems are formulated. One of the main ones is the predominant interpretation's inability to clearly identify duties and institutions able to realize the promises of this right.

Chapter three digs into the principle of solidarity. The chapter investigates solidarity's meaning, its origins and its link to the right to health. The task is finished by looking at both international human rights and various world constitutions. Within international human rights, expressions of solidarity can be found in several instruments, importantly in the Universal Declaration of Human Rights, but also other instruments specifically linked to the right to health.

The study's main hypothesis is fully developed in chapter four. This chapter provides a more normative analysis. Adopting the challenge of overcoming human rights fragmentation and taking into consideration the insights of chapters two and three, this chapter critically addresses the predominant interpretation of the right to health. More specifically, I look at the aptitude of the legal techniques this interpretation deploys to realizing the goals of this right. I maintain that basic frameworks within human rights law, such as the normative framework of the right to health, as advanced by General Comments 3 and 14, lead to a contradictory account that makes it hard to address the fundamental concerns of social rights. By the same token, the chapter shows how important notions within this trend such as non-discrimination or affordability do not lead to the consolidation, promotion or enforcement of the institutions needed to guarantee the main promise of this right, namely, equal access to healthcare for all. I argue that this is a major problem when seeking to accomplish human rights promises, namely, to enfranchise the entire community equally. While the chapter begins by critically addressing the elements put forward

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a functional part of them and they therefore owe themselves to those majorities.' UN News Centre, 'Uruguayan President Focuses on Climate Change, Environment in UN Assembly Speech', 24 September 2013 <http://www.un.org/apps/news/story.asp?NewsID=45989#.WaGIdYolFKs> accessed 23 June 2017.

in chapter two, it concludes by examining the implications of a solidarity-based interpretation of this human right.

Chapters five and six are devoted to the jurisprudential and institutional implications derived from the discussion in chapter four. Chapter five assesses a selection of salient judicial decisions that have attracted international attention. The chapter begins with a critical account of the ways in which the right to health has been enforced under the purview of the predominant interpretation of the right to health. In this respect, it is argued in the study, the essentialist and individualistic focus of human dignity as an interpretational tool does not help identify the duties and institutions needed to protect the right to health. This does not mean that there is something wrong with the notion of human dignity. What I argue is wrong is the attempt to expect values like dignity and principles like non-discrimination to realize the entirety of the human rights enterprise. Furthermore, the chapter seeks to answer what it means to adjudicate the right to health from the perspective of solidarity, and how this perspective helps the right to health become part of the distinctive category of social rights.

Chapter six argues that the legal rules concerning the provision and financing of health systems are *the* main challenges for the right to health to address. After looking at a variety of health-financing systems, the predominant interpretation of the right to health appears to fit much more easily with the application of medicalised focuses that could be detrimental to the financial sustainability of healthcare systems. On the contrary, the solidarity perspective of the right to health hypothesized in chapter four fits more naturally with the free-of-charge focus that allows the universal and equal ensuring of the right to health.

5. METHODOLOGY

This thesis is placed in the field of international human rights law, and human rights legal theory. Traces of legal philosophy, constitutional law, social theory, economy and public health can also be found. This attempt to exceed the boundaries of the law is deliberate. The methodology responds to the conviction that addressing the topic of social rights exclusively from the legal perspective is a flawed approach. As chapter three shows, the entire picture, history and purpose of social rights becomes blurred when addressed only from the legal perspective.

Primary literature includes international human rights law instruments, salient cases from various jurisdictions, legal norms dealing with the fundamental framework of the reviewed health-financing systems, and some domestic legal norms enshrining solidarity. Secondary sources include specialized literature in the abovementioned fields. The analysis of the literature is based on the so-called *good reasons* approach. This approach is concerned with:

> [W]hat one is justified in believing or doing in light of an actual, contextualized process of argument. This process of argumentation is socially situated in the sense that ideas are taken as

> good reasons and afforded different weights in the light of an assumed context. It is a pragmatically oriented process, because what is important is to provide enough backing to justify belief or action, even when theoretical certainty is not achieved.[92]

This study is comprised of both descriptive and normative parts. A mostly descriptive account of the right to health would not be recommendable given the existence of Brigit Toebes' work, one of the most comprehensive studies in the field.[93] This is therefore a normative and critical study. A normative study is not the same as biased research. The latter assumes the inherent truth of a certain hypothesis, accumulating evidence to its favour and simply discarding the alternatives. A normative study, on the other hand, focuses not on the law as it is, but addresses the law from the perspective of principles that are insufficiently developed. This process involves a confrontation of arguments, legal evidence, interpretations, and doctrines. As to the critical nature of the study, I think that the legal scholarship should consider the words of Monedero:

> Por el contrario, no hay mayor ratonera que la de condenar a la inteligencia a pensar que sólo existe un presente desconectado de su pasado. Se trataría de defender que las cosas no sólo no son ahora de otra manera, sino que no han podido ser jamás de otra manera, que nunca fueron en realidad de otra manera, y que no podrán ser de otra manera en el futuro. Por eso, reconstruir el pasado buscando en él las claves de explicación y justificación de los conflictos actuales (en marcha o potenciales) es un primer paso relevante en el camino de la emancipación ... Como señala Walter Benjamin en su "Tesis VII", hay que "cepillar la historia a contrapelo", para que salte lo que estaba escondido en la trama del tejido.[94]

My work identifies itself with the 'protest school' of thought.[95] This is reflected in my focus on the principle of solidarity. Solidarity is one of the normative and critical elements of the study. I have avoided shying away from the application of this principle.[96] The reasons for this are

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92 Gustavo Arosamena, *Rights, Scarcity, and Justice: An Analytical Inquiry into the Adjudication of the Welfare Aspects of Human Rights* (Intersentia 2014) 11.

93 Toebes, *International* (n 79).

94 'On the contrary, there is not greater trap than condemning intelligence to thinking that the present is disconnected from the past. It would be about defending not only that things are not otherwise now, but that they could have never been otherwise, and that they will also not be otherwise in the future. Therefore, reconstructing the past seeking the keys of explanation and justification of the present conflicts (either potential or in motion) is a first relevant step in the path toward emancipation … As stated by Walter Benjamin in his 'Thesis VII', history must be brushed against the grain', so that that which is hidden comes out.' Juan Carlos Monedero, *El Gobierno de las Palabras: Política para Tiempos de Confusión* (2nd edn, Fondo de Cultura Económica 2014) 124.

95 Marie-Bénédict Dembour, 'What Are Human Rights? Four Schools of Thought' (2010) 32 (1) Human Rights Quarterly 1, 9.

96 As with different principles Hayek would do, see F A Hayek, *New Studies in Philosophy, Politics, Economics, and the History of Ideas* (first published 1967, Routledge 1978) 264.

twofold. On the one hand, by allowing principles to fully unleash themselves, one may see more clearly their less positive sides, something inherently constructive. I think it is a bad intellectual habit to too easily nuance the effect of legal principles. If principles were to be rapidly modulated by considerations of proportionality, perhaps it would be better to spare the effort and declare that the only legal principle in force is proportionality.[97] On the other hand, by allowing principles to fully unleash themselves, it may become clear that what thwarts a principle is only a practical or political hindrance. For example, one could be tempted not to bring solidarity too far in order not to meet the formidable resistance of those who believe that human rights can be advanced by the business sector through commercialization.[98] Ferrajoli puts it in this way: '[I]f we do not want to hide the responsibilities of politics we must not confuse between conservation and realism, discrediting as "unrealistic" or "utopian" what simply contrasts with the interests of the strongest'.[99] While it is true that practical difficulties can be formidable, legal scholarship would greatly justify its function if it were to admit it, rather than disregarding the principles themselves. I have therefore tried to let the implications of solidarity to flow naturally and far.

As is clear by now the study does neither circumvent the posing of politically loaded questions nor does it avoid taking sides. Nevertheless, a sound scientific methodology does not assume that just because it deals with human rights it should be labelled as positive, an assumption often encountered within human rights legal research.[100] A way of nuancing this conundrum − never totally escaping it − consists in acknowledging that research on topics connected to social justice cannot be justified in a political vacuum. Thomas Piketty gave a good example of the intellectual honesty required when embarking on a research project with these variables: 'Whenever one speaks about the distribution of wealth, politics is never very far behind, and it is difficult for anyone to escape contemporary class prejudices and interests'.[101] Or, to put it even more explicitly as Sir Michael Marmot did:

> [S]ociety and health, by its nature, is a highly political issue. When we published the CSDH [Commission on Social Determinants of Health] report, one country labeled it 'ideology with evidence'. It was meant as criticism. I took it as praise. We do have an ideology, I responded: health inequalities that can be avoided are unjust ... Putting them right is a matter of social justice, but the evidence really matters.[102]

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97 For a critical appraisal of the effects of this principle, Lorenzo Zucca, *Constitutional Dilemmas: Conflicts of Fundamental Legal Rights in Europe and the USA* (OUP 2007) 88, 137; Guglielmo Verdirame, 'Rescuing Human Rights from Proportionality' in Rowan Cruft, Matthew Liao and Massimo Renzo (eds), *Philosophical Foundations of Human Rights* (OUP 2015).

98 For example, by substituting government obligations with NGO or community action, see London (n 46) 68.

99 Ferrajoli (n 10) 318.

100 Fons Coomans, Fred Grünfeld and Menno Kamminga, 'Methods of Human Rights Research: A Primer' (2010) 32 (1) Human Rights Quarterly 179, 182.

101 Thomas Piketty, *Capital in the Twenty-First Century* (HUP 2014) 4.

102 Michael Marmot, *The Health Gap: The Challenge of an Unequal World* (Bloomsbury 2015) 19.

If still unsatisfactory, I would gladly take the label of partiality in the way Archbishop Desmond Tutu would have done it:

> If you are neutral in situations of injustice, you have chosen the side of the oppressor. If an elephant has its foot on the tail of a mouse and you say that you are neutral, the mouse will not appreciate your neutrality.[103]

The study is based on qualitative legal research.[104] Chapter two assesses a review of mainly primary sources that extends to both hard and soft law norms. These correspond to human rights treaties and interpretational instruments issued by human rights bodies, respectively. Chapter three and four rely mainly on secondary literature except for the domestic law references. These two chapters develop a normative *lex ferenda* type of analysis. Chapters five and six do not have the ambition of carrying out comparative legal research. The main goal of these chapters consists only in illustrating the arguments put forward in chapter four.

Although I have looked at experiences from varied corners of the world, including Argentina, Bolivia, Brazil, Canada, Chile, Colombia, Cuba, Ecuador, Germany, the Netherlands, Paraguay, Peru, South Africa, Spain, the United States and Venezuela, I have written this thesis with my eyes on the Global South.[105] The Global South, a region that coped with colonialism and entered the neo-colonial era of commercialization at a younger age, has managed to build some resilience.[106] My hope is that the Southern peoples continue that trend so that access to healthcare becomes not an issue to be decided by the economic capacity of the family household, but as a human right, ie as something the community grants equally to all.

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[103] Robert McAfee, *Unexpected News: Reading the Bible with Third World Eyes* (Westminster Press 1984) 19.

[104] Joseph Maxwell, *Qualitative Research Design: An Interactive Approach* (Sage 2005) 22-23.

[105] Barreto (n 50) 404.

[106] An expression of this lies in the World Social Forum that gathers human rights grassroots activists, NGOs, indigenous movements, academics, working union federations, movements of peasants, and of women's rights. The World Social Forum is held in parallel to the World Economic Forum that annually gathers the political and economic elites of the world at Davos, Switzerland. It began in 2001 and has been carried in several cities of the world aside of its main seat in Porto Alegre. The World Social Forum had its origins in the first wave of international protests against neoliberal globalization (its routes can be traced back to the protests against the G7 in Seattle, in 1999). Joseph Stiglitz, *Globalization and its Discontents* (Penguin Books 2002) 3; Leo Panitch (n 22) 271; Vijay Prashad, *The Poorer Nations* (Verso 2014) 242-248.

CHAPTER TWO
THE PREDOMINANT INTERPRETATION OF THE RIGHT TO HEALTH

1. INTRODUCTION

As stated in the introduction of this thesis, a description of the right to health under international human rights law would not be original work. Brigit Toebes, in her *Right to Health as a Human Right in International Law*,[1] carried out such a task in a work that almost twenty years after its publication, remains an obligatory reference in the right-to-health literature. In this chapter I provide an account of the way this human right has been authoritatively interpreted. I have labelled the set of views comprising that understanding *the predominant interpretation of the right to health*.

The Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights are the instruments that I consider the *lex lata* dimension of the right to health. My analysis extends to the text of the right-to-health under these two instruments, including some references to the *travaux préparatoires*. According to Matthew Craven, the utility or value of the *travaux préparatoires* should be read in the light of Article 32 of the Vienna Convention on the Law of Treaties.[2] Namely, with the purpose of 'confirm[ing] the meaning resulting from the application of Article 31, or to determine the meaning when the interpretation according to Article 31: a) leaves the meaning ambiguous or obscure; or b) leads to a result which is manifestly absurd or unreasonable'.[3] Although various right-to-health provisions can be encountered in other important human rights treaties such as the Convention on the Rights of the Child[4] and the Convention on the Elimination of All Forms of

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

2 Matthew Craven, *The International Covenant on Economic, Social and Cultural Rights: A Perspective on its Development* (Clarendon Press 1995) 3.

3 Vienna Convention on the Law of Treaties (adopted 23 May 1969) 1155 UNTS 331, art 32.

4 Convention on the Rights of the Child (adopted 20 November 1989) 1577 UNTS 3, art 24.

Discrimination Against Women,[5] I have excluded them. The reason is that these instruments do not add any new element necessary for the sake of the arguments presented in this thesis.

After this analysis, I move towards the way these constitutive norms have been interpreted. Such a task leads me to focusing on the work of a few bodies. In the first place, the work of the United Nations Committee on Economic, Social and Cultural Rights (from now onwards, 'the Committee'). The bulk of its work has been carried out through General Comments that interpret the International Covenant on Economic, Social and Cultural Rights (from now onwards, 'the ICESCR' or 'the Covenant') − Articles 2(1) and 12 in particular − but also this body's Concluding Observations in processes of international periodic review. I also include the opinions expressed by the Special Rapporteur of the Right to Health and instruments issued by the United Nations Office of the High Commissioner of Human Rights. Finally, I also include documents from the International Commission of Jurists. As I explain further, the work of this organization has been crucial to the development of these interpretations. Although the Committee is the body that officially interprets the Covenant, I regard its interpretation *lex ferenda*. Different from the treaty itself, these interpretations have varied with time and Members States are not obliged to follow the Committee's view. Hence, discussing the coherency of this interpretation in the light of the promises of the integration and indivisibility of all human rights is an exercise where legal scholars should take part and which I exercise seeking to contribute to the effective realization of the Covenant.

2. THE BILL OF HUMAN RIGHTS

The Universal Declaration of Human Rights (from now onwards 'the Universal Declaration'), the International Covenant on Civil and Political Rights and the ICESCR comprise the Bill of Human Rights. The Universal Declaration constitutes the apex of the international human rights order. Published in San Francisco on 10 December 1948, the Universal Declaration influences the entirety of human rights law. While my focus is the right to health, looking at the context in which the Universal Declaration and the Covenant emerged helps introducing this right and the dilemmas inherent to its interpretation.

2.1. THE UNIVERSAL DECLARATION OF HUMAN RIGHTS

In spite of the different ideologies of the drafters of the Universal Declaration, it is possible to speak of a consensus within the Commission on Human Rights (from now onwards, 'the Commission') with regard to the intention of including economic, social and cultural rights in

[5] Convention on the Elimination of All Forms of Discrimination Against Women (adopted 18 December 1979) 1249 UNTS 13, arts 11(1)(f), 11(2)(d), 12(2).

its text.[6] The United States, the United Kingdom and Australia were the States that most strongly opposed the idea of including such rights in the text of the Universal Declaration.[7] That the United States accepted the inclusion of economic, social and cultural rights was largely thanks to the conciliatory role played by Eleanor Roosevelt. She defended her husband's legacy who had in turn advanced the notion of freedom from want.[8]

Several shifts in the position of the members of the Commission exemplify the ideological adjustments that every State had to make for the Universal Declaration to be adapted. The case of the Soviet Union exemplifies this. From a doctrinal perspective, Marxism is contrary to the language of rights. The Soviets would have wished the idea of the 'rights of the State' to prevail, while at the same time denying individual rights.[9] Marxism generally sees rights as bourgeoisie rights: entitlements that can at best be exercised by the capitalist class and that at worst can become a further instrument of oppression against the working classes.[10] The need to find a consensus led the Soviet Union to accommodate its views. It hence defended positions that acknowledged the importance of the duties of the individual towards the community and reinforced economic, social and cultural rights.

The inclusion of economic, social and cultural rights is not only the result of principled ideas, but it should also be understood as the result of pragmatic calculation.[11] Besides the abovementioned ideological adjustment, there was a widely shared view that failing to overcome the destruction and misery of the war would entail a fertile soil for the surfacing of doctrines contrary to Western democracy, a perspective put forward by older organizations such as the International Labour Organization.[12] The delegates, citing the preamble of the Charter of the United Nations[13] and backed by the ideological legacy of President Roosevelt, made direct

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6 Only the South African Union expressed that the UN Charter should not have as a purpose to include these rights. According to Samnøy, the only impact of this intervention was that of strengthening even further the opinion of the delegates of including these rights as South Africa was already very isolated, see Åshild Samnøy, *Human Rights as International Consensus: The Making of the Universal Declaration of Human Rights 1945-1948* (Chr. Michelsen Institute 1993) 83.

7 Mary Ann Glendon, *A World Made New: Eleanor Roosevelt and the Universal Declaration of Human Rights* (Random House 2001) 116; ibid 21-22.

8 Samnøy (n 6) 42-43.

9 M Glen Johnson and Janusz Symonides, *The Universal Declaration of Human Rights. A History of its Creation and Implementation, 1948-1998* (UNESCO Publishing 1998) 57.

10 ibid 43-44.

11 Samnøy (n 6) 20-21.

12 Daniel Roger Maul, 'The International Labour Organization and the Globalization of Human Rights, 1944-1970' in Stefan-Ludwig Hoffmann (ed), *Human Rights in the Twentieth Century* (CUP 2011) 304.

13 Which begins stating that 'We, the peoples of the United Nations, determined to save succeeding generations from the scourge of war, which twice in our lifetime has brought untold sorrow to mankind', Universal Declaration of Human Rights (adopted 10 December 1948) UNGA Res 217 A (III).

mention of the existing relation between the Universal Declaration, freedom from want[14] and the objective of impeding the scourge of war.[15]

While the interest of developing a declaration was linked to the purpose of building a minimum global agreement in the field of human rights after World War Two, the Universal Declaration was largely regarded as not legally binding by the superpowers.[16] The Secretary of the Commission John Humphrey considered that the attitude of the United States and other States, which made constant references to the non-binding value of the Universal Declaration, limited its importance and did not contribute to the cause of human rights.[17] Countries such as Chile and Lebanon, however, gave it more than a merely moral value.[18] Cassin, in turn, emphasized the danger of considering the Universal Declaration as lacking all legal value and only as an orientation. For him, the Universal Declaration was supposed to constitute a complement and clarification of the Charter of the United Nations.[19] With the same argument, the representative of Chile, Hernán Santa Cruz, suggested that insofar human rights entailed a constitutive part of the principles of the UN, any violation of the Universal Declaration would involve a violation of the Charter.[20] As the Universal Declaration has gradually become part of international customary law, international law has confirmed its importance.[21] Yet, the opinion that prevailed was that of the United States in the sense that the legally binding document would emerge in the form of the future Covenants.[22]

Independently of the question of its legal value, the Universal Declaration has had an important effect. Its norms gave an impulse to emancipatory political processes such as the decolonization of Africa,[23] the creation of regional human rights systems in Europe, the Americas and Africa, and permeated the provisions of several constitutions.

Norms concerning economic, social and cultural rights are included in Articles 22 to 27 of the Universal Declaration. They include the right to social security, the right to work, the right to rest and leisure, the right to an adequate standard of living (which includes adequate medical

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14 The second paragraph of the Preamble of the Declaration states that 'Whereas disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind, and the advent of a world in which human beings shall enjoy freedom of speech and belief and freedom from fear and want has been proclaimed as the highest aspiration of the common people'. ibid.

15 Johnson and Symonides (n 9) 55; Glendon (n 7) 238.

16 Hersch Lauterpacht, 'The Universal Declaration of Human Rights' in Joseph Weiler and Alan Nissel (eds), *International Law. Critical Concepts in Law*, vol 4 (Routledge 2011) 493-521.

17 Johnson and Symonides (n 9) 64-65.

18 Samnøy (n 6) 73; Lauterpacht (n 16).

19 Johnson and Symonides (n 9) 65.

20 ibid 64-65.

21 Toebes (n 1) 40.

22 Johnson and Symonides (n 9) 62.

23 Jochen von Bernstorff, 'The Changing Fortunes of the Universal Declaration of Human Rights: Genesis and Symbolic Dimensions of the Turn to Rights in International Law' (2008) 19 (5) The European Journal of International Law 903, 912; Johnson and Symonides (n 9) 67.

care), the right to education, the right to participate in the cultural life of the community and the right to an equitable social and international order. The inclusion of economic, social and cultural rights entails an illustrative example of how the Universal Declaration was not born in an ideological vacuum, but in a context marked by a strong social concern. The delegates developed their work with the legacy of the social policies implemented in the nineteenth and twentieth centuries, but also with the expectation of expanding the welfare state.[24] Drawing on the experience of social policies from Western Europe, the Scandinavian countries, the United States' *New Deal* legislation, the Soviet bloc and some experiences of Latin-American countries, the majority of the delegates of the Commission accepted the inclusion of norms of economic and social content.[25]

Conflicts arose in relation to the legal nature and scope that those different norms were supposed to have, an issue that remains controversial. The right to health exemplifies this conundrum. Not only because the language that was used to address the right to health considerably varies from the Universal Declaration to the Covenant, but also because these different notions coincide with different conceptions about the role of the State, its relationship with the economy, the nature of the public and private divide and definitions of the nature and scope of human rights altogether.[26]

2.2. THE INTERNATIONAL COVENANT ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS

I shall discuss two issues here. Firstly, I shall pose a question which I will attempt to answer further on in the study concerning the individual legal scope of the rights enshrined in the Covenant. Secondly, I shall assess a few issues that emerged in the context of the Covenant's *travaux préparatoires* regarding the material scope of the obligations established in Article 12.

Are the rights enshrined in the Covenant exclusively legal rights? A stark contrast can be found in terms of the different scope of the provisions of the International Covenant on Civil and Political Rights by comparison to the ICESCR. While the International Covenant on Civil and Political Rights established that: 'Each State Party to the present Covenant undertakes to respect and to ensure to all *individuals* within its territory and subject to its jurisdiction the rights recognized in the present Covenant...',[27] the ICESCR established that: 'Each State Party to the present Covenant undertakes to take steps...' This is a significant omission from the Economic,

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[24] Bård-Anders Andreassen, 'Article 22' in Gudmundur Alfredsson and Asbjørn Eide (eds), *The Universal Declaration of Human Rights: A Common Standard of Achievement* (Martinus Nijhoff Publishers 1999).

[25] The role of the Chilean delegate Hernán Santa Cruz was crucial in this respect, see Johannes Morsink, *The Universal Declaration of Human Rights: Origins, Drafting, and Intent* (University of Pennsylvania Press 1999) 89-90, 131.

[26] Andreassen (n 24) 477.

[27] International Covenant on Civil and Political Rights (adopted 16 December 1966) 999 UNTS 171, art 2(1).

Social and Cultural Rights Covenant by comparison to the Civil and Political Rights Covenant. I am not referring to the largely theorized discussion between the language of 'respecting and ensuring' by comparison to the language of 'taking steps'.[28] Rather, I am asking who are the beneficiaries of the Economic, Social and Cultural Rights Covenant? While the reference to 'all individuals' seems to be linked to the importance of excluding non-individuals such as corporations,[29] I find this strong emphasis of the Civil and Political Covenant on individuals remarkable by comparison to the total absence of any such mention by the Economic, Social and Cultural Rights Covenant. By the same token, the most important legal comments written about the ICESCR − Craven's[30] and Saul and others[31] − do not make any reference to this issue. The debate has been mostly centred in the by now old discussion of whether economic, social and cultural rights can or not be considered justiciable rights.[32] I shall deal with this interrogation further in the thesis. A second topic of interest concerns the *travaux préparatoires* of Article 12. These took place during the seventh and eighth session of the Commission. Further, discussions took place in the Third Committee of the United Nations General Assembly.[33]

The right to an adequate standard of living in the Universal Declaration was made the object of a specific provision in Article 11 of the Covenant. In turn, the notion of adequate medical care from the Universal Declaration was transformed in the more comprehensive right to the highest attainable standard of physical and mental health of Article 12 of the Covenant. For this, the drafters of the Covenant relied less on the Universal Declaration and more on the Constitution of the WHO.[34] This provision does not have its antecedent in the Universal Declaration, but in fact in the older language taken from the Constitution of the WHO. While the Universal Declaration was published on 10 December 1948, the Constitution of the WHO

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28 Asbjørn Eide and Allan Rosas, 'Economic, Social and Cultural Rights: A Universal Challenge' in Asbjørn Eide, Catarina Krause and Allan Rosas (eds), *Economic, Social and Cultural Rights: A Textbook* (2nd edn, Martinus Nijhoff Publishers 2001) 23.

29 For example, in the opinion of Thomas Buergenthal, the reference to all individuals should be considered indicative of the fact that 'only natural persons are protected by the Covenant [by contrast to] corporations and other legal entities [which] do not have "human rights"', Thomas Buergenthal, 'To Respect and to Ensure: State Obligations and Permissible Derogations' in Louis Henkin (ed), *The International Bill of Rights. The Covenant on Civil and Political Rights* (Columbia University Press 1981) 72, 73; also Marc J Bossuyt, *Guide to the "Travaux Préparatoires" of the International Covenant on Civil and Political Rights* (Martinus Nijhoff Publishers 1987) 53.

30 Craven (n 2).

31 Ben Saul, David Kinley and Jacqueline Mowbray, *The International Covenant on Economic, Social and Cultural Rights: Commentary, Cases, and Materials* (OUP 2014).

32 Eide and Rosas (n 28) 10; UNCESCR, 'General Comment 9: The domestic application of the Covenant', UN Doc E/C.12/1998/24, 3 December 1998, para 10; Martin Scheinin, 'Justiciability and the Indivisibility of Human Rights' in John Squires, Malcolm Langford, Bret Thiele (eds), *The Road to a Remedy: Current Issues in the Litigation of Economic, Social and Cultural Rights* (Australian Human Rights Centre 2005) 17.

33 Toebes (n 1) 41.

34 ibid 43.

was published in the First World Health Assembly, held in New York on 22 July 1946. The Constitution of the WHO stated in its Preamble 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.' Further, its Article 1 stated that 'the objective of the World Health Organization (hereinafter called the Organization) shall be the attainment by all peoples of the highest possible level of health'. The decision to follow the definition of the right to health as established in the Constitution of the WHO was adopted in opposition to the views of the representative from China, who proposed that the right to health should be limited to the obligations of the government with respect to this agency.[35] The opinion that prevailed was that of the representative of the Soviet Union, who proposed that the text should contain concrete obligations for the governments.[36] This perspective was supported by the representative of Chile, who highlighted the responsibility of the State in the adoption of preventive measures against diseases through public healthcare services.[37] These opinions were supported by the majority, and are reflected in the proposal of Egypt, further modified by the United States and Chile.[38]

Another important point was linked to the definition of health. Although the Commission did not incorporate this concept in the text of the Covenant, this was because the definition of health from the WHO was largely considered embedded in the Covenant.[39] The definition of health from the WHO made reference not only to the absence of illness, but it also extended to a complete state of physical, mental and social health.[40] Although the proposal to include that definition was expressly rejected,[41] the obligations that are mentioned in the second part of the Article reflect that the broader concept of health was indeed adopted.[42]

Another important issue concerned the content of the obligations. The opinion that prevailed was that of the representative of the Soviet Union, which included 'medical service' and 'medical attention'.[43] This was because despite the importance of a correct diagnosis, access

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35 ibid.
36 ibid.
37 H D C Roscam Abbing, *International Organizations in Europe and the Right to Health Care* (Kluwer 1979) 72.
38 ibid.
39 Toebes (n 1) 43.
40 Such a definition indicates 'Health entails a complete state of physical, mental and social wellbeing, and not just the complete absence of diseases', WHO, Constitution of WHO as adopted by the International Health Conference, New York, 19 June - 22 July 1946, signed on 22 July 1946 by the representatives of 61 States (Official Records of WHO, no 2, p 100) and entered into force on 7 April 1948.
41 Toebes (n 1) 48.
42 ibid 51-52.
43 ibid 43-44.

to medicines, hospitalization, and other similar aspects were also considered necessary especially given that in many countries both drugs and healthcare treatments were very expensive.[44]

Similarly, the obligations enumerated under paragraph 2 of Article 12 should be understood only as examples that at the time of the draft were considered urgent and not a type of exhaustive enumeration.[45] Despite that, H D C Roscam Abbing opines that Article 12 only constitutes a mentioning of the conditions deemed essential to the protection and promotion of individual health.

The final provision of Article 12 reads as follows:

> 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.

3. THE PREDOMINANT INTERPRETATION OF THE RIGHT TO HEALTH

3.1. INTRODUCTION

With the 'predominant interpretation of the right to health' I refer to a set of views put forward by a group of authoritative bodies within the United Nations. These bodies include the Committee, which has deployed its interpretation through General Comments and Concluding Observations, the Special Rapporteur of the Right to Health, which has put forward its perspective through Reports, and the United Nations Office of the High Commissioner of Human Rights, which has contributed through principles and guidelines, including the important Vienna Declaration and Plan of Action, issued after the Human Rights World Conference held in Vienna in 1993.[46] These views concern these bodies' understanding of economic, social and cultural rights in general and the right to health in particular. This analysis would be incomplete if one did not mention the work of the International Commission of Jurists. The depth of its

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[44] ibid 44.
[45] Roscam Abbing (n 37) 77.
[46] OHCHR, 'Vienna Declaration and Programme of Action', UN Doc A/CONF.157/23, 12 July 1993, para 5.

contributions is remarkable. Not only because of the coherence of its focus, but also because of the impact it has had on the work of the United Nations.

While the Covenant came into force in 1976, one decade afterward the International Commission of Jurists issued the Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights.[47] The Limburg Principles are a set of guidelines that resulted from a discussion held at the request of the International Commission of Jurists, the Urban Morgan Institute for Human Rights and the University of Cincinnati. The goal of the meeting was to elaborate on the legal nature and scope of the obligations of the State Parties regarding the ICESCR, the nature of the reports of State Parties, the role of the Committee and the theme of international cooperation. In 1997, exactly a decade after the delivery of this crucial contribution, the International Commission of Jurists issued the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights.[48] These Guidelines elaborated the Limburg Principles about the nature and scope of violations of economic, social and cultural rights as well as appropriate responses and remedies. In 1995, shortly before the Maastricht Guidelines, the Commission issued the Bangalore Declaration and Plan of Action, an instrument that emphasized the role of lawyers, contributing to settling a judicial focus on the understanding of economic, social and cultural rights.[49] As recently as 2011, a recognized group of international scholars in the field of economic, social and cultural rights participated in the issuing of the Maastricht Principles on the Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights.[50] This set of guidelines released at the call of the International Commission of Jurists, complemented the United Nations Office of the High Commissioner of Human Rights' Principles of Business and Human Rights,[51] reflecting on the complex challenges that human rights face in the context of globalization.

Describing social rights such as the right to health only as legal obligations derived from a multilateral treaty would be inaccurate. The nature and scope of social rights involves a political and philosophical debate about the justification of human and people's rights. At the same time, different philosophical views impact the way the State and its role in the economy is understood. For this reason, although the purpose of these various instruments is to answer a

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47 UNCHR, 'Note Verbale Dated 5 December 1986 from the Permanent Mission of the Netherlands to the United Nations Office at Geneva Addressed to the Centre for Human Rights ("Limburg Principles")' UN Doc E/CN.4/1987/17, 8 January 1987, para 5 (Limburg Principles).

48 The Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, 26 January 1997 <www.refworld.org/docid/48abd5730.html> accessed 15 June 2017 (Maastricht Guidelines).

49 International Commission of Jurists (ICJ), 'Bangalore Declaration and Plan of Action', 1995 (Bangalore Declaration).

50 Maastricht Principles on Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights, adopted 28 September 2011, available at multiple places online including <www.etoconsortium.org/nc/en/main-navigation/library/maastricht-principles/?tx_drblob_pi1%5BdownloadUid%5D=23> accessed 15 June 2017 (Maastricht Principles).

51 OHCHR, 'Guiding Principles on Business and Human Rights', HR/PUB/11/04, June 2011.

very concrete legal question − what obligations the Covenant imposes upon State parties – economic, social and cultural rights pose also more theoretical questions. While my focus remains legal, I attempt to look more broadly at the nature, scope and effects of the right to health beyond a purely judicial conception. Hence, while the coming sections of this chapter describe what this interpretation amounts to, chapters four, five and six deal with the dilemmas deriving from this understanding.

For the coming sections of this chapter, my method consists in intertwining the various instruments in a question-and-answers format. I have tried to provide a step-by-step description, seeking as much as possible to let the various instruments speak by themselves. For this reason, while I literally insert texts from the relevant instruments, I have purposefully avoided quoting them. What I have done is to reference them using as few editorial remarks as possible. I conclude this chapter listing the challenges that in my view this perspective insufficiently tackles.

3.2. INSTRUMENTS COMPRISING THIS VISION

3.2.1. LEGAL NATURE OF ECONOMIC, SOCIAL AND CULTURAL RIGHTS (WHAT IS THE LEGAL NATURE OF THE RIGHTS ENSHRINED IN THE COVENANT?)

- Human rights integration. All human rights constitute an indivisible, interdependent and interrelated whole. Economic, social and cultural rights are as important as civil and political rights for human dignity.[52]
- Economic, social and cultural rights are legal rights.
  - Justiciability. Despite the tendency to legalize issues that are more appropriately decided in a context, and according to considerations, larger than typically found in courts of law,[53] lawyers and judges are important in the development of these rights. For example, in India they have judicially enforced economic, social and cultural rights in the context of the right to life, fair trial, equality before the law, equal protection of the law and other civil and political rights.[54] Jurists should play a greater part in the realization of economic, social and cultural rights.[55] Access to an effective

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52 Limburg Principles (n 47) paras 1, 3; ICJ, Bangalore Declaration (n 49) para 5; Maastricht Guidelines (n 48) paras 3, 4.

53 Bangalore Declaration (n 49) para 11.

54 ibid para 12.

55 ibid, para 12; Maastricht Guidelines (n 48) para 28; UNCESCR, 'General Comment 14 The Right to the Highest Attainable Standard of Health', UN Doc E/C.12/2004/4, 11 May 2000, para 61; UNCESCR, 'Concluding Observations of the Committee on Economic, Social and Cultural Rights, Benin', UN Doc E/C.12/1/Add.78, 5 June 2002, para 30.

remedy should be extended to protect, via litigation, economic, social and cultural rights.[56]

- Justiciability of the Covenant. The Covenant should move towards the establishment of an Optional Protocol (a reality today[57]) to allow for an individual complaints mechanism.[58]
- Compatibility with the capabilities approach. The capabilities approach recognizes rights as both constitutive of and instrumental to the overall process of development; that is, rights and freedoms are not only necessary tools in achieving the goals of development, but the realization of rights should constitute an end-goal of development itself. More particularly, this approach holds that human rights are entitlements which make up a part of a set of central capabilities: a core set of freedoms, or rights, which form the basis of the very opportunities necessary to achieve a requisite level of human development.[59]
- Compatibility with human rights-based approaches. A human rights-based approach requires special attention to be given to disadvantaged individuals and communities; it requires the active and informed participation of individuals and communities in policy decisions that affect them; and it requires effective, transparent and accessible monitoring and accountability mechanisms. The combined effect of these − and other features of a human rights-based approach − are to empower disadvantaged individuals and communities.[60] The adoption of a right to health framework, in respect

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[56] UNCESCR, 'Concluding Observations on the Combined Second and Third Periodic Reports of Tajikistan', UN Doc E/C.12/TJK/CO/2-3, 25 March 2015, para 7; UNCESCR, 'Concluding Observations on the Sixth Periodic Report of Canada', UN Doc E/C.12/CAN/CO/6, 23 March 2016, paras 5, 6; OHCHR, 'Economic, Social and Cultural Rights: Handbook for National Human Rights Institutions', (Professional Training Series 12, United Nations, 2005) 25-27.

[57] Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, UNGA A/RES/63/117, 10 December 2008.

[58] Bangalore Declaration (n 49) paras 4, 7; Maastricht Guidelines (n 48) paras 3, 31.

[59] UNHRCL, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Anand Grover', UN Doc A/HRC/17/25, 12 April 2011, para 11.

[60] UNCHR, 'Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt', UN Doc E/CN.4/2006/48, 3 March 2006, paras 25, 26; concerning drug addiction, see UNCESCR, 'Concluding Observations on the Combined Fourth to Sixth Periodic Report of Belarus', UN Doc E/C.12/BLR/CO/4-6, 13 December 2013, para 25; concerning the prevention of maternal morbidity and mortality, see UNCESCR, 'Concluding Observations on the Fourth and Fifth Periodic Report of Angola', UN Doc E/C.12/AGO/CO/4-5, 15 July 2016, para 52 (a); concerning the use of tobacco addiction, see UNCESCR, 'Concluding Observations on the Initial Report of Indonesia', UN Doc E/C.12/IDN/CO/1, 19 June 2014, para 35 (d); concerning persons with disabilities, see UNCESCR, 'Concluding Observations on the Second Periodic Report of Lebanon', UN Doc E/C.12/LBN/CO/2, 24 October 2016, para 22 (b).

of health, and of human rights-based approaches more generally is one method by which genuine synchronicity can be achieved in respect of health-related development work and human rights.[61]

- An independent judiciary is considered indispensable for the effective implementation of economic, social and cultural rights.[62]

3.2.2. ABIDANCE TO THE TRIPARTITE TYPOLOGY OF DUTIES

- Compliance with the respect, protect and fulfil framework.[63]
  - The obligation to respect requires States to refrain from interfering with the enjoyment of economic, social and cultural rights.[64]
  - The obligation to protect requires States to prevent violation of such rights by third parties.[65]
  - The obligation to fulfil requires States to take appropriate legislative, administrative, budgetary, judicial and other measures towards the full realization of such rights.[66]

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61 UNHRCL, A/HRC/17/25 (n 59), para 17; interesting to note that the approach extends even to the field of international cooperation, see UNCESCR, 'Concluding Observations on the Sixth Periodic Report of the United Kingdom of Great Britain and Northern Ireland', UN Doc E/C.12/GBR/CO/6, 14 July 2016, para 15 and UNCESCR, 'Concluding Observations on the Third Periodic Report of Japan, Adopted by the Committee at its Fiftieth Session (29 April-17 May 2013)', UN Doc E/C.12/JPN/CO/3, 10 June 2013, para 32.

62 ICJ, Bangalore Declaration (n 49) paras 14, 18(4); UNCESCR, 'Concluding Observations of the Committee on Economic, Social and Cultural Rights, Azerbaijan', UN Doc E/C.12/1/Add.20, 22 December 1997, para 15; UNCESCR, 'Concluding Observations of the Committee on Economic, Social and Cultural Rights, Uzbekistan', UN Doc E/C.12/UZB/CO/1, 24 January 2006 para 37; UNCESCR, E/C.12/TJK/CO/2-3 (n 56), para 8.

63 Maastricht Guidelines (n 48) para 6; UNCESCR, General Comment 14 (n 55) paras 33-37; OHCHR, Business (n 51); UNCESCR, 'Concluding Observations of the Committee on the Second Periodic Report of Greece', UN Doc E/C.12/GRC/CO/2, 27 October 2015, para 8.

64 UNCESCR, 'Concluding Observations of the Committee on Economic, Social and Cultural Rights, The Kingdom of the Netherlands', UN Doc E/C.12/NDL/CO/4-5, 9 December 2010, para 28.

65 UNCESCR, 'Concluding Observations on the Second Periodic Report of China, Including Hong Kong, China, and Macao, China', UN Doc E/C.12/CHN/CO/2, 13 June 2014, para 8.

66 UNCESCR, E/C.12/GRC/CO/2, 27 (n 63) para 36(a).

3.2.3. POLITICAL NEUTRALITY (SHOULD STATES ADAPT THEIR POLITICAL AND ECONOMIC REGIMES TO COMPLY WITH THIS OBLIGATION?)

- Although the trend of reducing the role of the State and to rely on the market to resolve problems of human welfare is admitted,[67] the view is that this obligation can be met in the context of various political settings, including the market economy.[68]

3.2.4. OBLIGATION TO TAKE STEPS UNDER ARTICLE 2(1) OF THE COVENANT

- *Rationae temporae* (When should States comply with this obligation?)
  - Immediate implementation in full of the right to non-discrimination,[69] allowing judicial review.[70]
  - Immediate implementation through progressive realization of the rest of the provisions of the Covenant.[71] State parties should move as expeditiously as possible towards the full realization of the rights of the Covenant.[72] Steps towards that goal must be taken within a reasonably short time after the Covenant's entry into force and they should be deliberate, concrete and targeted as clearly as possible towards meeting the obligations recognized in the Covenant.[73] In that regard, any deliberately retrogressive measures would require the most careful consideration and would need to be fully

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67 Maastricht Guidelines (n 48) para 2; UNHRCL, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Paul Hunt' (31 January 2008) UN Doc A/HRC/7/11, para 27.

68 UNCHR, Limburg Principles (n 47) para 6; UNCESCR, 'General Comment 3: The Nature of States Parties' Obligations (Art 2, Para. 1, of the Covenant)', UN Doc E/1991/23, 14 December 1990, para 8; ICJ, Bangalore Declaration (n 49), para 5; UNCESCR, 'Concluding Observations of the Committee on Economic, Social and Cultural Rights, Poland', UN Doc E/C.12/1/Add.26, 16 June 1998, para 9.

69 UNCHR, Limburg Principles (n 47) paras 8, 22; UNCESCR, General Comment 3 (n 68) para 1; UNCESCR, 'General Comment 20 Non-Discrimination in Economic, Social and Cultural Rights (Art 2, Para 2 of the International Covenant on Economic, Social and Cultural Rights)', UN Doc E/C.12GC/20, 4-22 May 2009, para 7; UNCESCR, 'Concluding Observations of the Committee on Economic, Social and Cultural Rights, Canada', UN Doc E/C.12/CAN/CO/4-5, 22 May 2006, para 50.

70 UNCHR, Limburg Principles (n 47) para 35; UNCESCR, E/C.12/CAN/CO/4-5 (n 69), para 36; UNCESCR, 'Concluding Observations on the Sixth Periodic Report of Sweden' UN Doc E/C.12/SWE/CO/6, 14 July 2016, para 44 (b).

71 UNCHR, Limburg Principles (n 47) paras 16, 21; Maastricht Guidelines (n 48) para 8; UNCESCR, 'Concluding Observations of the Committee on Economic, Social and Cultural Rights, Democratic Republic of Congo' UN Doc E/C.12/COD/CO/4, 16 December 2009, para 16.

72 UNCHR, Limburg Principles (n 47) para 21; UNCESCR, General Comment 3 (n 68), para 9; UNCESCR, General Comment 14 (n 55) para 31.

73 UNCESCR, General Comment 3 (n 68), para 2; UNCESCR, E/C.12/CAN/CO/4-5 (n 69), para 44; UNCESCR, 'Concluding Observations on the Sixth Periodic Report of Cyprus' UN Doc E/C.12/CYP/CO/6, 28 October 2016, para 36.

justified by reference to the totality of the rights provided for in the Covenant and in the context of the full use of the maximum available resources.[74]

- *Rationae personae* (to whom should States make this obligation applicable?)
  - The obligation applies to both nationals and non-nationals living under the State's jurisdiction.[75]
- *Rationae materiae* (What should States do and how should they act to comply with this obligation?)
  - Resource scarcity does not relieve States of certain minimum obligations. At least minimum subsistence rights for all should be provided regardless of economic development. States should guarantee a minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights[76] as well as the provision of essential services.[77]
  - Emphasis on non-discrimination.[78]

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74 UNCESCR, General Comment 3 (n 68), para 9; UNCESCR, General Comment 14 (n 55) paras 32, 48; UNHRCL, A/HRC/7/11 (n 67) para 49; UNCESCR, E/C.12/1/Add.78 (n 55) paras 28, 56; UNCESCR, 'Concluding Observations of the Committee on Economic, Social and Cultural Rights, India' UN Doc E/C.12/IND/CO/5, 8 August 2008, para 45.

75 UNCHR, Limburg Principles (n 47) para 42.

76 UNCHR, Limburg Principles (n 47) para 25; UNCESCR, General Comment 3 (n 68), para 10; Maastricht Guidelines (n 48) paras 9, 10, 14(g); UNCESCR, 'General Comment 2: International Technical Assistance Measures (Art 22 of the Covenant)', UN Doc E/1990/23, 2 February 1990, para 9; UNCESCR, 'General Comment 8: The Relationship between Economic Sanctions and Respect for Economic, Social and Cultural Rights', UN Doc E/C.12/1997/8, 12 December 1997, para 7; UNCESCR, General Comment 14 (n 55) para 47; UNHRCL, A/HRC/17/25 (n 59), para 19; UNCESCR, 'Concluding Observations on the Combined Third and Fourth Periodic Reports of Jamaica, Adopted by the Committee at its fiftieth Session (29 April – 17 May 2013)', UN Doc E/C.12/JAM/CO/3-4, 10 June 2013, para 7.

77 UNCHR, Limburg Principles (n 47) para 28.

78 UNCHR, Limburg Principles (n 47) para 13; UNCESCR, General Comment 14 (n 55) paras 18, 19, 30; UNCESCR, General Comment 20 (n 69), para 2; UNHRCL, A/HRC/7/11 (n 67) para 43; OHCHR, 'Guiding Principles on Extreme Poverty and Human Rights', UN Doc A/HRC/21/11, 26 September 2012, para 57; furthermore, the Committee addresses the right to health in the light of the various prohibited grounds of the discrimination such as non-citizens (see UNCESCR, 'Concluding Observations on the Fifth Periodic Report of Norway' UN Doc E/C.12/NOR/CO/5, 13 December 2013, para 17), the elderly (see UNCESCR, 'Concluding Observations of the Committee on Economic, Social and Cultural Rights, Iraq' UN Doc E/C.12/1/Add.17, 12 December 1997, para 37), internal migrants, nomadic people, stateless persons, ethnic minorities (see UNCESCR, 'Concluding Observations of the Committee on Economic, Social and Cultural Rights, Uzbekistan' UN Doc E/C.12/UZB/CO/2, 13 June 2014, para 9), the position of women vis-a-vis men (see UNCESCR, 'Concluding Observations on the Fourth Periodic Report of Paraguay' UN Doc E/C.12/PRY/CO/4, 20 March 2015, para 14), accessibility of healthcare of those living in rural areas by comparison to those living in urban areas (see UNCESCR, 'Concluding Observations on the Fourth Periodic Report of France' UN Doc E/C.12/FRA/CO/4, 13 July 2016, para 44), LGBT persons (see UNCESCR, 'Concluding Observations on the Third Periodic Report of Guatemala' UN Doc E/C.12/GTM/CO/3, 9 December 2014, para 9), intersex persons, persons living with HIV/AIDS, women involved in prostitution,

- Emphasis on the poor and other disadvantaged groups.[79]
- Popular participation is required at all stages.[80]
- All appropriate means must be used including legislative measures.[81] However, legislative measures are not sufficient. Effective remedies, including judicial remedies

persons with a drug addiction, persons with disabilities (see UNCESCR, 'Concluding Observations on the Combined Second and Third Periodic Reports of Kyrgyzstan' UN Doc E/C.12/KGZ/CO/2-3, 7 July 2015, paras 22 (a), 23), asylum seekers (see UNCESCR, 'Concluding Observations on the Fourth Periodic Report of Austria' UN Doc E/C.12/AUT/CO/4, 13 December 2013, para 21), refugees, internally displaced persons (see UNCESCR, 'Concluding Observations on the Second Periodic Report of Serbia' UN Doc E/C.12/SRB/CO/2, 10 July 2014, para 11 (a)), same sex partners, the mentally ill (see UNCESCR, 'Concluding Observations on the Initial Report of Uganda' UN Doc E/C.12/UGA/CO/1, 8 July 2015, paras 32, 34), non-residents (see UNCESCR, 'Concluding Observations of the Committee on Economic, Social and Cultural Rights' UN Doc E/C.12/1/Add.94, 12 December 2003, para 12), rural-to-urban migrant workers (see UNCESCR, 'Concluding Observations on the Second Periodic Report of China, Including Hong Kong, China, and Macao, China' UN Doc E/C.12/CHN/CO/2, 13 June 2014, para 33) displaced persons (see UNCESCR, 'Concluding Observations on the Initial Report of Montenegro' UN Doc E/C.12/MNE/CO/1, 15 December 2014, para 24(c)), and prisoners (see UNCESCR, 'Concluding Observations on the Second Periodic Report of Lithuania' UN Doc E/C.12/LTU/CO/2, 24 June 2014, para 21)).

79 UNCHR, Limburg Principles (n 47) para 14; UNCESCR, General Comment 20 (n 69), para 27; UNCESCR, General Comment 2 (n 76), para 9; the Committee often addresses the situation of specific groups and minority communities that face discrimination. Examples include the Israeli-Arabs, the Palestinians, (see UNCESCR, 'Concluding Observations of the Committee on Economic, Social and Cultural Rights, Israel' UN Doc E/C.12/1/Add.27, 4 December 1998, paras 10, 20), the Roma people (see UNCESCR, E/C.12/GRC/CO/2 (n 63), para 9), persons of Afro ascendency (see UNCESCR, 'Concluding Observations of the Committee on Economic, Social and Cultural Rights, Colombia' UN Doc E/C.12/COL/CO/5, 7 June 2010, para 25), the Sami people (see UNCESCR, E/C.12/NOR/CO/5 (n 78), para 17), indigenous peoples (see UNCESCR, E/C.12/CAN/CO/6 (n 56), paras 19, 49), persons with immigrant background (see UNCESCR, E/C.12/GRC/CO/2 (n 63), para 9), gypsies (see UNCESCR, 'Concluding Observations of the Committee on Economic, Social and Cultural Rights, Spain', UN Doc E/C.12/ESP/CO/5, 6 June 2012, para 11), the Maori (see UNCESCR, 'Concluding Observations of the Committee on Economic, Social and Cultural Rights, New Zealand', UN Doc E/C.12/NZL/CO/3, 31 May 2012, para 12), the Dalits (see UNCESCR, 'Concluding Observations on the Third Periodic Report of Nepal' UN Doc E/C.12/NPL/CO/3, 12 December 2014, para 11), Crimean Tatars (*see* UNCESCR, 'Concluding Observations on the Sixth Periodic Report of Ukraine' UN Doc E/C.12/UKR/CO/6, 13 June 2014, para 9), Al-Akhdam people (see UNCESCR, 'Concluding Observations of the Committee on Economic, Social and Cultural Rights, Yemen' UN Doc E/C.12/YEM/CO/2, 22 June 2011, para 8) among others; in some cases, the Committee focuses on cases that involve various interlinked grounds of prohibited discrimination (see UNCESCR, 'Concluding Observations of the Committee on Economic, Social and Cultural Rights, Estonia' UN Doc E/C.12/1/Add.85, 19 December 2002, para 49).

80 UNCHR, Limburg Principles (n 47) para 11.

81 UNCHR, Limburg Principles (n 47) para 17; UNCESCR, General Comment 3 (n 68), para 3; UNCESCR, 'Concluding Observations of the Committee on Economic, Social and Cultural Rights, Iran', UN Doc E/C.12/1993/7, 9 June 1993, para 8.

are also required.[82] Importantly, legislative measures should establish access to effective remedies[83] and combat discrimination.[84]

- Increasing resources.[85]
- Equitable international order. States must dedicate efforts to international cooperation.[86] This contribution must be based on the principle of the equal sovereignty of States[87] and be oriented to the establishment of a social and international order in which the rights of the Covenant can be fully realized.[88] In this regard, the Maastricht Guidelines consider a violation the failure of a State not to take into account its international legal obligations in the field of economic, social and cultural rights when entering into bilateral or multilateral agreements with other States, international organizations or multinational corporations.[89] Concerning their extraterritorial obligations in the area of economic, social and cultural rights, States should act with due diligence.[90] With respect to acts by international organizations, the State holds responsibility to protect. States must influence, encourage and generalize the trend for these organizations to revise their policies and programmes so that they consider economic, social and cultural rights.[91]
- In an equitable and effective way.[92]

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82 UNCHR, Limburg Principles (n 47) para 19; UNCESCR, General Comment 3 (n 68), para 5; UNCESCR, General Comment 14 (n 55) para 60; UNCESCR, E/C.12/CAN/CO/4-5 (n 69), para 36.

83 UNCESCR, E/C.12/CAN/CO/6 (n 56), para 6.

84 UNCESCR, 'Concluding Observations on the Initial Report of Burkina Faso', UN Doc E/C.12/BFA/CO/1, 12 July 2016, para 11.

85 UNCHR, Limburg Principles (n 47) para 23; UNCESCR, E/C.12/COL/CO/5 (n 79), para 26.

86 UNCHR, Limburg Principles (n 47) para 26; UNCESCR, E/C.12/FRA/CO/4 (n 78), para 7.

87 UNCHR, Limburg Principles (n 47) para 33; Maastricht Principles (n 50), para 10.

88 UNCHR, Limburg Principles (n 47) para 30.

89 Maastricht Guidelines (n 48) para 15(j); UNCESCR, General Comment 14 (n 55) para 50; Maastricht Principles (n 50) paras 17, 29, 32-35; UNCESCR, 'Concluding Observations of the Committee on Economic, Social and Cultural Rights, Ecuador', UN Doc E/C.12/1/Add.100, 7 June 2004, para 55; UNCESCR, E/C.12/COL/CO/5 (n 79), para 10.

90 Maastricht Guidelines (n 48) para 18; various principles within the Guiding Principles on Business and Human Rights address the notion of due diligence, see OHCHR, Business (n 51) principles 4, 15, 17; OHCHR, Poverty (n 78) para 56; UNCESCR, E/C.12/CAN/CO/6 (n 56), para 16; UNCESCR, E/C.12/FRA/CO/4 (n 78), para 7.

91 Maastricht Guidelines (n 48) para 19; Maastricht Principles (n 50) para 15; UNCESCR, E/C.12/FRA/CO/4 (n 78) para 11; UNCESCR, 'Concluding Observations of the Committee on Economic, Social and Cultural Rights, Ireland', UN Doc E/C.12/1/Add.77, 5 June 2002, para 37.

92 UNCHR, Limburg Principles (n 47) paras 23, 27; UNHRCL, A/HRC/7/11 (n 67) paras 43, 50; UNCESCR, 'Concluding Observations of the Committee on Economic, Social and Cultural Rights, New Zealand', UN Doc E/C.12/1/Add.88, 26 June 2003, para 34; UNCESCR, E/C.12/1/Add.94 (n 78), para 59.

- Progress should be measured via constant monitoring.[93] Monitoring is based on targets, goals, benchmarks and indicators.[94]

3.2.5. NON-COMPLIANCE (WHAT DOES LACK OF COMPLIANCE AMOUNT TO?)

- In complying with the Covenant's obligations, State parties are afford a margin of discretion.[95] Yet, a failure by a State party to comply with an obligation contained in the Covenant is considered a violation of it under international law.[96]
- Violations can occur either by action or omission.[97]
- A State party will be in violation if: it fails to take a step which it is required to take by the Covenant; it fails to remove promptly obstacles which it is under a duty to remove to permit the immediate fulfilment of a right; it fails to implement without delay a right which it is required by the Covenant to provide immediately; it wilfully fails to meet a generally accepted international minimum standard of achievement, which is within its powers to meet; it applies a limitation to a right recognized in the Covenant other than in accordance with the Covenant; it deliberately retards or halts the progressive realization of a right, unless it is acting within a limitation permitted by the Covenant or it does so due to a lack of available resources or *force majeure*; it fails to submit reports as required under the Covenant.[98]

3.2.6. ACCOUNTABILITY (WHAT ARE THE CONSEQUENCES OF LACK OF COMPLIANCE?)

- The State must establish mechanisms to correct such violations including monitoring, investigation, prosecution, and remedies for victims.[99]

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93 UNCESCR, 'General Comment 1: Reporting by States Parties', UN Doc E/1989/22, 27 July 1981, para 4; UNCESCR, General Comment 3 (n 68), para 11.

94 UNCHR, Limburg Principles (n 47) paras 79, 89; UNCESCR, General Comment 1 (n 93) para 6; UNHRCL, A/HRC/7/11 (n 67) para 48; OHCHR, Vienna (n 46) para 98; UNCHR, E/CN.4/2006/48 (n 60) paras 22, 26, 27, 34; UNCESCR, 'Concluding Observations of the Committee on Economic, Social and Cultural Rights, Bolivia', UN Doc E/C.12/BOL/CO/2, 8 August 2008, paras 13, 26; UNCESCR, 'Concluding Observations on the Combined Second and Third Periodic Reports of Albania', UN Doc E/C.12/ALB/CO/2-3, 18 December 2013, para 12.

95 UNCHR, Limburg Principles (n 47) para 71; Maastricht Guidelines (n 48) para 8.

96 UNCHR, Limburg Principles (n 47) para 70; Maastricht Guidelines (n 48) paras 5, 6, 11; UNCESCR, E/C.12/CAN/CO/6 (n 56), para 5.

97 Maastricht Guidelines (n 48) paras 14, 15.

98 UNCHR, Limburg Principles (n 47) para 72; Maastricht Guidelines (n 48) paras 14, 15.

99 Maastricht Guidelines (n 48) para 16; Maastricht Principles (n 50) para 37; UNCESCR, E/C.12/LBN/CO/2 (n 60), paras 18, 19(d).

- Any person or group who is a victim of a violation of an economic, social or cultural right should have access to effective judicial or other appropriate remedies at both national and international levels.[100]
- All victims of violations of economic, social and cultural rights are entitled to adequate reparation, which may take the form of restitution, compensation, rehabilitation, and satisfaction or guarantees of non-repetition.[101]

3.2.7. SPECIFICITIES OF THE RIGHT TO HEALTH

- The right to health is linked to other human rights including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement.[102]
- The right to health goes beyond the right to healthcare. The right to health embraces a wide range of socioeconomic factors that promote conditions in which people can lead a healthy life and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.[103]
- The right to health is comprised of both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation. By contrast, the entitlements include the right to a system of health protection, which provides equality of opportunity for people to enjoy the highest attainable level of health.[104]
- Primary health care and other elements of the Alma-Ata Declaration[105] are considered important in the context of the progressive realization of the right to health.

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[100] Maastricht Guidelines (n 48) para 22; UNCESCR, General Comment 14 (n 55) para 59.

[101] Maastricht Guidelines (n 48) para 23; UNCESCR, General Comment 20 (n 69), para 40; Maastricht Principles (n 50) para 38; UNCESCR, E/C.12/GTM/CO/3 (n 78), para. 7.

[102] UNCESCR, General Comment 14 (n 55) para 3.

[103] ibid paras 4, 11; UNHRCL, A/HRC/7/11 (n 67), para 45; UNCHR, E/CN.4/2006/48 (n 60) paras 4, 5, 9.

[104] UNCESCR, General Comment 14 (n 55) para 8; UNHRCL, A/HRC/7/11 (n 67) para 15; UNHRCL, A/HRC/17/25 (n 59) paras 4, 5, 10.

[105] The Alma-Ata Declaration was the result of a conference held by representatives of the WHO in 1978. The Declaration is considered one of the most important international documents in the field of health. The Declaration considers the right to health a fundamental human right in no way disconnected from the combatting of national and international health inequities. To this purpose the Declaration considers that in order to attain the goal of health for all, action on health should be based on primary healthcare, international cooperation in line with the New International Economic Order, inter-sectorial collaboration, popular participation and communitarian action in the field of health. WHO, 'Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR' (6-12 September 1978); UNHRCL,

- The right to health's normative content is comprised of several interrelated and essential elements.[106]
  - Availability. There should be a sufficient quantity of facilities, goods and services.
  - Accessibility. Access should be for everyone within the jurisdiction of the State party. This element is comprised of: non-discrimination, physical accessibility (for all sections of the population, especially the vulnerable and including rural areas), economic accessibility (affordability), which means that health facilities, goods and services must be affordable for all.[107] Payment for health-care services, as well as services related to the underlying determinants of health, has to be based on the principle of equity, ensuring that these services, whether privately or public provided, are affordable for all, including socially disadvantaged groups. Equity demands that poorer households should not be disproportionality burdened with health expenses as compared to richer households. In this respect, the Guiding Principles on Extreme Poverty and Human Rights establish that States should ensure the affordability of facilities, goods, and services relevant to those living in poverty. No one should be denied access to essential services because of an inability to pay. In some cases, States must provide free access; for example, primary education must be compulsory and free of direct and indirect costs.[108] States should ensure that facilities, goods and services used by persons living in poverty are of the highest attainable quality, including by monitoring the quality of public and private service providers. Providers must be well qualified and aware of the particular needs of persons living in poverty.[109] States should ensure that persons living in poverty have access to safe and affordable medicines and that inability to pay does not prevent access to essential health care and medicine.[110] Finally, information accessibility includes the right to seek, receive and impart information and ideas concerning health issues.
  - Acceptability. All health facilities, goods and services must be respectful of medical ethics and culturally appropriate.
  - Quality. This requires skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.

A/HRC/7/11 (n 67), paras 21, 22, 24, 47; UNCESCR, 'Concluding Observations on the Combined Second and Third Periodic Reports of Tajikistan', UN Doc E/2007/22, 23 November 2006, para 507; UNCESCR, 'Concluding Observations on the Combined Second to Fourth Periodic Reports of the Former Yugoslav Republic of Macedonia', UN Doc E/C.12/MKD/CO/2-4, 15 July 2016, para 16.

106 UNCESCR, General Comment 14 (n 55) para 12.

107 UNCESCR, E/C.12/IND/CO/5 (n 74), para 73.

108 OHCHR, Poverty (n 78), para 58.

109 ibid, para 60.

110 ibid, para 82(c).

- Article 12(2)(d) of the Covenant is interpreted as including the provision of equal and timely access to basic preventive, curative, rehabilitative health services and health education, regular screening programmes; appropriate treatment of prevalent diseases; the provision of essential drugs; appropriate mental health treatment and care; participation of the population and participation in political decisions relating to the right to health taken at both the community and national levels.[111]
- Core obligations of the right to health.[112] Based on the Programme of Action of the International Conference on Population and Development [113] and the Alma-Ata Declaration, the following are considered core obligations:
  - a) To ensure the right of access to health on a non-discriminatory basis, especially for vulnerable or marginalized groups;
  - b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
  - c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
  - d) To provide essential drugs, as from time to time defined under the World Health Organization Action Programme on Essential Drugs;
  - e) To ensure equitable distribution of all health facilities, goods and services;
  - f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action shall be devised, and periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, by which progress can be closely monitored; the process by which the strategy and plan of action are devised, as well as their content, shall give particular attention to all vulnerable or marginalized groups.
- The Committee considers that the following are obligations comparable in priority to core obligations:[114]
  - a) To ensure reproductive, maternal (prenatal as well as post-natal) and child health care;
  - b) To provide immunization against the major infectious diseases occurring in the community;
  - c) To take measures to prevent, treat and control epidemic and endemic diseases;
  - d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them;

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[111] UNCESCR, General Comment 14 (n 55) para 17.
[112] ibid para 43; UNHRCL, A/HRC/7/11 (n 67) paras 51-53.
[113] UNFPA, 'Report of the International Conference on Population and Development', UN Doc A/CONF.171/13/Rev.1, 5-13 September 1994.
[114] UNCESCR, General Comment 14 (n 55) para 44.

- e) To provide appropriate training for health personnel, including education on health and human rights.

- Violations. These can be the result of either action or omission by the State.[115]
  - Violations of the obligation to respect are those that contravene the standards set out in Article 12 and are likely to result in bodily harm, unnecessary morbidity and preventable mortality.[116]
  - Violations of the obligation to protect follow from the failure of a State to take all necessary measures to safeguard persons within their jurisdiction from infringements of the right to health by third parties.[117]
  - Violations of the obligation to fulfil. These occur through the failure of States parties to take all necessary steps to ensure the realization of the right to health. Examples include: insufficient expenditures or misallocation of public resources, failure of monitoring, failure to reduce the inequitable distribution of health facilities, failure to adopt a gender-sensitive approach, and the failure to reduce infant and maternal mortality rates.[118]

3.3. ANALYSIS

The Human Rights World Conference held in Vienna in 1993 represented a decisive moment in the evolution of human rights. Although economic, social and cultural rights existed as human rights before, this moment marked its acceptation to the family of rights preponderant in the Western tradition. The Vienna Declaration had the merit of placing economic, social and cultural rights on an equal foot with civil and political rights. In a statement that would became rephrased numerous times, the Conference held:

> All human rights are universal, indivisible and interdependent and interrelated. The international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis. While the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of States, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms.[119]

Since its inception in 1952, the International Commission of Jurists focused on the rule of law. During its first two decades of existence, the work of the organization was the one of an

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[115] ibid, paras 33, 48, 49.
[116] ibid, para 50.
[117] ibid, para 51.
[118] ibid, para 52.
[119] OHCHR, Vienna (n 46) para 5.

unreserved player in the Cold War context.[120] In the field of economic, social and cultural rights, the work of the organization dates back to the early 1980s.[121] In its conceptualization, the Commission placed the judiciary at the centre through a focus on access to remedies, minimums and non-discrimination.[122] This approach pervaded the interpretation through which official bodies understood this set of rights. The so-called tripartite typology of duties, obligation to respect, obligation to protect and obligation to fulfil, operationalized its views.

According to Toebes, the tripartite typology of duties is a functional theoretical concept widely recognized in international human rights law. Its purpose is to 'clarify the obligations inherent to all human rights'.[123] For Toebes, the origins of the doctrine are to be found on Henry Shue's theory of Basic Rights, published in 1980.[124] In analysing the history of the typology, Toebes observes that Asbjørn Eide successfully applied this framework to the right to food in his role of Special Rapporteur of this human right, back in the 1980s.[125] Only with some alterations that Eide would have introduced in Shue's original notion of the obligation to protect, the tripartite typology of duties would date back to that time. As was shown in section 3.2.7, the obligations to respect, protect and fulfil are structured by the Committee in its General Comment 14, more specifically, in what the Committee calls 'the normative framework of the right to health', also known as 'the AAAQ' (availability, accessibility, acceptability and quality).

Despite some innovations, General Comment 14 is not conceptually distant from the Committee's interpretation of the obligation to take steps under Article 2(1) of the Covenant (General Comment 3). All along the decade ranging from 1986 to 1997, the Committee had effectively absorbed the International Commission of Jurists' interpretation put forward in the Limburg Principles and the Maastricht Guidelines. This was why the organization came to regard the justiciability of economic, social and cultural rights as a development that put an end to the Cold War legacy, where only civil and political rights had the ability of becoming operational in

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120 ICJ, *International Congress of Jurists. West Berlin 1952: Complete Report, Discourses, Protocols* (ICJ 1952) <www.icj.org/international-congress-of-jurists-west-berlin-1952-complete-report-discourses-and-protocols/> accessed 15 June 2017; ICJ, 'For the Rule of Law' Bulletin no 1 (ICJ 1954); ICJ, *Injustice The Regime: Documentary Evidence of the Systematic Violation of Legal Rights in the Soviet Zone of Germany: 1954-1958* (Rudolf Otto 1958).

121 ICJ, 'History' <www.icj.org/history/part-two-1970-1990/> accessed 17 June 2017; Philip Alston, Development and the Rule of Law (ICJ 1981) <www.icj.org/development-and-the-rule-of-law-prevention-versus-cure-as-a-human-rights-strategy/> accessed 17 June 2017; Asbjørn Eide, 'Realization of Social and Economic Rights – The Minimum Threshold Approach' (1989) 43 International Commission of Jurists Review 40.

122 Eide (n 121).

123 Toebes (n 1) 311.

124 ibid 307[75].

125 ibid 309.

court.[126] In the organization's view the justiciability of these rights entailed the clearest sign that both sets of rights had been put on an equal footing. Justiciability entailed:

> [T]hat people who claim to be victims of violations of these rights [economic, social and cultural] are able to file a complaint before an independent and impartial body, to request adequate remedies if a violation has been found to have occurred or to be likely to occur, and to have any remedy enforced.[127]

From the Limburg Principles and other instruments of the organization assessed above, the language of justiciability, lawyers, violations, effective remedies, accountability, and the requirement of an independent judiciary occupied a primary role in the definition and organization of the provision of these rights. Economic, social and cultural rights became fundamentally legal notions whose primary place was courts of law. As phrased in a recommendation to Tajikistan, the Committee was concerned:

> [A]bout the lack of effective remedies in the event of violations of economic, social and cultural rights, owing to high lawyers' fees and court costs, as well as limited access to free legal aid by rights holders who need it, in particular victims of violations. The Committee recommends that the State party take the necessary measures, including legislative measures, to ensure that free legal aid with regard to economic, social and cultural rights is provided to persons who need it, in particular those belonging to disadvantaged and marginalized groups, and that it is adequate with respect to coverage, eligibility and services provided.[128]

What is the effect of justiciability on human rights? Justiciability entails the adjudication of an individual interest in court. For this to happen, the interest must be narrowed-down so that it can be processed by a court of law. This operation involves shifting both the legal subject and the content of the claim. Regarding the legal subject, communitarian elements are excluded and reduced to either an individual or a group. They become the claimants or right holders. In this way, even if the role of the State can still theoretically be linked with the promotion of the general welfare, what matters from the legal point of view is that the entitlements of the right holder can be made actionable in court. A further step is also required. The interest needs to be narrowed down at the level of the claim's content. Given the limited access to economic, social and cultural rights by marginalized individuals and groups, non-discrimination largely assisted that process. As a principle enshrined in both Covenants, non-discrimination has undisputable credentials influencing the structuring of human rights law. This process was completed by the doctrine of minimum core rights. This doctrine, which appears reflected first in the Limburg Principles, later

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[126] ICJ, *Courts and the Legal Enforcement of Economic, Social and Cultural Rights: Comparative Experiences of Justiciability* (ICJ 2008) 1.
[127] ibid.
[128] UNCESCR, E/C.12/TJK/CO/2-3 (n 56), para 7.

in General Comment 3 and further in the Maastricht Guidelines, entails one of the most important pillars of the predominant interpretation of this set of rights. The attractiveness of the doctrine derives from two main reasons. In the first place, it does not close the door to a protection beyond the minimum core. It simply limits itself to the idea that what would be legally impermissible would be to cut off certain basic minimums. These minimums, often interlinked with the principle of non-discrimination, are presented as standards of reasonability.[129] Thus, as the very idea of reasonability suggests, the first consequence of the doctrine is to allow the identification of a section or segment of the right that would be located beyond ideological contestation. In that way, the doctrine avoids frontally clashing with more maximalist notions of social rights. Secondly, this allegedly non-partisan identification of the content of the claim allows its legal operationalization in the narrowly defined contours of the legal sphere. Namely, the doctrine of the minimum core opens the way to economic, social and cultural rights as legal rights whenever individual entitlements are at stake.

The predominant interpretation's attractiveness lies in its *legalization* or, put more accurately, in its *judicialization*. It was thanks to this interpretation that social rights attracted a great deal of attention becoming the object of everyday legal disputes. In line with so-called rights-based approaches, this interpretation has opened room to the establishment of an effective remedy, which is said to empower marginalized individuals.

Despite all this progress in the recognition of these human rights, a definition of what social rights are remains stubbornly absent. A recent account appears to corroborate this conclusion. Analysing legally protected socio-economic interests in the case law of the European Court of Human Rights, A E M Leijten describes the Court's body of case law in a non-substantive way. In her comprehensive study, Leijten concludes that these socio-economically protected interests would be activated whenever: a) the rights of minorities, persons and groups at disadvantage or in a position of vulnerability are at stake, b) minimum (core) rights are entertained or c) non-discrimination is involved.[130] Interestingly, none of these categories are distinctive or exclusive to social rights. These elements could well be predicated from civil and political rights. To what extent do these elements assist in the identification of the more specific content of social rights?

4. UNRESOLVED PROBLEMS

In the context of the drafting of the Universal Declaration and the ICESCR, the legal nature of the right to health and more generally economic, social and cultural rights remained moot.

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[129] Fernando Atria, *La Forma del Derecho* (Marcial Pons 2016) 287-288.

[130] A E M Leijten, *Core Rights and the Protection of Socio-Economic Interests by the European Court of Human Rights* (Leiden University 2015) 292-301.

Although in principle open to its inclusion, the views of the Western bloc transitioned gradually, in the context of the Cold War, into a mere aspiration to achieve rather than into a firm legal commitment. Since the ideas of the Latin-American countries, the Soviet bloc, the Middle East and the Asian countries were favourable to these rights, the situation remained in a relative stalemate. Despite some proximity under the Presidency of Carter,[131] the balance was tilted with the end of the Cold War. The falling of the Eastern bloc led to an even stronger opposition from the United States to economic, social and cultural rights. This was particularly manifest under the presidency of Ronald Reagan.[132] While the 1993 Vienna Conference had the effect of upgrading economic, social and cultural rights to the family of human rights recognized in the West, this also narrowed down these rights' legal substance. Social rights such as the right to health became legal rights.

Embedded in this interpretation, the right to health and social rights have been conceived primarily as judicial realities. They are operationalized by virtue and in the interest of specific individuals or groups in the context of courts of law. Even though the former Special Rapporteur for the Right to Health Paul Hunt insisted that the right to health was primarily a right to a health system,[133] it is hard to reconcile that statement with the idea of the right to health as a legal right, namely, the right to health as an individual legal right to claim in court a minimum core of access to healthcare especially in cases of discrimination. Notions of violations, justiciability and accountability to individual or group victims have come at the price of severing social rights from the communitarian rationale with which several countries used to associate the logic of social rights. This fundamental contradiction is at the centre of the predominant interpretation of the right to health.

The Committee's view, expressed in General Comment 14, that the right to health includes the right to a system of health protection which provides equality of opportunity,[134] is a further affirmation of this contradiction. The reason is that so much focus on equality of opportunity unavoidably leaves the door open to various ways in which those healthcare services can be provided, including their private provision.[135] The question is then, can this view be put at the service of the goal of equal access to healthcare for all?

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[131] American Association for the International Commission of Jurists, 'Toward an Integrated Human Rights Policy: A Commentary on the Interrelationship of Economic, Social, Cultural, Civil and Political Rights' (American Association for the International Commission of Jurists 1979) <www.icj.org/toward-an-integrated-human-righs-policy-a-commentary-on-the-interrelationship-of-economic-social-cultural-civil-and-political-rights/> accessed 17 June 2017.

[132] Philip Alston, 'Putting Economic, Social and Cultural Rights Back on the Agenda of the United States' in William F. Schulz (ed), *The Future of Human Rights: U.S. Policy for a New Era* (University of Pennsylvania Press 2008) 122-123.

[133] UNHRCL, A/HRC/7/11 (n 67) para 15.

[134] See n 104.

[135] Antenor Hallo de Wolf and Brigit Toebes, 'Assessing Private Sector Involvement in Health Care and Universal Health Coverage in Light of the Right to Health' (2016) 18 (2) Health and Human Rights Journal

Moreover, from the perspective of international cooperation, the agenda of the right to health has shifted. It used to be strongly influenced by Article 28 of the Universal Declaration and, as the next chapter shows, by ideas put forward in the 1970s by countries of the Global South through the New International Economic Order Declaration and the Charter of Economic Rights and Duties of States. In this sense, it is not a coincidence that the Alma-Ata Declaration – possibly the most influential instrument on health as a human right – explicitly envisioned the New International Economic Order as a route of development.[136] However, one effect of the Limburg Principles has been to develop the idea of violations at the extraterritorial level. While the Maastricht Guidelines made a step forward in that direction,[137] the Principles on Business and Human Rights, and afterwards, the Maastricht Principles on the Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights completed that work. The contribution of this framework to put social rights at the centre of development dynamics has not been successful. The roots of the social crises of the world (financial crises since 1994,[138] multiple armed conflicts, the rise of income inequality and the refugee crisis) remain largely unaddressed. Despite references to involve human rights in international agreements, the priority of international economic law over human rights law reflects not just a formidable obstacle to overcome, but also a set of structural deficiencies of this latter framework. Fundamentally, there is a tendency of these frameworks to amalgamate to these politico-economic trends, rather than to radically modify them.

As has been already cautioned, one of the characteristic difficulties of the predominant interpretation of the right to health is that it simply fails to clarify what social rights are about. While the obligation to take steps does refer to the rights enshrined in the Covenant, the predominant interpretation addresses the problem more negatively than positively. It focuses more on what cannot be done, rather than on what needs to be done. One could argue that this perspective is perfectly compatible with democratic politics, as the initiative to define social rights is left to the people in Parliament while the judicial branch limits itself to define what is legally impermissible. Yet, could not the negative terms of the predominant interpretation of the right to health be influencing this social right's final content? The risk, in other words, that the doctrine of the minimum core, instead of a basic floor, becomes the final ceiling to attain. Could not the notion of the minimum core open the door to the targeted social policies privileged by neoliberal politics, which have brought so much inequality? Could not the emphasis in non-discrimination bring into oblivion the need to establish institutions capable of providing equal access to healthcare for all? Could not the emphasis in judicialization lead to the irrelevance of critical notions for health such as popular participation and the social determinants of health as established in the Ottawa Charter for Health Promotion and the Alma-Ata Declaration?

79, 80.

136 WHO, 'Global Strategy for Health for All by the Year 2000' (WHO 1981), paras III, X.

137 Maastricht Guidelines (n 48) para 15(j).

138 The 1994 'tequila' crisis, the 1997 'Asian' crisis, the 2008 economic financial crisis among them.

Furthermore, several more specific problems remain unsolved:

- Can the doctrine of violations and core minimum obligations of the right to health put the accent on equity in access to healthcare?
- Does the normative framework of the right to health lead to views that truly emphasize problems of equity in access to healthcare?
- Can non-discrimination articulate an equal enjoyment of access to healthcare for all?
- Does the predominant interpretation of the right to health incentivise the private provision of healthcare services? If so, does this affect health equity?
- Can the resources of the private sector be effectively put to work for the interest of the many?
- To what extent does the judicialization of the right to health lead the way towards equal access to healthcare for all?

These various interrogations aim to the very questions that the predominant interpretation pose. Does this focus on the vulnerable help them in advancing their needs? Does this focus on the vulnerable help the right to health reconnect with its social justice routes? In the next chapter I explore a critical notion for the right to health – the principle of solidarity, sometimes also called, equity. Contrasting the points of view addressed in this chapter with those of the next chapter, chapters four, five and six address the questions formulated above.

CHAPTER THREE
SOLIDARITY AND HEALTH

1. INTRODUCTION

The previous chapter suggested an institutional contradiction within the predominant interpretation of the right to health, ie the dilemma posed by a dynamic where the more that social rights are operationalized as legal rights, the greater the hindrances to some of the dimensions of the goal of health equity.

I take as my point of departure the theses from Fernando Atria. This scholar argues that the legal relationships emanating from human rights have been framed by the technique of legal rights.[1] This notion involves right holders exercising their claims at the expense of duty bearers. From a historical point of view, Atria points out, the distinctive nature of social rights originates in a republican and socialist vision linked to the concept of solidarity.[2] For those that understand human rights as legal rights, the main or only challenge that is left consists in ensuring an effective remedy so that social rights can be upgraded to the family of *real* rights. In that way, all human rights would become integrated, indivisible and protected on an equal footing. However, accepting *arguendo* that the notion of solidarity is indeed explanatory of social rights, does the structurally adversarial scheme of legal rights allow protecting it? Atria's thesis is that it does not. Far from solidarity, the emphasis on legal rights individualizes and transforms the right to health into a property right. This focus is not just de-aligned with the history of social rights but it also runs contrary to solidarity. Justiciability of the right to health, a feature that the predominant interpretation presents with pride, would be in fact problematic. The reason is that the only claims that become justiciable in this framework are those linked to equality before the law. Since those claims do not generate access to the material goods necessary for life − a crucial

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1 Fernando Atria, '¿Existen los Derechos Sociales?' (2004) 4 Discusiones: Derechos Sociales 15 and Fernando Atria, 'Réplica: Derecho y Política a Propósito de los Derechos Sociales' (2004) 4 Discusiones: Derechos Sociales 145.

2 Atria, *Existen* (n 1) 18.

aspect for the world's majority − the justiciability of such equality could be more indicative of the inexistence of social rights than of its protection.[3]

An assumption involved in this account is that solidarity is the notion that most genuinely captures the definition of social rights. This chapter is devoted to the analysis of this assumption. I seek to establish whether solidarity can be demarcated as a distinctive legal principle in the sense of being conceptually different from other principles. If so, I shall consider the main accounts of solidarity, and whether these accounts have attained legal expression. This assumption also involves that the right to health is closer to a collective right than to an individual or group right. To find this out I proceed as follows. Section two begins by briefly assessing the function of legal principles in the legal order. Section three re-constructs the main accounts of solidarity. Further, section four contrasts these perspectives with several expressions in the context of international human rights law and constitutional law. This demands assessing how consistent the State practice is in the application of this principle. I should caution that it is not my purpose to present solidarity as customary international law. Acknowledging the *lex ferenda* nature of this exploration, it suffices with showing that solidarity has been utilized as the structuring principle of the right to health and to what extent it would be plausible to conceiving this social right devoid from this notion.

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[3] *'[P]ero al hablar de esto no estamos hablando de la exigibilidad de los derechos sociales, sino del viejo derecho a la igualdad formal, el derecho a la igualdad que aparece en la declaración francesa de 1789 y la americana de 1776: la igualdad de ricos y pobres para atender una mediocre escuela pública, o postular a una minúscula vivienda pública, o concurrir a un desmedrado consultorio de salud estatal. 'Mediocre', 'minúscula' o 'desmedrado' no porque la provisión de servicios públicos sea desigualitaria (en nuestros países todas las escuelas, viviendas y consultorios públicos son mediocres, minúsculas o desmedradas en comparación con sus equivalentes privados). Lo que Abramovich y Courtis dejan 'siempre abierto' no implica estándar alguno de evaluación entre los sistemas públicos y privados. Pero aun cuando es posible ir más allá de lo que 'queda siempre abierto', y cuando la violación a un derecho social puede ser directamente invocada ante un tribunal, es necesario que ella sea 'reformulada [...] en términos de violación individualizada y concreta, en lugar de en forma genérica'. De este modo el derecho social a la protección de la salud, que originalmente consistía en que se garantizara un nivel de atención de salud a todos (porque una comunidad en la que todos nos preocupamos por los otros es una comunidad más decente que otra en la que cada uno persigue su bienestar individual y el resto lo hace la mano invisible), se convierte en un derecho individual alegado por el demandante de que se obligue al Estado a dar una determinada prestación de salud, sin que las necesidades de los otros puedan ser relevantes (las necesidades de los otros aparecen ante el juez como no distribuidas, es decir, como objetivos de política o aspiraciones comunitarias, y por eso los derechos las triunfan). Lo que llega al tribunal no es un derecho social, no puede ser un derecho social, sino una demanda privada, que expresa ya no la idea de una forma superior de comunidad sino la negación de ésta: la pretensión del demandante de que su interés sea atendido, aun a costa del interés de los demás'*, ibid 45.

2. THE FUNCTION OF LEGAL PRINCIPLES

2.1. LEGAL PRINCIPLES?

I shall begin by distinguishing between values and principles. According to Angel Garrorena the difference between these two categories is functional. Values are abstract: ideal categories historically adopted by a community as essential for their living together. They are at the level of the substantive foundations of that common life. Legal principles on the other hand are in the field of operative statements. They assist the work of legal agents. Some are at the level of the roots of the legal order as an essential axiological basis, and others, instead, are closer to the consequences of the legal order and their role is to simply assist legal practice.[4]

Yet, what specific place do legal principles occupy in the legal order? What role should be assigned to them and how different are they from legal rules? The most widespread perspective on legal principles is Ronald Dworkin's. Basing himself largely on Dworkin's legacy, Robert Alexy elaborated a further theory with specific additions that distanced him from Dworkin. Only recently, András Jakab has offered a theory opposed to Alexy's, something that not even his critics had done, including Neil McCormick and H L A Hart, who still agreed upon 'a structural difference between *legal* principles and *legal* rules'.[5] This section shall provide a brief description of the Dworkin-Alexy approach and Jakab's approach. Later, I shall adopt a stance on these two alternatives.

2.2. ALEXY'S THEORY OF LEGAL PRINCIPLES

Alexy thinks that principles should be conceived in a structurally different way to rules. For Alexy, legal principles are a species of legal norms by means of which optimization commands are applicable at several degrees in accordance to normative and factual possibilities.[6] Alexy maintains that unlike principles, rules only have an all-or-nothing character. Principles would be optimization imperatives, as they can be fulfilled to varying degrees. In contrast to rules, principles would not directly determine normative consequences.[7] Rules are always norms that can either be fulfilled or not fulfilled. A second difference comes in situations of conflict. When

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4 Ángel Garrorena Morales, 'Valores Superiores y Principios Constitucionales' in *Estudios de Derecho Público: Homenaje a Juan José Ruiz-Rico*, vol 1 (Tecnos 1997) 35.

5 András Jakab, 'Re-Defining Principles As "Important Rules". A Critique of Robert Alexy', in Martin Borowski (ed) *On the Nature of Legal Principles. Proceedings of the Special Workshop "The Principles Theory" Held at the 23rd World Congress of the International Association for Philosophy of Law and Social Philosophy (IVR), Kraków, 2007* (Nomos 2010) 146.

6 Humberto Ávila, *Theory of Legal Principles* (Springer 2007) 9.

7 ibid 10.

one rule conflicts with another, the collision is resolved by rules of conflict (for example, *lex posterioris*). Instead, conflicts of principles are settled within a contingent relation of precedence between the two relevant principles, considering the circumstances of the case. The final difference is that the more a principle supersedes another, the greater its need for justification.[8]

2.3. JAKAB'S IMPORTANT RULES CRITERIA

Jakab criticizes that principles have an all-or-nothing character. He renders this strict demarcation criteria 'superfluous'.[9] Principles, says Jakab, are 'not logically different than rules in structure'.[10] Under Jakab's legal framework, more than the truth or falseness of concepts, what matters is their 'expediency', 'explanatory force' or 'ability to explicate'.[11] Therefore, a given conceptual system of legal theory is better, if within its framework: '(1) the greater number of legal phenomena can be explained, (2) this is done coherently, and (3) with the highest possible degree of simplicity. (4) Political and ideological factors can also play a role'.[12] His goal is, in other words, to work with the simplest or most conceptually economic explanation. According to Jakab, the difference between a rule and a principle is fundamentally rhetoric.[13] Yet, this is not meant in pejorative terms. Principles are simply important rules firstly because they are not structurally different than rules, but also because of their degree of abstraction or ability to explicate legal rules with great conceptual economy, namely, without resorting to other concepts.

Finally, according to Jakab, legal principles' function is either heuristic ('to assist in structuring and systematizing legal material to make it manageable'), practical (argumentative support; gateway for the application of legal rules that either are not formally applied anymore, or for other legal orders, or for ideas of social and political morality; developing the law), meta-normative (either *ex ante* by programming the legislation, or *ex post* by justifying rules), or performative of social functions (reconciliatory integrating function and the value integrating function).[14]

2.4. CONCLUSION

I shall adopt Jakab's criteria. For one thing Jakab's view unveils the practical lack of utility of Alexy's distinction. It is unclear when the principle should prevail over the rule. Jakab's perspective, instead, shifts away from that focus. His approach to principles as important rules

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8 Jakab (n 5) 147.
9 ibid 145.
10 ibid 151.
11 ibid 148.
12 ibid.
13 ibid 152.
14 ibid 155-159.

is valuable because it allows to understand and justify further rules that do not have the nature of important rules.

My way of understanding Jakab's criteria sets one of the challenges of the present thesis: for solidarity to be regarded a relevant principle for social rights and the right to health, solidarity must be able to provide a conceptually economic justification of the duties behind this human right. This challenge is twofold: can the right to health be explained without solidarity, and can other principles provide a more economic justification for the right to health?

3. APPROACHING SOLIDARITY

3.1. A CONCEPTUAL APPROXIMATION

There are various ways of understanding solidarity. One understanding comes from Roman law.[15] Napoleon's 1804 *Code Civil* incorporated the Roman notion of solidarity in the law of obligations. Drafted by the jurist Andrés Bello, Chile's *Código Civil* was enacted in 1855. It largely followed the Napoleon Code in this regard. Paragraphs two and three of Article 1,511 offer an example of solidarity in this understanding:

> Either by virtue of a convention, testament or legal statute, the entirety of the debt can be claimed from each and any of the debtors by any of the creditors. In these cases the obligation is considered *in solidum*. Unless established by legal statute, solidarity must always be expressly declared.[16]

This provision understands solidarity as a form of collective responsibility for certain debts where each and all the debtors can be hold accountable for the totality of the debt by any of the creditors. This definition of solidarity has remained intact in the context of the law of obligations. However, from the times of the French Revolution, and especially from the second half of the nineteenth century, several European authors began to shift the old Roman meaning of solidarity. Revolutionary France marked the beginning of solidarity's re-birth. This happened first through

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[15] According to Sorto, in solidum obligations are widely registered in the Digest in books IX, X, XIV, XV, XVI, XXVI, XXXIX, XLII, XLIII, XLV, XLVI meaning 'in its entirety' or 'totally', see Fredys Orlando Sorto, 'La Compleja Noción de Solidaridad como Valor y como Derecho: la Conducta de Brasil en Relación a Ciertos Estados Menos Favorecidos', in Mario Losano (ed), *Solidaridad y Derechos Humanos en Tiempos de Crisis* (Dykinson 2011) 98[1].

[16] The original provision in Spanish states: *'Pero en virtud de la convención, del testamento o de la ley puede exigirse a cada uno de los deudores o por cada uno de los acreedores el total de la deuda, y entonces la obligación es solidaria o insólidum. La solidaridad debe ser expresamente declarada en todos los casos en que no la establece la ley.'*

the notion of *fraternity* or *brotherhood*. Further, French social thinking by authors such as Pierre Leroux (1789-1871), shifted the term into a social and political notion.[17] Amidst the development of capitalism, the idea was to combine individual rights and liberties with social cohesion.[18] Pierre Leroux proposed a democratic and social constitution based on solidarity.[19] More specifically, Leroux proposed substituting Christian charity with social solidarity.[20] The reason was that while charity would have been too vague to lead to concrete legal obligations, the revolutionary notion of fraternity was considered excessively sentimental.[21]

During the nineteenth century various other French doctrines envisioned new ways of understanding society and politics. Saint Simon came up with his model of industrial technocracy. Proudhon, in turn, proclaimed the abolition of private property. Fourier proposed the Phalanstry. Stjernø describes the Phalanstry as a group of 1,500 to 1,600 people living and working together in harmony in common households. According to Stjernø, solidarity would be used in four different ways here: first, as a principle of insurance (in the sense of the *Code Napoleon*), second, as the preparedness to share resources with people in need, third, in describing a feeling of community, and fourth, understood as a guaranteed minimum income and for family support.[22] According to Stjernø the fourth meaning is close to the association between solidarity and the modern welfare state.[23]

Another important author was Léon Burgeois (1851-1925). Burgeois developed the work of Auguste Comte who, against both *laissez-faire* and communism, had conceived solidarity as continuity: an intergenerational dependence that makes the accumulation of experiences and resources possible, allowing the production of goods and services. Paraphrasing Comte, Stjernø comments that 'because wealth is created by the effort of many, the individual is not free to use his wealth as he pleases. Wealth is always entrusted to someone tacitly for a social purpose'.[24] Burgeois understood solidarity as a legal obligation: an inter-generational duty in favour of the ancestors and the contemporary. This duty would not be justified in a moral but in a legal obligation − a quasi-contract. Unlike Rousseau's social contract, Burgeois thought that civil society was founded on a quasi-contract, a will that could only be presumed. According to Mario Losano, Burgeois' understanding of the obligation of solidarity can be described in the following way:

- Who must pay? Those that have become richer thanks to present or past members of society. The owner of property does not have an absolute right over property;

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17 Stefan Stjernø, *Solidarity in Europe: The History of an Idea* (CUP 2004) 29.
18 ibid 26.
19 Mario Losano, 'La Cuestión Social y el Solidarismo Francés' in Mario Losano (ed), *Solidaridad y Derechos Humanos en Tiempos de Crisis* (Dykinson 2011) 17.
20 Stjernø (n 17) 29.
21 Losano, *Cuestión* (n 19) 19.
22 Stjernø (n 17) 28.
23 ibid.
24 ibid 32.

- Who receives the payment? All those that have not received their share in the goods created by social collaboration. Since these creditors cannot be individualized, the State or societies of beneficence can assume their representation;
- How much to pay? The sum is fixed considering the present circumstances as if society would have been based on a contract retroactively adopted. Ultimately, a minimum amount is needed to protect against the risks of life;
- How to pay? Voluntarily, in favour of the abovementioned societies of beneficence. If the payment is not carried out, the State intervenes making the social solidarity tax obligatory. Just like with respect to other legal obligations, the State acts as the guarantor of all contracts.[25]

The most famous representative of the French tradition on solidarity, Émile Durkheim (1858-1917), criticized liberalism in his *The Division of Labour in Society*. Stjernø comments that against Hobbes, Locke, Spencer and others, Durkheim argued that what held society together was not the result of rational calculation, self-interest or social contract; society would be 'based upon social norms, shared valued and rituals, and solidarity is one of the normative mechanisms that integrate members of society.' [26] In Durkheim's account deep social inequities would compromise solidarity.[27]

Later, with the emergence of social democracy after World War Two, solidarity was reinvigorated. Referring to the idea of solidarity in this period, Stjernø summarizes it as:

> [T]he preparedness to share resources with others by personal contribution to those in struggle or in need and through taxation and redistribution organized by the state. […] Solidarity implies a readiness for collective action and a will to institutionalize that collective action through the establishment of rights and citizenship.[28]

This account entails a modern way of linking solidarity to concrete operative modes of State action: collection of taxes, and its redistribution through rights and citizenship status. The sociologist T H Marshall in his seminal essay *Citizenship and Social Class*[29] linked the three sets of basic rights − civil, political and social – to the citizenship project. For Marshall, the end of the nineteenth century in Britain would have marked a shift in the notion of social citizenship: from assistance to the destitute – represented by Britain's Poor Laws[30] – to class restructuring through redistribution, progressive taxation and social policy. Marshall did not regard social citizenship as the improvement of the conditions of those living under extreme poverty;[31]

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25 Losano, *Cuestión* (n 19) 23-24.
26 Stjernø (n 17) 33.
27 ibid 35.
28 ibid 2.
29 T H Marshall, *Citizenship and Social Class and other essays* (CUP 1950).
30 T H Marshall, *The Right to Welfare and other essays* (Heinemann 1981) 57.
31 I take this line of argument from Atria, *Existen* (n 1) 32-33.

contemporary notions of citizenship had to go beyond the combatting of destitution, and extend to the struggle against social inequalities. Marshall understood social citizenship as part of a larger project aimed at attaining 'a kind of basic human equality'.[32] First through civil rights, then by means of political rights, and finally through social rights:

> [C]lass-abatement is still the aim of social rights, but it has acquired a new meaning. It is no longer merely an attempt to abate the obvious nuisance of destitution in the lowest ranks of society. It has assumed the guise of action modifying the whole pattern of social inequality. It is no longer content to raise the floor-level in the basement of the social edifice, leaving the superstructure as it was. It has begun to remodel the whole building, and it might even end by converting a sky-scraper into a bungalow.[33]

Stjernø comments in this respect that:

> In a modern society there can be no real solidarity, either in a socialist, social democratic or Christian democratic version, if solidarity is not institutionalised. This means that solidarity in modern societies must be embedded in public economic, social and educational policies and in international trade and foreign policy. There can be no solidarity without accepting the right to political participation and expression of opinion, legal rights to protection against the hazards of life and terms of trade, and foreign aid that embodies the aim to share resources and improve the situation of peoples in other parts of the world. In his classic essay, Citizenship and Social Class, T. H. Marshall directed our attention to how the concept of citizenship expanded from including first, civil rights in the eighteenth century to political rights in the nineteenth century, and finally, social rights in the twentieth century (Marshall 1965). Without using the term solidarity, his emphasis on the concept of citizenship makes clear that the concept of citizenship is a condition for solidarity in modern society.

Contemporary notions of solidarity include the work of philosophers such as Jacques Maritain and Michael Sandel. For the former, solidarity appears intrinsically connected to human rights. According to William Sweet, Maritain would like people to respect human rights and actively engage in work that will promote these rights. In doing so people would develop the disposition to 'be in solidarity' which is necessary as human rights are a matter of common interest.[34] For Sandel, solidarity appears as a requisite for democratic citizenship. Sandel submits that excessive inequalities, in terms of a too great 'gap between rich and poor' will ultimately 'undermine the solidarity that democratic citizenship requires'. Drawing from the reality of the United States, Sandel comments:

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[32] Marshall, *Citizenship* (n 29) 8.
[33] ibid 47.
[34] William Sweet, 'Solidarity and Human Rights' in William Sweet (ed), *Philosophical Theory and the Universal Declaration of Human Rights* (University of Ottawa Press 2003) 226-227.

> As inequality deepens, rich and poor live increasingly separate lives. The affluent send their children to private schools (or to public schools in wealthy suburbs), leaving urban public schools to the children of families who have no alternative. A similar trend leads to the secession by the privileged from other public institutions and facilities. Private health clubs replace municipal recreation centers and swimming pools. Upscale residential communities hire private security guards and rely less on public police protection. A second or third car removes the need to rely on public transportation. And so on. The affluent secede from public places and services, leaving them to those who can't afford anything else. This has two bad effects, one fiscal, the other civil. First, public services deteriorate, as those who no longer use those services become less willing to support them with their taxes. Second, public institutions such as schools, parks, playgrounds, and community centers cease to be places where citizens from different walks of life encounter one another. Institutions that once gathered people together and served as informal schools of civic virtue become few and far between. The hollowing out of the public realm makes it difficult to cultivate the solidarity and sense of community on which democratic citizenship depends.[35]

In line with T H Marshall, Sandel's account does show concern towards the rise of economic disparities, but his point is mainly about the value of communities characterized by more sharing and social cohesion.[36] In what ways have legal institutions developed this concern?

3.2. AN INSTITUTIONAL APPROXIMATION

In Austria, Karl Renner (1870-1950) and Anton Menger (1841-1906) formed part of a school of thought known as the *Austromarxists*. While the former worked on the social function of private law, the latter thought that civil law was classist. Family law, inheritance law and the law of obligations focused fundamentally on the problems of the richer classes. Menger devised the critical need of focusing on the needs of the poorer families.[37]

In Germany Marxism had become a dominating influence in the labour movement. According to Stjernø, the concept of solidarity developed later and was adapted to express the

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[35] Michael Sandel, *Justice: What's the Right Thing to Do?* (Penguin Books 2009) 266-267.

[36] According to a report issued by the Economic Commission for Latin America and the Caribbean (ECLAC), social cohesion includes three components: 1) distances or divides (reflected in employment, incomes and poverty, social welfare, education, access to new technologies, health, consumption and the availability of basic services); 2) institutional inclusion-exclusion mechanisms (they have an effect upon the structure of opportunities, accumulation of advantages and disadvantages, and the processes and results of inclusion-exclusion), and 3) sense of belonging (its dimensions are multiculturalism and non-discrimination, social capital (informal social networks, confidence and participation), prosocial values and solidarity, future expectations and prospects of social mobility, and the sense of integration and social affiliation). Economic Commission for Latin America and the Caribbean (ECLAC) and EuropeAid, 'A System of Indicators for Monitoring Social Cohesion in Latin America' (United Nations 2007) <www.cepal.org/en/publications/2888-system-indicators-monitoring-social-cohesion-latin-america> accessed 25 May 2015, 27-28.

[37] Losano, *Cuestión* (n 19) 27-28.

need for cohesion and unity in the working class and in the labour movement.[38] Later, Catholic social thought developed French solidarity especially after Leo XIII's *Rerum Novarum* encyclical letter.[39] Based on these ideas, but also following Soviet models, the Weimar Republic carried out several legislative and institutional innovations. In 1919, a council for the national economy was created. The council served as an advisory body for the government with the power to propose bills for legislative discussion. The council grouped 326 representatives of workers, employers, consumers, public employees and liberal professions. The government appointed 24 of these representatives. The Nazis suppressed the council.[40] During National Socialism the provision of social rights remained strong, but the principle of universality, which was in application from the time of Bismarck's social laws, disappeared. The provision was thus restricted to specific groups of the population on grounds of race.[41]

In Britain, the 'Beveridge Report' largely determined the structure of that country until the 1960s. The project had to wait until the elections of 1945, when Clement Atlee defeated Winston Churchill. The National Health Service (NHS), created in 1949 by Aneurin Bevan, was founded on three foundational principles: 1) the health system must respond to everyone's needs; 2) the provision must be free-of-charge at the point of delivery, and 3) the provision must be distributed in accordance to need and not ability to pay.[42] Although the National Health Service is the most well-known result from the Beveridge Report, Beveridge's ideas went further and contemplated measures to control the working force, fiscal measures of Keynesian inspiration and a comprehensive control over the means of production.[43]

In Chile, the civic-military coup of 11 September 1973 abruptly shifted the developmentalist trend in which the country had embarked from the 1930s, and more intensely from the 1950s, following the economic theses of ECLAC[44] and the development of social medicine in Latin America and Chile.[45] This period also coincided with the establishment of an increasingly wider scheme of social protection.[46] While in the nineteenth century healthcare was largely private and social assistance was a task dependent on the charity of the Catholic Church,[47]

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38 Stjernø (n 17) 26.
39 Losano, *Cuestión* (n 19) 32.
40 ibid 34-35.
41 ibid 46.
42 Fernando Atria, *Derechos Sociales y Educación: Un Nuevo Paradgima de lo Público* (Lom 2014) 248.
43 Losano, *Cuestión* (n 19) 51.
44 Gabriel Salazar and Julio Pinto, *Historia Contemporánea de Chile: Estado, Legitimidad, Ciudadanía*, vol 1 (Lom 1999) 162[81].
45 Oliva López y Florencia Peña, 'Salud y Sociedad: Aportaciones del Pensamiento Latinoamericano' (2006) 1 (3) Medicina Social 82; Carlos Molina, 'El Dr. Salvador Allende Gossens a 100 Años de su Nacimiento: una Deuda Pendiente' (2008) 48 (2) Cuadernos Médico Sociales Chile 93, 95-96.
46 Tomas Moulián, *Chile Actual: Anatomía de un Mito* (3rd edn, Lom 2012); Chile was the first country in the world to apply monetarist policies, see Lizzie Munsey (ed), *The Book of Economics* (DK 2012) 260.
47 Salazar (n 44) 132.

the first presidency of Arturo Alessandri Palma (1920-1924) was the first to address workers' social conditions, otherwise referred to as 'the social question' by encyclical letters such as Pope Leo XIII's *Rerum Novarum*.[48] In 1924 the Ministry of Hygiene, Assistance and Social Security and the Workers' Social Security Depository (*Caja de Seguro Obrero*) were created. The function of the Workers' Social Security Depository was to cover the risks related to illness, age and death.[49] In 1925, the Chilean Constitution was the first in the world to establish a constitutional right 'to the protection of health'.[50] In 1939, under the presidency of Pedro Aguirre Cerda, a new bill sought to join several dispersed healthcare services into a unitary healthcare service, similar to the British NHS.[51] The bill became law on 8 August 1952 through the Act of Parliament No 10,383. This act created the 'National Health System' (*Servicio Nacional de Salud*). Its function was to protect the health of the whole population, and contribute to the promotion and recovery of the health of workers, their spouses and children until the age of 15.[52]

This process was furthered under the presidencies of the Christian-Democrat Eduardo Frei Montalva (1964-1970), and the Socialist, Salvador Allende Gossens (1970-1973). Under the presidency of the former, an obligatory insurance for accidents at work and professional illnesses was created (Act of Parliament 16,744 of 1968[53]). At the same time 59 new hospitals were built, doubling the availability of hospital beds.[54] Under the presidency of Allende, thousands of young volunteer professionals were sent to the south of the country to teach writing and reading skills, and to provide medical attention to a section of the population that had been previously ignored.[55] A program of food supplements was extended to all children of primary schools and to all pregnant women. The program included half a liter of daily milk per family.[56]

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48 Pope Leo XIII, 'Rerum Novarum: Encyclical of Pope Leo XIII on Capital and Labor' (originally published 1891, Libreria Editrice Vaticana) <http://w2.vatican.va/content/leo-xiii/en/encyclicals/documents/hf_l-xiii_enc_15051891_rerum-novarum.html> accessed 23 June 2017, paras 20, 36, 45.

49 Chile's Ministry of Health, 'Hitos de la Salud Chilena' (Chile's Ministry of Health) <http://web.minsal.cl/hitos-de-la-salud-chilena/> accessed 23 June 2017.

50 Iain Byrne, 'Enforcing the Right to Health: Innovative Lessons From Domestic Courts' in Mary Robinson and Andrew Clapham (eds), *Realizing the Human Right to Health* (3 Rüffer and Rub 2009) 526.

51 Arturo Jirón Vargas, 'Recuerdo Médico del Dr. Salvador Allende Gossens' (2013) 53 (3) Cuadernos Médico Sociales Chile 158.

52 Chile's Ministry of Health, *Hitos* (n 49).

53 Act of Parliament 16,744 (1 February 1968) (Chile's National Congress) <www.leychile.cl/Navegar?idNorma=28650&buscar=16744> accessed 23 June 2017.

54 Marcelo Muñoz, 'Consideraciones Iniciales en torno al Trabajo de Juan Marconi en Chile: El Abordaje Intracomunitario en Salud Mental' (III Congreso Internacional de Investigación y Práctica Profesional en Psicología, XVIII Jornadas de Investigación, Séptimo Encuentro de Investigadores en Psicología del MERCOSUR, Buenos Aires, 2011) <www.aacademica.org/000-052/141> accessed 23 June 2017.

55 Carlos Molina, 'Una Mirada Historiográfica acerca del Desarrollo de la Institucionalidad Sanitaria Chilena: 1889-1989' (Tesis para optar al grado de Magister en Historia con Mención en Historia de Chile, Universidad de Chile 2007).

56 Jirón (n 51).

At the same time, primary healthcare centres were established at working-class neighbourhoods with at least one healthcare centre every 40,000 inhabitants.[57] Medical personnel was increased by 6.6% with emphasis on dentists and nurses. All this came hand in hand with an extensive program of healthcare prevention.[58] The epidemiological impact of the programs and campaigns of this period have been recorded in all health statistics and indicators of morbidity and mortality.[59]

3.3. SOLIDARITY AND THE RIGHT TO HEALTH: FROM CLASSICAL TO CONTEMPORARY UNDERSTANDINGS

The idea that de-commodifying a given good, interest or area is the appropriate way of legally ensuring a basic right has been a core understanding within liberalism. In fact, de-commodification – not the extension of justiciability – was the mechanism the liberals of the Post-War era resorted to in order to protect social rights. As the last chapter showed, the predominant interpretation of the right to health shifted away from that tradition.

The great shocks of the twentieth century, the First World War, the Great Depression and World War Two, were events from which the great reformers of the time – T H Marshall, William Beveridge and John Maynard Keynes, extracted important lessons.[60] A great deal of the social policy of these so-called *New Liberals* consisted in coming to terms with the idea that basic social areas had to become non-commodities.[61] Furthering the solidaristic ideals of the

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57 Cecilia Sepúlveda Carvajal, 'Salvador Allende y la Salud Pública a 40 años del Golpe de Estado' (2013) 53 (3) Cuadernos Médico Sociales Chile 179.

58 ibid.

59 Molina, *100* (n 45) 97.

60 Mark Blyth, *Austerity: The History of a Dangerous Idea* (OUP 2013) 117.

61 Peter Dwyer, *Understanding Social Citizenship: Themes and Perspectives for Policy and Practice* (2nd edn, The Policy Press and the Social Policy Association 2010) 93; one of the points of transition between laissez-faire liberalism and the New Liberals was the work of Walter Lippmann. Lippmann, who had characterized laissez-faire as 'one of the cardinal fallacies of nineteenth-century liberalism', stated that 'any modern state is bound to recruit a large body of officials charged with the enforcement of public rights against individuals and with the furnishing of public services. The question then is whether such an expansion of government activity is to be regarded as an unavoidable departure from liberal principles. Herbert Spencer thought so and in his crabbed old age we find him denouncing public-health measures as an unwarranted interference with human liberty. If he was right, then liberalism would indeed be bankrupt because it would be unable to deal with the most obvious practical necessities. But we have taken no such view, and we have seen that the agenda of liberalism is a long one.' Walter Lipmann, *The Good Society* (Transaction Publishers 2005) 298; TH Marshall connected liberalism with the tradition of solidarity. The 'protection against illness, old age and unemployment and guarantees of certain opportunities were both seen as the necessary *rights* of civilized life and part of the *solidaristic* goals of society. Taxation could be used to foster this civil solidarity, connecting the private civil to the public civil interest'. Avital Simhony and David Weinstein (eds), *The New Liberalism: Reconciling Liberty and Community* (CUP 2001) 213.

nineteenth century, the idea was to envision duties and institutions that could generate a *real liberty*, an *equal liberty* or *freedom for all*.[62] Attempts to carry this out can be observed first in Germany in the constitutional compromises of the Weimar Constitution,[63] but also in the Post-War institutions that were organized in Britain.

The Cold War, far from a deterrent, became a facilitator of that development. The 'state of compromise' that ensued after World War Two was largely thanks to the fear of the red spectre: either armed conflict with the USSR, or communist infiltration in Western Europe.[64] The European Social Welfare State largely responded to that threat. Notions of universality, free-of-charge and conditionality to need rather than ability to pay were put in practice in institutions such as the British NHS.[65] This form of provision was extremely successful. Access to healthcare became a right of citizenship.[66] Likewise, income inequality went down significantly.[67] In the context of the East-West ideological confrontation, this also proved that capitalism could incorporate mechanisms to ensure equality of condition and social protection from the 'cradle to the grave'. This move was not the first one of its kind. Von Bismarck had been engaging in a similar approach in the context of the emergence of the German working movement at the end of the nineteenth century.[68] The ideas and institutions he envisioned had so much success that an entire field of law – social law – was created.[69] In the field of the right to health, the apex of these ideas was reached in the Alma-Ata Declaration in the context of the WHO's strategy of *Health for All*.[70]

How come liberalism detracted from this path? The answer seems partially theoretical and partially practical. Theoretically, the end of this interpretation is linked to the ideological confrontation that ensued within liberalism itself. On the other hand, from a practical perspective, the fall of the Berlin Wall put an end not just to the Cold War but it also left in disarray predominant arrangements of Post-War liberalism. These events have impacted the way human rights are understood today.

From the theoretical point of view, one should point out the influence exerted by Friedrich Hayek. Hayek regarded the path taken by the New Liberals an unfaithful expression of liberalism.[71] Together with other thinkers like Ludwig von Misses, Hayek claimed that only

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62 Simhony (n 61) 87-88.
63 Ignacio Sotelo, *El Estado Social: Antecedentes, Origen, Desarrollo y Declive* (Trotta 2010) 196-201.
64 Prem Jha, *The Twilight of the Nation State: Globalisation, Chaos and War* (Pluto Press 2006) 295; Kees van der Pijl, *Global Rivalries: From the Cold War to Iraq* (Pluto Press 2006) 34.
65 Allyson Pollock, *NHS plc: The Privatization of Our Health Care* (Verso 2005) 83; Atria, *Paradigma* (n 42) 248.
66 Sotelo (n 63) 237.
67 Dany Dorling, *Inequality and the 1%* (Verso 2014) 11.
68 Sotelo (n 63) 172.
69 ibid 173, 176.
70 See ch 2, n 105.
71 Rachel Turner, *Neo-Liberal Ideology: History, Concepts and Policies* (2nd edn, Edinburgh University Press

a minimum State and the guarantee of property were genuine representatives of the liberal tradition.[72] Indeed, while Hayek managed to make a formidable case for property as a pre-requisite of autonomy, the New Liberal view convincingly put forward the idea that the challenge for liberalism consisted in harbouring the social needs of all so that freedom could become effectively universalized.[73] The struggle of the New Liberals was not unprecedented. As theorized by T H Marshall, social rights constituted one of various instruments tasked with the operationalization of a more holistic project of citizenship.[74] First, this was done via civil rights, then via political rights, and further via social rights.

From the practical point of view, a second set of reasons explains the shift towards the predominant interpretation of the right to health. Devoid of the ideological and military deterrent of the USSR, the capitalist system could fully unleash itself. For reasons that I shall explain in the next chapter, during the Cold War human rights had to remain relegated to a minimum.[75] While the fall of the Berlin Wall made clear that capitalism had defeated socialism, it then seemed less clear that capitalism was also on the march to defeat Post-War liberalism and social democracy. The reinvention of this latter doctrine by the hand of Tony Blair, in what Antony Giddens called the *Third Way*, was in fact the full-scale victory of Margaret Thatcher and her political legacy.[76]

While the Thatcher era begins after her victory in the elections of 1979, this process had begun some years before amidst the 1973 oil crisis. It was that very year that the state of compromise had begun to crumble. In 1973, a civic military coup backed up by the United States Central Intelligence Agency,[77] allowed the Chilean military led by General Pinochet to seize power (1973-1990). The story is well known. In two decades, General Pinochet brutally revolutionized the country. A new constitution was adopted in 1980; the organization of the economy radically shifted towards a model of open economy,[78] and the provision of public

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2011) 124, 149-150.

72 ibid 192.

73 ibid 41.

74 Dwyer (n 61) 5-7.

75 See ch 4, s 2.

76 When the former Prime Minister was asked, what had been the greatest achievement of her political carrier, her answer was: 'New Labour'. This suggests that Thatcher had been politically and ideologically so successful that she was able to force her adversaries to choose between redefining their fundamental views or politically succumb. Conor Burns 'Margaret Thatcher's Greatest Achievement: New Labour' (ConservativeHome, 11 April 2008) <http://conservativehome.blogs.com/centreright/2008/04/making-history.html> accessed 23 June 2017; Andy McSmith, Ben Chu and Richard Garner, 'Margaret Thatcher's Legacy: Spilt Milk, New Labour, and the Big Bang - She Changed Everything' The Independent (London, Monday 8 April 2013) <www.independent.co.uk/news/uk/politics/margaret-thatchers-legacy-spilt-milk-new-labour-and-the-big-bang-she-changed-everything-8564541.html> accessed 23 June 2017.

77 Noam Chomsky and Edward Herman, *The Washington Connection and Third World Fascisms: The Political Economy of Human Rights*, vol 1 (Pluto Press 2015) 58.

78 Manuel Gárate, *La Revolución Capitalista de Chile (1973-2003)* (Ediciones Universidad Alberto Hurtado

services was largely privatized.[79] The historian Gabriel Salazar comments this last episode in the following terms:

> [O]f greater originality was, no doubt, to have privatized and commercialized public services (healthcare, education and social security) of what used to be the welfare state (*Estado Social-Benefactor*), and of even substantive parts of the public policies of the old Liberal State of 1925 (especially policies of local development). The 'technical' nature of this second wave of commercialization did not respond so much to the fact that new economic groups were being created, but that on the basis of these services and policies, new processes of accumulation were being installed. These (non-productive) processes of accumulation were stress-free as they did not require to despoil workers, but contributors (through healthcare and social security contributions), and parents (through education fees), all with the poor being instrumentalized under poverty-surmounting policies, and with contributors turning into the passive stakeholders of these businesses.[80]

The views of the New Liberals and social democracy became the expression of something antiquated. The identification of social rights with duties and institutions that granted universal protection shifted. Although Thatcher failed in dismantling the NHS, managerial principles that asserted market superiority promised more efficient outcomes in the organization of those services.[81] These policies were more successfully introduced under Tony Blair.[82] Within human rights, social rights became re-interpreted, not along with the identification of the duties, institutions and principles asserted by the New Liberals, but in line with neoconstitutionalism and transformative constitutionalism, which emptied social rights of their communitarian and transformative potential.[83] In a *Fukuamaist* world beyond left and right, it was nothing but expectable that the Limburg Principles would put the social justice project largely in the hands of judges. Yet, their ability to advance this project remained weak amidst their naturally limited democratic legitimacy. Except for the social determinants, the predominant interpretation of the right to health conceived this right basically as an individual legal right.[84] As I show in the next

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2012) 191.

79 ibid 260, 308-316.

80 Salazar (n 44) 110.

81 Janet Newman, *Modernizing Governance: New Labour, Policy and Society* (Sage 2001) 47; Turner, *Ideology* (n 71) 157-159.

82 Newman, *Governance* (n 81) 92; Pollock (n 65) 54.

83 Atria, *Paradigma* (n 42) 35, 47, 53.

84 The social determinants of health were not a product of the predominant interpretation. As General Comment 14 acknowledges, its history is linked to the work of the Third Committee of the UNGA, see UNCESCR, 'General Comment 14 The Right to the Highest Attainable Standard of Health', UN Doc E/C.12/2004/4, 11 May 2000, para 8; Vicente Navarro notes that the study of the social determinants of health is not new but quite old. Given his analysis of the living conditions of the English working class, Navarro places Engels as one of the founders of the scholarship on the social determinants of health, see Vicente Navarro, 'History of the Social Determinants of Health: Global Histories, Contemporary Debates (Review)' (2009) 83 (3) Bulletin

chapter, the role of the State shifted from direct provider of an equal and universal public service, to the guarantor of an obligation to protect a minimum provision (not necessarily served by the State) to those excluded by the market.[85]

3.3.1. THE RIGHT TO VOTE: AN ANALOGY

T H Marshall's conception of rights as waves of rights (first civil, then political and ultimately social rights) entails a coherent interrelation between them. In the case of the modern understanding of the right to vote, the rule of the majority may be traced back to the old Greeks.[86] Yet, important accommodations had to take place for liberalism to amalgamate with democracy.[87] It was only a virulent and long-lasting political struggle that removed the institution of census suffrage and other class and property considerations from the right to vote.[88] The ability of ridding democracy of race considerations and the power of the capital owners of the nineteenth and twentieth centuries was what allowed the universality of the franchise. In that sense, the modern understanding of the human right to vote owes mostly to the struggles of social movements such as the European working movement, the feminist movement, the United States' civil rights movement and the anti-apartheid movement. Modern electoral systems based on universal suffrage and majority rule would not have been possible without them. It is only the struggle against the constant attempts to co-opt it which keeps (what is left of the universality of) the human right to vote.[89]

The perspective of the Human Rights Committee corroborates the actuality of this view.[90] This body accepts not only that the right to vote should be universal, but also that it

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of the History of Medicine 620.

85 Dwyer (n 61) 65; Turner, *Ideology* (n 71) 150.

86 Fundamentally in Athens, especially at the Ecclesia, see Ricardo Chueca Rodríguez, *La Regla y el Principio de la Mayoría* (Centro de Estudios Constitucionales 1993) 27.

87 Locke was opposed to it, ibid; John Stuart Mill was reluctant to it, see Sotelo (n 63) 130-131.

88 Brian Roper, *The History of Democracy: A Marxist Interpretation* (Pluto Press 2013) 128, 135, 207.

89 In *Citizens United* (Supreme Court of the United States, *Citizens* (see ch 1, n 4)), the United States Supreme Court broke up, in a certain way, with the principle of one person, one vote as asserted in *Reynolds v Sims* 377 U S 533 (1964). Whereas in that decision the Court considered that legislative apportionment schemes could not have the effect of making one vote less valuable than another, *Citizens United* by regarding private wealth in the form of donations to political campaigns as protected under freedom of expression, had the effect of giving wealthy voters more ability to influence the political process. This trend of case law was recently confirmed in *McCutcheon v Fed Election Comm'n* 572 US _ (2014), where the US Supreme Court struck down as unconstitutional the limits on the amount an individual can make to parties, federal candidates and political action committees combined. Lately, evidence of financial involvement from foreign companies in federal campaigns has emerged, Jon Schwarz, 'Foreign Spending on U.S. Elections Threatens National Security, FEC Commissioner Says' The Intercept (Washington 12 September 2016).

90 The general comment states that 'although the Covenant does not impose any particular electoral system, any system operating in a State party must be compatible with the rights protected by art 25 and must guarantee and give effect to the free expression of the will of the electors. The principle of one person, one

should be *equally* enjoyed. The reason is that the right to vote as a human right would be of little worth if despite it being assured to everyone (universal) it would not do so in *equal terms*, hence, the principle of 'one-person, one-vote'. This is in line with the New Liberals' views on social rights. They did not think that for everyone to have an equal right, the rights had to be transformed in individual entitlements that could be made justiciable in court. What they did was simply not accept that social class and economic privilege could become the condition to access social rights such as access to healthcare.[91]

In terms of its value, the right to vote demanded the electoral system to make the 'weight' of the entitlement equal when compared to the entitlement of anybody else's (principle of one person, one vote). Concerning the right to health, the New Liberals' view was not different: the function of the national healthcare system consisted in materializing that fundamental equality of result in access to healthcare. Not via justiciability, but by rejecting the idea that the right to health could depend on social class and economic privileges and by conceding it free-of-charge to all at the point of service.

4. SOLIDARITY IN THE LAW

4.1. INTRODUCTION

While the Universal Declaration of Human Rights adopted a certain stand by incorporating the expression 'brotherhood' in Article 1, this is arguably a feeble basis to affirm the status of solidarity in international law. Lack of explicit recognition describes the way binding international human rights law instruments have dealt with solidarity.[92] The problem goes

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vote, must apply, and within the framework of each State's electoral system, the vote of one elector should be equal to the vote of another. The drawing of electoral boundaries and the method of allocating votes should not distort the distribution of voters or discriminate against any group and should not exclude or restrict unreasonably the right of citizens to choose their representatives freely'. UNHRC, 'CCPR General Comment 25: Article 25 (Participation in Public Affairs and the Right to Vote) The Right to Participate in Public Affairs, Voting Rights and the Right of Equal Access to Public Service', UN Doc CCPR/C/21/Rev.1/Add.7, 12 July 1996, para 21.

91 T H Marshall, *Welfare* (n 30) 92; Ricardo García Manrique, *La Libertad de Todos: Una Defensa de los Derechos Sociales* (El Viejo Topo 2013) 21.

92 Janelle Diller, *Securing Dignity and Freedom through Human Rights: Article 22 of the Universal Declaration of Human Rights* (Martinus Nijhoff Publishers 2012) 125; the United Nations Millennium Declaration situates solidarity among the fundamental values of the new century. The Declaration states: 'Global challenges must be managed in a way that distributes the costs and burdens fairly in accordance with basic principles of equity and social justice. Those who suffer or who benefit least deserve help from those who benefit most'. UNGA, 'United Nations Millennium Declaration' Res. 55/2, UN Doc A/Res/55/2, 18 September 2000, para 6.

further. Even with respect to the explicitly declared values and purposes of the Universal Declaration of Human Rights, scholars resent that 'the Declaration is each time more Declaration and each time less living law'.[93]

While the notion of brotherhood provides an argument to consider solidarity part of the human rights law edifice, much more is needed to fill in the gap of international human rights law. Is solidarity a mere aspiration devoid of any legal value? As stated earlier I shall not embark in the effort of showing whether solidarity entails customary international law. While that would be an interesting research project, I think that for present research purposes it suffices to ask whether there is ground to consider solidarity as an operative principle able to justify legal duties linked to social rights. If that turns out to be so, there would be room to propose solidarity as a theoretical legal notion able to explain and articulate human rights and more specifically social rights such as the right to health. In the coming sections I intend to trace solidarity in a few international and national human rights instruments.

4.2. INTERNATIONAL HUMAN RIGHTS LAW

4.2.1. THE UN CHARTER

The entire Preamble of the UN Charter could well be understood as a solidarity declaration. It begins with the use of the first-person plural: 'We'. In a repetition of the famous use the term attained in the United States Declaration of Independence of 1789, this is a clear reaffirmation of the idea of a group united by bonds of solidarity. The difference is that while in the former case a Nation State was being constituted, the ultimate ambition of the drafters of the UN Charter was to build a larger, albeit thinner, political project. The universal ambition of other expressions utilized in the preamble accentuates this view: 'succeeding generations', 'mankind', 'equal rights of men and women and of nations large and small', 'better standards of life in larger freedom', 'live together in peace with one another as good neighbours', 'unite our strength', 'common interest', 'all peoples'.

4.2.2. THE UNIVERSAL DECLARATION OF HUMAN RIGHTS

When the drafting of the Universal Declaration of Human Rights was ended, its first Article stated: 'All human beings are born free and equal in dignity and rights. They are endowed with reason and conscience and should act towards one another in a spirit of brotherhood'.[94] Cassin,

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[93] Eduardo Cifuentes, 'La Urgencia de Revitalizar y Perfeccionar el Proyecto Constitucional Universal' in Ana Lucía Córdova and Francisco López-Bermúdez (eds), *Cohesión Social y Derechos Humanos* (Corporación Nacional Editora 2009).

[94] Cassin argued that '[T]he idea of the solidarity of men should be made explicit in the Article to convince the peoples of the world that the United Nations firmly believed in their essential brotherhood', Intervention of Prof Cassin, UNCHR, Summary Record of the Fiftieth Meeting [of the Commission on Human Rights] UN

in the draft of the report of the Third Committee, stated that the following fundamental principles should be incorporated: '1) the unity of the human race or family; 2) the idea that every human being has a right to be treated like every other human being; and 3) the concept of solidarity and fraternity among men'.[95]

The *travaux préparatoires* of Article 1 reveal that following the trend of the French Revolution, the expression 'in a spirit of brotherhood', was made synonymous with fraternity and social solidarity. Cassin mentioned that the allusion:

> [T]o the three fundamental questions of liberty, equality, and fraternity [was] because, during the war, these great fundamental principles of mankind had been forgotten. The text was trying to convey the idea that the most humble men of the most different races have among them the particular spark that distinguishes them from animals, and at the same time obligates them to more grandeur and to more duties than any other beings on earth. He added that there were still one or two ideas not yet mentioned, the concept of man as a reasonable being and the concept of reciprocal duties among men. These concepts, developed on the juridical plane, would concern mutual obligations or mutual rights or solidarity. However, he felt that men generally would understand the expression "men are brothers" more easily than a juridical expression concerning "mutual rights and obligations.[96]

The reference to brotherhood is in the first Article of the Universal Declaration, and it was finished after a lengthy discussion. Cassin linked the French Revolution's *fraternité* to the Declaration: 'The universal declaration of human rights was a considerable effort on the part of individuals, groups and States alike. In common with the 1789 Declaration, it was founded upon the great principles of liberty, equality and fraternity'.[97] The Latin-American countries, the main promoters of a catalogue of rights in the UN Charter[98], supported that view.[99] The meaning of solidarity within the Universal Declaration of Human Rights, as the *travaux préparatoires* show, relates to internationalism, social rights, the avoidance of war, and to a way of conducting human and international relations pursuing peace.[100] In this respect, the representative of Syria stated that:

Doc E/CN.4/SR.50, 27 May 1947, Lake Success, New York; Roger Normand and Sarah Zaidi, *Human Rights at the UN: The Political History of Universal Justice* (Indiana University Press 2008) 187.

95 UNCHR, Summary Record of the Second Meeting [of the Drafting Committee of the Commission on Human Rights], UN Doc E/CN.4/AC.1/SR.2, 11 June 1947.

96 UNCHR, Summary Record of the Eighth Meeting [of the Drafting Committee of the Commission on Human Rights] UN Doc E/CN.4/AC.1/SR.8, 17 June 1947.

97 UNGA, Verbatim Record of the Hundred and Eightieth Plenary Meeting [of the General Assembly], UN Doc A/PV.180, 9 December 1948.

98 Åshild Samnøy, *Human Rights as International Consensus: The Making of the Universal Declaration of Human Rights 1945-1948* (Chr. Michelsen Institute 1993) 15-17.

99 John Tobin, *The Right to Health in International Law* (OUP 2012) 9; UNCHR, E/CN.4/SR.50 (n 94).

100 The representative of Chile, Hernán Santa Cruz, indicated that: 'The delegation of Chile believed that both

> With regard to the third point, the word "brotherhood" was not defined in the draft declaration. In his opinion, it was an expression of the ideal moral relationships that should exist between men and meant that all men should behave to others, as they would wish others to behave to them. If that was the generally accepted meaning of the word, he thought that it should be retained.[101]

In turn, Ribnikar from Yugoslavia:

> Stressed the far reaching effects which the Bill of Human Rights would have throughout the world: it would establish new bonds of solidarity, and would be an expression of the social realities of our time, defining the relations between the individual and society. He outlines the history of liberalism. New economic conditions in the twentieth century had given birth to a collective spirit, a consciousness of solidarity. Personal freedom could only be attained through perfect harmony between the individual and the community. The social ideal lay in the interests of society and of the individual being identical.[102]

Yet, Pavlov, the representative of the USSR, reacted against the notion of brotherhood. Not because he did not believe in the ideal but because the world reality at the time was too far away from it. He was quoted to have stated that:

> The second sentence of Article 1, with its mention of the "spirit of brotherhood", was too far divorced from the realities of the modern capitalist world to be acceptable. The relations between the United Kingdom and Malaya, between the Netherlands and Indonesia, between different groups in Spain, between the rich and poor everywhere could not be described as brotherly unless the brothers referred to were Cain and Abel. A real spirit of brotherhood was possible only in the absence of exploitation of men by their fellow men, of weak nations by strong nations. In a socialist society, where such exploitation had been abolished, the very basis for oppression had disappeared. The precept "Dog eat dog" had given way to the nobler motto, "One for all and all

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the Declaration and the Covenant must be inspired by the principles of the Charter. It had been recognized at San Francisco, when the horrors of war and totalitarianism were still fresh in the memory of the world, that if the causes of war were to be eliminated the sovereignty of States must be limited by considerations of international solidarity and co-operation, and the economic level of the peoples of the world must be raised. The Chilean delegation had made it clear in the Drafting Committee that it could not support a Declaration that did not embody those principles. Economic and social rights must find their place in the Declaration; the right to work, the right to an equitable salary, the right to health, education and social security, and to the benefits of culture and scientific progress must not be omitted. Mr. Santa Cruz urged the importance of taking into account the ideals which had inspired the French revolution'. UNCHR, E/CN.4/SR.50 (n 94).

[101] Summary Record of the Ninety-Ninth Meeting [of the Third Committee], UN Doc A/C.3/SR.99, 11 October 1948.

[102] UNCHR, Summary Record of the Eighth Meeting [of the Commission on Human Rights], UN Doc E/CN.4/SR.8, 31 January 1947.

> for one". It could be said that article 1 was meant to be a goal for the future; but the declaration would in effect be a recommendation of the General Assembly. It should therefore be realistic, and state only what existed or could be attained at the current stage of human development. The United Nations should not lay itself open to accusations of wishful thinking or hypocrisy.[103]

Ramirez Moreno from Colombia, on the other hand, stated that:

> It had been maintained moreover that there could be no brotherhood because imperialistic countries exploit Native tribes in their colonies; but it should be remembered that the document under discussion was designed to be not a chronicle of crime but an affirmation of a doctrine. Exploitation of man by man had been mentioned in the debate. He wished to point out that as the representative of a Christian country, he could never be the mouthpiece of capitalism. He was speaking in the name of the worker of the future, of the man of the South American Continent who desired to place social consideration above economic ones.[104]

From these references, the following normative meanings of the idea of solidarity can be traced: solidarity as a duty of every person towards every other fellow human being and of every people towards every other people; solidarity as the ideal of fraternity, as inspired by the French Revolution. Its implications can be noted in areas such as education, internationalism, the prevention of war, as an intergenerational duty between generations and as a duty to protecting the environment; solidarity as absence of exploitation and the value of human labour; solidarity as an understanding of liberty, which would be reached by harmonizing the interests of the individual with those of the community (redistribution, protection of the vulnerable, social economy).

As T H Marshall would further conceptualize, the Universal Declaration of Human Rights linked the objective of social rights to citizenship.[105] Article 22 of the Declaration understood it in connection with both 'dignity' and 'the free development of the personality'.[106] The *travaux préparatoires* of Article 22 show the existence of a consensus around the idea to protect social security. This is further reflected in the fact that it was the very delegation of the United States, which proposed and managed to attain the approval of the expression 'and other

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[103] Summary Record of the Ninety-Eighth Meeting [of the Third Committee], UN Doc, A/C.3/SR.98, 9 October 1948.

[104] ibid.

[105] As Marshall states: 'social rights imply an absolute right to a certain standard of civilization which is conditional only on the discharge of the general duties of citizenship', see Marshall, *Citizenship* (n 29) 43.

[106] This language was used before the Universal Declaration of Human Rights by the American Declaration of the Rights and Duties of Man in relation to the duties to society, see Inter-American Commission on Human Rights (IACHR), American Declaration of the Rights and Duties of Man, 2 May 1948, art XXIX; After the Universal Declaration, the wording was corroborated by the Declaration on the Right to Development, see UNGA, Declaration on the right to development. 97th Plenary meeting. 4 December 1986, 41/28, art 2(2); Diller (n 92) 121-122.

necessary social services' in Article 25.[107] By the same token, the reference to the personality of Article 22 should not be interpreted in an individualistic way. Not only because the same provision indicates that the right to social security is conferred by virtue of being 'a member of society', but also, because Article 29 (1) stated that the personality of the individual could not be developed severed from the community.[108] The importance that duties had in this context was beyond all doubt and it was not the first time it emerged. Even before the establishment of the Commission in charge of the drafting of the Universal Declaration, an International Intellectual Commission convened by the UNESCO had invited to a symposium to set the 'Philosophical Principles of the Rights of Man'.[109] Famously, Mahatma Gandhi did not attend the meeting on the grounds that the purpose was to discuss purely a Declaration on Human 'Rights'. Gandhi stated his view on the issue in a one-page letter addressed to UNESCO's Director General:

> I learnt from my illiterate but wise mother that all rights to be deserved and preserved came from duty well done. Thus, the very right to live accrues to us only when we do the duty of citizenship of the world. From this one fundamental statement, perhaps it is easy enough to define the duties of Man and Woman and correlate every right to some corresponding duty to be first performed. Every other right can be shown to be a usurpation hardly worth fighting for.[110]

Further, although the Commission was not able to agree on the content of the duties that would secure the rights set forth, the Declaration did indicate that everyone had duties towards the community.[111]

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[107] UNCHR, Summary Record of the Sixty-Sixth Meeting [of the Commission on Human Rights], UN Doc E/CN.4/SR.66, 9 June 1948.

[108] Article 29(1) states: '(1) Everyone has duties to the community in which alone the free and full development of his personality is possible', UNGA, Universal Declaration of Human Rights, 10 December 1948, 217 A (III); Johannes Morsink, *The Universal Declaration of Human Rights: Origins, Drafting, and Intent* (University of Pennsylvania Press 1999) 248.

[109] UNESCO, 'Report of the First Meeting of the Committee of Experts Convened by UNESCO on the Philosophical Principles of the Rights of Man', Paris 31 July 1947.

[110] UNESCO, 'Human Rights: Comments and Interpretations' UNESCO/PHS/ 3 (rev), Paris, 25 July 1948, p. 3.

[111] In the context of the discussion of what later became Article 22, Mr Pavlov, representative of the USSR, stated that 'the India/United Kingdom text omitted all reference to the right of the family to a dignified standard of living, and the right of man to medical care and housing. The Declaration must contain clauses emphasizing these rights, and he asked the Drafting Sub-Committee to take his suggestions into consideration. Referring to the high cost of medical aid and the lack of hospitals and health centres in the United States of America, he pointed out that in the Union of Soviet Socialist Republics not only was all medical aid provided free of charge to workers, but the hospital network system had been increased five times and the number of physicians 500 per cent during the last quarter of a century. Expenses in connection with the improvement of health services were increasing yearly. Stressing the right of man to adequate housing, he said that in the Union of Soviet Socialist Republics only one to four per cent of a worker's earnings was spent on housing, whereas in certain other countries the average spent on housing was 30

In this respect, the discussion of Article 29(1) is extremely interesting. It mostly took place in the context of the Hundred and Fifty-Fourth Meeting of the Third Committee.[112] What comes next are all quotations belonging to that session.

The representative of the Netherlands began the discussion by stating that it had to 'be admitted that an individual had duties towards the community independent of the character of that or the other community. The fact that a State did not grant political rights to a certain category of citizens, though deplorable, was not a sufficient reason for the citizen in question refusing, for instance, to pay their taxes'. The delegation of Cuba recalled in this respect 'the Bogotá declaration. That solemn declaration of social solidarity would be a safeguard against the exaggerated individualism which had done so much ill'. Further, the representative of the USSR argued that 'it was imperative to safeguard the just demands of the democratic State precisely because it alone was capable of defending the individual against the encroachment of forces such as high finance or trusts. Those who refused to recognize that fact showed that they preferred oligarchy to democracy'.

It was however the representative of Australia, Mr Watt, who proposed the text in the terms that were finally approved. He 'suggested inserting the phrase "in which alone the free and full development of his personality is possible", in paragraph 1 after the word "community".' The representative of the United States proposed to delete the word 'alone', while the representative of Belgium argued that it was an error to think that the individual could develop his personality only within the framework of society. He recalled the famous book by Daniel Defoe, *Robinson Crusoe*. In this respect, Mr Pavlov, the representative of the USSR:

> [T]hought, on the contrary, that the text proposed by the Australian representative was important in that it stressed the harmonious relations which should exist between the individual and the society in which he lived. The word "alone", which had been criticized by some delegations, seemed to him excellent. It rightly stressed the fact that the individual could not fully develop his personality outside society. The example of Robinson Crusoe, far from being convincing, had, on the contrary, shown that man could not live and develop his personality without the aid of society. Robinson had, in fact, had at his disposal the products of human industry and culture, namely, the tools and books he had found on the wreck of his ship. The Australian amendment was perfectly justified. In view of the fact that the Australian delegation had withdrawn it, he would take it up in the name of his own delegation.

The representative of the United Kingdom:

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percent'. In response, the representative of the United States indicated that 'Speaking as representative of the United States of America she pointed out that in that country the poor received free medical aid, and that although the idea of socialized medicine was not generally accepted, several hospital insurance schemes were being tried out. Taken on a basis of population she thought that there were more doctors in the United States of America and more hospital beds than there were in the USSR'. UNCHR, E/CN.4/SR.66 (n 107).

[112] Summary Record of the Hundred and fifty-Fourth Meeting [of the Third Committee], UN Doc A/C.3/SR.154, 24 November 1948.

> [S]hared the opinion of the USSR representative; that amendment in no way modified the substance of Article 27, but eliminated the ambiguity pointed out by the USSR representative and by other delegations. Moreover the word "alone" in that text stressed the essential fact that the individual could attain the full development of his personality only within the framework of society'. By the same token Professor Cassin recognized that the new text eliminated any ambiguities. The Chairman put to the vote the proposal to include the word "alone" in the text of the USSR amendment. That proposal was adopted by 23 votes to 5, with 14 abstentions. The Chairman put to the vote the USSR amendment as a whole. The amendment was adopted by 35 votes to none, with 6 abstentions.

4.2.3. INTERNATIONAL INSTRUMENTS AND CONSTITUTIONS

In this section I have compiled some international documents as well as two sets of constitutions. The international documents contain both explicit and implicit references to solidarity. The following instruments have been included:

1. American Declaration of the Rights and Duties of Men (1948).[113]
2. Universal Declaration of Human Rights (1948).[114]
3. European Social Charter (1961).[115]
4. International Covenant on Economic, Social and Cultural Rights (1966).[116]
5. American Convention on Human Rights 'Pact of San José, Costa Rica' (1969).[117]
6. Declaration on Social Progress and Development (1969).[118]
7. Declaration on Principles of International Law concerning Friendly Relations and Co-operation among States in accordance with the Charter of the United Nations (1970).[119]
8. Declaration on the Establishment of a New International Economic Order (1974).[120]
9. Charter of Economic Rights and Duties of States (1974).[121]
10. Convention on the Elimination of All Forms of Discrimination Against Women (1979).[122]

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[113] IACHR, Declaration (n 106).
[114] UNGA, Declaration (n 108).
[115] European Social Charter, 18 October 1961, ETS 35.
[116] International Covenant on Economic, Social and Cultural Rights (adopted on 16 December 1966) 993 UNTS 3.
[117] American Convention on Human Rights, 'Pact of San Jose', Costa Rica, 22 November 1969 (Organization of American States (OAS)).
[118] UNGA, Declaration on Social Progress and Development, Res 2542 (XXIV) 11 December 1969.
[119] UNGA, Declaration on Principles of International Law concerning Friendly Relations and Cooperation among States in accordance with the Charter of the United Nations, 24 October 1970, A/RES/2625 (XXV).
[120] UNGA, Declaration on the Establishment of a New International Economic Order, 1 May 1974, UN Doc A/Res/S-6/3201.
[121] Charter of Economic Rights and Duties of States, 12 December 1974, UN Doc A/Res/29/3281.
[122] Convention on the Elimination of All Forms of Discrimination Against Women (adopted 18 December 1979) 1249 UNTS 13.

11. African Charter on Human and Peoples Rights (1981).[123]
12. Declaration on the Right to Development (1986).[124]
13. Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights, 'Protocol of San Salvador' (1988).[125]
14. Rio Declaration on Environment and Development (1992).[126]
15. Vienna Declaration and Programme of Action (1993).[127]
16. United Nations Millennium Declaration (2000).[128]
17. Proposed Draft Declaration on the Right of Peoples and Individuals to International Solidarity (2017).[129]

The constitutions can be divided in two groups. Firstly, there are some classical expressions of social constitutionalism and a few more recent constitutional texts. The first group of constitutions covers 80 years ranging from 1917 to 1997. In this group, I have included the following constitutions: Mexico's 1917 Constitution, the Weimar 1919 Constitution, Chile's 1925 Constitution, the 1931 Constitution of the Spanish Republic, Italy's 1947 Constitution, Germany's 1949 Constitution, Cuba's 1976 Constitution, Spain's 1978 Constitution and South Africa's 1996 Constitution.

A second group of more contemporary constitutions contemplates those issued in the last twenty years (1997-2017). I looked at 37 constitutions: 14 are from the African continent, 8 from the European continent, 6 from the Asian continent, 5 from South America and the Caribbean, 3 from the Middle East and 1 from Oceania.[130] Despite the more reduced issuance of

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[123] African Charter on Human and Peoples' Rights ('Banjul Charter'), 27 June 1981, CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982) (Organization of African Unity (OAU)).

[124] UNGA, Development (n 106).

[125] Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights (Protocol of San Salvador) (entered into force 16 November 1999) OAS Treaty Series No 69 (1988) reprinted in Basic Documents Pertaining to Human Rights in the Inter-American System OEA/Ser L V/II.82 Doc 6 Rev 1 at 67 (1992) (Organization of American States (OAS)).

[126] UNGA, Rio Declaration on Environment and Development (1992) UN Doc A/CONF.151/26 (vol. I), 31 ILM 874.

[127] OHCHR, Vienna Declaration and Programme of Action, UN Doc A/CONF.157/23, 12 July 1993.

[128] UNGA, Millennium (n 92).

[129] OHCHR, 'Report of the Independent Expert on Human Rights and International Solidarity, Virgina Dandan', UN Doc A/HRC/26/34, 1 April 2014, Annex.

[130] The following constitutions were assessed: Afghanistan's (2004); Albania's (1998); Angola's (2010); Bahrain's (2002); Bhutan's (2008); Bolivia's (2009); the Democratic Republic of Congo's (2006); the Dominican Republic's (2010); Ecuador's (2008); Egypt's (2014); Fiji's (2013); Finland's (2000); Haiti's (2012); Hungary's (2011); Iraq (2005); Ivory Coast's (2000); Kenya's (2010); Kyrgyzstan's (2010); the Libyan Interim Constitutional Declaration (2011); Madagascar's (2010); the Maldives's (2008); Montenegro's (2007); Myanmar's (2008); Nepal's (2007); Niger's (2010); Nigeria's (1999); Poland's (1997); Rwanda's (2003); Serbia's (2006); Somalia's (2012); South Sudan's (2011); Sudan's (2005); the Swiss Federal Constitution (1999); Thailand's (2007); Tunisia's (2014); the Fundamental Law of the Vatican City

constitutions in the latest years, South America is the region where I found the most advanced constitutional developments in the field of social rights and solidarity. On those grounds, I have selected the following three constitutions: Venezuela's (1999), Ecuador's (2008) and Bolivia's (2009).

The content of the various provisions has been arranged in two tables separated by content. I first provide a few examples of each of these, and at the end, a table with the relevant provisions.

4.2.3.1. Solidarity as a bond between citizens

Article 132 of the 1919 Weimar Constitution stated that 'every German is, in accordance with the law, obliged to take on honorary activities'.

4.2.3.2. Solidarity as a value orienting education

Article 48 of the 1931 Constitution of the Spanish Republic stated: 'Instruction will be secular, will work at the heart of its business and will draw on methodological ideals of human solidarity. The right of churches, subject to state inspection, to teach their doctrines in their own establishments is recognized'.

4.2.3.3. Solidarity as a principle orienting internationalism

The Cuban Constitution establishes in its Article 12: 'The Republic of Cuba espouses the principles of anti-imperialism and internationalism, and … b) establishes its international relations based on the principles of … international cooperation for mutual and equitable benefit and interest, … ; c) reaffirms its desire for integration and cooperation with the countries of Latin America and the Caribbean … ; d) advocates the unity of all Third World countries in the face of the neo-colonialist and imperialist policy which seeks to limit and subordinate the sovereignty of our peoples, and worsen the economic conditions of exploitation and oppression of the underdeveloped nations; … h) considers wars of aggression and of conquest international crimes; recognizes the legitimacy of the struggle for national liberation, as well as of armed resistance to aggression; and considers that its solidarity with those under attack and with the peoples that struggle for their liberation and self-determination constitutes its internationalist duty. … '

4.2.3.4. Solidarity as an intergenerational duty to protect natural ecosystems

Article 250 of the Ecuadorian Constitution establishes: 'The territory of the Amazon provinces is part of an ecosystem that is necessary for the planet's environmental balance …'

State (2000); Venezuela's (1999) and Zimbabwe's (2013).

4.2.3.5. In relation to labour

4.2.3.5.1. The value of labour

Article 1 of Italy's 1947 Constitution states: 'Italy is a democratic Republic founded on labour …'

Article 1 of the 1931 Constitution of the Spanish Republic stated: 'Spain is a democratic republic of workers of all classes, organized under a regime of Freedom and Justice …'

4.2.3.5.2. The promotion of employment

Article 40 of Spain's Constitution states: '(1) Public authorities shall promote favourable conditions for social and economic progress and for a more equitable distribution of regional and personal income within the framework of a policy of economic stability. Special emphasis will be placed on the realization of a policy aimed at full employment …'

4.2.3.5.3. Participation of workers

Article 165 of the 1919 Weimar Constitution stated: 'Workers and employees are called upon to participate, on an equal footing and in cooperation with the employers, in the regulation of wages and working conditions as well as in the economic development of productive forces. The organizations formed by both sides and their mutual agreements are recognized. Workers and employees are granted, in order to represent their social and economic interests, legal representations in Enterprise Workers' Councils as well as in District Workers' Councils, organized for the various economic areas, and in a Reich Workers' Council. …'

4.2.3.5.4. Workers' internationalism

The Weimar 1919 Constitution established in its Article 162: 'The Reich advocates an international regulation of the rights of the workers, which strives to safeguard a minimum of social rights for humanity's working class'.

4.2.3.6. In relation to a fairer distribution of income and wealth

4.2.3.6.1. Redistribution

Article 9(2) of Spain's Constitution establishes: '[I]t is the responsibility of the public authorities to promote conditions ensuring that freedom and equality of individuals and of the groups to which they belong are real and effective, to remove the obstacles preventing or hindering their full enjoyment, and to facilitate the participation of all citizens in political, economic, cultural and social life'.

4.2.3.6.2. Establishment of national social services

Article 10(14) of Chile's 1925 Constitution established: '[I]t is the duty of the State to safeguard public health and the hygienic wellbeing of the country. Each year a sufficient sum of money should be earmarked in order to maintain a national health service'.

Article 48 of the 1931 Constitution of the Spanish Republic stated: '[T]he service of culture is an essential function of the State, and shall be provided through educational institutions

linked by the unified school system. Primary education is free and compulsory. … The Republic shall legislate in the sense of providing Spaniards who are economically needy, access to all levels of education so that is conditioned only by skill and vocation …'

Article 50 of Cuba's Constitution states: '[E]verybody has the right to health protection and care. The State guarantees this right by providing free medical and hospital care by means of the installations of the rural medical service network, polyclinics, hospitals and preventive and specialist treatment centers; by providing free dental care; by promoting the health publicity campaigns, health education, regular medical examinations, general vaccinations and other measures to prevent the outbreak of diseases. All the population cooperates in these activities and plans through social and mass organizations'.

Section 27 of South Africa's Constitution states: '(1) Everyone has the right to have access to - (a) health care services, including reproductive health care; (b) sufficient food and water; and (c) social security, including, if they are unable to support themselves and their dependents, appropriate social assistance. (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. (3) No one may be refused emergency medical treatment'.

Article 32 of Ecuador's Constitution states: 'Health is a right guaranteed by the State whose fulfilment is linked to the exercise of other rights, among which there is the right to water, food, education, sports, work, social security, healthy environments and others that support the good way of living. The State shall guarantee this right by means of economic, social, cultural, educational, and environmental policies; and the permanent, timely and non-exclusive access to programs, actions and services promoting and providing integral healthcare, sexual health, and reproductive health. The provision of healthcare services shall be governed by the principles of equity, universality, solidarity, interculturalism, quality, efficiency, effectiveness, prevention, and bioethics, with a gender and generational approach'.

Article 35(I) of Bolivia's Constitution states: '[T]he state, in all its levels, shall protect the right to health. It shall promote public policies oriented to improve the quality of life, the collective wellbeing and the free-of-charge access of the population to health services'.

4.2.3.7. In relation to the protection of the vulnerable

4.2.3.7.1. Motherhood

With few amendments, the original Article 125(V) of Mexico's 1917 Constitution states: 'Within the three months previous to giving birth, pregnant women shall not perform jobs that demand considerable effort. They shall be entitled to a resting period of one month after delivery, to receive their complete salaries and to keep their working posts and contractually acquired entitlements. During the breastfeeding period mothers shall be everyday entitled to a couple of extraordinary resting periods of half an hour each to breastfeeding their babies'.

4.2.3.7.2. Other vulnerable persons or groups

Article 35 of Ecuador's Constitution states: 'Elderly persons, girls, children and adolescents, pregnant women, persons with disabilities, persons in prison and those who suffer from disastrous or highly complex diseases shall receive priority and specialized care in the public and private sectors. Persons in situations of risk, victims of domestic and sexual violence, child mistreatment, natural or manmade disasters, shall receive the same priority care. The State shall provide special protection to persons who are doubly vulnerable'.

4.2.3.7.3. Indigenous communities

Article 35(II) of Bolivia's Constitution states: 'The health system is unified and includes traditional medicine of the nations and indigenous peoples of the countryside'.

4.2.3.8. As equitable distribution of resources between regions and countries

Article 104(a)(6) of Germany's Constitution states: '… In cases of financial adjustments by the European Union affecting more than one State [Land], Federation and States [Länder] carry the burden at the ratio of 15 to 85. The States at large provide 35% of the total burden in solidarity according to an allocation key; the States [Länder] that have caused the obligation carry 50% of the total burden according to their share in the funds received. Details are regulated by a federal statute requiring the consent of the Senate [Bundesrat]'.

4.2.3.9. As a duty of citizens towards the community

Article 2 of Italy's Constitution establishes: '[T]he Republic recognizes and guarantees the inviolable rights of the person, both as an individual and in the social groups where human personality is expressed. The Republic expects that the fundamental duties of political, economic and social solidarity be fulfilled'.

4.2.3.10. As a principle of economic implications

4.2.3.10.1. Mixed and social economy

Article 25 of Mexico's 1917 Constitution, as amended in February 1983, states: 'National economic development shall be carried out by a joint effort undertaken by the public sector, the private sector and the social sector working together. The public sector shall have power to manage – in an exclusive way – the strategic areas established as such by article 28 paragraph four of this Constitution. … Taking into account social fairness, productivity and sustainability as guidelines, the public sector shall help out and promote enterprises at both the private and the social sector of the economy. … The social sector of the economy shall be formed by owners of communal lands, worker's unions, cooperative unions, communities, enterprises owned partially or totally by workers and any other kind of social organization aimed to produce, distribute and consume necessary commodities and services within society'.

Further, Article 123 of the Mexican Constitution states: '… cooperative societies destined to the construction of affordable and hygienic houses shall be considered of social utility. Workers can acquire them in instalments'.

4.2.3.10.2. Social function of property and natural resources

Article 44 of the 1931 Constitution of the Spanish Republic stated: 'All the country's wealth, whoever may be its owner, is subordinated to the interests of the national economy and affects the sustainability of public duties, in accordance with the Constitution and the law. The ownership of all kinds of goods is subject to forcible expropriation for the sake of social utility through adequate compensation, unless otherwise provided by a law adopted by the votes of an absolute majority in parliament. With the same requirements ownership can be socialized. The utilities and farms affecting the common interest can be nationalized in cases where the social necessity so requires. The State may intervene by law expropriation and coordination of industries and companies when so required to streamline production and the interests of the national economy. Under no circumstance the penalty of forfeiture of property shall be imposed'.

Furthermore, Article 44 of Italy's Constitution states: 'For the purpose of ensuring the rational use of land and equitable social relationships, the law imposes obligations and constraints on the private ownership of land; it sets limitations to the size of property according to the region and the agricultural area; encourages and imposes land reclamation, the conversion of latifundia and the reorganisation of farm units; and assists small and medium-sized properties …'

	1. Bond/ Fraternity	2. Education	3. Internationalism, disarmament, peace	4. Protection of natural ecosystems	5. Labour				6. Fairer distribution of income and wealth		7. Protection of the vulnerable			8. Between regions and between countries	9. Duties of citizens	10. Economic implications	
					5.1. importance	5.2. employment	5.3. participation	5.4. internationalism	6.1. redistribution/social security	6.2. public services	7.1. motherhood	7.2. other	7.3. indigenous communities			10.1. Mixed and social economy	10.2. Social function of property and natural r.
1	Preamble	XII			XIV[2]				XXXVI duty to pay taxes, XXXV	XI, XXXVI	VII	VII			XXIX, XXXVI		
2	1	26[2]	26[2]		23-25	23[1]			22, 25[1]	26[1]	25[2]	25[2]			29[1]		
3					2-4	1	5-6, 22, 29			12-14	8	7, 16	15, 19, 23				
4		13[1]			6-8	6[2]	8		9	12, 13[2][c]	10[2]	10[3]				11[2]	11[2]
5	32[1]																
6			2, 27		6		10[a], 15[b], 20[a]		10[c], 11[a], 16[b-c]	10[d-f], 19	11[b]	11[c], 19[d]		7[2], 9, 12, 14		16-17	18
7			x														
8			4[h, i]											4[c, j-p, r-s]		4[g]	
9			15, 16, 26	29, 30										8-11, 14, 17-21, 24, 31			
10					11[a]					12[1], 14	12						
11	23[1-2]		23		15					16[2]				21[4]	29[4, 6]		
12			5, 7							8				3			
13	15[3][d]				6-7		8		9	10[2], 11[1], 13[3]	15[3][a]	16	17-18				
14			24-27	4, 7, 14,										6			
15	Preamble		16	11								21	19, 20, 24, 63	12			
16	6		8	6, 21							20		26	14-18, 28			
17	Preamble, 1-5		1, 2[b]	9, 12[h], 11[1][a]						10[3]	4	4		4[2][a]			

	1. Bond/ Fraternity	2. Education	3. Internationalism, disarmament, peace	4. Protection of natural ecosystems	5. Labour				6. Fairer distribution of income and wealth		7. Protection of the vulnerable			8. Between regions and between countries	9. Duties of citizens	10. Economic implications	
					5.1. importance	5.2. employment	5.3. participation	5.4. internationalism	6.1. redistribution/social security	6.2. public services	7.1. motherhood	7.2. other	7.3. indigenous c.			10.1. Mixed and social economy	10.2. Social function of property and natural resources
		3[2]	3[2]		123	25[1], 123			25[1]		123[V]	4[9]	2[B][2]			25[2-7], 28	27[3]
		148	162		157	163	165	162	151	145, 146, 147, 161	161	122			132, 133, 163	151	153, 155, 156
									10[16][5]								44[10][2]
	43	48[4-6]			1	46[2]	46[2]	46[2]	46[2]	44[1]	43[6], 46[2]	43[6], 47			44[1]		44
	3				1		3, 46		3	2				119	2	45	42, 43, 44
	20, 23, 28			20[a]										104[a]			
	1		12		1	9			1, 9, 49, 52								
	Preamble, 1, 39[3]			45		40[1]	129	42	Preamble, 9[2], 10, 40[1]			39[4], 50		2, 40[1], 138		128, 129[2]	33[2], 33[3]
									Preamble	27, 29		28					25
	Preamble, 2, 4, 70, 274, 326, 75, 123, 135	102	152, 153, 156[13]		89	92			20, 112, 299			80		4	132	70, 184[3], 184[5], 299, 302-310	115
	1, 83[9], 95	26, 27	Preamble, 276[5]	250, 258		326[1]			3[1], 3[5], 11[2], 31, 48, 66[5], 85[1], 85[3], 383	83[15]	43	35-39, 44-51		238, 270, 284[5]	83[15]	66[15], 276[2], 281[10], 283, 288, 308-311, 313-320	276[6], 281[4], 282, 321-323
	Preamble, 1, 8[II], 51[II], 219[III]	78[III]	255[II][2], 255[II][3], 255[II][5], 265	33, 34, 108[15], 255[II][7], 380, 390, 391	Preamble, 397	54, 391			Preamble, 9[1], 43, 312[II], 313[2], 330, 353	108[7]	45[III], 45[V]	58-61, 67-68, 70-74	Preamb1e, 3, 4, 30-31, 93[IV], 100, 353	270, 313[4]	108[7], 108[15]	20[II], 38, 55, 306[II], 306[III], 306[IV], 310, 311[II][6], 314, 316, 334.1., 359, 378, 408	56, 57, 315, 369, 373, 393, 395, 400, 401, 404

5. CONCLUSIONS

1. This chapter sought to tackle two research goals. Firstly, to explore the normative content of the principle of solidarity. Secondly, to determine whether, and if so how, solidarity informed social rights such as the right to health.
2. Analysis of the conceptualization of legal principles permitted to set two requirements for their identification: efficiency and explanatory force. These requirements mean that principles must be sufficiently demarcated from other principles, values or concepts. They must be able to explain a legal phenomenon without needing to resort to other principles. A strong presumption of a legal principle's explanatory force exists when rights are hard to justify without resorting to such principles.
3. Research on the conceptual history of solidarity permitted to demarcate the boundaries of solidarity as a principle with a certain level of specificity and distinctiveness. Solidarity unleashes a set of layers of communitarian bonds that tie individuals to communities. In connection with social rights, solidarity means the universalization of access to the material conditions that make liberty and communal life possible. This is corroborated when looking at the institutional implications of social rights. Under solidarity, social services address not an individual but a collective problem. Private dynamics or the subsidiarity of State action are replaced by public dynamics where the areas covered by social rights are *socialized*. As the privileged acquire obligations toward the less privileged, the risks affecting everyone are minimized, and scarcities are distributed among all members of society more equitably. Solidarity is also about the universalization of liberty ('equal liberty', 'liberty for all' or 'real liberty'). In this way solidarity limits the principle of competence of the modern liberal State (freedom understood as 'autonomy' or 'non-interference'). As an area informed by solidarity, the legal nature of the exchanges and dynamics of social rights are public – they do not resist their reduction to commodities. In this sense, solidarity can provide a justification to the legal duties of social rights.
4. In its origins, the distinctiveness of social rights was not linked to court justiciability. In the West, the original components of the right to health are to be found in the reaction to the great shocks of the twenty-century: The Great War, the Great Depression and World War Two. Notions such as universality and access free-of-charge on the basis of need are by no means exclusive to the Eastern bloc but reflect fundamental aspects of the protection given to social rights by Post-War liberalism. In Europe, this tradition had an earlier antecedent in the nineteenth century: Von Bismarck's social insurances policies. Institutions from various latitudes materialized these duties. This happened in Latin America, the countries of the Eastern bloc, the Scandinavian countries, and major powers of the West such as Britain. As

Franklin Delano Roosevelt's Second Charter of Rights shows, the United States was not alien to this influence.

5. Looked at through legal lenses, solidarity seems to have been captured by the Universal Declaration and by several of the cited constitutions and international documents. Solidarity orients the 'social services' that would attain and universalize liberty for all (Article 22 of the Universal Declaration, Article 10(16)(2) of the 1925 Chilean Constitution, Article 3(2) of the Italian Constitution, Article 9(a) of the Cuban Constitution, Article 10(1) of the Spanish Constitution, Preamble of the South African Constitution, Article 20 of the Venezuelan Constitution, and Articles 48, 66(5) and 383 of the Ecuadorian Constitution). The challenge, in the terms set forth by the Universal Declaration, consists in arranging social services in a way in which the human personality could be fully and freely developed. According to Article 29(1) of the Universal Declaration this could 'only' be possible in the context of the community by means of duties in its favour. From the point of view of human rights law, the Bill of Rights, regional human rights conventions and several international declarations match solidarity's most comprehensive dimension: the idea of mankind or human race. A narrower meaning of solidarity overlaps with the State's constitutional commitments in the field of human rights.

CHAPTER FOUR
THE RIGHT TO HEALTH AS A SOCIAL RIGHT

1. INTRODUCTION

Not long ago I had the chance to briefly speak with a reputable South African human rights scholar. I asked him: 'How could it be that in South Africa − a country credited as a bastion of social rights due to the legal developments of the last two decades − inequality had grown to a greater extent than under the times of the apartheid regime?' The professor, who so far had been acting relaxed and cheerfully, automatically altered his tone. He seemed irritated at my inquiry. He suggested confusion on my part: failure in social rights' enforcement had nothing to do with a society's income inequality. Wanting social rights to reduce levels of income inequality was asking something for which social rights were not designed. Was the alteration in tone a circumstantial shift in someone's temper, or an indication of a deeper set of theoretical assumptions about core understandings of what human rights are and what they do?

In the remaining chapters of this thesis I intend to explore the contradictions and limitations of the predominant interpretation of the right to health, as presented in chapter two. While the present chapter unfolds the hypothesis of this thesis, chapter five interrogates the predominant interpretation of the right to health from a case law perspective. I shall argue that the triumphalism with which the adjudication of economic, social and cultural rights has been welcomed grounds its confidence from the successful protection of property rights in court, as well as from the jurisprudential developments that have expanded the scope of classical rights. My assessment is that the supporters of the predominant interpretation know such a strategy does not suit social rights. This awareness does not mean that they are engaged in some sort of conspiracy against social rights. I think that their attitude reflects a pragmatic understanding about how best to advance the difficult enterprise of social rights. Their intention consists in granting social rights at least some degree of protective power. My intention is to show the limitations of that strategy while at the same time to find out if there are other ways to conceive the function of the social right to health. Chapter six, finally, looks at three different ways of organizing health-financing systems. I show that the way human rights inform the institutions

and duty bearers in charge of providing and financing healthcare is critical to attaining the status and dignity promised by the right to health.

As announced, the present chapter unfolds the main hypothesis of this study. I essentially do three things. Firstly, I look at the frameworks that envisage the political neutrality of human rights with respect to political and economic regimes. Focusing on how this structure makes it difficult for the right to health to deliver something different than a legal right, I show how core concepts necessary to construct a social right to health are renounced. Secondly, I criticize the predominant interpretation of the right to health. My main claim is that this interpretation relies excessively on equality before the law, an approach that fails tackling social rights' core concerns. In doing so, I show how the right to health shifts from the declared goal of *equal access to healthcare for all* to the goal of *a justiciable minimum for those unable to buy healthcare services*. This latter view struggles to fulfil the basic equality of treatment promised by human rights. Since social rights cannot be logically advanced when they transmute into something else, the indivisibility and integration of all human rights fails to be attained.[1] Thirdly, taking the conclusions from chapter three as a point of departure, I argue in favour of an alternative way of interpreting the right to health. I argue that this right should be applied in line with solidarity and I show how that could be attained in the light of the legal duties and institutions solidarity helps to identify.

If the strategy of protecting social rights as legal rights or in connection with other human rights is faulty, I believe that caution should replace the triumphant tone often used in proclaiming the attainment of the integration project via the justiciability of social rights.[2] More

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1 The goal of human rights integration can be partially understood in relation to the goal of protecting equally and on the same foot the entirety of human rights (civil, political, economic, social and cultural). Upendra Baxi presents this account by referring to its attempt of seeking 'interconnectedness and interdependence of the two kinds of human rights … They need to be read together and as a whole, always bearing in mind the reciprocal connection', see Upendra Baxi, 'Failed Decolonisation and the Future of Social Rights' in Daphne Barak-Erez and Aeyal Gross (eds), *Exploring Social Rights: Between Theory and Practice* (Hart Publishing 2007) 47; other dimensions of the integration project are linked to the unification of the totality of human rights norms in a single global legal order, which is not the understanding that I have taken here. For that perspective, see Moritz Baumgärtel and others, 'Hierarchy, Coordination, or Conflict? Global Law Theories and the Question of Human Rights Integration' (2014) 3 European Journal of Human Rights.

2 OHCHR, 'Key Concepts on ESCRs - Are Economic, Social and Cultural Rights Fundamentally Different from Civil and Political Rights?' <www.ohchr.org/EN/Issues/ESCR/Pages/AreESCRfundamentallydifferentfromcivilandpoliticalrights.aspx> accessed 23 June 2017; Council of Europe portal <www.coe.int/en/web/turin-european-social-charter/-european-social-charter-and-european-convention-on-human-rights> accessed 17 June 2017; another example can be found in the understanding of the International Commission of Jurists, where the problem of the lower status of economic, social and cultural rights appears exclusively linked to their lack of justiciability, see International Commission of Jurists (ICJ), *Courts and the Legal Enforcement of Economic, Social and Cultural Rights: Comparative Experiences of Justiciability* (Human Rights and Rule of Law Series No 2, ICJ 2008) 1.

importantly, if there is any truth to my analysis, there is nothing paradoxical in the fact that India, Brazil, South Africa, Chile and Colombia are amongst the most unequal countries in the world while at the same time certain aspects of their social rights' protection systems meet the main requirements of the predominant human rights view.[3] However, if there is no link between human rights and social justice, the human rights community should perhaps accept that the mystique linked to human rights struggles is out of place and that human rights are just another grey area of government. If this conclusion is to be accepted, I think that the human rights movement should overall renounce what would be the pretence that human rights could bring social justice. I reject that conclusion both on historical and teleological grounds. Human rights have been and are linked to social justice.[4] What is out of place is either to deny this connection or to affirm it utilizing legal means that are inapt to delivering. While I indeed think that we are faced with the challenge of human rights integration, unlike the predominant interpretation of the right to health, I think that we are neither close to realizing such a project nor moving in the right direction.

I shall begin by addressing what I consider to be a fundamental framework within human rights law. I claim that this framework sets a division line between law and politics that leads to the present lower status of economic, social and cultural rights by comparison to civil and political rights.

2. THE LAW AND POLITICS DIVIDE IN THE POLITICAL ECONOMY OF GLOBAL CAPITALISM

In December 1990, during the twilight days of the USSR, the United Nations Committee on Economic, Social and Cultural Rights published its General Comment 3. This General Comment dealt with the legal nature of states obligations due by virtue of the ICESCR.[5] While paragraph 8 of the General Comment did not break with the text of Article 2 of the Covenant and the idea of *progressive realization*,[6] this provision did establish a particular stand with respect to the

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3 Langford thinks that State failure is what generates the reaction from the judiciary. But this is at odds with the way in which he envisions the protection of social rights, which is mostly a judicial notion. In his view economic, social and cultural rights are legal rights because 'legislative rights are not always sufficient to protect human rights' as they are 'subject to amendment by a simple majority of the population'. Michael Langford, 'The Justiciability of Social Rights: From Practice to Theory' in Michael Langford (ed), *Social Rights Jurisprudence: Emerging Trends in International and Comparative Law* (CUP 2008) 3, 29-31, 33.

4 eg, UNGA, Declaration on Social Progress and Development, Res 2542 (XXIV) 11 December 1969, art 2.

5 UNCESCR, 'General Comment 3: The Nature of States Parties' Obligations (Art 2, Para. 1, of the Covenant)', UN Doc E/1991/23, 14 December 1990.

6 Ben Saul, David Kinley and Jacqueline Mowbray, *The International Covenant on Economic, Social and Cultural Rights: Commentary, Cases, and Materials* (OUP 2014) 134.

relation between human rights law and politics.[7] The paragraph stated that the obligation to take steps under Article 2(1) of the Covenant:

> [N]either requires nor precludes any particular form of government or economic system being used as the vehicle for the steps in question, provided only that it is democratic and that all human rights are thereby respected. Thus, in terms of political and economic systems the Covenant is neutral and its principles cannot accurately be described as being predicated exclusively upon the need for, or the desirability of a socialist or a capitalist system, or a mixed, centrally planned, or laissez-faire economy, or upon any other particular approach. In this regard, the Committee reaffirms that the rights recognized in the Covenant are susceptible of realization within the context of a wide variety of economic and political systems, provided only that the interdependence and indivisibility of the two sets of human rights is recognized and reflected in the system in question. The Committee also notes the relevance in this regard of other human rights and in particular the right to development.[8]

This reference was later corroborated by paragraph 5 of the Human Rights World Conference held in Vienna in 1993.[9] Its effect was to insulate political and economic regimes from human rights discussions. In the still bipolar world of 1990 this may have made sense. It is persuasive to argue that during the Cold War the role of human rights had to be limited in order not to expose human rights to further instrumentalization by both blocs. Human rights had to be minimal to allow for a common ground between antagonistic powers.[10] However, the fact that this framework remained after the bipolar order had ended led to a distortion: while the world rapidly transitioned toward the unipolar political economy of global capitalism,[11] this minimalistic human rights framework remained.

My argument is that the framework contained in paragraph 8 of General Comment 3 may have been unavoidable in the bipolar context of the Cold War. Yet, such a framework appears far from suited to address human rights − especially economic, social and cultural rights − in the context of the unipolar political economy of global capitalism.

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7 ibid 170.

8 UNCESCR, General Comment 3 (n 5) para 8.

9 This perspective had been already advocated in 1986, in the context of the Limburg Principles, see UNCHR, 'Note Verbale Dated 5 December 1986 from the Permanent Mission of the Netherlands to the United Nations Office at Geneva Addressed to the Centre for Human Rights ("Limburg Principles")', UN Doc E/CN.4/1987/17, 8 January 1987.

10 Roger Normand and Sarah Zaidi, *Human Rights at the UN: The Political History of Universal Justice* (Indiana University Press 2008) 173, 197-200, 237, 240-241.

11 This is despite China and Vietnam, which notwithstanding their significant levels of State control over the economy, have nonetheless become integrated into the capitalist system, see Chris Harman, *A People's History of the World* (Verso 2008) 592 and David Harvey, *The Enigma of Capital and the Crises of Capitalism* (Profile Books 2011) 34.

In this constellation, I see two effects aiming in the same direction. On the one hand, there is *over-restraint* due to differences no longer relevant. On the other, there is *insensitivity* toward issues crucial for the development of human rights. As to the first effect, the law and politics framework discourages the discussion of certain issues by considering them beyond what human rights law is or what it does. This over-restraint leads to an approach that considers everything that does not fall within the scope of this minimalistic framework, political and therefore, legally irrelevant. In the field of civil and political rights over-restraint was less pronounced before 1990. The United Nations had engaged in very loud and clear cases of 'regime-denouncing'. The 'naming-and-shaming' technique was often put in place against regimes that had challenged basic civil and political rights.[12] This happened in South Africa,[13] Israel[14] and Chile.[15] Yet, the dominant human rights view shied away from using the same standard when it came to addressing the impact global capitalism was exercising on human rights. This, it will be shown, is linked to the second effect derived from the human rights law-politics divide: insensitivity.

Insensitivity actively pulls issues out of the scope of human rights law. This effect takes place whenever a human rights issue presents a structural tie with the fundamental tenets of a political regime insofar as, in the words of paragraph 8 of General Comment 3, human rights do not 'preclude any particular form of government or economic system', while they are also 'susceptible of realization within the context of a wide variety of economic and political systems'. Today's political economy is unipolar.[16] Hence, the more that a human rights issue touches upon the perimeter of the main tenets of global capitalism, the bigger the likelihood that such an issue will be considered outside the scope of what human rights law are or what they do. While in the present context self-restraint impedes human rights law from formulating questions worth formulating, insensitivity makes it difficult to challenge interests that would need to be challenged for systematic forms of abuse to be halted.

Several human rights law theorizations reflect this analysis. For example, Toebes argues that:

> [T]he ICESCR Committee does not interfere with the health system that States parties choose. It, however, notes that privatisation does not relieve States from their obligations in the field of health.[17]

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12 Kenneth Roth, 'Defending Economic, Social and Cultural Rights: Practical Issues Faced by an International Human Rights Organization' (2004) 26 (1) Human Rights Quarterly 63.

13 UNGA, Declaration on the right to development, 97th Plenary meeting, 4 December 1986, 41/28, art 5.

14 Darren Hawkins, *International Human Rights and Authoritarian Rule in Chile* (University of Nebraska Press 2002) 26, 62.

15 ibid 62.

16 Normand (n 10) 322; Tony Evans, *The Politics of Human Rights: A Global Perspective* (2nd edn, Pluto Press 2005) 26-27.

17 Brigit Toebes, *The Right to Health as a Human Right in International Law* (Intersentia 1999) 328.

This is an example of how human rights have been understood in alignment with today's prevalent forms of economic organization. Privatization of public healthcare has not in itself been understood as a challenge to the right to health. In fact, there is in principle nothing problematic with privatization in this human rights interpretation. As I show with more detail later, it is only failure to comply with other further requirements that may lead the State to incompliance in the discharging of its human rights obligations.

It is precisely this kind of view that makes it possible for human rights to amalgamate with the political economy of global capitalism and ultimately render human rights dispensable. Yet, while the prospects of peace, democracy and prosperity have disappointed the projections of the 1990s, a certain triumphalism remains deposited in human rights. While I claim that human rights remain a critically important tool of emancipation, certain interpretations have proven unable to reshape our political economy in line with the goals of human rights: liberty, equality and global justice. In what comes next I focus on this phenomenon in the context of the right to health.

3. A CRITICAL APPRAISAL OF THE PREDOMINANT INTERPRETATION OF THE RIGHT TO HEALTH

3.1. BY WAY OF INTRODUCTION: THE NARRATIVE OF THE VULNERABLE

The idea that human rights relate to vulnerability is attractive.[18] As I showed in chapter two, the interpretative framework of the right to health is very much in line with this view. In chapter three I even discussed some instantiations where this assertion carries truth from the perspective of solidarity.[19] Yet, I would like to begin my analysis by reflecting on some possibly pernicious effects of equalizing human rights with vulnerability.

The first aspect I would like to consider is the assumptions underlying a narrative of vulnerability. An overstated link between human rights and dire conditions of deprivation or disadvantage may end up establishing pre-requisites to the enjoyment of human rights. Consider

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[18] eg Martin Scheinin suggesting that the role of these rights is intrinsically linked to these concerns: '[E]conomic and social rights ... have their place ... in the network of human rights treaties aimed at the eradication of discrimination and the protection of certain vulnerable groups', see Martin Scheinin, 'Economic and Social Rights as Legal Rights' in Asbjørn Eide, Catarina Krause and Allan Rosas, *Economic, Social and Cultural Rights: A Textbook* (Martinus Nijhoff Publishers 1995) 29.

[19] See ch 3, s 4.2.3.7.

this tweet by UNICEF of 2 April 2016: 'Refugee and migrant children with disabilities face extra challenges & are especially vulnerable'.[20] The statement contains reasoning commonly used by human rights bodies.[21] While no one could dispute the fact of these children's vulnerability, I do not think one should welcome the suggestion that the greater the number of vulnerability layers that are added, the more legitimate human rights claims should be. That trend can be disempowering. If tomorrow UNICEF adds another condition of vulnerability in a further tweet, should we perhaps stop focusing our attention on the children with the conditions described in the tweet of 2 April? Vulnerable individuals and groups should be paid special attention, but not in ways that exhaust the universality of human rights.[22] As there can always be someone more underprivileged, overstated focuses on deprivation may incentivize a race to the bottom where the protection of human rights appears conditioned to an ever-greater scale on the recipient's vulnerability. In line with classical thinkers such as Richard Titmuss, I find it questionable whether that approach benefits welfare and human rights as an integrated whole.[23] By the same token, by exacerbating the individual's subjectivity, this focus may end up overlooking the fact that most conditions of vulnerability are not isolated features, but outcomes caused or aggravated by structural social phenomena such as poverty and an unequal distribution of wealth, opportunities and power.[24] I think that those features do not come to us as a given but they are strongly linked to an unequal provision of essential services, including healthcare services.[25]

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[20] UNICEF, 'Refugee and Migrant Children with Disabilitities Face Extra Challenges & are Especially Vulnerable' (Twitter, 10 April 2016) <https://twitter.com/UNICEF/status/716358372233191424?lang=nl> accessed 23 June 2017.

[21] eg Audrey Chapman and Benjamin Carbonetti, 'Human Rights Protections for Vulnerable and Disadvantaged Groups: The Contributions of the United Nations Committee on Economic, Social and Cultural Rights' (2011) 33 (3) Human Rights Quarterly 682; in the context of the European Court of Human Rights, see Alexandra Timmer, 'A Quiet Revolution: Vulnerability in the European Court of Human Rights' in Martha Fineman and Anna Grear (eds), *Vulnerability: Reflections on a New Ethical Foundation for Law and Politics* (Ashgate 2013) 147.

[22] Not infrequently, vulnerability is seen as the exception to the norm – only some ('the others') are seen as vulnerable. Then the concept can become stigmatizing, disempowering and can ultimately subvert the notion of universality itself, see eg, Brian Turner, *Vulnerability and Human Rights* (The Pennsylvania State University Press 2006); Martha Fineman, 'The Vulnerable Subject: Anchoring Equality in the Human Condition' (2008) 20 (1) Yale Journal of Law and Feminism 1.

[23] Peter Dwyer, *Understanding Social Citizenship: Themes and Perspectives for Policy and Practice* (2nd edn, The Policy Press and the Social Policy Association 2010) 52.

[24] Evans (n 16) 30-31; Ruth Lister, *Poverty* (Polity 2004) 53, 96, 187; in order to measure inequality, the World Bank provides information based on the Gini index. This index is criticized for being overly sensitive to the middle 50%. The Palma ratio on the other hand − named after the Chilean economist Gabriel Palma − seeks to overcome this by measuring the ratio of the income share between the top 10% and the bottom 40%. This measure has gained traction. For example, it has been proposed by Joseph Stiglitz as the basis for a target in a post-2015 global goal to reduce income inequality, see Oxfam International, 'Even It Up: Time to End Extreme Inequality' (Oxfam International 2014) 29.

[25] Markus Kaltenborn, *Social Rights and International Development: Global Legal Standards for the Post-*

Thanks to the work of Michael Marmot, President of the WHO Commission on the Social Determinants of Health, it is well known that wealth inequalities increase health inequalities. This means that people worse off directly pay the price of disparities by, for example, living less long than the better off.[26] As shown by a recent report on the health of Australians, levels of morbidity to several chronic diseases such as diabetes, coronary heart disease or arthritis are strongly correlated to people's income rate.[27] It is important to take note that these numbers do not justify the struggle against poverty or extreme poverty only. If wealth inequalities impact the life expectancy or the morbidity to certain diseases, that does not affect only the poor in comparison to the rich, but it also affects those in the middle.[28] It is not just the rights of the weakest that could be impaired by those inequalities.

Furthermore, attention should be paid to the logic that an increased focus on the vulnerable would be incentivising, for example, the risk of stigmatization that targeted policies may lead to.[29] Even more crucially, when the protection of human rights focuses fundamentally on the most deprived or on a minimum provision of healthcare services, individual responsibility and unequal principles of distribution such as commercialization could become the *default* way of providing those services. Furthermore, when social rights are portrayed as something fundamentally oriented to the most deprived, the assumption that social rights are to be handled by the market is not challenged but strengthened.[30] Human rights become relegated to an action oriented to provide access or treatment to the segments the market rejects due to their lack of financial attractiveness. Under that logic, only those people that really need it (or the ones that *really really* need it) become subjects of social rights such as the right to health. The poor (except perhaps the extremely poor) and those in the middle become disenfranchised by a narrative in which they would be seemingly self-interested for claiming human rights protection while at the same time the rich can buy their way out of the public system and get any healthcare they want. Finally, these targeted approaches may be disempowering because they assume that poverty and inequality will always exist, while not envisioning their abolition.[31]

2015 Development Agenda (Springer 2015) 1.

26 Michael Marmot, *The Health Gap: The Challenge of an Unequal World* (Bloomsbury 2015) 15.

27 Australian Institute of Health and Welfare, 'Australia's Health 2016' (Australia's Health Series no 15 Cat no AUS 199, Australian Institute of Health and Welfare 2016) 184.

28 Michael Marmot, 'Introduction' in Michael Marmot and Richard Wilkinson, *The Social Determinants of Health* (2nd edn, OUP 2011) 2.

29 Lynn Freedman and others, 'Who's Got the Power? Transforming Health Systems for Women and Children' (United Nations Millennium Project Task Force on Child Health and Maternal Health 2005) 31; Dwyer (n 23) 54.

30 Fernando Atria, 'Las Cosas Cambian Cuando le Pones el "Tú": Sobre Universalismo, Focalización y Regresividad' in Javier Couso (ed), *Anuario de Derecho Público UDP* (Universidad Diego Portales 2012) 21.

31 eg Milton Friedman, *Capitalism and Freedom* (first published 1962, University of Chicago Press 2002) 191.

As shown in greater detail in chapter two, the predominant interpretation of the right to health is strongly embedded into this narrative. With its focus on non-discrimination, violations and core obligations, General Comment 14 is a crucial instrument in support of that connection.[32] In what comes next, I engage in a critical appraisal of the obligations of the right to health, as enshrined by this instrument.

3.2. LEGAL OBLIGATIONS

3.2.1. OBLIGATION TO RESPECT

According to General Comment 14, States are required 'to refrain from interfering directly or indirectly with the enjoyment of the right to health'.[33] According to Toebes, this obligation involves:
1) the obligation to respect equal access to health care,
2) the obligation not to interfere with the provision of health care and
3) the obligation not to interfere with the provision of health care related information.[34]

I do not take any different approach in this regard.

3.2.2. OBLIGATION TO PROTECT

According to General Comment 14, the obligation to protect includes, inter alia, 'the duties of States to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties'.[35]

Despite having written before the publication of General Comment 14, Toebes understood the obligation to protect in the same terms as the General Comment would later contemplate.[36] In her view, choice of health system and privatization only potentially raise human rights issues. What is critical is that:

> [T]he State has to protect citizens against certain practices imposed by health care providers in order to safeguard the quality and the accessibility of the health care services provided. Private insurance companies may be inclined to exclude persons, such as the elderly, people with certain diseases or persons with certain genetic defects. They may also be inclined to only accept patients who can afford the (more expensive) care. Another characteristic of privately offered services may be that curative care is stressed over preventive care, or specialised care over primary care, given the fact that they offer a greater profit. The State is required to adopt legislation and to take

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[32] UNCESCR, 'General Comment 14 The Right to the Highest Attainable Standard of Health', UN Doc E/C.12/2004/4, 11 May 2000, paras 12(b), 18, 35, 37, 40, 43(a) and (f), 52, 62, 65.
[33] ibid 33.
[34] Toebes, *International* (n 17) 314.
[35] UNCESCR, General Comment 14 (n 32) para 33.
[36] Toebes, *International* (n 17) 327.

> other measures to assure that health care providers do not disadvantage or exclude individuals or groups.[37]

The fact that this *inclination to exclude* is admitted within human rights frameworks provides insight about the way social rights are understood under the predominant interpretation of the right to health. An inclination takes place before an incentive, in this case, as Toebes admits, 'a greater profit'. Yet, we are told that this incentive should not go as far as 'to exclude', an expression that comes with a negative load attached.

In general, the law is a language that relies on imperative commands. Article 1 of Chile's Civil Code for example, states that legal statutes can *oblige, prohibit or permit*.[38] What kind of legal commands would be necessary so that private for-profit healthcare providers could on the one hand be allowed to carry out their activities to get a greater profit while at the same time induce them to refrain from their inclination to exclude?

General Comment 14 bans neither privatization nor marketization.[39] These are two different things which, and although both reflect commercialization dynamics, it is convenient to define. Strictly speaking, privatization does not necessarily entail marketization. Privatization refers to 'the sale or transfer of state-owned assets into private hands'.[40] Marketization entails 'a shift to market-led provision from state-constrained systems'. [41] The General Comment establishes that States have 'to ensure that privatization of the health sector does not constitute a threat to the ... accessibility ... of health facilities, goods and services'.[42] The question is: what forms of distributing healthcare constitute a threat to the accessibility of health facilities, goods and services if privatization and marketization are in no way discouraged?

This question is not explicitly answered. Yet, based on General Comment 3, one could attempt an answer, specifying the obligation in negative terms, namely, of what General Comment 14 *could not* be made compatible with. In determining this, we could take our cue from paragraph 2 of General Comment 3. This paragraph indicates that the steps Member States are to take by virtue of Article 2(1) of the Covenant should be 'deliberate, concrete and targeted

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37 ibid 328.

38 The Chilean Civil Code defines legal statutes in the following way: *'La ley es una declaración de la voluntad soberana que manifestada en la forma prescrita por la Constitucion, manda, prohibe o permite'*, see Decree with Force of Law No. 1 (30 May 2000) Ministry of Justice <https://www.leychile.cl/Navegar?idNorma=172986&r=6> accessed 23 June 2017.

39 Brigit Toebes, 'Taking a Human Rights Approach to Healthcare Commercialization' in Patricia Cholewka and Mitra Motlagh (eds), *Health Capital and Sustainable Socioeconomic Development* (CRC Press 2008) 442.

40 Maureen Mackintosh and Meri Koivusalo, *Commercialization of Health Care: Global and Local Dynamics and Policy Responses* (Palgrave Macmillan 2005) 4.

41 ibid.

42 UNCESCR, General Comment 14 (n 32) 33.

as clearly as possible towards meeting the obligations recognized in the Covenant'.[43] The characterization of this obligation seems hard to reconcile with the way particular forms of market capitalism have been envisioned. In his *Capitalism and Freedom*, Milton Friedman accepted as only legitimate that the State:

> [M]aintained law and order, defined property rights, served as a means whereby we could modify property rights and other rules of the economic game, adjudicated disputes about the interpretation of the rules, enforced contracts, promoted competition, provided a monetary framework, engaged in activities to counter technical monopolies and to overcome neighborhood effects widely regarded as sufficiently important to justify government intervention, and which supplemented private charity and the private family in protecting the irresponsible, whether madman or child.[44]

Friedman explicitly ruled out any other form of welfare provision or social security, including medical care.[45] Yet, he devoted a chapter of his book to the 'alleviation of poverty'.[46] There, Friedman proposed negative taxes to help the poor, but no State-fund initiative exists to support any medical healthcare institution, or any other deliberate form of welfare or social security. Those actions are framed 'a large-scale invasion into the personal lives of a large fraction of the nation'.[47] I think that one does not need to be very savvy to see that such an approach could hardly be regarded as sufficiently 'deliberate, concrete and targeted' to meeting the obligations imposed by the Covenant.

However, since according to the abovementioned paragraph 8 of General Comment 3 no political or economic regime is precluded, and the Covenant is susceptible of realization within the context of a wide variety of economic and political systems, one should conclude that the point is moot and open to interpretation. Thus, the General Comment leaves open the question of what constitutes a threat to the accessibility of health facilities, goods and services. The fact that none of the general comments explicitly regards the commercialization of healthcare a threat to the accessibility of the right to health leads to the conclusion that the profit seeking interest does not clash with the right to health.

This is not a minor omission. In line with the insensitivity effect discussed in section 2, the General Comment does not cast blame on the commercialization of healthcare as a key reason of why people are deprived from access to healthcare.[48] This allows concluding that General

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43 UNCESCR, General Comment 3 (n 5) 8.
44 Friedman (n 31) 34.
45 ibid 35-36, 177.
46 ibid 190.
47 ibid 182.
48 An interesting example of this can be found in the Concluding Observation on Chile, where the Committee notes that 'despite the Government's measures to improve health services, some members observed that the trend towards privatization in this sector *seemed to have made health services too costly for a part of the*

Comment 14 (and more generally, the predominant interpretation of the right to health) does not identify the commercialization of healthcare as a challenge to the accessibility of the right to health.

Consequently, the commercialized distribution of healthcare is not illegitimate. Within commercialized schemes, access to goods, services or facilities are conditioned by the ability to pay. Not as an exception, but as a rule. This may be the reason why under the predominant interpretation human rights are forced to navigate within narrow margins: attempting to exist, but without going to the extent of challenging commercialization. Back to Toebes' analysis, what to do with the providers and financiers of healthcare services who in their quest of greater profits may become inclined to exclude?

For a start, it is fair to describe profit-maximization as the dominant way of organizing business activities in the context of our present political economy. As Atria points out, it may be the case that a baker gives some bread without charging to someone who is starving, but running businesses in that way describes more the exception than the rule.[49] As I pointed out, once it becomes accepted that the healthcare sector can be organized around profit-maximization, any reasonable entrepreneur should not only 'be inclined to exclude', but *should exclude anyone* unwilling or incapable (whether one is unwilling or incapable is irrelevant from the point of view of the one who sells services in a for-profit regime) of paying whatever the provider or financier deems necessary for him or her to make greater profits. While regulations may include considerations of competition, price regulations or other market restrictions, these cannot be considered a given. Commercialized schemes entail that the maximization of profits will be pursued as much as possible until they are obstructed by the limits established by the regulatory authority. The same approach orients the nature of the services delivered. Unless State regulations are in place, if entrepreneurs of the healthcare industry conclude that the provision of curative services is more profitable than investing in preventive healthcare services, there is no reason to think that the latter course of action will be adopted.[50] Again, the regulatory

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population' (emphasis is ours). UNCESCR, 'Concluding Observations on the Initial and Second Periodic Report of Chile', UN Doc E/C.12/1998/SR.12, 16-18 February 1988, para 198; a similar example can be found in the Concluding Observations on Poland, where the 'Committee notes with concern the continuous decrease in public spending on health and the negative consequences thereof on the enjoyment of rights to health', UNCESCR, 'Concluding Observations of the Committee on Economic, Social and Cultural Rights, Poland', UN Doc E/C.12/POL/CO/5, 2 December 2009, para 29. These remarks reflect the Committee's awareness about the structural effects of privatization, but also the Committee's decision not to consider it opposed to what the human rights framework can oppose.

49 Fernando Atria, *Derechos Sociales y Educación: Un Nuevo Paradigma de lo Público* (Lom 2014) 127.

50 While General Comment 14 addresses this issue, it does so exclusively from the point of view of the public sector, not from the perspective of the private for-profit sector, see UNCESCR, General Comment 14 (n 32) paras 17, 19.

authority may limit agents to one area, but this is only the result of political action, not a given that market exchanges naturally lead to.[51]

Not-for-profit organizations aside, healthcare businesses can always incorporate a dose of charity, for example, by giving away a portion of its profits to help an HIV foundation. However, as stated in the Introduction of this thesis, rights are only rights when the language of legal obligations, not charity, is what drives them. While legal obligations may happen to coincide with someone's moral code, the moral code and the legal obligations are not therefore the same thing.

Abstractly assessed as a means of distribution, commercialization is neither moral nor immoral. What is susceptible of criticism, however, are the merits of a legal interpretation that assumes that the egalitarian and universalistic foundations of human rights can be made compatible with commercial principles. The fact that healthcare has been designated as an area protected by one such human right – the right to health – should serve as the clarification of the dilemma: commercial principles, insofar they entail a non-egalitarian distribution of the protected good, cannot be let run in these areas. In this way, the failure of General Comment 14 to explicitly oppose the commercialization of healthcare leads to an astonishing distortion: far from ensuring the equal and universal protection demanded by human rights, the obligation to protect, organized along the lines established by this instrument, validates and normalizes the commercialization of healthcare, namely, a form of provision that assigns access to healthcare services not based on citizenship or other democratic considerations, but on the basis of economic privilege.

In a further study, Hallo de Wolf and Toebes interpret the obligation to protect of paragraph 3 of General Comment 3 as an obligation of the State to *regulate*.[52] According to these scholars, the role of regulation is the 'sustained and focused attempt to alter the behaviour of others'.[53] In this case, 'the conduct of actors operating in the health care arena'.[54] Well entrenched in the predominant interpretation of the right to health, the goal of the obligation to protect consists not in challenging the market as the main source of inequality of access to healthcare services, but in correcting 'market failures', namely, 'situations in which "[m]arket imperfections make it impossible for market forces to achieve an efficient allocation of resources"'.[55] Regulation is fundamentally directed towards healthcare providers and insurers. Its goal is to limit the range of actions where they can legally operate. Healthcare insurers may be obliged to finance more or less comprehensive insurance packages. Generally speaking, as

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51 Atria, *Paradigma* (n 49) 135.

52 Antenor Hallo de Wolf and Brigit Toebes, 'Assessing Private Sector Involvement in Health care and Universal Health Coverage in Light of the Right to Health' (2016) 18 (2) Health and Human Rights Journal 79, 84.

53 ibid, 85[44].

54 ibid, 85[43].

55 ibid, 85[46].

long as their level of profit is ensured, the State is not called to intervene. This, however, may change whenever the insurer is expected to finance insurance packages for segments of the population where profits are more limited. In those cases, State action may consist either in financing those packages or subsidising poor persons so that those treatments become affordable.[56] In any case State regulation should not be too restrictive in order not to 'strangle the market'.[57]

If the desired goal is that access to healthcare services becomes equal for all, it is puzzling why the role of human rights should be immediately understood as the correction of the market's pernicious but in no way unforeseeable effects. The reason why the role of human rights is interpreted as a mandate to regulate the market, rather than a mandate to keep the market away is not of legal but of strictly ideological nature. Yet, the former interpretation carries the empirical burden that for most of the countries that have transited towards the regulated commercialization of their healthcare, no definitive data supports the idea that access has become more extended.[58] On the contrary, significant data suggests the opposite.[59]

Hallo de Wolf and Toebes also indicate that issues of accessibility require regulating non-discrimination in access to private healthcare facilities.[60] This idea matches paragraph 35 of General Comment 14 which enumerates other instantiations of the obligation to protect, including measures to protect all vulnerable or marginalized groups of societies such as women, children, adolescents and older persons. As stated at the beginning, subjectivizing vulnerability is not an approach exempt of challenges. Just like T.H. Marshall and Richard Titmuss would have pointed out,[61] it is the commercialization of healthcare that goes directly against the efforts of human rights to focus on the vulnerable. Further on, I dedicate a special sub-section to look at the potential of non-discrimination to address issues of financial accessibility.

3.2.3. OBLIGATION TO FULFIL

The analysis of the obligation to protect makes clear that under the predominant interpretation of the right to health this right is not about opposing the commercialization of healthcare. With respect to the obligation to fulfil, General Comment 14 states that:

> States parties [must] give sufficient recognition to the right to health in the national political and legal systems, preferably by way of legislative implementation, and to adopt a national health

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56 As it happens with pharmaceutical companies, see Joo-Young Lee and Paul Hunt, 'Human Rights Responsibilities of Pharmaceutical Companies in Relation to Access to Medicines' (2012) 40 (2) Journal of Law, Medicine and Ethics 220, 228.

57 Hallo de Wolf (n 52) 86[52].

58 See n 94.

59 See eg Robert Chernomas and Ian Hudson, *To Live and Die in America: Class, Power, Health and Healthcare* (Pluto Press 2013) 140-146.

60 Hallo de Wolf (n 52), 86.

61 Dwyer (n 23) 55.

> policy with a detailed plan for realizing the right to health. States must ensure provision of health care, including immunization programmes against the major infectious diseases, and ensure equal access for all to the underlying determinants of health ...[62]

Further, the General Comment adds that States must ensure 'the provision of a public, private or mixed health insurance system which is affordable for all'.[63]

This set of obligations makes clear that the General Comment does not understand the obligation to fulfil as an obligation to establish a free-of-charge public healthcare service. While privatization is not conceived as a human rights challenge *per se*, the provision of healthcare can be arranged by means of a public, private or mixed system.[64] Taking a stand on the provision of Article 12(2)(d) of the Covenant, the General Comment states that from the economic perspective of accessibility, human rights are to be understood in connection with *affordability*. As analysed in chapter two, affordability is an element of accessibility that forms part of the normative framework of the right to health.[65] If the General Comment does neither oppose the commercialization of healthcare, nor requires a free-of-charge public healthcare service to fulfil the right to health, what exactly is affordability?

While no explicit answer is provided, the General Comment states that 'payment for health-care services ... has to be based on the principle of equity, ensuring that these services, whether privately or publicly owned, are affordable for all, including socially disadvantaged groups'. The General Comment defines equity by stating that this principle 'demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households'.[66] The notion of equity is strong in the right-to-health literature.[67] The former Special Rapporteur for the Right to Health, Paul Hunt, defined equity as 'equal access to health according to need'.[68] Moreover, other instruments such as the Guiding Principles on Extreme

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62 UNCESCR, General Comment 14 (n 32) [36].

63 ibid.

64 Toebes, *Commercialization* (n 39) 442.

65 See ch 2, s 3.2.7.

66 UNCESCR, General Comment 14 (n 32) para 12(b).

67 ibid paras 12(b), 52; WHO, 'Primary Health Care: Report of the International Conference on Primary Health Care, Alma-Ata, USSR' (6-12 September 1978) paras II, III, V, VI; (WHO), 'Ottawa Charter for Health Promotion' (17-21 November 1986) WHO/HPR/HEP/95.1; UNGA, 'United Nations Millennium Declaration' Res. 55/2 (18 September 2000) UN Doc A/Res/55/2, para 6; The People's Health Movement (PHM), 'The People's Charter for Health' (People's Health Movement Global Secretariat 2000) 4; UNHRCL, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Paul Hunt', UN Doc. A/HRC/7/11, 31 January 2008, paras 13, 22, 44-46; Organization of American States (OAS), 'Social Charter of the Americas' (2012) AG/doc. 5242/12 rev. 2, arts 1, 3, 14, 16, 17.

68 UNHRCL, A/HRC/7/11 (n 67) para 43.

Poverty state that 'no one should be denied access to essential services because of an inability to pay'.[69]

General Comment 14 has operationalized the obligation to fulfil through a set of sub-obligations: the obligations 'to facilitate', 'to provide' and 'to promote' the right to health. The obligation to facilitate involves States to inter alia take 'positive measures that enable and assist individuals and communities to enjoy the right to health'.[70] The obligation to provide refers to the State obligation to deliver 'a specific right ... when individuals or a group are unable, for reasons beyond their control, to realize that right themselves by the means at their disposal'.[71] Concerning the obligation to promote, the General Comment indicates that 'the right to health requires States to undertake actions that create, maintain and restore the health of the population'.[72]

Further, on what the General Comment calls 'core obligations', paragraph 43 establishes that 'States have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care'. Moreover, in connection with what the General Comment calls 'violations of the obligation to fulfil', paragraph 55 includes 'the failure to take measures to reduce the inequitable distribution of health facilities, goods and services'. This brings us back to the notion of equity − a concept that General Comment 14 does not necessarily operationalize via State ownership or a free-of-charge provision of healthcare services. The normative framework of the right to health does not provide guidance as to the institutional conditions under which the legal entitlements it creates are to be provided. It also leaves open the crucial question of how equal the provision of healthcare should for all be. What it does state, however, is that the degree of equality with which healthcare should be provided, is an equality of *opportunity*. By the same token, while paragraph 17, which indicates that the obligation of Article 12(2)(d) of the Covenant 'includes the provision of equal and time access to … health services', paragraph 19 dissolves this equality by providing a very concrete identification of who these beneficiaries are, namely: 'those who do not have sufficient means'.

In this way, if healthcare commercialization is not forbidden and the State is not required to own a national healthcare service, taking paragraphs 5 and 10 of General Comment 3 (non-discrimination and the minimum core doctrine), together with the above cited paragraphs of General Comment 14, one must conclude that affordability means *the obligation to provide a minimum of core services to those without enough resources to purchase healthcare services by themselves*.

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69 OHCHR, 'Guiding Principles on Extreme Poverty and Human Rights', UN Doc A/HRC/21/11, 26 September 2012, para 58.

70 UNCESCR, General Comment 14 (n 32) para 37.

71 ibid.

72 ibid.

This understanding has two consequences. On the one hand, it means that the goal of equal access to healthcare for all is replaced by subsidiary State action in favour of those who do not have the means to buy social rights. On the other hand, it means that from the perspective of the right to health, the nature of the organization of the provision of healthcare services is something perfectly irrelevant. These can be public, mixed or private.[73] Specifically, commercial business corporations are able to provide such minimums, something that they often do in exchange of State subsidies.[74]

The motivation of the defenders of the predominant interpretation of the right to health is to make economic, social and cultural rights legally justiciable. Their goal is to equalize their protection with that of classical rights and in that way put both sets of rights on an equal footing.[75] In her book Toebes rightly warned how this approach could lead to a situation in which violations of core minimums would become the only relevant thing.[76] Yet, not committing these violations is something largely compatible with the commercialization of healthcare.

3.3. NON-DISCRIMINATION

As has been shown, the predominant interpretation of the right to health has a frugal way of understanding the obligations derived of this right. What supposedly puts the house in order is the individual justiciability of the right to health via non-discrimination.[77] There are great

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[73] UNCESCR, General Comment 14 (n 32) para 12 (b).

[74] In Egypt, scholars found that 'public subsidies to healthcare services … are not pro-poor, meaning that subsidies tend to benefit wealthier groups more than the poorer groups', see Ahmed Shoukry Rashad and Mesbah Fathy Sharaf, 'Who Benefits from Public Healthcare Subsidies in Egypt?' (2015) 4 Social Sciences 1162, 1172; in Indonesia the World Bank estimated that in 2006 'subsidies to hospitals accounted for 40% of all health spending, noting that this benefits the better-off economic quintiles … Using Susenas data the World Bank found little change between 1985 and 2005', see Asia Pacific Observatory on Health Systems and Policies, *The Republic of Indonesia: Health System Review* (WHO 2017) 220; in the United States government agencies' expenditures to purchase private insurance for public sector employees and tax subsidies for private firms' purchase of insurance for their employees reaches 23% of personal healthcare expenditures, see Samuel Dickman, David Himmelstein, Steffie Woolhandler, 'Inequality and the Health-Care System in the USA' (2017) 389 The Lancet 1431, 1435. See also Jon Greenberg, 'Michael Moore: Obamacare sends over $100 billion annually to insurers' (*PunditFact*, 3 January 2014) <www.politifact.com/punditfact/statements/2014/jan/03/michael-moore/michael-moore-obamacare-sends-over-100-billion-ins/> accessed 17 June 2017.

[75] Asbjørn Eide and Allan Rosas indicate that the only specificity of economic, social and cultural rights lies in the eventual lack of immediately available means to realize them, see Asbjørn Eide and Allan Rosas, 'Economic, Social and Cultural Rights: A Universal Challenge' in Asbjørn Eide, Catarina Krause and Allan Rosas, *Economic, Social and Cultural Rights: A Textbook* (Martinus Nijhoff Publishers 1995) 22-23; Scheinin, *Legal* (n 18) 42.

[76] Toebes, *International* (n 17) 276.

[77] See ch 2, n 69, 78.

expectations of this legal remedy. As stated by the Special Rapporteur of the right to health, Paul Hunt, non-discrimination is more powerful than equity.[78]

As addressed in chapter two, non-discrimination in the field of social rights is linked to General Comment 20.[79] A look at three prohibited grounds of discrimination − social origin,[80] property[81] and economic or social situation[82] − give the impression that discrimination based on wealth would be addressed. This way if someone attempts to obtain a private healthcare treatment and would be impeded from doing so because of his or her inability to pay, such a reading appears to suggest that that person would have been the victim of discrimination. General Comment 20 shows, however, that this is not the case. These grounds do not refer to the money asked for in exchange for social services. Justiciability emerges not from being denied social services for lacking money – an objective privation so to say – but from a more sociological ground. According to the General Comment, the discrimination that the Covenant addresses is the one that 'may result in pervasive discrimination, stigmatization and negative stereotyping'.[83] This means that discrimination is not at stake if one is impeded from enjoying a private healthcare service for not having enough money to pay for them. In this scenario, if for example a treatment for a broken leg in a private clinic costs US$25,000,[84] and someone is denied access to that treatment on the basis that the person lacks such an amount of money, no discrimination has occurred.[85] Hypothetically, in order to align with the language of the Covenant, the potential

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78 UNHRCL, A/HRC/7/11 (n 67) para 43.

79 UNCESCR, 'General Comment 20 Non-Discrimination in Economic, Social and Cultural Rights (Art 2, Para 2 of the International Covenant on Economic, Social and Cultural Rights)', UN Doc E/C.12GC/20, 4-22 May 2009.

80 ibid [24].

81 ibid [25].

82 ibid [35].

83 ibid.

84 eg 'Broken Leg Cost' (CostHelperCost) <http://health.costhelper.com/broken-leg.html> accessed 23 June 2017.

85 Examples of the Committee's impotence can be found in many Concluding Observations of the United Nations Committee on Economic, Social and Cultural Rights. For example, in the Committee's Concluding Observations on China, including Hong Kong, China and Macao, rather than tackling the cause of the problem, the Committee limited itself to note with concern 'that despite the expansion of hospitals, there is a lack of doctors, who are absorbed into the higher-paying private health sector'. UNCESCR, 'Concluding Observations on the Second Periodic Report of China, Including Hong Kong, China, and Macao, China', UN Doc E/C.12/CHN/CO/2, 13 June 2014, para 50. See also the Concluding Observations on Colombia, where the Committee noted that it seemed that physicians trained in the country 'progressively went over to the private sector', UNCESCR, 'Sessional Working Group of Governmental Experts on the Implementation of the International Covenant on Economic, Social and Cultural Rights', UN Doc E/1986/EG.1/SR.6, 22 April 1986, para 15; in its Concluding Observations on Lebanon, the Committee noted 'that a considerable part of the public budget for health and education is spent on contracts for the delivery of services by private schools and private medical facilities', UNCESCR, 'Concluding Observations on the Initial and Second Periodic Reports of Djibouti', UN Doc E/C.12/DJI/CO/1-2, 30 December 2013, para 30.

victim of discrimination would have to prove that the privation is the result of a subjective element: that he or she was the victim of stigmatization or negative stereotyping that resulted in lack of access to the service.[86]

According to Matthew Craven, the reason why discrimination cannot be configured in wealth-related cases is because 'unlike sex, age or race, wealth is not an immutable or inherent attribute of the human person and therefore may be excluded under the *eiusdem generis* principle'.[87] Wealth would not entail discrimination since it would be a different *kind* of ground to those referred to by the Covenant. While it is true that being deprived of a social service for not being able to pay is not the consequence of a judgment intrinsically linked to the individual's personality (only to the size of the purse), healthcare services remain basic human needs.[88] All of them are critical to the free development of one's personality, and the *criteria* to satisfy these needs remain a sensitive human rights matter, irrespective of whether human rights instruments recognize it.[89]

Furthermore, General Comment 20 develops a language of substantive discrimination. These provisions, although applicable to groups, fail to improve things as they also rely on the same subjective considerations of prejudice and stigma already analysed.[90] In this way, since wealth is not – cannot be under this framework – a legally forbidden form of discrimination, this principle is unsuited to address these kinds of inequalities.

Having said this, it would be wrong to try to reconcile my objection with an interpretation in which lack of money could become a forbidden ground of discrimination. I do not find anything unusual or wrong in the denial of access to private healthcare services due to inability to pay for them within the framework of commercialization. Nor do I think that it is the role of the principle of non-discrimination to *correct* that. What I find delusionary is to expect healthcare commercialization to lead towards universal access to equal healthcare. Just like it is disingenuous to expect non-discrimination law to carry out the entirety of the human rights enterprise including challenging the commercialization of healthcare, an area to which this principle is clearly unsuited. If access to healthcare keeps on being addressed in connection with the question of whether an individual was discriminated against, solutions will remain elusive to the goal of equal access to healthcare for all.

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86 See ch 2, n 78, 79.

87 Matthew Craven, *The International Covenant on Economic, Social and Cultural Rights: A Perspective on its Development* (Clarendon Paperbacks 1995) 176.

88 Tom Campbell, *The Left and Rights. A Conceptual Analysis of The Idea of Socialist Rights* (Routledge 1983) 138.

89 ibid 133.

90 UNCESCR, General Comment 20 (n 79) para 8 (b).

3.4. MARKET EFFICIENCY AND HUMAN RIGHTS

To address a discussion on efficiency from a human rights perspective it is necessary to identify the basic coordinates of such a discussion. If in a community of 100 persons, 10 of them get excellent healthcare at a comparatively low cost, while the other 90 get poorer healthcare, can such an outcome be regarded as efficient? Focusing on the fact that such a system may spend relatively less than another one where those 10 need to pay more for that excellent healthcare, that situation could claim Pareto superiority.[91]

Yet, while greater or lesser efficiency can be attained within commercialized schemes, commercialization can also lead to an economic lack of accessibility in healthcare services for the poor. The poor cannot afford market prices which others are able and willing to pay; in some cases, they may not even constitute a lucrative market for private companies altogether. To this effect, one should also consider the further deprivation the poor experience when healthcare is distributed on the basis of ability to pay. The WHO has estimated that 11% of the world's population suffers financial catastrophe (defined as paying more than 40% of household income directly on health care after basic needs have been met) each year in covering health costs, while up to 5% are forced into poverty because they must pay for health services by the time they obtain them.[92] However, I do not think that the fact that the poor are punished when healthcare is distributed on the basis of ability to pay should be surprising. Lack of universal access to equal healthcare and further pauperization of the poor are only to be expected when access to healthcare services is distributed based on ability to pay.[93] When access to healthcare is made conditional on ability to pay, equal access to healthcare for all remains elusive.[94] In those cases,

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[91] For a concise explanation of Pareto superiority see Giovanni Sartor, 'A Sufficientist Approach to Reasonableness in Legal Decision-Making and Judicial Review' EUI Working Papers Law 2009/07 2009 20-21 and Encyclopedia of HealthCare Management 415-416.

[92] WHO, *The World Health Report. Health Systems Financing: The Path to Universal Coverage* (WHO 2010) 5.

[93] A conclusion corroborated by Gunnar Myrdal's theory of circular and cumulative causation, which predicts growing inequalities within and between countries participating in a free market, see Laura Turiano and Lanny Smith, 'The Catalytic Synergy of Health and Human Rights: The People's Health Movement and the Right to Health and Health Care Campaign' (2008) 10 (1) Health and Human Rights 137, 144-145; Gorik Ooms and Rachel Hammonds, 'Taking Up Daniels' Challenge: The Case for Global Health Justice' (2010) 12 (1) Health and Human Rights 29, 31.

[94] Lister states that the work of the Equitap project (Equity in Asia Pacific Health Systems) has been considered by its authors 'the most comprehensive and systematic assessment to date of the available empirical evidence of health system equity performance in Asia'. Lister states that 'the project concluded that universal, free or extremely low-priced services are more effective at achieving equity and widening access than two-tier systems with specific services "targeting" the poorest and, moreover, that user fees could be reduced or eliminated by governments spending as little as 2 per cent of GDP on a universal health system that would give most benefit to the poor'. John Lister, *Health Policy Reform: Global Health Versus Private Profit* (Libri Publishing 2013) 13-14.

the provision of healthcare services on the condition of ability to pay for them brings as a result that these services becomes fragmented: one kind of healthcare services for the rich *vis-a-vis* another kind of healthcare services for the poor (less extended and of lower quality). Furthermore, the retrieving tendency of State-based forms of services provision increments capital accumulation and consequent income disparities.[95]

As my analysis of General Comment 14 showed, the interpretative framework of the right to health does not oppose the commercialization of healthcare services *per se*, it does not demand State ownership of healthcare services, and it does not engage or necessarily require a free-of-charge provision of healthcare services. What the General Comment does is to discourage the fiercest consequences of commercialization. That is to say, it attempts remedying the pauperization of those whom the market rejects. In line with the insensitivity effect of General Comment 3, human rights may develop in a myriad of ways as long as they do not conflict with the main tenets of the capitalist economy. Non-discrimination, affordability and a universal healthcare minimum are all elements that can be fused into capitalist schemes.[96] At best, these legal tools succeed in universalizing a healthcare minimum. The universalization of a minimum not only means to renounce to an equal healthcare provision. If vulnerability – measured by the market – is what ultimately triggers State involvement, the market is nothing less than an essential component of this interpretation.

Definitions of efficiency that account for how much money the healthcare system spends but which fail to question that the rich access excellent healthcare while the poor access mediocre healthcare should be rejected from a human rights perspective. Those views instrumentalize the poor, something that should not be made compatible with the universality and equality human rights proclaim. A debate on efficiency should be limited to the alternatives that acknowledge human rights' intrinsic pre-eminence. In the context of the right to health this means to acknowledge that the goal to pursue is the highest attainable standard of health of *everyone in the community, equally*.[97] This leads me to take the stand that, from the perspective of human rights, a discussion on efficiency should be regarded as flawed whenever it is only a

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[95] Donald Donini, 'Is China Becoming Neoliberal?' (2008) 28 (2) Critique of Anthropology 145, 151; Christoph Hermann and Birgit Mahnkopf, 'The Past and Future for the European Social Model' Institute for International Political Economy Berlin, Working Paper No 5/2010 6; Christoph Hermann and Birgit Mahnkopf, 'Still a Future for the European Social Model?' (2010) 1 (3) Global Labour Journal 314, 319; Alessandra Sciurba (ed), *Living in Dignity in the 21st Century. Poverty and Inequality in Societies of Human Rights: The Paradox of Democracy* (Council of Europe 2012) 138-139; Audrey Chapman, *Global Health, Human Rights, and the Challenge of Neoliberal Policies* (CUP 2016) 87, 267.

[96] Rachel Turner, *Neo-Liberal Ideology: History, Concepts and Policies* (2nd edn, Edinburgh University Press 2011) 150-151.

[97] This is considering that according to Braveman and Gruskin, the notion of the 'highest attainable standard of health' 'can be understood to be reflected by the standard of health enjoyed by the most socially advantaged group within a society', see Paula Braveman and Sofia Gruskin, 'Defining Equity in Health' (2003) 57 (4) Journal of Epidemiology and Community Health 254.

plurality that obtains access to a high standard of healthcare, even when such access may come at a relatively lower cost for the community in comparison to another. Moreover, when those better conditions are the result of economic privilege, human rights would be playing a role in legitimizing inequity. Valid alternatives should be limited to those that pass first the human rights test, ie, those that tackle the needs of a community of equals.[98]

3.5. THE AAAQ AND DISTRIBUTIVE JUSTICE

As discussed in chapter two, the normative framework of the right to health consists of availability, accessibility, acceptability and quality.[99] Although these elements have a different hierarchy from the perspective of distributive justice, the predominant interpretation of the right to health equalizes their importance.[100] This makes it hard to introduce a discussion about social rights informed by solidarity. While a discussion of other elements is no doubt important, presenting a plethora of issues with the same weight in terms of distributive justice may have the effect of missing that critical point.[101] For example the issue of quality appears often as one of the most important ones.[102] Yet, in a community of equals – and especially when greater quality is the consequence of greater ability to pay – quality should only be discussed once equal conditions of access have been ensured for all those capable of claiming such status.[103] In sum, the question of access precedes the question of the quality of the good to which one has such access.

The opposite approach involves avoiding questions of distributive justice that are at the core of social rights: if social rights are truly *fundamental* (or at least as fundamental as civil and political rights), why is money (or its lack thereof) allowed to demarcate differences in the extension and quality of social rights? Whenever this question is replaced by the logic of

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98 Undocumented immigrants are not citizens. Yet, as I argue in the next section, solidarity is the source not only of the duties that justify the rights of citizens. Solidarity is also the source of a duty of the State of moving towards a notion of global citizenship, where the rights of these persons can also be tackled, see n 119.

99 See ch 2, n 106.

100 An example of how these different issues are given the same priority can be found in Brigit Toebes, 'The Right to Health and the Privatization of National Health Systems: A Case Study of the Netherlands' (2006) 9 (1) Health and Human Rights 102, 115.

101 Atria, *Focalización* (n 30) 44-45.

102 Organization for Economic Cooperation and Development (OECD), *Towards High-Performing Health Systems: Summary Report* (OECD Publishing 2004) 10; Organization for Economic Cooperation and Development (OECD), *Health at a Glance 2015: OECD Indicators* (OECD Publishing 2015) 21; Health Consumer Powerhouse, *Euro Health Consumer Index 2015: Report* (Health Consumer Powerhouse 2016).

103 It is worth mentioning that even from the perspective of quality and consumer satisfaction, evidence confirms that not-for-profit delivery of healthcare performs better than its for-profit counterpart, see Chernomas (n 59) 145-146.

improving the quality of the services for the poor, the vulnerable or the disadvantaged, questions of distributive justice − why are parallel regimes permissible and why is wealth a legitimate ground to secede from the public regime into a qualitatively better system − fail to be tackled.[104]

Under managerial notions of the citizen-consumer the issue is sometimes presented as a matter of freedom of choice.[105] Yet, as reasoned in an important decision from Israel's Supreme Court, if the right to choose a physician would have been part of autonomy, 'this would have required allowing each patient to elect a physician without payment'.[106] When freedom to choose is only available to those with economic resources, rather than a human right, we are in the presence of an economic advantage: the privilege of the rich to secede from the public healthcare system so that their healthcare needs can take priority over those without such a privilege.

Far from a commitment to 'the vulnerable',[107] when money can buy a right to secede from the public system, the incentives that this generates are counter to strengthening access to healthcare for the poor. If one of the fundamental premises of social rights is that privilege should not determine access to the services covering basic human needs, a discussion on social rights must not begin with the quality of different parallel healthcare systems, but by questioning the legitimacy of the rules that allow parallel healthcare systems to exist.[108] In this respect, Fernando Atria maintains that the defence of this parallelism is rather similar to the arguments given in support of the segregationist policies that were defeated during the civil rights struggle in the United States. Indeed, the doctrine of 'separate but equal' that *Brown v Board of Education* defeated, was that separating black people could still allow treating them with the same degree

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[104] An example of this kind of approach can be found in Toebes and San Giorgi who, in analysing the Dutch healthcare system, circumvent the question of distributive justice, legitimize the for-profit provision of healthcare, and consider that since focussing on quality matches the AAAQ framework, human rights concerns can be considered satisfied. Brigit Toebes and Maite San Giorgi, 'Dutch Realities: Evaluating Health Care Reform in the Netherlands from a Human Rights Perspective' in Brigit Toebes and others (eds), *The Right to Health: A Multi-Country Study of Law, Policy and Practice* (Springer 2014) 418.

[105] For example, under the government of John Major in the United Kingdom, the idea of the citizen consumer entailed that consumers were 'supposedly able to select schools, health providers and other services on the basis of league tables and other performance data. Once again the capacity of users to choose was constrained by a number of factors. However, the idea of public services being directly accountable to their users, and of consumers as the agents through which standards of performance would be enhanced, are significant points of continuity between the Major and Blair government'. Janet Newman, *Modernizing Governance: New Labour, Policy and Society* (Sage 2001) 49, 50.

[106] Aeyal Gross commenting on Justice Berliner's view on the *Kiryati* case, see Aeyal Gross, 'Is There a Human Right to Private Health Care?' (2013) Journal of Law Medicine and Ethics 138, 142.

[107] Aristotle identified corrective justice as 'that which plays a rectifying part in transactions between man and man' and opposed it to distributive justice, 'which is manifested in distributions of honour or money or the other things that fall to be divided among those who have a share in the constitution (for in these it is possible for one man to have a share either unequal or equal to that of another)'. Aristotle, *The Nicomachean Ethics* (OUP 2009) 84.

[108] T H Marshall, *Citizenship and Social Class and Other Essays* (CUP 1950) 28.

of quality.[109] While indeed quality did not appear to be put at risk, such a separation generated several inequalities attached to this form of segregation. Segregation in itself − the Supreme Court ruled − contributed to perpetuate the position of social privilege of the white majority, and the conditions of marginalization of the black minority.[110] It is inconsistent with the alleged fundamentality of social rights that unlike for instance the right to vote – where a right of equal weight is enshrined – the right to health only generates an equal right to a minimum.

Having looked at the limitations of the predominant interpretation of the right to health, it is time to put forward a different interpretation. Taking into consideration chapter three, the perspective I shall explore presents solidarity as the principle of justification of the duties of the right to health.

4. NOTES FOR A THEORY OF THE RIGHT TO HEALTH UNDER SOLIDARITY

4.1. INTRODUCTION

As an alternative to the predominant interpretation, I claim that from the perspective of solidarity, the right to health is a non-marketed right. Its purpose is the establishment of a set of legal obligations that place the provision of healthcare outside the market. To this purpose, I make mine Ricardo García Manrique and Fernando Atria's definitions of social rights. For the former, social rights are a community's democratic standards that specify the distribution of wealth and opportunities necessary for the satisfaction of everyone's needs of assistance, education and labour.[111] For the latter:

> [L]os derechos sociales son aspectos del bienestar de cada uno que no dependen del hecho fáctico de que cada uno pueda obtener en el mercado lo que necesita, y la medida en que cada uno recibe no estará dada por lo que de hecho tenga, sino por su estatus de ciudadano.[112]

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[109] Fernando Atria, *La Mala Educación: Ideas que Inspiran al Movimiento Estudiantil en Chile* (Catalonia 2012) 73; Atria, *Paradigma* (n 49) 114-115; Atria, *Focalización* (n 30) 44-45.

[110] *Brown v Board of Educ* 347 U S 483 (1954) (Supreme Court of the United States).

[111] Ricardo García Manrique, *La Libertad de Todos: Una Defensa de los Derechos Sociales* (El Viejo Topo 2013) 34; Atria, *Paradigma* (n 49) 24-25.

[112] 'Social rights are aspects of everyone's welfare which consist not in making conditional of what one gets, what one can obtain on the market; and the measure in which one receives will not be given by what everyone possesses, but by the status of citizen.' Atria, *Paradigma* (49) 236.

According to Colleen Flood the right to health should be based on 'an egalitarian theory of distributive justice in allocating health care resources, [namely, one] that considers that access to health care should occur on the basis of need as opposed to ability to pay'.[113] I thus take the view that under solidarity the right to health demands socializing or de-commodifying access to healthcare, namely, 'to remove something from the market domain'[114] in the field of access to healthcare.[115]

This understanding fundamentally requires the shifting of the obligations to protect and to fulfil. This shift is linked both to the content of the right to health and the actors in charge of its protection. Concerning the question of the right's content, this means establishing the legal obligations and institutions necessary so that everyone in the community can enjoy equal access to healthcare services, namely, the progressive de-commodification of access to healthcare. Solidarity requires making the right to health shift from its gradual dependence on economic privilege, towards citizenship and medical need.

Concerning the actors in charge of protecting the right to health, as much as with respect to other social rights, the community has an important say in defining the priorities of the right to health (I address this issue further in section 4.4 under the label of 'social rights' democratic pedigree'). This is reflected in Article 2(1) of the ICESCR. As follows from this provision, it is fundamentally the legislative and executive branches that define the standard the right to health comprises, as well as the specific priorities and trade-offs of the system.[116] While administrative courts and the judiciary are tasked with the function of ensuring that that standard is applied fairly, the specifically judicial and institutional implications of solidarity are the object of the next two chapters. Chapter five deals with the role of the judiciary, and chapter six addresses the question of the provision and financing of healthcare.

4.2. LEGAL SCOPE

I have argued that under solidarity the right to health should not be conditioned by ability to pay but by citizenship, and medical need. If solidarity makes the right to health conditional on citizenship, what happens with the human rights of non-citizens located within the State's jurisdiction? On the one hand, it is not disputed that the State has an obligation to discharge its human rights obligations with respect to its national citizens.[117] On the other, I have also stated

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[113] Gross (n 106) 139.

[114] Fernando Atria, *Veinte Años Después: Neoliberalismo con Rostro Humano* (Catalonia 2013) 156.

[115] Benjamin Mason and Ashley Fox, 'International Obligations Through Collective Rights: Moving from Foreign Health Assistance to Global Health Governance' (2010) 12 (1) Health and Human Rights Journal 61.

[116] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966) 993 UNTS 3, art 2(1).

[117] Dwyer, *Citizenship* (n 23) 39-40; in the case of a person unlawfully deprived of his nationality, the United

that the right to health should be made conditional on medical need. Can this statement have implications on the way the scope of this human right is understood?

The ICESCR does not distinguish between nationals and non-nationals.[118] Article 2(2) of the Covenant obliges the State to discharge its obligations without discrimination on grounds of nationality. The State is in principle obliged to provide the same healthcare services it provides to its nationals to all individuals under the State's jurisdiction. It is in this respect that medical need – 'the event of sickness' Article 12(2)(d) of the Covenant refers to – helps supplementing the idea of citizenship. While the mixture between citizenship and medical need can be interpreted in favour of every person located under the State's jurisdiction (including foreigners), it could also be argued that the obligation extends beyond territorial borders. Following Stephen Ratner, my view is that the State is obliged to fulfil these rights directly for any individual on the State territory, and indirectly to non-nationals located in other States by means of international cooperation.[119]

The limited development of non-discrimination on grounds of nationality reflects how difficult it has been to move forward on this issue.[120] This is particularly challenging in the context of the current refugee crisis. Although no Western nation is part of the top ten list of countries receiving the greatest amount of refugees,[121] with 244 million people on the move, 65 million of which are forcibly displaced, 21 million which are refugees and more than 3 million that are asylum seekers, the world is witnessing the biggest migration crisis since World War Two.[122] The complexity of the situation is aggravated by the precariousness in the provision of public healthcare services under increasing commercialization.[123] Blaming lack of access to

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States Supreme Court stated that what this individual was losing was 'the right to have rights', see *Trop v Dulles* 356 U S 86, 102 (1958) (Supreme Court of the United States).

118 In her review of the *travaux préparatoires* of the ICESCR, Toebes shows that the idea to limiting the scope of Article 12 to the State's 'nationals', was deleted precisely by recommendation of the United Nations High Commissioner for Refugees 'because he feared that limiting the provision of health care to nationals would deprive refugees of the opportunity to secure medical care', see Toebes, *International* (n 17) 42-43.

119 Steven Ratner, *The Thin Justice of International Law: A Moral Reckoning of the Law of Nations* (OUP 2015) 270; Cuba has set an example of how to carry out this obligation, see ch 6, n 54.

120 eg Article 18 of the Treaty of the Function of the European Union distinguishes between EU citizens and third country nationals. Moreover, Article 3(1) of the EU Racial Equality Directive while it prohibits discrimination on the basis of racial or ethnic origin on access to healthcare, explicitly excludes nationality as an illegitimate ground of discrimination, see Council Directive 2000/43/EC of 29 June 2000 implementing the principle of equal treatment between persons irrespective of racial or ethnic origin. See <http://eur-lex.europa.eu/legal-content/en/TXT/?uri=CELEX%3A32000L0043> accessed 23 June 2017.

121 These countries are Turkey, Pakistan, Lebanon, Ethiopia, Jordan, Kenya, Uganda, Sudan, Iraq, and Afghanistan, see Silke von Brockhausen and others, UNDP, '#Refugeeswelcome: Helping the Helpers (16 September 2016)' <http://stories.undp.org/refugeeswelcome-helping-the-helpers> accessed 23 June 2017.

122 ibid.

123 See n 95.

healthcare as the result of the increasing pressure migrants would be exercising over healthcare systems benefits a political agenda opposed to human rights.[124]

4.3. TRADE-OFFS

As argued in in the Introduction of this thesis, trade-offs are a key aspect of social rights. By trade-offs, I specifically mean rationing in the provision of healthcare services due to economic reasons. Since resources are scarce, difficult decisions need to be adopted to decide the treatments that will be covered, the extent of that coverage and the groups of individuals that may have different degrees of priorities of access.

The idea that human rights entitlements may be limited by economic trade-offs is hard to grasp within the discipline. For a long time the argument that social rights were not human rights relied on the fact that they depended on economic contingency. This, it was argued, rendered them 'programmatic provisions', closer to aspirations than to legal protections.[125] However, a solidarity-based account of the right to health is compatible with the existence of trade-offs. In fact, the belief that trade-offs will be definitively obliterated from the provision of social rights is a dangerous deception. Trade-offs will never disappear from the provision of social rights. The biomedical approach, predominant today, focuses on its effectiveness in the curing of diseases.[126] While its merits remain debatable,[127] it is also unclear how such an approach would not risk the financial sustainability of healthcare systems that seek to cover the needs of all. Social and hygienic measures, a focus on prevention, education, the participation of the community and other measures that can be found in the social medicine approach offer interesting prospects in this respect.[128]

A human rights focus on trade-offs should be more complex than merely opposing them. The emphasis should not be placed so much on eliminating trade-offs but on distinguishing

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[124] In this regard, Colin Crouch argues that 'the old predominant conflict axis around inequality and redistribution is itself becoming interpreted through nationalism rather than through class politics', see Colin Crouch, 'The Familiar Axes of Politics Are Changing, With Momentous Consequences' (Open Democracy, 23 September 2016) <www.opendemocracy.net/uk/colin-crouch/familiar-axes-of-politics-are-changing-with-momentous-consequences> accessed 23 June 2017.

[125] Isabel Masanque 'Progressive Realization Without the ICESCR: The Viability of South Africa's Socioeconomic Rights Framework, and its Success in the Right to Access Health Care' (2012-2013) 43 California Western International Law Journal 461, 465[19].

[126] Chernomas (n 59) 145.

[127] ibid.

[128] Arjun Suri, 'Social Medicine: Lessons from Cuba' (2016) 387 The Lancet 641; Audrey Chapman, 'The Social Determinants of Health, Health Equity, and Human Rights' (2010) 12 (2) Health and Human Rights 17; Oliva López y Florencia Peña, 'Salud y Sociedad: Aportaciones del Pensamiento Latinoamericano' (2006) 1 (3) Medicina Social 82; Anne-Emmanuelle Birn and Laura Nervi, 'Political Roots of the Struggle for Health Justice in Latin America' (2015) 385 The Lancet 1174.

between them. Not every trade-off should be regarded as necessarily incompatible with the right to health. A distinction between discrimination, lack of solidarity and lack of resources needs to be set out. In what comes next I shall explain how only lack of resources can be reconciled with the right to health.

With respect to discrimination, a good example can be found in the denial of healthcare that took place in the context of the emergence of the HIV virus. The disease began to be formally tracked in the United States in 1982.[129] Although there has been progress, until today the disease remains insufficiently addressed, even in Europe.[130] During the first decade after its discovery, the disease was associated with drug addiction and homosexuality. HIV generated a double challenge: challenges to the right to health and challenges to the right not to be discriminated against. Legal non-discrimination became an effective tool to oppose lack of coverage.[131]

Another often encountered reason for the limitation or denial of access to healthcare is failure to incorporate solidarity. Whether it is lack of solidarity that limits access to healthcare must be determined step by step. Firstly, it must be determined whether different regimes for access to healthcare exist in parallel in the same country. If only one public healthcare system that conditions entitlements to citizenship and medical need exists, trade-offs may still be not in line with the right to health but the issue at stake would not be failure to incorporate solidarity. Secondly, it must be measured whether any of those different regimes makes the provision of healthcare conditional on ability to pay. If that is so, trade-offs within the public healthcare system to cover needs that are at the same time covered in the parallel commercial system, cannot be justified on lack of resources. Since it is the same legislative authority that allows the existence of both parallel systems, it is the State that would be ultimately allowing such an unequal treatment.

Under solidarity the right to health fundamentally requires approaching its object of concern under a non-marketed logic, namely, to oppose the privatization of its legal nature. In the situation of a dual system of healthcare provision, it is evident that healthcare resources exist within the community. What fails is the ability or willingness of the State authority to distribute scarcity in a fairer way so that the poor are not the only ones forced to carry the scarcities. Yet, if it is true that human rights are the moral ground floor of our times − as organizations like Human Rights Watch enthusiastically assert − human rights should be in fact universalized. Not

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[129] The Aids Institute, 'Where Did HIV Come From?' (*The Aids Institute*) <http://www.theaidsinstitute.org/node/259> accessed 17 June 2017.

[130] A recent WHO report concluded that 'more than three decades into the HIV epidemic in Europe, HIV infection continues to affect the health and well-being of hundreds of thousands of people in the WHO European Region and to be of serious concern, particularly in the eastern part of the Region', see European Centre for Disease Prevention and Control (ECDC) and WHO, 'HIV/AIDS Surveillance in Europe 2015' (ECDC and WHO 2016) 28.

[131] Rajat Khosla, Nuna Van Belle and Marleen Temmerman, 'Advancing the Sexual and Reproductive Health and Human Rights of Women Living with HIV: A Review of UN, Regional and National Human Rights Norms and Standards' (2015) 18 (Suppl 5) Journal of the International AIDS Society, 3.

just against the abuses of dictatorial regimes in the Global South, but also to the detriment of the rules of commercialization. In this way, human rights should assert its alleged pre-eminence precisely where they lack it, namely, in opposing the idea that the poor should carry their own burdens in times where notions of individual responsibility shape the entirety of the social enterprise. It is thus the struggle against commodification what human rights should more vigorously address. Failure to do so not only unveils that the rules of commercialization have pre-eminence over human rights law, but it also unveils the selective commitment of these outspoken human rights advocates.

Looked through the lenses of solidarity, social rights consist in the declaration and continuous vindication of the public nature of social rights. Thus, solidarity's legal effect is twofold. Firstly, it spreads the distribution of the burden of scarcity to all members of society. Secondly, it creates positive incentives. Aside from the fact that the richer can always resort to healthcare tourism, in single payer healthcare systems, ie systems in which the residents pay the State to cover healthcare costs rather than individuals buying from private insurers competing for their business, the richer only obtain better healthcare by improving the national healthcare system. As the needs of the rich get greater priority, this action has the effect of improving the quality and extension of everyone's entitlements.[132]

Lack of resources is the only reason that in my view can legitimize trade-offs. Yet, this should be exercised in limited terms. Developing countries often claim that lack of access to healthcare for important segments of the population is linked to their lack of resources.[133] However, the comprehensiveness, universality and free-of-charge features that have been attained by Cuba's healthcare system, a country with a modest gross domestic product,[134] makes this argument doubtful.

To know if the limitation or denial of access to healthcare is a consequence of lack of resources, and can therefore be justified, involves several steps. As stated earlier, both discrimination and lack of solidarity are not legitimate grounds for trade-offs. When access to healthcare is denied because of prohibited grounds of discrimination the problem, in principle, is not lack of resources. By the same token, when ability to pay is the ticket of entrance to a health intervention that those unable to pay are deprived of, it becomes evident not only that

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[132] Opposing the idea that improving the quality of social services is the most appropriate solution to the lack of enjoyment of social services to the poor, Fernando Atria argues that the issue is linked to power and influence, which is precisely what the poor lack. Therefore, there is more probability that political attention to intervene and gather resources will be given when the problems at stake are those of the rich, a reason why the provision of social services should be universal, and not specifically targeted on the poor, see Atria, *Paradigma* (n 49) 115; Atria, *Focalización* (n 30) 44-45.

[133] Amnesty International, *Human Rights for Human Dignity: A Primer on Economic, Social and Cultural Rights* (2nd edn, Amnesty International 2014) 94.

[134] In its 2015 GDP measurement, the World Bank positioned Cuba in place 65 out of 199 countries, with 87,133 million dollars, see World Bank, 'Gross Domestic Product Ranking Table' (World Bank 2015) <http://data.worldbank.org/data-catalog/GDP-ranking-table> accessed 24 June 2017.

healthcare resources exist but also that what makes this access possible are the legal rules conditioning access to healthcare to ability to pay. In those circumstances, it is the unwillingness of distributing scarcity more justly what leads to the act of exclusion, not lack of resources.

As commented by the Committee, in the context of the progressive realization and with a view to make use of the maximum amount of available resources for the right to health, health budgets should be prioritized in relation to other State expenditures. This was regarded as inappropriate in some cases. In the case of Sudan, funds were diverted from education, health and social protection to be used in considerable security and military purchases.[135] In the case of the Philippines the Committee noted that the national budget devoted to military spending was greater than the budget on housing, agriculture and health combined.[136] If not distracting resources in this manner a country still lacks financial resources, it should seek them through donations and international cooperation.[137] Only after having carried out all those previous steps and still lacking resources, can a country establish valid trade-offs in the provision of healthcare.

Trade-offs are not necessarily an indication that social rights are being instrumentalized. Trade-offs can also reflect a fair way of dealing with the challenge of scarcity. Embedded in a trade-off, tragic decisions, like prioritizing the use of chemotherapy for persons with the chance of recovering, may need to be adopted.[138] Those tragic decisions, although always confronting, are not *per se* opposed to human rights. A tragic decision may indicate that a community sees itself forced to choose between two interests, both of which are valuable. The WHO has offered basic guidelines of how to deal with those conundrums.[139] In sum, solidarity does not mean that

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[135] UNCESCR, 'Concluding Observations on the Second Periodic Report of the Sudan', UN Doc E/C.12/SDN/CO/2, 27 October 2015, para 15.

[136] UNCESCR, 'Concluding Observations of the Committee on Economic, Social and Cultural Rights, Philippines', UN Doc E/C.12/1995/7, 7 June 1995, para 21.

[137] Various Authors, 'Maastricht Principles on Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights', adopted 28 September 2011, available at multiple places online including <www.etoconsortium.org/nc/en/main-navigation/library/maastricht-principles/?tx_drblob_pi1%5BdownloadUid%5D=23> accessed 15 June 2017 (Maastricht Principles), paras 8(b), 29; Amnesty International (n 133) 72[136].

[138] *Soobramoney*, Chaskalson, Constitutional Court of South Africa, para 3, ch 5 s 3.2.1.

[139] The following situations have been regarded by the WHO as 'unacceptable trade-offs': 'To expand coverage for low- or medium-priority services before there is near universal coverage for high-priority services. This includes reducing out-of-pocket payments for low- or medium-priority services before eliminating out-of-pocket payments for high-priority services'; 'to give high priority to very costly services whose coverage will provide substantial financial protection when the health benefits are very small compared to alternative, less costly services'; 'to expand coverage for well-off groups before doing so for worse-off groups when the costs and benefits are not vastly different. This includes expanding coverage for those with already high coverage before groups with lower coverage'; 'to first include in the universal coverage scheme only those with the ability to pay and not include informal workers and the poor, even if such an approach would be easier'; 'to shift from out-of-pocket payment toward mandatory prepayment in a way that makes the financing system less progressive'. WHO, *Making Fair Choices in the Path to Universal Health Coverage:*

economic resources will be made infinitely available nor that all healthcare needs will be satisfied. Understood through the lenses of solidarity the right to health means that the burdens resulting from trade-offs will be justly shared, by opposition to allocating them exclusively on the shoulders of the weakest. This idea should not lead to the conclusion that to live up to this standard everyone should contribute the same or that everyone should be entitled to the same in absolute terms. Healthy persons should not get the same healthcare than sick persons. Likewise, relatively speaking, younger persons generally require less healthcare than older persons, while new-born babies and their mothers need special attention by comparison to the rest of the adult population. As their morbidity is greater, poorer persons should often get more healthcare by comparison to the richer.[140] The justice of solidarity is not based on an equality that can be fulfilled by assigning everyone a uniform amount, but through equity. As opposed to commercialization, equity entails the replacement of economic privilege by citizenship and medical need as the criteria to decide how to set priorities to address a community's healthcare needs. Solidarity will certainly not solve all possible access-to-healthcare conundrums (eg, should people with rare diseases that require expensive medical treatments get full coverage by comparison to diseases that affect the majority?). Yet, solidarity should contribute to rule out systemic forms of economic exclusion the right to health cannot be made compatible with. Providing an answer about how to address a critical aspect of the right to health, solidarity moves along with theories of justice embedded in the Alma-Ata Declaration,[141] and the WHO's strategy of *Health for All*.[142] Unfortunately, this perspective has been replaced by the strategy of *Universal Health Coverage*,[143] which fails to question the commercialization of healthcare.

Final Report of the WHO Consultative Group on Equity and Universal Health Coverage (WHO 2014) 38-41.

[140] Looking at various studies carried out in the United States which examined several health indicators, Chernomas and Hudson indicate that 'the risk of stroke is 80 percent lower for those with some university education than those without a high school diploma. The incidence of diabetes is two times higher in people who have not completed high school compared with those with a BA. Once people reach 25, college graduates live five years longer than those who do not finish high school. If every person in the United States were to have the mortality rate of those who attended (even if they did not graduate from) university, it would save seven times as many lives as all biomedical advances. The incidence of cardiac arrest in the poorest 25 percent of neighbourhoods in four big US cities is almost double than in the richest quartile'. Chernomas (n 59) 100.

[141] WHO, Alma-Ata (n 67).

[142] WHO, 'Global Strategy for Health for All by the Year 2000' (WHO 1981).

[143] See ch 6 n 16.

4.4. SOCIAL RIGHTS' DEMOCRATIC PEDIGREE

Human dignity offers a profound justification for the rights of the (isolated) individual.[144] As such, it is hard for human dignity to provide a sound justification for social rights such as the right to health. I think that solidarity is what provides that justification. The difficulty lies in the fact that the solidarity of social rights can only be conceived in the context of our living together. As democracy is the form of government most generally regarded as compatible with classical rights, definitions of solidarity will naturally emerge in the context of democratic decision-making. Hence, because of the mediating role that democracies naturally play in the adjudication of collective interests, political decision-making through democratic institutions will inevitably play a pivotal role in the conceptualization of solidarity.

Yet, that democratic institutions are regarded as the formal part of the equation does not mean that solidarity can be compatible with any decision. But this feature is not unique to social rights. As discussed in chapter three, something similar happens in the context of the human right to vote. An important element of what this human right requires is the obligation of shaping electoral systems under the principle of one person, one vote.[145] This shows that even though the role of the Parliament remains ineradicable, the right to vote also has a clear content. Similarly, the right to health cannot be understood devoid of a national healthcare system informed by the principle of solidarity.[146]

As stated above, at the core of the institution of the national healthcare system lie the rules concerning the organization of the provision and financing of healthcare. Legislative schemes *are* the irreplaceable formal instruments by which means a community's scarcities are distributed. In their general aptitude, legislative standards − by opposition to dispersed judicial adjudications – naturally suit the distributive justice concerns behind the right to health.[147]

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[144] As expressed by Habermas, '[T]he *liberal rights*, which crystallize around the inviolability and security of the person, around free commerce, and around the unhindered exercise of religion, are designed to prevent the intrusion of the state into the private sphere. They constitute, together with the *democratic rights of participation*, the package of so-called classical civil rights. In fact, however, the citizens have equal opportunities to make use of these rights only when they simultaneously enjoy guarantees of a sufficient level of independence in their private and economic lives and when they are able to form their personal identities in the cultural environment of their choice. Experiences of exclusion, suffering, and discrimination teach us that classical civil rights acquire "equal value" (Rawls) for all citizens only when they are *supplemented* by social and cultural rights'. Jürgen Habermas, 'The Concept of Human Dignity and the Realistic Utopia of Human Rights' (2010) 41 (4) Metaphilosophy 464, 468.

[145] UNHRC, 'CCPR General Comment 25: Article 25 (Participation in Public Affairs and the Right to Vote) The Right to Participate in Public Affairs, Voting Rights and the Right of Equal Access to Public Service', UN Doc CCPR/C/21/Rev.1/Add.7, 12 July 1996, para 21.

[146] UNHRCL, A/HRC/7/11 (n 67) paras 109-123.

[147] Jeremy Waldron has emphasized generality as a fundamental element of a democratic jurisprudence, see Jeremy Waldron, 'Can There Be a Democratic Jurisprudence?' (2008) New York University School of Law,

Legislative standards are important because they make visible the rationale behind priorities and tragic trade-offs. Nevertheless, while legislative schemes constitute a formally irreplaceable component of solidarity, only the content of the created entitlements is the ultimate way to determine the extent such a system is driven by *the logic of solidarity*. This is so because the justice of the trade-offs will have to be measured by the extent to which they move along the gradual path towards the de-commodification of access to healthcare. In this sense, the entitlements can be universal or limited, conditioned to ability to pay or to citizenship and medical need, restricted to nationals or not, guaranteeing a minimum for the extremely poor or otherwise vulnerable, granting equal entitlements for all or entitlements that merely make healthcare 'affordable' to the poor, etc. As such, these rules constitute the primary way of both implementing and assessing the state of affairs of the right to health.

4.5. OBLIGATIONS

In sum, when interpreted in accordance to solidarity, the right to health consists in three obligations.

4.5.1. THE OBLIGATION TO RESPECT

Also from a solidarity perspective, the obligation to respect entails the obligations to respect equal access to health care, not to interfere with its provision and of information related to health care.

4.5.2. THE OBLIGATION TO PROTECT

I concluded that the predominant interpretation of the right to health, far from protecting the right, can even serve as an enabler of healthcare commercialization. Since a solidarity perspective of the right to health regards the goal of equal access to healthcare for all its main goal, healthcare commercialization, with its inability to guarantee such equal right, is a threat to that goal. Understood in the frame of solidarity, the obligation to protect consists in enacting regulations, especially legislation, that primarily discourages, and further prohibits, the commercialization of healthcare. The private healthcare sector can participate, but not based on the unequal treatment towards which commercialized principles lead.[148]

Public Law and Legal Theory Research Paper Series no 08-35, 14 <http://ssrn.com/abstract=1280923> accessed 23 June 2017.

[148] This is not the same than stating that the private sector cannot provide healthcare services. Provided that access is not determined by social privilege, namely, that is not carried out in a for-profit basis, see Eduardo Arenas Catalán, 'Solidaridad Social y Derecho a la Salud: la Asequibilidad en el Suministro de Servicios Esenciales Públicos de Salud' (2015) 25 Revista Europea de Derechos Fundamentales 333; a challenge in this respect consists in dealing with the so-called 'health tourism' phenomenon, see Ivan Rodríguez Cardo, 'El Reembolso de Gastos Sanitarios en el Derecho de la Unión Europea: El Peligro de Fomentar el Turismo

4.5.3. THE OBLIGATION TO FULFIL

As concluded earlier, under the predominant interpretation, the obligation to fulfil the right to health consists in guaranteeing a minimum provision of healthcare. The challenge of attaining this is pressing in systems that in different degrees integrate the for-profit delivery of healthcare. The problem arises more specifically in connection with segments of the population unable to purchase healthcare services by themselves. The solution of the predominant interpretation, careful to remain within the spectrum of its own conceptualization of political neutrality, ends up adopting *another* political position: on the one hand it reacts with indifference to the commercial organization of healthcare; on the other, it understands that the role of the right to health consists in providing a minimum provision of healthcare for those segments of the population that the market regards as unattractive.[149] In so doing the predominant interpretation not only regards healthcare commercialization as a reality not to be disputed, but it also considers that its minimum healthcare provision neither has to be provided free-of-charge, [150] nor necessarily by the public healthcare sector.[151]

Conceived from the perspective of solidarity, the positive obligations deriving from the right to health do not lead to an individual legal right to claim the services of physicians, hospital beds, or the technology comprising healthcare. Neither is the right to health an individual right to be healthy.[152] Healthcare systems such as Cuba's, which effectively realize a constitutional right of equal access to free healthcare for all, exemplify this.[153] As García Manrique put it, the primary issue of social rights consists in servicing fundamental social needs so that liberty can become attainable for all members of the community, rather than only by those capable of buying social rights.[154]

Sanitario' in Miguel Angel Presno Linera and Ingo Wolfgang Sarlet (eds), *Los Derechos Sociales como Instrumento de Emancipación* (Aranzadi 2010); another challenge is the so-called 'self-provision of healthcare services', which are always available for the upper classes, see Nissim Cohen, 'The Self-Provision of Public Healthcare Services: a Threat to Democracy' (2013) 6 (1) Journal of Politics and Law 128.

149 Rebeca Jasso-Aguilar, Howard Waitzkin and Angela Landwehr, 'Multinational Corporations and Health Care in the United States and Latin America: Strategies, Actions and Effects' in Maureen Mackintosh and Meri Koivusalo, *Commercialization of Health Care: Global and Local Dynamics and Policy Responses* (Palgrave Macmillan 2005) 48, 56; Jean-Pierre Unger and others, 'Disintegrated Care: the Achilles Heel of International Health Policies in Low and Middle-Income Countries' (2006) 6 (3) International Journal of Integrated Care, 4; Toebes, *Commercialization* (n 39) 452.

150 s 3.2.3.

151 ibid.

152 UNCESCR, General Comment 14 (n 32) para 8.

153 ch 6, n 73.

154 Ricardo García Manrique, *La Libertad de Todos: Una Defensa de los Derechos Sociales* (El Viejo Topo 2013) 34.

Considering economic scarcity a given, the right to health as a social right acknowledges that difficult trade-offs between expensive social needs will take place.[155] Efficiency in the use of these scarce resources (understood in the context of a community of equals) is imperative. The poorer the society, the more dramatic those trade-offs will be. Diseases, a critical aspect for the right to health, are not regarded as exceptional affronts to human dignity but as features intrinsically attached to the human condition. For this reason, access to the means of prevention, curing and rehabilitation of the disease are regarded as a basic issue of the distributive justice the members of the community owe to one another. This is not different from stating that these distributive justice criteria are at the core of what the right to health is.[156] Such an acknowledgment goes hand in hand with the recognition of the limited and fallible attempts a community faces in arranging them. In this scheme, the right to health is conceived as always precarious and never fully realized.[157]

According to Atria, the scarcity of the goods, services and infrastructure, far from becoming an argument against the possibility of social rights, is exactly what justifies its collective management and rationalization.[158] The first step in realizing the obligation to fulfil under solidarity is the designation of health (healthcare in this case) as a sphere sufficiently important to justify its management by means other than the market. One could understand the ratification of the ICESCR as an expression of such a designation. Secondly, an obligation to protect must be established. As analysed in the previous section, this involves the discouragement or prohibition of for-profit healthcare systems parallel to the public sector. Thirdly, an alternative way to conditioning the provision of services must be established. In line with the New Liberals' rejection of social class or economic privilege as the condition to access basic social services such as healthcare, solidarity entails replacing ability to pay for citizenship and medical need. The corollary of this interpretation is that the obligation to fulfil and the positive obligations derived from the right to health require providing healthcare services as a matter of principle *free of charge*.[159]

From the perspective of the positive obligation to fulfil, an encroachment of the right to health does not take place as soon as individual harm is experienced. Individual harm could be *indicative* of the right's impairment. Yet, as such, individual harm does not *trigger* an impairment of the right to health. This is proven by the fact that impairment of this right can take

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155 As acknowledged by the WHO, see WHO, Report (n 92) 12, 88.

156 The WHO and its campaign of 'Health for All' is an example of this. This agency recognizes that what was behind this campaign was a 'political idea', namely, 'the public responsibility for ensuring all citizens' entitlements to the protection of their health', see WHO, *Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action* (WHO 2007) 4.

157 WHO, Report (n 92) 12.

158 Atria, *Paradigma* (n 49) 61.

159 Also in line with the expectation of 'welfare provision', as identified by Böckenförde, see Ernst W Böckenförde, *State, Society and Liberty: Studies in Political Theory and Constitutional Law* (Berg Publishers 1991) 173, 196.

place even if no individual harm is experienced. For example, the publication of an act of parliament by means of which a unit of the national healthcare system becomes open for bidding to further its privatization entails a step towards the commercialization of healthcare. As such, this threatens the right to health conceived as a social right. However, the entry into force of a statute does not trigger any individual harm *per se*. While individual harm could be indicative of impairment of the obligation to fulfil the right to health, I do not think that individual harm does trigger *per se* a violation of this right. If this right is infringed, this occurs prior to the occurrence of the individual harm that may be caused. The infringement would depend on a normative act or an omission on the part of the State. Since the right to health would not be an individual legal right, any of these cases, although susceptible of being initiated individually, would not have the nature of an individual legal complaint.[160] The obligation to fulfil can be impaired for example by steps towards the commercialization of the public healthcare system.[161] In sum, disrespect of the obligation to fulfil consists in failing to protect the public legal nature of social rights.

Only guidelines can be provided in this respect. Rather than *violations*, which appear naturally linked to individual impairments, it is more appropriate to speak of steps in favour of and steps away from or going against the obligation to fulfil. Under solidarity the right to health is not merely an individual entitlement. If it would be, social rights would be nothing but possessions. While the several shortcomings of that view have been discussed in the first half of this chapter, such a view would need no less than to rewrite the socialist and republican history of the social movements that originated social rights, movements which certainly did not conceive of them as private property. Under solidarity, social rights such as the right to health consist in a *logic*. The logic that without understanding rights as charity − the mistake of confusing human rights with entitlements only for the poor[162] − regards certain areas as protected by the community, to the extent of limiting other arrangements such as property or freedom of enterprise.

Finally, sometimes it is said that human rights protection can never be free of charge and only aims towards affordability because even in universal healthcare systems healthcare services need to at some point be purchased. As Atria states, this argument does not focus on the politically relevant sense in which this assertion is made. Indeed, if access to healthcare services is to be considered as 'mana flowing from heavens', yes, access to healthcare services cannot be free-of-charge. But the politically relevant sense of the assertion is different. Insofar as access to healthcare services are not considered a commodity to be distributed according to the unequal

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[160] In this respect, one should be able to distinguish between impairments of the right to health, and unfair treatment by state healthcare-related institutions. These latter issues should be ideally dealt with by special tribunals or courts, see Dwyer (n 23) 7.

[161] Much in line with the Alma Ata Declaration, see WHO, Alma-Ata (n 67).

[162] Octavio Ferraz, 'Poverty and Human Rights' (2008) 28 (3) Oxford Journal of Legal Sciences 585, 599.

logic of the market but based on solidarity, the protection of this human right can indeed be considered free-of-charge.[163]

5. CONCLUSIONS

1. Famously proclaimed by the Human Rights World Conference held in Vienna in 1993, the integration, universality, indivisibility and interrelatedness of all human rights remains an important goal for human rights law.
2. Having conceived social rights under the predominant interpretation of the right to health, ie as legal rights, legal scholars notice the lack of a watertight distinction between civil and political rights and economic, social and cultural rights. Such a conceptual homogeneity leads scholars to regard quantitative increments of jurisprudential developments that affirm the individual nature of social rights positively. The integration project appears to move forward.
3. After the Berlin Wall fell, the Vienna Declaration marked the West's welcoming of social rights to the family of accepted human rights. Not in the same fashion, however. The Limburg Principles issued in 1987 and the Committee's General Comments 3 and 14, issued in 1990 and 2000 respectively, set the main coordinates of this acceptation. As established in chapter three, the Committee's interpretation of this human right did *not* entail to socialize or de-commodify access to healthcare.
4. Instrumental to the pervasiveness of the predominant interpretation have been a set of legal frameworks that establish a divide between human rights law and politics. With its effects of over-restraint and insensitivity, these frameworks limit the development of social rights such as the right to health from threats posed against it in the context of our present political economy.
5. Under the predominant interpretation, the normative framework of the right to health consists in the AAAQ (availability, accessibility, acceptability and quality). This chapter showed how this interpretation fails to single out the commodification of healthcare as a main source of impairments to the economic accessibility of the right to health. Moreover, the AAAQ-framework puts on the same level questions that have a different hierarchical position from the point of view of distributive justice. The chapter showed that the AAAQ is compatible with rules of access differentiated by economic privilege. According to these rules, the wealthy are entitled to access more healthcare services, of better quality and with less waiting time as those without those privileges. This is intrinsically incompatible with the idea of equal access to healthcare for all. As the work of the United Nations Committee on Economic, Social and Cultural Rights fails to pinpoint at the commercialization of

[163] Atria, *Paradigma* (n 49) 193.

healthcare as the main challenge to be tackled, the frameworks set by the predominant interpretation of the right to health are compatible with this outcome.

6. Legal non-discrimination is one of the most important features of human rights law. Extending non-discrimination to the right to health is desirable. Yet, this general principle does not say anything specific about this right's distinctive content. Something similar happens with understanding the right to health as a protection for the vulnerable, or as a minimum right or the rights of minorities. In the first place these elements do not say anything distinctive about the right to health (at least no more than with respect to other human rights). In the second place, such a focus may lead to several counterproductive outcomes. For example, targeting resources on the so-called 'deserving poor' may lead to a regressive 'race to the bottom', where gradually extended degrees of deprivation become pre-requisites to the enjoyment of human rights.
7. As a legal principle non-discrimination appears to be asked more than what it could possibly deliver. Non-discrimination has been driven by the confusion that the principle can deliver equal access to healthcare for all. This idea together with the view that the market *excludes* and that it should therefore *be corrected* are both preposterous. The market does not exclude, it is simply not its purpose to grant the same to everyone. Non-discrimination should not become the exclusive concept informing the right to health. The appropriate inquiry should not renounce to measure equality by looking at how much equality of outcome the provision of healthcare services deliver. Countries where a private healthcare system for the rich lives together with a public healthcare system for the poor suggests nothing only to those that want to find nothing. Following chapter three's analogy with the right to vote,[164] as well as Anne Phillips' observation,[165] the equality of opportunity proclaimed by General Comment 14[166] needs to be reviewed. The meagre equality of outcome generated in societies with commercialized healthcare systems describes the greatest challenge for the human right to health, a challenge on which non-discrimination appears limited to delivering.
8. With respect to *affordability* the chapter showed that this sub-principle reflects the concession involved in the previously analysed frameworks. The thesis' critical account of affordability should not be understood to mean that social rights, as much as any other right, do not cost money. The realization of all rights, including the right to health, cost money in the context of the market economy. What the thesis does is to contest affordability because as an interpretation of the right to health, this notion does not challenge the commercialized provision of healthcare services. Affordability circumvents the fact that what generates healthcare inequalities are the very market principles grounded in this form of distribution. As such, the affordability-based framework does not attempt to challenge, and on the contrary it assumes, that the provision of healthcare services will be normally provided

[164] See ch 3, s 3.3.1.
[165] See ch 1, n 69.
[166] See ch 2, n 104.

within commercial schemes. As at best affordability becomes a mechanism of protection for those in dire straits, affordability plays a role in normalizing the question of access to healthcare as a commodity. Namely, it helps doing precisely what it should be helping to prevent: to deter the main source of inequalities in healthcare. Furthermore, as an interpretation of the literal wording of the Covenant, affordability shifts away from understanding access to healthcare as a universal right that must be equally granted to all. The interpretational innovation of affordability amounts to *correcting* the market so that those incapable of buying healthcare services by themselves can nonetheless obtain some degree of access. While this is attained at different levels, as expressed in the previous conclusion, the transformative goal of equal access to healthcare is replaced with the idea of minimum entitlements for those unattractive to the market. In other words, affordability does not seek the obliteration of unequal treatment. On the contrary, it leads to reinforce and normalize unequal provision of healthcare services by admitting that the privileged can access the healthcare services that they want, while the poor can access only a minimum.

9. The chapter proposes an alternative interpretation of the right to health. Not by using vulnerability as the notion that justifies the duties protecting social rights, but grounded on solidarity, a principle that contemplates vulnerability but which goes beyond, in a more comprehensive and transformative sense.
10. Primarily, the chapter limited the terms in which ideas of economic efficiency could be discussed. Not because these considerations are regarded unimportant. As stated in the introduction of this thesis, one of the study's main motivations lies in the need to efficiently handle scarce public resources. Moreover, the chapter did refer to situations where the public handling of healthcare resources led to more efficient results. Most importantly, the chapter put forward the idea that for a definition of efficiency to be acceptable from the perspective of human rights, the needs that had to be tackled where the ones of a community of equals. Instrumentalizations, especially regarding the poor, could not pass that test.
11. To say that the right to health is grounded in solidarity means that the goal of this right consists in the ever-increasing path towards equal access to healthcare for all. From an access conditioned to social privilege, to an access dependent on citizenship and medical need. The main idea behind solidarity consists not in proclaiming an individual legal right for one or more individuals, but in understanding the right to health as a public good in constant need of promotion through obligations to respect, protect and fulfil. The chapter did not find differences regarding the obligation to respect. As to the obligation to protect, it described it as the discouragement or prohibition of the for-profit provision of healthcare and parallel private healthcare systems based on economic privilege. The obligation to fulfil was described as the establishment of a non-marketed right of access to public healthcare services free-of-charge based on citizenship and medical need. The institution of the national

healthcare system is irreplaceable to the right to health, or at least as replaceable as the judiciary is for the right of access to justice.[167]

[167] UNHRCL, A/HRC/7/11 (n 67) para 12.

CHAPTER FIVE
ADJUDICATION

1. INTRODUCTION

The effort of chapter four consisted both in showing the limitations of the right to health under the predominant interpretation and in offering an alternative understanding grounded in solidarity. That chapter showed that the nominal emphasis embedded in the predominant interpretation of the right to health protected little of the distinctive elements of social rights as they unveil under solidarity. If it is true that solidarity has any connection with social rights, *upgrading* the right to health to the list of recognized human rights might be coming at the cost of transmuting its main features. If that is so, social rights would not be evolving towards universality, integration, interrelatedness, indivisibility and protection on an equal footing with all human rights.

While chapter four provided an alternative explanation of the meaning of the right to health under solidarity, the present chapter explores whether that understanding has been supported at the case law level. The purpose of this inquiry is to find out what courts have mainly been doing in access-to-healthcare cases, what salient case law trends can be detected, and whether any of these protects the right to health in line with the alternative understanding provided in the second half of chapter four.

Two case law trends are dealt with. The first one conceives the right to health as an individual legal right. Namely, it affirms the legitimacy of the judiciary's action to step in and challenge legislative arrangements that limit individual or groups' access to healthcare. In this understanding courts have protected the right to health both directly and indirectly. Concerning the direct protection, my analysis shall focus mostly on the legal connection with the value of human dignity. The study poses two critical questions in this regard. Firstly, does this interpretative effort fit the natural trade-offs the institutions in charge of providing healthcare services regularly confront? As analysed in the previous chapter, these trade-offs involve opposite claims in a context of scarce resources. Secondly, I ask if a legal right to health can ever protect the integrity of the public healthcare system. More specifically I ask whether these

elements remain unavoidably confined to the lower status of aggregated demands, namely, claims that must always bow to the fundamentality of individual interests that coincide with the scope of classical rights.

I also look at indirect efforts of protection, namely, cases where the right to health has been protected via other human rights. Such an indirect understanding is performed on the assumption not only that there is no watertight division between both sets of rights,[1] but also that social rights such as the right to health attain protection.[2] The rights involved in this process include the right to life, but also other rights such as the rights to property, security, physical integrity and privacy, education and information, housing, food and work or the prohibition of cruel, inhuman or degrading treatment.[3] In my analysis I have limited myself mostly to the right to life and the prohibition of inhuman treatment. Due to the assistance the right to health receives from other rights for its protection, I have labelled this trend 'collateral' or 'indirect'.[4]

The main objection I explore with respect to this indirect approach is that although medically speaking it makes sense to relate poor health to the curtailment of life, the extent to which such a link proves a *legal* interrelation is unclear. I begin by asking: when is one right successfully put at the service of another? While a legal interrelation does not require the rights to life and health to be identical, for a *symbiotic* interrelation the distinctive constitutive elements of the right to health would need to become enforced. In other words, I depart from the assumption that for a collateral or indirect approach to be regarded as successful, the *supporting* right (the right to life) must articulate the protection of the *supported* right (the right to health). More specifically, the supporting right needs to actively engage in the protection of the normative content, means of redress and legal scope of the supported right. In this respect, it seems safe arguing that if the main components of the right to health attain legal protection, it matters little whether this happens through a direct adjudication or indirectly, via other human rights. Yet, if only the elements of the supporting right are the ones attaining protection while

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1 This argument has been used by many scholars who, since the *Airey* case (*Airey v Ireland* (1979) Series A no 2 EHRR 305), understand social rights under the predominant interpretation, eg, Maite San Giorgi, *The Human Right to Equal Access to Health Care* (Intersentia 2012) 109 and A E M Leijten, *Core Rights and the Protection of Socio-Economic Interests by the European Court of Human Rights* (Leiden University 2015) 5-6.

2 Eva Brems, 'Indirect Protection of Social Rights by the European Court of Human Rights' in Daphne Barak-Erez and Aeyal Gross (eds), *Exploring Social Rights. Between Theory and Practice* (Hart Publishing 2007) 137.

3 Brigit Toebes, *The Right to Health as a Human Right in International Law* (Intersentia 1999) 260; Stephen Marks, 'The Emergence and Scope of the Human Right to Health' in Jose Zuniga, Stephen Marks, and Lawrence Gostin (eds), *Advancing the Human Right to Health* (OUP 2013) 311-17.

4 A label I borrow from Colin Warbrick, see Colin Warbrick, 'Economic and Social Interests and the European Convention on Human Rights' in Mashood Baderin and Robert McCorquodale (eds), *Economic, Social and Cultural Rights in Action* (OUP 2007) 247.

those of the supported right are not, can we say that we are in front of a *symbiotic* legal interrelation?

I also detect a second trend. Unlike the first one, this path does not justify itself with the rationale of individual legal rights but in an adjudicatory effort that fits the concept of solidarity. Instantiations of this trend are enforced whenever courts *corroborate* legislative formulations that grant access to healthcare, something they can do either by: 1) striking down administrative acts that deprive somebody from enjoying a healthcare provision to which he or she was entitled based on a previous legislative standard, or 2) upholding an administrative act that rejects the enjoyment of a healthcare provision following a legislative standard in force.

As it was noted in the previous chapter, solidarity leads primarily to a legislative understanding of the right to health. As explained, this was not because of a parliamentary infallibility in upholding this notion of social rights. The reason is that in democratic polities the generality of legislation makes Parliaments the most suited institutions to adjudicate the fundamental rules of rights with a democratic pedigree, namely, those that can be characterized by its primordially distributive justice component; those which address not the isolated individual but what everyone in the community owes to everyone else.

Yet, in a development that resembles the prohibition of retrogression,[5] I argue that the *outlawing* of legislative healthcare provisions by the judiciary are also a possibility within this trend: courts can strike down an administrative act or legal statute to respect, protect or fulfil the right to health under solidarity. This happens when the statute challenges the solidarity embedded in the healthcare system. In this case, the court can put back in place a former healthcare provision that better aligns with this criterion. The court uses solidarity as a guideline that operationalizes the progressive realization of the right to health. The judiciary realizes this human right by engaging in the ever-increasing path towards equal access to healthcare for all. Namely, it vetoes attempts of conditioning access to healthcare to economic privilege. Because of social rights' democratic pedigree, the judiciary cannot operate actively but only reactively. It can only review a legislative decision, not generate new policy.

From the outset, it must be said that the outlawing of legislative decisions is not easy to justify. Not only it questions the popular will − thus limiting social rights' democratic pedigree − but it also supposes the accommodation of a distributive justice problem within the confines of the function exercised by the judiciary. The modern understanding of the judicial function is *par excellence* alien to deciding on general or aggregated considerations of distributive justice.[6] Those considerations are located beyond what a legal controversy is supposed to be about, namely, a conflict of interests between two parties that is adjudicated based on a previously

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[5] The prohibition of retrogression is a remedial tool envisioned by General Comment 3 (UNCESCR, 'General Comment 3: The Nature of States Parties' Obligations (Art 2, Para. 1, of the Covenant)', UN Doc E/1991/23, 14 December 1990, para 9). Although there are resemblances with the perspective I suggest here, by the end of the chapter I shall argue why only certain understandings of this notion appear to fit this remedy.

[6] Fernando Atria, *La Forma del Derecho* (Marcial Pons 2016) 150-154.

enacted rule of law. This, not a forum of general discussion, is the setting where the judiciary is generally considered to be functionally apt. This happens even in the cases of countries that bestow their constitutional courts with some form of *a priori* abstract judicial review powers (allowing courts to review the constitutionality of a legal norm without reference to any specific case before the bill has become law).[7] In spite of the progression constitutional law has experimented in the last decades, the judiciary's fundamental function remains corrective, rather than distributive.[8] The generally accepted function of the judiciary can be defined as one that revolves around the particular circumstances of the case, and where any distributive justice considerations are not just uninvolved but expressly excluded. These ideas are in line with the principle of impartiality, a critical notion shaping the nature of the judicial function. According to the International Commission of Jurists, 'an impartial body is one that is capable of making decisions solely on the law and on the facts, without bias for one side or the other'.[9] Although the neutrality of the judge with respect to the parties is accentuated in this definition, the judge must be also impartial with respect to the content of the legal controversy. The judge should only consider the law and the facts framed in the specific case to the exclusion of others. For these reasons, it is difficult to expect the judge to comply with this mandate of impartiality if at the same time, he or she should also pay attention to these distributive considerations. Comparing different standards of healthcare de-commodification *in abstracto* appears unavoidably to lead towards outcomes where political considerations would be given greater weight than legal ones.

However, my criticism of the *new constitutionalism* has not been grounded on their intentions but on how they have tackled the intersection between politics and the law. In order not to be exposed to the accusation of engaging in politics, this legal scholarship has attempted to judicialize the political. The path to do it has been by limiting social rights to equality before the law. This move has excluded solidarity. For this reason, I am interested in exploring whether courts have understood the question posed by the right to health as something beyond whether A has an entitlement to X. If according to solidarity the obligation to fulfilling the right to health consists in protecting a non-marketed right, I ask whether courts regard as problematic that although both A and B live under the same legislative authority, A's right to health can mean something of a substantively greater extension and quality than that of B's.

This question is assessed in the light of the two interpretations I have explored in this thesis: the one of chapter two, where the right to health is an individual legal right, and that of

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7 Michael Gallagher, Michael Laver, Peter Mair, *Representative Government in Modern Europe: Institutions, Parties, and Governments* (McGraw-Hill 2001) 20.

8 Alexander Bickel, *The Least Dangerous Branch: The Supreme Court at the Bar of Politics* (first published 1962, Yale University Press 1986); Kent Roach, 'The Challenges of Crafting Remedies for Violations of Socio-Economic Rights' in Michael Langford (ed), *Social Rights Jurisprudence. Emerging Trends in International and Comparative Law* (CUP 2008) 47.

9 International Commission of Jurists (ICJ), *Courts and the Legal Enforcement of Economic, Social and Cultural Rights: Comparative Experiences of Justiciability* (ICJ 2008) 8.

the second half of chapter four, where the right to health's obligation to fulfil is a collective right of access to a public service. In the case of the present chapter, my purpose is to assess the validity of the hypothesis of the study in a more empirical way, namely, the idea that understanding the right to health from the angle of classic individual human rights may have pernicious consequences for the true nature of this right and the protection it can offer, which is collective. Secondly, and closely related to the first hypothesis, I assess the hypothesis that only certain understandings about the role of courts are representative of the right to health's collective nature. I claim that the individualistic definition of the right to health that so far courts have been fundamentally adjudicating is not representative of this right's distinctive nature. The problem is not that that view would be *per se* wrong. My only claim is that it fails to identify the critical fibre the right to health is really made of.

I begin by making the case for the first trend in the case law which conceives the right to health as an individual legal right. I enrich my analysis by looking back and forth at various salient judicial decisions on access to healthcare. In doing so, my constant focus is on the prospects of this view to enforce the distinctive elements the right to health possesses. I have not sought to develop an exhaustive analysis of access-to-healthcare decisions. I have simply tried to look critically at the main narratives and interpretations of salient decisions that can be found in this field. Further, using the same methodology, I look at the second trend, which may better fit the concept of solidarity.

2. REALIZING THE RIGHT TO HEALTH UNDER THE PREDOMINANT INTERPRETATION

2.1. A DIRECT INDIVIDUAL PROTECTION OR THE HUMAN DIGNITY STANDARD

As a legal standard applied by courts, human dignity is a recurrent interpretative tool used in the context of the right to life and other individual rights. Two examples of the ways this standard has been used in the context of the right to health are provided by the *Meza Garcia* case, before Peru's Constitutional Court, and case *T-737/11* before the Colombian Constitutional Court.

In *Meza García*, the Court conceded the claim of the applicant – a woman who, living in extreme poverty and infected with HIV, claimed that her rights to life and health had been violated. The Court granted an antiretroviral treatment to combat her HIV infection. In short, the Court's reasoning was that not to grant such a treatment would entail a constitutional omission on the part of the State.[10] The State would in this case be obliged to act in defence of the right to

[10] *Azanca Alhelí Meza García*, Exp no 2945-2003-AA/TC, para 39 (Peru's Constitutional Court) (*Meza García*).

health of the applicant, and its inaction would involve an infringement of the applicant's right to life. Given the applicant's conditions of economic deprivation together with the health-related implications of HIV, the Court concluded that the applicant would be impeded from undergoing the illness with dignity.[11] HIV/AIDS severely limits the exercise of autonomy when there is no possibility to access an adequate treatment. As the Court stated in this case, HIV/AIDS has also the potential of affecting the psychology and the social relations of the person. In many cases the person is effectively reduced to the status of a 'social pariah'.[12] The Court's decision rests on the effects of a grave illness that together with the applicant's position of vulnerability makes her situation critical. Hence, the Court established that the applicant deserved 'integral treatment', which required the 'provision of the totality of the medical requirements (examinations, medicines) with the purpose of overcoming the illnesses' consequences'.[13]

Similarly, in the *T-737/11* case,[14] filed before Colombia's Constitutional Court, protection was granted to Mr Luís Fernando Figueroa Ruiz, an indigent 40 year-old-man affected by multiple brain strokes and in chronic need of psychoactive drugs. The Court addressed the conditions of poverty and indigence of the claimant. It stated in this respect that poverty:

> [T]hreatens the effectiveness of fundamental rights. Its structural causes are to be combatted through legislative and macro-economic policies. Its effects, instead, demand a direct immediate State intervention which is grounded on the social nature of the State and the effectiveness of the principles, rights and duties enshrined in the Constitution.[15]

The Court argued that in these cases, when people with disabilities, minors and old people were at stake, medical care could become fundamental in protecting human dignity.[16]

These two cases assessed the vulnerability of the applicants based on their medical and social conditions. They looked at the legal problem from the perspective of how these conditions limited the applicant's personal enjoyment of their fundamental rights, and although a connection with the right to health was made, the tribunals heavily relied on the notion of human dignity as the critical factor triggering legal protection.

In the *T-737/11* case, the Colombian Constitutional Court recognized the effects of poverty. Just like the *Meza García* case, the argument in the *T-737/11* case was that medical treatment for persons that have had brain strokes was crucial to a person's individual integrity. This, according to the Court, resulted in the granting of an integral protection to the affected individual.

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11 ibid para 22.
12 ibid.
13 ibid para 48.
14 *T-737/11 Olivia de Jesús Ruiz de Figueroa* (2011) (Colombia's Constitutional Court) (*T-737/11*).
15 ibid para 2(4).
16 ibid paras 2(1), 2(2).

While admittedly the HIV/AIDS pandemics have been the focus of the right to health and public health in the last two decades, the focus of the abovementioned judgments did not explicitly take those developments as its point of departure. The assessment in these cases was exclusively based on the individual's circumstances. In the *T-737/11* case, poverty is acknowledged, but only to the extent it affects the claimant. After the Court's reflections on poverty and its decision to act upon it, one ends up with the impression that poverty is a somehow unusual phenomenon in Colombia. One ends up wondering whether the same assessment could not have been used to arrive at the exact same conclusion – full integral protection – not just in all cases involving HIV and poverty, but also in a longer list of other grave health threats presently affecting these two countries.[17]

This apparently sudden realization of the gravity of HIV and cerebrovascular diseases is striking. Long before these judgments, countries such as Peru and Colombia had been suffering these and other health threats, including what the WHO calls 'infectious diseases of poverty'.[18] This happens when people live in extreme poverty, a percentage that remains high in both countries.[19] Should it be regarded as a sound reflection on poverty to focus on whether poverty and indigence affect someone's life?

If one takes the reasoning of the Court to the letter, a right-to-life rationale based on human dignity would advise full healthcare coverage to a very long list of treatments to everyone at any event. Framing these social problems from the perspective of individual human dignity

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[17] In the case of Colombia, the top causes of death for both sexes in adults (30-64 years old) for the period 2007-2009 and 1997-1999 were ischemic heart disease and cerebrovascular diseases. In the case of Peru, acute respiratory infections, ischemic heart disease and cerebrovascular diseases occupied the first positions of leading causes of death for the year 2007. WHO and Pan-American Health Organization (PAHO), *Health in the Americas (2009)* (WHO and PAHO 2009) 527, 528.

[18] Both Peru and Colombia have great morbidity on major infectious diseases which include bacterial diarrhoea, malaria, the zika virus and yellow fever. At the same time, both Peru and Colombia's population are also affected by five other diseases which are included in a WHO list of the main neglected tropical diseases worldwide, also called 'infectious diseases of poverty'. These are rabies, schistosomiasis, leishmaniasis, African trypanosomiasis and dengue fever, see WHO, 'Global Report for Research on Infectious Diseases on Poverty' (WHO 2012) 13; Indexmundi, 'Peru Major Infectious Diseases' <www.indexmundi.com/peru/major_infectious_diseases.html> accessed 23 June 2017; Indexmundi, 'Colombia Major Infectious Diseases' <www.indexmundi.com/colombia/major_infectious_diseases.html> accessed 23 June 2017.

[19] According to a study of the World Bank, in 2004 (the year of the analysed judgment was 2003) 'just over half of Peru's population was poor and about 20 per cent were extremely poor'. The same study indicates that 'Peru's poverty levels are below those of Ecuador and Colombia', see World Bank, 'Peru. Opportunities for All: Peru Poverty Assessment' (December 2005) Report No 29825-PE, 1; in 2015 Poverty in Peru reached 21.8% of the population World Bank, 'Poverty Headcount Ratio at National Poverty Lines (% of the Population)' <http://databank.worldbank.org/data/reports.aspx?source=2&type=metadata&series=SI.POV.NAHC#> accessed 23 June 2017.

involves an essentialist *all-or-nothing* approach, namely, that the only way of restoring the threatened dignity consists in granting the claimed protection.[20]

It is certainly disingenuous to expect that an individualized approach will seriously deal with an issue experienced by so many. This would require entirely restructuring the budget priorities of these States. Nothing like that happened after these judgments. Despite some progress, Colombia and Peru, as much as India, still register high levels of poverty. Priorities need to be established not only within health interventions themselves, but also in considering other rights that are highly dependent on the State's social budget. In the *T-165/95* case, the Colombian Constitutional Court granted the claim requested by a girl suffering from leukaemia.[21] Reasoning from the perspective of human dignity, the Court ordered the public system to finance the girl's treatment in a specialised clinic in the United States. Besides funding for the entire medical treatment, the judgment included coverage of the plane ticket to the girl and one of her parents on the grounds of the right to life.[22]

This should not be understood to mean that human dignity is an altogether wrong legal outcome or that it is not linked with these social issues. The question is to what extent the approach of human dignity suits the context of multifaceted and opposed needs that in a context of scarce resources describe the background of social rights such as the right to health. These issues, which have also been referred to as 'polycentric problems',[23] reflect the great dilemma posed by social rights. Namely, that an exclusive focus on (individual) human dignity may protect vulnerable subjects here and there, but may also lead to the denial of the human dignity of many others. While admittedly the courts addressed the principle of solidarity, their way of doing so did not lead to institutions that would systematically protect social rights. The connection was simply that solidarity was a duty towards 'the vulnerable', which should automatically trigger State action as otherwise the State would violate human dignity.[24]

A similar dilemma can be observed in cases that have more explicitly linked individual human dignity with the right to health, considered as an autonomous constitutional right. In this understanding, whenever medical attention is not made available, the right to health is regarded as infringed.[25] This view has gained traction. Regarded as an *absolute* understanding of the right to health, it has been applied in countries like Brazil.[26] Not only have the weakest not benefitted

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20 Octavio Ferraz, 'Harming the Poor Through Social Rights Litigation: Lessons from Brazil', (2011) 89 (7) Texas Law Review 1643, 1659.

21 *T-165/95 Carolina Urina Jassir* (19 April 1995) (Colombia's Constitutional Court).

22 ibid, III(2).

23 See s 3.1.

24 *Meza García* (n 10) paras 16, 24; *T-737/11* (n 14) para 2(3).

25 Ferraz (n 20) 1659-1660.

26 ibid; also referred to as *syllogistic* reasoning, see Mariana Mota Prado, 'The Debatable Role of Courts in Brazil's Health Care System: Does Litigation Harm or Help?' (2013) 41 (1) Journal of Law Medicine and Ethics 124,130.

from that approach,[27] but also the economic sustainability of the healthcare system has been put at risk.[28] Rather than focusing on the universal and egalitarian supply of the provision, the accent is put on the demand, ie the medical treatments of the individuals that succeed in bringing their complaint to court.[29] However, maintaining or extending the life of those who succeed in court does not equate with better access to healthcare. It can in fact entail the opposite. The practical ineffectiveness of these approaches is represented by the failure of the vertical strategies on healthcare that have been especially pursued from the 1990s.[30]

These results not only are inefficient. They also fail to answer what happens with the dignity of those that are hit by structural sources of deprivation, when similar absolute approaches cannot be made universally.

Furthermore, the abovementioned cases show that an excessive focus on the individual could lead to understandings where the right to health leads to medicalised adjudications, likely to damage the integrity and financial sustainability of healthcare systems.

2.2. LEGAL RIGHTS: FALSE FRIENDS?

A common difficulty for Spanish speakers that learn the English language lies in the so-called 'false friends' error, ie, thinking that a similarly written word means the same as in the other language. Often this is the case but, sometimes, it just is not. For example, the English word 'complement' does not only refer to the idea of supplementing something, but it may also mean 'flatter'. By the same token 'realize' may be referring not the idea of fulfilling something but to the idea of becoming aware of something...

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27 ibid; Carlos Portugal Gouvêa, 'Social Rights Against the Poor' (2013) 7 (4) ICL Journal 454; Daniel Liang Wang and Octavio Motta Ferraz, 'Reaching Out to the Needy? Access to Justice and Public Attorneys' Role in Right to Health Litigation in the City of São Paulo' (2013) 18 Sur - International Journal on Human Rights 159; Jacob Mchangama and Christian Bjørnskov, 'Do Social Rights Affect Social Outcomes?' (2013) Aarhus University Economic Working Papers 18/2013, 18 <http://econ.au.dk/fileadmin/site_files/filer_oekonomi/Working_Papers/Economics/2013/wp13_18.pdf> accessed 23 June 2017; Octavio Ferraz and Fabiola Vieira 'Direito à Saúde, Recursos Escassos e Equidade: Os Riscos da Interpretação Judicial Dominante' (2009) 52 (1) DADOS – Revista de Ciências Sociais Rio de Janeiro 223, 225; Ludovic Reveiz and others, 'Litigios por Derecho a la Salud en Tres Países de América Latina: Revisión Sistemática de la Literatura' (2013) 33 (3) Revista Panamericana de Salud Pública 213, 220.

28 ibid Portugal Gouvêa 463; ibid Liang Wang 165.

29 This is irrespective of whether more collective remedies can limit this tendency, an argument put forward by Langford (Michael Langford, 'The Justiciability of Social Rights: From Practice to Theory' in Michael Langford (ed), *Social Rights Jurisprudence: Emerging Trends in International and Comparative Law* (CUP 2008) 37). Yet, if the point is that collective remedies can ameliorate that process, that argument accepts the inherent importance of the generality of the standard.

30 Joseph Stiglitz, *The Price of Inequality* (Penguin Books 2013) 220.

Could it be the case that something regarded so self-evident as the fact that a legal right to health naturally leads to health equity may turn out not to lead to that result in practice? Could the rights discourse be premised on 'false friends' in the sense that far from leading towards health equity, they could actually be helping to advance the market in the healthcare sector? Paradigmatically, an excessive focus on human dignity, rather than protecting everyone's dignity, may also be compatible with the persistence of structural disparities in access to healthcare. While here and there exemplary cases of vulnerability may attain legal protection, the focus on human dignity may also lead to limiting State protection only to these exemplary cases, while structural rules of access remain unequal. While in those particular cases the unequal provision of the market is corrected and the vulnerable receive protection, the market does also become normalized: it is the very lack of market attention which entails the defining mechanism determining when the right to health is called into action.

A case that appears to reflect these kinds of dynamics is *Chaoulli*, a case issued by the Canadian Supreme Court.[31] In *Chaoulli*, a majority established that Quebec laws (section 11 of the Hospital Insurance Act and section 15 of the Health Insurance Act) prohibiting private health insurance for medical services were unconstitutional. The Court judged this prohibition to be in violation of the rights to life and security under section 7 of the Canadian Charter of Rights and Freedoms and section 1 of the Quebec Charter of Human Rights and Freedoms.

The appellants were Mr Chaoulli – a surgeon who complained against the prohibition to provide medical services in the private sector – and Mr Zeliotis, who was affected by long waiting lists while in need of hip surgery. Mr Zeliotis argued that the prohibition infringed Quebeckers' right to life, as some patients died as a result of waiting for treatment in the public system when they could have gained prompt access to care in the private sector.[32] The majority ruled that while the goals of the Quebec laws entailed a substantial objective – preserving the integrity of the public healthcare system by promoting healthcare of the highest possible quality for all Quebeckers regardless of their ability to pay – there was a wider range of measures that were less drastic, and also less intrusive than the absolute prohibition of private insurance.[33] Furthermore, by comparing the healthcare systems of other Canadian provinces and other Organisation for Economic Cooperation and Development countries, the majority concluded that even if the prohibition of insurance contracts was instrumental to preserving the public system's integrity, measures other than the prohibition could have had a similar effect.[34]

Moreover, the majority argued that the two guiding principles for paying deference to the legislature – the measures' consistency with democratic values and necessity to maintain public order and the general well-being of citizens[35] – did not apply in the instant case, as the

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31 *Chaoulli v Quebec (AG)* 2005 SCC 35, [2005] 1 SCR 791 (Supreme Court of Canada) (*Chaoulli)*.
32 ibid Deschamps J, para 37.
33 ibid paras 49, 55, 83.
34 ibid para 74.
35 ibid para 93.

Government could not choose to adopt measures in violation of Quebeckers' right to security.[36] Moreover, the effectiveness of the prohibition in ensuring its goals has not been proven.[37] Lack of timely healthcare, the majority argued, could threaten life and the psychological security of the person and thus engage section 7 on the security of the person.[38]

It is interesting noticing the dissenters' arguments – those of Justices Binnie and LeBel. These judges considered that the purpose of the Canada Health Act and its provincial counterparts consisted in providing healthcare based on need rather than on wealth or status.[39] While not all Canadian provinces prohibited private health insurance, almost all of them took steps to protect the public health system and discourage the private sector either by prohibiting private insurance, by prohibiting doctors who opt out of the public sector from billing their private patients more than in the public sector tariff, or by eliminating any form of cross-subsidy from the public to the private sector.[40] In their view, the difficulties in the implementation of this policy derived from a complex fact-laden policy debate, which did not fit easily within the institutional competence of courts of law.[41] Moreover, they questioned whether the establishment of a single or a two-tier health care system was a matter on which courts of law were called to decide.[42]

The dissenters argued that 'the appellants' case did not rest on constitutional law but on their disagreement with the Quebec government on aspects of its social policy. The proper forum to determine the social policy of Quebec in this matter was the National Assembly'.[43] For the dissenting judges, the equity and fairness of the policy came from the fact that the beneficiaries of the constitutional challenge would be 'Quebeckers who [had] the money to afford private medical insurance and [could] qualify for it,' and not of those Quebeckers 'who [did] not have the money to afford private health insurance, who [could not] qualify for it, or who [were] not employed by establishments that provided it'.[44]

Regarding the arbitrariness that the majority found on the prohibition, the dissenters stated that this argument was based:

> [O]n generalizations about the public system drawn from fragmentary experience, an overly optimistic view of the benefits offered by private health insurance, an oversimplified view of the adverse effects on the public health system of permitting private sector health services to flourish

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36 ibid para 97.
37 ibid para 98.
38 ibid The Chief Justice and Major J, paras 116, 124.
39 ibid Binnie and LeBel JJ, para 164.
40 ibid para 174.
41 ibid para 164.
42 ibid para 161.
43 ibid para 167.
44 ibid para 165.

> and an overly interventionist view of the role the courts should play to supply a "fix" to the failings, real or perceived, of major social programs.[45]

The dissenters also referred to the values behind the Canadian healthcare legislation. Reflecting on the question of who should be allowed to jump the queue, their answer was that:

> [I]n a public system founded on the values of equity, solidarity and collective responsibility, rationing occurs on the basis of clinical need rather than wealth and social status. … Patients who are in greater need of health care are prioritized and treated before those with a lesser need. … There are of course exceptions, and these exceptions are properly the focus of controversy, but in our view they can and should be addressed on a case-by-case basis.[46]

About the evidence by other countries, the dissenters stated that that situation had been already assessed in interim report recommendations – the Kirby and the Romanow Reports – that had suggested sticking with a single-tier system.[47] Among the considerations in these reports, there was an economic one. The Canadian Health Care System is ranked as one of the most efficient in terms of the ratio of productivity to administrative costs in the world.[48]

Reflecting on the decision, Aeyal Gross argues that the *Chaoulli* case shows how 'the idea of access was interpreted in a way that actually reinforces the relationship between wealth and health care, opening the door to a system where the determining factor will not be need but rather the ability to pay for private health insurance'.[49] In this constellation, the case appears as a warning of how 'introducing human rights to the area of public health care may be used not to expand equality, but rather to re-articulate claims to private health care as human rights claims'.[50]

In commenting on the decision, Jeff King stated that:

> [T]he Charter privileged a right to security of the person over the competing interest of providing effective and efficient public health care to those who cannot afford private insurance. The majority found, as have English courts in a similar context, that there is no freestanding right to health care. Thus the richer patient's right to buy private insurance trumps the poorer person's mere policy interest in being provided with high quality medical care. … Had the constitution recognized a right to health care with positive dimensions, the majority would have had to confront rather than ignore this conflict of rights.[51]

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45 ibid para 169.
46 ibid para 223.
47 ibid paras 226, 230.
48 ibid para 252.
49 Aeyal Gross, 'Is There a Human Right to Private Health Care?' (2013) 41 (1) The Journal of Law, Medicine and Ethics 138, 140.
50 ibid 143.
51 Jeff King, 'Constitutional Rights and Social Welfare: A Comment on the Canadian Chaoulli Health Care Decision' (2006) 69 (4) The Modern Law Review 619, 639.

While King's suggestion is worthwhile (a right to health included in the Bill of Rights), the difficult road towards health equity and social justice cannot be fully explained by a simple lack of constitutional eloquence. In my view the real difficulty lies in the conditions under which social rights have been welcomed in our legal culture.

As Fernando Atria notices, Western legal systems are largely based on the Dworkinian distinction between arguments of principle and arguments of politics.[52] Arguments of politics successfully justify any decision as long as they do not clash with arguments of principle. Arguments of principle are those referred to the most fundamental questions of political morality[53] (where one would expect to find basic liberal notions such as civil and political rights). Unlike arguments of principle, arguments of politics are not correct or incorrect. They just need to be adopted in accordance with pre-established procedures such as, for example, the required legislative quorum. Arguments of politics only reflect citizens' opinions. For this reason, they need to be aggregated. Those accumulating a greater number of preferences become adopted on behalf of the community.

The private insurance and private provision prohibitions reflect a way of protecting the healthcare system's integrity as reasoned by the dissenters in *Chaoulli*. Taking Dworkin's view to these issues, they would not be arguments of principle since they do not engage any fundamental question of political morality. Something different happens with the individual rights the majority judges in *Chaoulli* protected. Those rights do entertain fundamental questions of political morality and are therefore not reducible to transaction. So much that is the case that their protection justifies striking down prohibitions that resulted in a healthcare system which, according to specialized medical reports cited in the case, was one of the most efficient in the world.[54]

As Jeff King suggests, I also believe that a great deal of improvement in favour of the right to health can be gained by means of its constitutional inclusion. Yet, I do not think that that is the only or even the major challenge at stake (many countries with non-solidary access to healthcare have those provisions[55]). In my view the challenge is, to put it in Dworkin's terms, whether the right to health – understood not as an individual legal right, but in line with solidarity – could ever become protected on an equal footing together with the select group of the fundamental questions defining 'our' political morality.

So far, the development has not led to a lot. One even wonders to what extent the right to health became palatable in our legal culture *precisely* because of its operationalization as an

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52 Atria (n 6) 304.

53 ibid.

54 n 48.

55 At least 'in 63 countries, the constitution, bill of rights, or other statute recognise the right to health', see Gunilla Backman and others, 'Health Systems and the Right to Health: An Assessment of 194 Countries' (2008) 372 The Lancet 2047, 2075.

individual legal right, namely, due to its inability to distance itself from commercialization and radically transform the question of access to healthcare in a question of medical need. Yet, could the right to health overcome this difficulty, and be envisioned as a non-marketed right, as presented in chapter four?

As I have noted in chapter two, the predominant interpretation of the right to health leads to the protection of a minimum core, the rights of the vulnerable or the guarantee of non-discrimination. Since these three notions are already included in other rights, this perspective says nothing or very little about the right to health's substance. In some cases, it has been made compatible with extending processes of healthcare commercialization. Based on the premise that the right to health is a legal right, the Committee has thought to advance the right to health by extending judicial review. Yet, from this perspective, protecting the right to health has nothing to do with guaranteeing the collective integrity of the public healthcare system. As discussed in chapter four, that notion has no quarrel with healthcare commercialization. Still, it calls the attention to observe how the Committee is willing to guarantee the said notion even if this could come at the cost of commercializing one of the most exemplary healthcare systems in the world. In its Concluding Observations on Canada, the Committee expressed it in this way:

> The Committee recalls that, within the limits of the appropriate exercise of their functions of judicial review, courts should take account of the Covenant rights where this is necessary to ensure that the state party's conduct is consistent with its obligations under the Covenant, in line with the Committee's general comment No. 9 (1998) (see for example *Chaoulli v. Quebec – Attorney General*).[56]

Developments such as the *Chaoulli* case stand as a stark indication of the predominant interpretation's unclear contribution to Public Health and health equity. This should not lead to abandon the cause of the right to health, but to the quest of identifying what means can deliver these goals.

In what comes next I shall address another expression of the predominant interpretation, namely, the collateral trend, or the extension of the positive obligations derived from other human rights with the purpose of protecting the right to health.

2.3. THE RIGHT TO HEALTH AND OTHER HUMAN RIGHTS: A SYMBIOTIC RELATIONSHIP?

Toebes suggests that although medically speaking it makes sense to relate health to life, such a link does not prove the existence of a *legal* interrelation between the right to life and the right to

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[56] UNCESCR, 'Concluding Observations of the Committee on Economic, Social and Cultural Rights, Canada' UN Doc E/C.12/CAN/CO/4-5, 22 May 2006, para 36.

health when considered from the perspective of its distinctive elements.[57] However, also conceiving the right to health as an individual right, protection has been attempted indirectly, especially after landmark decisions adopted by India's Supreme Court in the 1980s.[58]

The existence of different normative goals of the right to life and the right to health respectively do not render the collateral or indirect protection of social rights impossible. On the contrary, attaining the realization of the supported right with a supporting right *supposes* the existence of different normative goals.[59] Hence, the challenge consists in determining whether despite these different normative goals, the right to life can become an appropriate auxiliary mechanism for the protection of the core elements of the right to health.

In the case of the right to life, this right's normative goals involve two dimensions: a negative and a positive one. From a negative point of view the right to life entails that the State refrains from depriving persons of their life arbitrarily.[60] From a positive point of view the right to life entails an obligation for the State to safeguard human life.[61] This latter obligation requires further obligations such as enacting criminal legislation, or the provision of police and prosecutorial mechanisms towards the criminal loss of life.[62] As I analyse further on, it is under this second dimension that a link between the right to life and the right to health has been attempted: the right to health could be protected through positive obligations deriving from the right to life.[63]

The normative goal of the right to health does not consist in the protection of life as such. While the approach of the right to life focuses on human life from a more physical and psychical perspective, the right to health is not to be regarded as an individual right to be healthy.[64] From the perspective of healthcare, the right to health must be made accessible in case of illness.[65] In developing this idea, General Comment 14 states that this duty contains entitlements, including 'the right to a system of health protection which provides equality of

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57 Toebes (n 3) 259.

58 In a case involving torture, the Supreme Court of India regarded the right to health a fundamental right embedded within the right to life, see *Francis Coralie Mullin v The Administrator, Union Territory of Delhi & Ors* [1981] INSC 12, 1981 2 SCR 516 (Supreme Court of India); something similar was held in *Paramanand Katara v Union of India* & *Ors* [1989] INSC 254, (1989) 4 SCC 286 (Supreme Court of India) (*Katara*), a case where emergency medical care was not granted; Langford, *Justiciability* (n 29) 7.

59 Warbrick (n 4) 241-242.

60 In the context of the European Convention on Human Rights, this right is not a guarantee against all threats to life, but against intentional deprivation and careless endangering of life, see Pieter van Dijk and others (eds), *Theory and Practice of the European Convention on Human Rights* (Intersentia 2006) 352.

61 *Osman v UK* [1998] ECHR 101, (1998) 29 EHRR 245, para 116.

62 Rhona Smith, *Textbook on International Human Rights* (OUP 2007) 195.

63 ibid 196.

64 UNCESCR, 'General Comment 14 The Right to the Highest Attainable Standard of Health', UN Doc E/C.12/2004/4, 11 May 2000, para 8.

65 International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966) 993 UNTS 3, art 12 (ICESCR).

opportunity for people to enjoy the highest attainable level of health'.[66] A tentative conclusion is that the right to life is compatible with the right to health when the supporting right leads towards the enforcement of a system of health protection that can provide equality of opportunity.

2.3.1. SIMILARITY OF MEANS OF REDRESS

When looking at the means of redress of the right to life and the right to health, an important overlap can be noted: the provision of healthcare. Healthcare is not the only output of the right to health (action on the social determinants of health is another important one[67]). Yet, despite the necessary prioritizations, trade-offs and sacrifices required by the very nature of the provision of social rights, the right to health cannot be theorized without contemplating access to healthcare.[68]

If lack of access to healthcare could affect the right to life, could not the violation of this right be put at the service of the right to health?

Courts have done this in several situations. They have reasoned that someone's life could be lost, threatened or severely undermined because of lacking access to healthcare. Situations that fit into this hypothesis include: emergency care,[69] protection of life while in medical care facilities,[70] right to a lifesaving drug,[71] the avoidance of inhuman or degrading

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66 UNCESCR, General Comment 14 (n 64), para 8.

67 ibid paras 9-11; UNCHR, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Paul Hunt', UN Doc E/CN.4/2006/48, 3 March 2006, paras 9, 10.

68 ICESCR (n 65) art 12; UNCESCR, General Comment 14 (n 64) para 8; UNCHR, E/CN.4/2006/48 (n 67) para 4; Toebes locates healthcare at the core of the right to health, see Toebes (n 3) 284.

69 *Katara* (n 58).

70 The European Court of Human Rights found in a case of medical negligence leading to the death of a new-born baby after delivery complications the right to life 'enjoins the State not only to refrain from the "intentional" taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction'. It noted that 'those principles apply in the public-health sphere too. The aforementioned positive obligations ... require States to make regulations compelling hospitals, whether public or private, to adopt appropriate measures for the protection of their patients' lives', see *Calvelli and Ciglio v Italy* [2002] ECHR 3, paras 48, 49; in another case concerning an individual suffering from schizophrenia who was admitted to a state medical facility reporting symptoms of great distress that later made him jump from a sixth-floor window, the Court established that 'an operational duty arose to take reasonable steps to protect him from a real and immediate risk of suicide and that that duty was not fulfilled', see *Reynolds v The United Kingdom* [2012] ECHR 437, (2012) 55 EHRR 35, para 61.

71 Commenting on the *Nitecki v Poland* case (*Nitecki v Poland* App no 65653/01 (ECtHR, 21 March 2002) (*Nitecki*) before the European Court of Human Rights (ECtHR), San Giorgi argues that irrespective of the fact that the complaint was ultimately dismissed, the right to a life-saving drug might be protected under Article 2, see San Giorgi (n 1) 103-104.

treatment[72] or healthcare provided to persons deprived of liberty.[73] Cases such as abortion, gender-reassignment, infrequent availability of medical care, destruction of necessary asthma medication, denial of authorization to receive a doctor in a prisoner's cell, and denial of authorization for examination in the hospital have been also mentioned.[74] In these cases courts have protected the individual's life by making healthcare accessible. At the outset, it would look as if the right to health, supported by the right to life, would acquire legal protection.

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[72] In *D v the United Kingdom* (*D v the United Kingdom* [1997] ECHR 25, (1997) 24 EHRR 423), the ECtHR ruled that expelling a person who suffered of an advanced stage of AIDS from the United Kingdom to St. Kitts (where the applicant was a national), after having served in prison for a criminal offence would entail a violation of Article 3 (inhuman treatment). San Giorgi comments that the ECtHR arrived at this decision setting a criteria whereupon it considers a) the severity of the individual's health condition, b) whether the treatment was available in the host country, and c) whether the applicant had children, family or other relatives to take care of him, see n 1, 105; in a case involving a four-limb-deficient thalidomide victim with numerous health problems including defective kidneys, the ECtHR considered that 'to detain a severely disabled person in conditions where she is dangerously cold, risks developing sores because her bed is too hard or unreachable, and is unable to go to the toilet or keep clean without the greatest of difficulty, constitutes degrading treatment contrary to Article 3 of the Convention', see *Price v The United Kingdom* [2001] ECHR 458, (2002) 34 EHRR 53, para 30.

[73] The *Velikova* case involved a person who died after have been apprehended by the police. Not accepting the Government's explanation that the individual died because of injuries after having fallen, the ECtHR held that 'Mr. Tsonchev died as a result of injuries inflicted while he was in the hands of the police'. Considering that no evidence was produced that the person was medically examined of his severe injuries while in custody led the ECtHR to regard the situation as a violation of Article 2 (right to life). *Velikova v Bulgaria* [2000] ECHR 198, paras 74-76; in another case, the ECtHR established that police officers' awareness of the deterioration of the conditions of a detainee and failure to promptly contact medical care constituted a violation of Article 2, see *Anguelova v Bulgaria* [2002] ECHR 489, (2004) 38 EHRR 31, paras 125-131; in another case, concerning a prison inmate suffering from a chronic mental disorder which involved psychotic episodes and feelings of paranoia, the ECtHR established that 'the lack of effective monitoring of Mark Keenan's condition and the lack of informed psychiatric input into his assessment and treatment disclose significant defects in the medical care provided to a mentally ill person known to be a suicide risk'. The ECtHR regarded that the application of a disciplinary punishment in those circumstances amounted to a violation of Article 3 of the Convention, see *Keenan v The United Kingdom* [2001] ECHR 242, (2001) 33 EHRR 38, para 116; under the framework of the International Covenant on Civil and Political Rights, the UNHRC found a violation of Article 6(1) and of Article 10(1). The case involved the detention of Mr Vladimir Lantsov in a Russian prison. The health condition of the detainee rapidly deteriorated due to the overcrowding of the prison and the lack of adequate medical care. The Committee stated that that it was 'up to the State party [to organize] its detention facilities to know about the state of health of the detainees as far as may be reasonably expected. Lack of financial means cannot reduce this responsibility. The Committee considers that a properly functioning medical service within the detention centre could and should have known about the dangerous change in the state of health of Mr. Lantsov. It considers that the State party failed to take appropriate measures to protect Mr. Lantsov's life during the period he spent in the detention centre'. *Yekaterina Pavlovna Lantsova on behalf of her son, Vladimir Albertovich Lantsov (deceased) v The Russian Federation* (15 April 2002) UN Doc CCPR/C/74/D/763/1997, para 9(2).

[74] Warbrick (n 4) 251; San Giorgi (n 1) 99-100.

Yet, should it be assumed that whenever healthcare is the legal output, the distinctive constitutive components of the right to health are being enforced? In other words, is the provision of healthcare a definitive indication that the right to health is being advanced? To some readers this may sound irrelevant − what is the need of demarcating theoretical distinctions when the purpose of healthcare will always be the same? While admittedly healthcare fulfils the same function under any theorization − preventing, curing or rehabilitating − the idea that the abovementioned cases would be advancing the right to health would need to be affirmed with the objective established in our preliminary conclusion, ie, that a system of health protection based on equality of opportunity is being advanced.[75]

As discussed in the first half of chapter four, the predominant interpretation of the right to health translates in healthcare provision to the unattractive segments of the market.[76] Cases such as the prison inmate can fit into this narrative because the role of the State is to act in cases of extreme vulnerability. In this way, the presence of medical equipment together with a precarious position in society could trigger the action of the right to health. As discussed in the second half of chapter four, this comes at the cost of admitting that the market plays a fundamental role in the right to health not only as the normal form of provision but as the determinant of State intervention.[77]

2.3.2. The positive obligations avenue: the Paraguayan cases of the Inter-American Court of Human Rights

The collateral strategy has to a large extent relied on the idea of positive obligations deriving from a number of individual rights such as the right to life. Two cases dealt with by the Inter-American Court of Human Rights illustrate this approach: the *Yakye-Axa indigenous community v Paraguay* case[78] and the *Sawhoyamaxa indigenous community v Paraguay* case.[79]

In these cases, the Court dealt with the situation of two indigenous communities living under extremely poor conditions. The two cases were rather similar. The members of the communities not only lacked access to health, education, and water but their situation was also aggravated by their exposition to the natural elements and the geographical and economic obstacles hindering their access to medical health. The Court also found that the communities' right to property over their ancestral lands had been violated, as the State had not formally acknowledged that ownership. This increased the deprivation of the communities as they were impeded from fishing and hunting. Their level of destitution was such that in both cases some

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75 ch 2, n 104.
76 ch 4, s 3.2.3.
77 ch 4, s 3.4.
78 *Case of the Yakye-Axa Indigenous Community v Paraguay* (Merits, Reparations and Costs) Inter-American Court of Human Rights, 17 June 2005.
79 *Case of the Sawhoyamaxa Indigenous Community v Paraguay* (Merits, Reparations and Costs) Inter-American Court of Human Rights, 29 March 2006.

members of the community died. This led the Court to the finding that Paraguay had violated the right to life of the inhabitants of the communities[80] and in some cases had even been directly responsible for individual deaths.[81]

In what comes next, I address a few challenges to the collateral strategy when trying to protect the right to health using positive obligations deriving from the right to life.

2.3.2.1. Limitations *rationae materiae* when addressing social rights

In *Sawhoyamaxa*, the privations were to do with extremely bad living conditions (lack of access to healthcare, water, sanitary installations and food). The Court began by recognizing that the State was faced with different operative choices, multiple priorities and limited resources to carry out its duties.[82] Although not expressly admitted, those circumstances perfectly fit what has been usually considered the background of social rights, where multiple needs meet limited resources.[83] Although the Court cited the right to health and other social rights,[84] its reference to them seems only metaphorical, as the Court did not invoke social rights as the legal argument triggering its decision. As a matter of fact, the Court could not have done that: Oswaldo Ruiz-Chiriboga comments that except for the right to unionization and the right to education, social and economic rights like the right to health or the right to food do not have direct applicability under the Inter-American System.[85]

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[80] In *Sawhoyamaxa*, the Court delimited the scope of the State's positive obligations. 'It is clear for the Court that a State cannot be responsible for all situations in which the right to life is at risk. Taking into account the difficulties involved in the planning and adoption of public policies and the operative choices that have to be made in view of the priorities and the resources available, the positive obligations of the State must be interpreted so that an impossible or disproportionate burden is not imposed upon the authorities. In order for this positive obligation to arise, it must be determined that at the moment of the occurrence of the events, the authorities knew or should have known about the existence of a situation posing an immediate and certain risk to the life of an individual or of a group of individuals, and that the necessary measures were not adopted within the scope of their authority which could be reasonably expected to prevent or avoid such risk.' ibid para 155; in *Yakye-Axa*, the Court relied on human dignity, see *Yakye-Axa* (n 78) paras 162, 168.

[81] While this was not accepted in the *Yakye-Axa* case (*Yakye-Axa* (n 78) paras 177, 178), it was accepted in the *Sawhoyamaxa* case (*Sawhoyamaxa* (n 79) paras 176, 178).

[82] *Sawhoyamaxa* (n 79) para 155.

[83] eg, *Nitecki* (n 71) 5.

[84] eg, *Sawhoyamaxa* (n 79) para 163.

[85] Oswaldo-Rafael 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 (2) Netherlands Quarterly of Human Rights 159; Francesco Seatzu and Amaya Ubeda de Torres, 'The Social Charter of the OAS: a Step Forward in the Enforcement of Socio-Economic Rights in the Americas' (2014) 32 (2) Netherlands Quarterly of Human Rights 130, 146; the abovementioned rights are enshrined in the Additional Protocol to the American Convention on Human Rights in the area of Economic, Social and Cultural Rights (Protocol of San Salvador) (entered into force 16 November 1999) OAS Treaty Series No 69 (1988) reprinted in Basic Documents Pertaining to Human Rights in the Inter-American System OEA/Ser L V/II.82 Doc 6 Rev 1 at 67 (1992), art 10.

Admittedly, the Court's judgment contributed to make significantly visible an otherwise much less noticeable everyday social tragedy. In the narrow contours of legal systems such as the Inter-American one − where civil and political rights are both formally and substantively prioritized over economic, social and cultural rights − this was possibly the only available legal avenue for the Court to address the situation of these extremely deprived communities. Yet, if I cast criticism on the indirect trend, it is not only on the grounds of theoretical coherence only, but based on the exploration this thesis proposes: the hypothesis that solidarity involves a theoretically sounder understanding of social rights *and*, more just and efficient practical results.

2.3.2.2. Conceptualization challenges

The Court's understanding of the positive obligations derived from the right to life is quite close to the area covered by the right to health. As stated already, for the collateral focus to be justified, both rights must be conceptualized as something different from one another. Yet, looking at the abovementioned Paraguayan cases dealt with by the Inter-American Court of Human Rights, it is difficult to see a marked conceptual contrast. The Court established a close link between the two rights, where the right to health appeared as some sort of indissoluble sub-element of the right to life. Citing its jurisprudence, the Court affirmed that:

> [T]he right to life is crucial in the American Convention, for which reason realization of the other rights depends on protection of this one. When the right to life is not respected, all the other rights disappear, because the person entitled to them ceases to exist. Due to the basic nature of this right, approaches that restrict the right to life are not admissible.[86]

The Court also opened room to the establishment of positive obligations emanating from the right to life:

> Essentially, this right includes not only the right of every human being not to be arbitrarily deprived of his life, but also the right that conditions that impede or obstruct access to a decent existence should not be generated.[87]

Similarly, special account of the vulnerability of indigenous communities was considered by adding that these groups' care 'becomes a high priority'.[88] The interaction between the right to life and the right to health was one where the latter right was made a pre-requisite of the earlier. However, the Court did not distinguish the ways the violations of these two different rights would take place. The Court limited itself to state that 'special detriment to the right to health, and

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86 *Yakye-Axa* (n 78) para 161.
87 ibid.
88 ibid para 162.

closely tied to this, detriment to the right to food and access to clean water, have a major impact on the right to a decent existence'.[89]

2.3.2.3. Reparations

As reparation, the Court granted a community development fund and program consisting in the supply of drinking water and sanitary infrastructure, and, a community development program consisting in the implementation of education, housing, agricultural and health programs for the benefit of the members of the community.[90]

Looking at the nature of these reparations, they do not differ substantively from social policy measures. From the perspective of equality before the law it is criticisable that public policy measures are adopted on an *ad-hoc* basis while other groups of persons may be suffering the consequences of structurally similar problems[91] (which is different from stating that all the population should be the subject of identical social policies[92]). If the causes of the problem are routed in structural social conditions such as poverty and marginalization, one can legitimately ask whether the dramatic reality of these indigenous communities is not being equally experienced by other indigenous communities, but also perhaps by other groups or persons submitted to equally stringent forms of social vulnerability, discrimination and stigmatization. How sound is a legal theory seeking to set things right for one of many groups experiencing the same problem?

Yet, the fact that the nature of the reparations does not differ from social benefits is not in itself a reason to dismiss the applicability of positive obligations deriving from the right to life. The applicability of positive obligations seems clearly justified in the example of the healthcare afforded to prison inmates or other cases where the State's action or inaction leads to the immediate obliteration of the right.[93] Due to the intense proximity of the State in those cases it was clear that the life of the prisoner depended solely on the actions and omissions of the State. Arguably, the greater the relation of dependency between the State and the concerned individual

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89 ibid para 167.

90 ibid paras 205, 221.

91 In the 2016 Human Development Report, Paraguay ranks 110 within medium human development countries, one slot above Egypt and one slot below Gabon. In Latin-American and the Caribbean region, El Salvador (117), Bolivia (118), Nicaragua (124), Guatemala (125), Guyana (127), Honduras (130) and Haiti (163) rank lower than Paraguay, see UNDP, *Human Development Report 2016: Human Development for Everyone* (UNDP 2016); at the same time, a report that took account of an important segment of 'chronic' poverty in Paraguay, regarded ethnicity as a factor connected to this form of poverty, see Renos Vakis, Jamele Rigolini and Leonardo Lucchetti, *Left Behind: Chronic Poverty in Latin American and the Caribbean* (World Bank 2016) 72.

92 In this respect, Canada for example addresses the specific needs of indigenous populations in a more comprehensive approach that involves community participation, see Public Health Agency of Canada, *Toward Health Equity: Canadian Approaches to the Health Sector Role* (Public Health Agency of Canada 2014) 15, 19.

93 See s 2.3.1.

or individuals, the greater the scope for positive obligations derived from the right to life.[94] This is because certain acts or omissions of the State can lead to a deprivation of life or to a situation where the applicant lives in inhuman conditions. This means that to determine the correct applicability of these positive obligations, the causal link between the action or inaction of the State and the violation must be particularly intense. Unless the case for positive obligations emanated from the right to life is made under exceptionally restricted circumstances, that legal doctrine runs the risk of depleting the sphere of involvement of the related social rights.[95] The difficulty seems to lie in establishing the demarcating line between positive obligations deriving from individual rights and social rights.

One possible point of orientation is that whenever the reparations suitable to the damage are not different from the obligation of fulfilling social rights, there is a strong indication that individual rights may be ill suited for dealing with those challenges.

3. ADJUDICATING THE RIGHT TO HEALTH ALONG WITH SOLIDARITY

The previous section assessed the prospects of attaining the goals of the right to health through individual rights either directly or through a collateral focus. In this section, I refer to the prospects of protecting the right to health by directly enforcing this rights' constitutive components as defined in the second half of chapter four. I begin by describing the conundrum social rights entail, the otherwise polycentric challenge affecting modern courts of law. As I further explain below, these are situations where any solution to a legal case would have consequences affecting the enjoyment of a plurality of goods and of a plurality of people in legally relevant ways.

My view is that unless one begins from a substantive definition of what social rights are, quantitative approaches (amount of decisions in the field of social rights) do not necessarily indicate whether these rights are being advanced. Langford, in his attempt to extend to social

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[94] This is to the extent of reversing the burden of proof in detention cases where death or injury occurs. For example, in the *Salman* case, the ECtHR established that 'where the events in issue lie wholly, or in large part, within the exclusive knowledge of the authorities, as in the case of persons within their control in custody, strong presumptions of fact will arise in respect of injuries and death occurring during such detention. Indeed, the burden of proof may be regarded as resting on the authorities to provide a satisfactory and convincing explanation'. *Salman v Turkey* [2000] ECHR 357, (2002) 34 EHRR 17, para 100; see also Alexandra Timmer, 'A Quiet Revolution: Vulnerability in the European Court of Human Rights' in Martha Fineman and Anna Grear (eds), *Vulnerability: Reflections on a New Ethical Foundation for Law and Politics* (Ashgate 2013) 154.

[95] Timmer, (n 94) ibid.

rights' individual justiciability,[96] is critical of President Nixon's administration due to the lack of judicial decisions on social rights. While there may be many reasons to be critical of that administration,[97] I am not convinced social rights is one of them.[98] Apparently, for Langford it is irrelevant that from the point of view of social rights from 1945 to 1985, the United States enjoyed the lowest levels of income inequality of its entire history.[99] Without any interest in the reasons of why that can be, and contrarily, based purely on jurisprudential developments, Langford deems the situation in Germany after 1972 as 'slightly more successful' for social rights.[100] He thinks that since the United States, France and Ireland 'have frequently been hostile to social rights', these jurisdictions cannot be labelled as 'predominantly "progressive"'.[101]

Langford's account, which avoids a substantive definition of social rights, appears close to a nominal understanding of social rights; a view disconnected from critical issues of social class and redistribution. Similarly, these accounts have blurred the definition of what it is to be progressive in the protection of social rights. No wonder that today, as Colin Crouch has argued, it is the far right and its nationalism that is successfully capturing the redistributive emancipatory horizons that human rights appear to be abandoning.[102] As set out in the Introduction and the second half of chapter four of this thesis, the right to health should not give up its concern for social justice from an economic perspective. While it should respect social rights' democratic pedigree, it should also strive to bring it forward at the legal level.

3.1. THE POLYCENTRIC CHALLENGE

Courts are in an uneasy relation with social rights. The obstacles should not be understood as a problem of mentality, in which courts would be ideologically reluctant to protect the content of social rights. That may certainly be the case with respect to many judges, but that is not a problem that I am interested in tackling. What I care is to address the institutional obstacles the collective nature of social rights pose for courts.

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96 Langford (n 29) 30-31, 43.

97 See ch 3, n 77.

98 The fact that under Nixon, a basic income plan was very closed from becoming law is not given any relevance, see Rutger Bregman, 'Nixon's Basic Income Plan: Why Richard Nixon Once Advocated for Basic Income – and Then Turned Against it', (5 May 2016 Jacobin) <www.jacobinmag.com/2016/05/richard-nixon-ubi-basic-income-welfare/> accessed 23 June 2017.

99 Thomas Piketty, *Capital in the Twenty-First Century* (HUP 2014) 24.

100 Langford (n 29) 6.

101 ibid 4.

102 Colin Crouch, 'The Familiar Axes of Politics Are Changing, With Momentous Consequences' (Open Democracy, 23 September 2016) <www.opendemocracy.net/uk/colin-crouch/familiar-axes-of-politics-are-changing-with-momentous-consequences> accessed 23 June 2017.

The modern understanding of the judiciary required the overcoming of the old legal notion of justice consisting in rendering to everyone his due (*suum ius cuique tribuere*).[103] It is hard to ask to a judge to on the one hand apply the law if on the other hand he or she is requested to pay attention to distributive justice considerations. To some, the idea of solidarity may entail exactly that – a political claim incapable of being translated into a legally operational language.

To make matters even more difficult, letting courts decide on healthcare priorities is an effort that the scholar Lon Fuller would have been likely to regard as an example of an allocation problem for which adjudication would be 'utterly unsuited'.[104] Fuller's statement had to do with the dimension inherent to cases that could be described as 'many centred'.[105] Jeff King, interpreting Fuller, states that 'a polycentric problem is one that comprises a large and complicated web of interdependent relationships, such that a change to one factor produces an incalculable series of changes to other factors'.[106]

Polycentric challenges seem particularly manifest in the adjudication of social rights. Here, any decision on right-to-health enfranchisements is likely to have repercussions on the extension of other enfranchisements linked to this right (not to mention other human rights). The problem seems to be related with the kind of 'demands'[107] these rights involve. In the context of social rights these demands are unlikely to satisfy the 'essential conditions' in which adjudication can be delivered. It is for example arguable whether judges, acting within the limited legal contours of their function, could ever overcome this difficulty, ie, to grant an entitlement that would not come at the expense of another entitlement. This is different from saying that social rights are too complex to be suited for judicial oversight. That would not be a good enough reason to renounce to judicial monitoring.[108] The point is not made on grounds of technical complexity but on whether a court, due to its institutional design, can even perceive the problems its decisions may generate. Arguably, the polycentric dimension can be present at several adjudicatory levels. Yet, Fuller's point did not consist in 'distinguishing black from white, [but it was] a question of knowing when the polycentric elements ... become so significant and predominant that the proper limits of adjudication have been reached.[109]

As I show further on when looking at the *Soobramoney* case,[110] judges have reflected on this problem and have sometimes preferred to defer the decision to legislatures. The underlying reasoning carries weight. It is not that legislators would be better suited to eradicate

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[103] Fernando Atria, 'Réplica: Derecho y Política a Propósito de los Derechos Sociales' (2004) 4 Discusiones: Derechos Sociales 145, 169.

[104] Lon Fuller, 'The Form and Limits of Adjudication' (1978) 92 Harvard Law Review 353, 401.

[105] ibid 395.

[106] Jeff King, 'The Pervasiveness of Polycentricity' (2008) Public Law 101, 101-102.

[107] Fuller (n 104) 363.

[108] ICJ (n 9) 90.

[109] Fuller (n 104) 398.

[110] *Soobramoney v Minister of Health, KwaZulu-Natal* [1997] ZACC 17, (1997) (12) BCLR 1696 (South Africa's Constitutional Court) (*Soobramoney*). Also see *Nitecki* (n 71).

the polycentric dilemma. On the contrary: it is the very fact that the problem cannot be eradicated which makes the political arena fit to the challenge. If the enforcement of an entitlement comes at the expense of sacrificing another one, leaving the decision in the hands of legislators provides at least political accountability.

In the coming subsections, I look at some jurisprudential developments on this matter. By the end, I show some instantiations where the judiciary has taken the challenge of contrasting the different criteria created by legislatures in a way that I regard consistent with the right to health informed by solidarity.

3.2. SOUTH AFRICA

3.2.1. THE *SOOBRAMONEY* CASE

In this important case, the South African Constitutional Court got closer to adopting the methodological approach of social rights, namely, a collective or at least a non-individual understanding of these rights.

The applicant, Mr Thiagraj Soobramoney, was a man suffering from a chronic renal disease. Prolonging his life depended on the application of regular renal dialysis treatment. Although the applicant had begun treatment at a private medical facility, he was not able to continue affording it. He then requested medical attention at the Addington State hospital in Durban. The applicant was refused treatment because, according to the hospital's guidelines, patients like the applicant, who suffered from chronic irreversible renal failure, or who were not eligible for a kidney transplant, were not automatically admitted to the renal program. The guidelines favoured cases where there was a possibility of total recovery, and not just a prolonging of the patient's life. The guidelines responded to the interests of a vast amount of people in search for these treatments in healthcare services where few dialysis machines were available, while at the same time they were severely understaffed and underfinanced in terms of human and economic resources. The High Court of Kwazulu-Natal rejected the applicant's claim. The applicant thus sought appeal to the Constitutional Court based on section 27(3) of the Constitution, 'No one may be refused emergency medical treatment'. And section 11, which stipulates 'Everyone has the right to life'. The Court decided to uphold the High Court's decision.

As its analysis was always holistic, the Court took note of the non-individual nature of social rights. Unlike the Paraguayan cases, in *Soobramoney*, the Court never reduced the right to health to an individual or group problem. At the same time, the Court addressed the polycentric dilemma involved in the case: the hospital guidelines – from which the solidarity, integrity and financial sustainability of the healthcare system depended – were upheld. In these regards, the decision appears as a clear expression of social rights adjudication in the terms set in the second half of chapter four.

The story changes in relation to the way the Court interpreted the positive obligations deriving from the right to health. The judgment did not address the extension of the South African healthcare system, its equity, specific treatment of marginalized populations, nor made any contrast between the private and the public sector. The Court delimits the problem to the availability of dialysis treatment within the public healthcare sector. The judgment does not tackle the coexistence of different parallel regimes of access to healthcare within South Africa. It also does not consider that what makes that parallelism possible was South African legislation. In that respect, access to healthcare was determined not by citizenship or medical need (prioritized, for example, based on quality-adjusted life years (QALYs)[111]), but merely on economic privilege – those with the ability to pay go to the private sector where they can purchase the services that they need. For the upper classes of South Africa who, thanks to South African legislation, are able to access a private healthcare system responsive to their specific healthcare needs, the idea of scarcity in healthcare was unknown. From the reading of *Soobramoney* one ends up with the impression that the jurisdiction of the Constitutional Court of South Africa to define what the right to health was about is limited not to 'all renal clinics throughout the land',[112] but only to those within the public healthcare sector.

Why was it not legally relevant that while Mr Soobramoney was not getting treatment due to understandable material constraints, other South Africans were obtaining exactly those treatments because of their economic privilege? Could not the Court, in line with solidarity, replace the legislation that granted commercialized healthcare by a more universal provision? This is particularly interesting considering that the Constitutional Court could have contrasted the healthcare system with universal and free-access schemes in place for the white population during the times of the apartheid regime in the ambit of tertiary services and academic medicine.[113] The Court did not do any of this and it simply limited itself to be deferent to Parliament.

Further, in its *TAC* judgment, the South African Constitutional Court adopted a standard that sought to justify when to step in and involve itself in these challenges. The *TAC* case draws upon the precedent set by the *Grootboom* decision.[114] Although *Grootboom* refers to a different fundamental right − the right to housing − *TAC* reproduces the same logic and the same legal standard (reasonability). For this reason, before dealing with the *TAC* case, I address first the *Grootboom* decision.

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[111] WHO, *Making Fair Choices in the Path to Universal Health Coverage: Final Report of the WHO Consultative Group on Equity and Universal Health Coverage* (WHO 2014) 13.

[112] *Soobramoney* (n 110) Chaskalson P, para 24.

[113] Solomon Benatar, 'Health Care Reform in the New South Africa' (1997) 336 (12) The New England Journal of Medicine 891.

[114] *South Africa v Grootboom* [2000] ZACC 14, 2001 (1) SA 46 (CC) (South Africa's Constitutional Court) (*Grootboom)*.

3.2.2. THE *GROOTBOOM* CASE

In this case, South Africa's Constitutional Court kept its non-individualistic assessment concerning social rights. The case referred to the situation of Mrs Irene Grootboom, a person who lived with a group of people in a squatter settlement in extremely precarious conditions. The settlers experienced permanent flooding during the winter rains, severe overcrowding and perilous proximity to busy roads. After being effectively evicted and their few possessions destroyed, the settlers sheltered themselves on the Wallacedene sports field. Mrs Grootboom filed an urgent application to the High Court. She claimed adequate basic temporary shelter or housing for the settlers and their children, pending their obtaining permanent accommodation. She also claimed basic nutrition, healthcare and social services to the respondents who were children.

The claim was based on two constitutional provisions – section 26[115] and section 28(1)(c)[116] of the Constitution.[117] Going beyond the classic individual human dignity approach – whether individuals' needs were met – the Court referred to the way the challenged norms excluded the affected group. The issue to be decided, according to the Court, was 'whether the nationwide housing program [was] sufficiently flexible to respond to those in desperate need in our society and to cater appropriately for immediate and short-term requirements.'[118] In other words, whether the absence of a component of the programme catering for those in desperate need could be regarded as 'reasonable'.[119] The Court concluded that budgetary support by the national government had to be capable to 'meet immediate needs'.[120] And also that '[those in desperate need] are not to be ignored in the interests of an overall program focused on medium and long-term objectives'.[121]

Nonetheless, the Court did admit that the situation of the applicants was 'no worse than that of thousands of other people, including young children, who remained at Wallacedene'.[122] The Court ordered 'to provide relief for people who have no access to land, no roof over their heads, and who are living in intolerable conditions or crisis situations'.[123]

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115 'Section 26 Housing (1) Everyone has the right to have access to adequate housing. (2) The State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right. (3) No one may be evicted from their home, or have their home demolished, without an order of court made after considering all the relevant circumstances. No legislation may permit arbitrary evictions.'

116 'Section 28 Children. Every child has the right - … (c) to basic nutrition, shelter, basic health care services and social services.'

117 *Grootboom* (n 114) Yacoob J, para 13.

118 ibid para 56.

119 ibid para 63.

120 ibid para 68.

121 ibid para 66.

122 ibid para 81.

123 ibid para 99(2)(b).

The standard inaugurated by the Court deserves some specific reflection.

3.2.3. THE REASONABILITY STANDARD

South Africa's Constitutional Court's rejection of the doctrine of the minimum core as promoted by the Committee appears more realistic. As material conditions for the realization of social rights may not exist, a minimum core of these social rights is not assumed.[124] Yet, the reasonability standard which was further developed in *Grootboom* is not exempt from challenges. What is really assessed when a court formulates a reasonability question? According to Avila, reasonableness can be understood in relation to three notions: fairness, congruence and equivalence. In connection with fairness, Avila states that from Aristotle, fairness is 'a remedy for the law when and where it is deficient for being general'.[125] In this respect, reasonability entails 'a tool to determine the factual circumstances that ought to be assumed as within normalcy'.[126] Linked to congruence, reasonableness requires a correlation between 'criterion and measure'.[127] Finally, reasonableness as equivalence, aims to a certain degree of 'proportionality' between the norm and its legal consequences.[128]

Avila also emphasizes the importance of proportionality, which is a criterion different from reasonableness. Proportionality requires:

> '[T]hat the Legislative and the Executive choose appropriate, necessary and proportional means in order to achieve their purposes. A means is appropriate if it promotes the purpose. It is necessary if, among all other equally appropriate means to promote the purpose it is the least restrictive regarding fundamental rights. And it is proportional, in a narrow sense, if the advantages it promotes are superior to the disadvantages it causes. The application of proportionality requires the relation of causation between means and purpose so that the adoption of the means promotes the purpose'.[129]

Thus, in a narrow sense the test of proportionality 'requires the comparison between the importance of realizing the end and the degree of restriction of the fundamental rights'.[130]

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[124] *Soobramoney* (n 110) para 11; *Minister of Health v Treatment Action Campaign (TAC)* [2002] ZACC 15, (2002) 5 SA 721, paras 34-35, 39 (South Africa's Constitutional Court) (*TAC)*.

[125] Humberto Ávila, *Theory of Legal Principles* (Springer 2007) 107.

[126] ibid 106.

[127] ibid 109.

[128] ibid 110.

[129] ibid.

[130] ibid 12; in a similar way, considering it a pure exercise of proportionality, Candia criticises the so-called 'substantial' margin of appreciation in the context of the Council of Europe human rights system, see Gonzalo Candia, 'Comparing Diverse Approaches to the Margin of Appreciation: The Case of the European and the Inter-American Court of Human Rights' (9 March 2014), <https://ssrn.com/abstract=2406705> accessed 23 June 2017, 9.

Western legal culture knows few ways of operationalization beyond the technique of individual legal rights.[131] While the technique of legal rights is suited for conflicts arising between two individuals, it seems in trouble when it comes to operationalizing communitarian legal claims. So far, as courts have worked under the purview of the predominant interpretation of the right to health, they do not see collective legal claims in social rights. The equality they care for is the equality of everyone not to experience the most abject deprivation. It does not include an 'institutional equality' or an 'equality of results', for cases in which economic or social privilege determines the quality of the institutions or the extent of the services everyone receives.

When the role of the legislature is limited to non-discrimination, human dignity, or reasonability, the question social rights tries to ask, never gets to be really formulated.[132] The question of the *Grootboom* case can be rephrased as follows: how come some individuals get an amount of X (in this case housing) below the standard of what we the judges regard as a minimum threshold for it to be compatible with human dignity?[133] In asking this question, the Court involved itself in a substantive appraisal of justice, namely, what is above and below the standard of human dignity.

In this analysis, the judiciary contrasts differences of access *within* this most basic regime of access (the one that services the needs of those who depend on social assistance). What the judiciary does not do, however, is contrast the disparities between persons located in the greater regimes of access. And neither does it look at the reasons why such greater access is granted. What this shows is that while the reasonability criteria work well when it comes to recognizing differences within the most basic regime of access, the criterion does not operate when looking at differences between different regimes of access. Due to its connection to human dignity, reasonability appears to work only when challenging statutes that deal with the conditions of the poorest. This is done under the alleged neutrality of this standard, namely, the idea that because this view emerges from a 'reasonable' standard or because it focuses on

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[131] See ch 1, n 80; in a similar vein, Frankenberg has described this phenomenon as 'a reduction of the imaginative space of emancipation', see Günter Frankenberg, 'Human Rights and the Belief in a Just World' (2014) 12 (1) International Journal of Constitutional Law 35, 54.

[132] In the landmark case *Broeks v The Netherlands* for example, the Human Rights Committee found that a widow who stopped being eligible for social security benefits did not fall under the right to social security of the ICESCR. The Committee found that the complainant was entitled to social security benefits by virtue of art 26 (non-discrimination). The Committee determined that the applicant had been discriminated on grounds of sex. Had she been a man she would have been entitled to receive the invoked benefits. The Committee found that the case did not concern 'whether or not social security should be progressively established in the Netherlands, but whether the legislation providing for social security violates the prohibition against discrimination contained in Article 26 of the International Covenant on Civil and Political Rights'. *Broeks v the Netherlands* Communication No 172/1984, UN Doc CCPR/C/OP/2 at 196 (1990) paras 6(3), 12(5) (UNHRC).

[133] *Grootboom* (n 114) para 44.

'discrimination' or the rights of 'the vulnerable' or on a 'core' of the right, it can claim political impartiality while automatically any further adjudicatory effort would be politically biased.

While the predominant interpretation presents its reliance on judicial adjudication and the reasonability standard as impartial, this is in fact quite dubious. A strong affinity between the predominant interpretation of the right to health and the doctrine of liberal egalitarianism can be detected. For a start, it is disputable that meta-legal concepts can claim any impartiality.[134] Despite its efforts to show the opposite, liberal egalitarianism is not the exception. Take John Rawls's approach to justice. Such a view consists not in directly defending the institutions favoured by the author (liberal democracy). Using the hypothetical tool of the veil of ignorance, Rawls arrives at his preferred result not offering reasons in its favour but based on what he regards the choices rational people would adopt.[135] Richard Bellamy and Chantal Mouffe have addressed the limitations of this approach. Bellamy criticizes Rawls's view as 'too indeterminate' and 'circular − building its results into its premises'.[136] Mouffe fleshes out this criticism arguing that in Rawls's conception 'reasonable persons are persons "who have realized their two moral powers to a degree sufficient to be free and equal citizens in a constitutional regime, and who have an enduring desire to honour fair terms of cooperation and to be fully cooperating members of society"'.[137] Mouffe asks 'What is this if not an indirect form of asserting that reasonable persons are those who accept the fundamentals of liberalism?'[138] Further, she claims 'What Rawls is really indicating with such a distinction [reasonable/unreasonable] is that there cannot be pluralism as far as the principles of the political association are concerned, and that conceptions which refuse the principles of liberalism are to be excluded. I have no quarrel with him on this issue. But this is the expression of an eminently *political* decision, not of a moral requirement'.[139] Mouffe concludes 'The political is always constitutive − which is precisely what liberalism denies'.[140]

Secondly, the alleged impartiality of the predominant interpretation is grounded on the public-private law distinction. It is to Marx and the legal realists to whom we owe our awareness about the partiality of that divide.[141] With its focus on the autonomous individual, certain forms of liberalism fail to identify the *raison d'être* of social rights, namely, the solidarity that justifies the duties and institutions required for its collective conceptualization.

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134 Atria, *Forma* (n 6) 321-322.
135 John Rawls, *Political Liberalism* (Columbia University Press 1993) 304-307.
136 Richard Bellamy, *Political Constitutionalism: A Republican Defence of the Constitutionality of Democracy* (CUP 2007) 185.
137 Chantal Mouffe, *The Democratic Paradox* (Verso 2009) 24.
138 ibid.
139 ibid 25.
140 ibid.
141 Juan Amaya Castro, 'Human Rights and the Critiques of the Public-Private Distinction' (DLaws thesis, Vrije Universiteit Amsterdam 2010) 39-42, 43-51.

The defenders of the reasonability criterion are enthusiastic as they can ground allegedly progressive outcomes on a legal device that would deliver beyond political ideology. The purpose of the reasonable/unreasonable distinction purports to appeal to anyone impartially, beyond left and right. But that is not the case. As Fernando Atria states, such an interpretation is simply a different partisan position.[142] For it is a completely partial view one where the poor are deprived of the same treatments the rich can access while at the same time this latter group is entitled to the right to secede from the public healthcare system, and access a special system designed exclusively for them. That view is perfectly consistent with the – certainly not neutral – philosophies that requires the provision of minimum standards for the poorest by means of targeted policies.[143] The reasonability criterion only allows for distinctions within one segment of society (differences between the poorest and the poor). That is certainly an instantiation of the principle of equality. What is far from clear is that such a notion can be established beyond ideological contestation or that it delivers the redistributive justice issues social rights require.

3.2.4. THE *TAC* CASE

The *TAC* case assessed the measures adopted by the South-African government in relation to its program to combat HIV. More specifically, it focused on the measures to combat the mother-to-child transmission of this virus. The measures included the administration of a drug called nevirapine, which significantly reduced the risk of transmission but it was to be applied exclusively at hospitals and clinics within research and training sites. These sites included two per province: one in a rural area, and another one at an urban area.

According to the applicants' contentions, the government's prohibition to provide nevirapine to public hospitals and clinics outside the research and training facilities would not be reasonable considering that the drug was free of cost and that it would be unavailable for a very vulnerable segment of the population.[144] Secondly, the applicants requested the government to have a comprehensive national program to prevent mother-to-child transmission of HIV including voluntary counselling and testing, antiretroviral therapy and the option of substitute feeding.[145] These two claims were grounded on two fundamental constitutional provisions –

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142 Atria, *Forma* (n 6) 321.

143 Oscar Feo, 'Las Políticas Neoliberales y su Impacto sobre la Formación en Salud Pública. Comentarios sobre la Experiencia Venezolana' (2008) 3 (4) Medicina Social 275, 276.

144 *TAC* (n 124) paras 48, 71; as admitted by Byrne (Iain Byrne, 'Enforcing the Right to Health: Innovative Lessons from Domestic Courts' in Mary Robinson and Andrew Clapham (eds), *Realizing the Human Right to Health* (3 Rüffer and Rub 2009) 526), the free-of-cost nature of the drug was probably more important than it is often commented as one of the reasons triggering this decision.

145 *TAC* (n 124) paras 45, 47.

sections 27 and 28.[146] These provisions originated positive and negative obligations the State was obliged to fulfil.[147]

Importantly, the judgment shows the inexistence of disagreement between the government, the applicants and the court with respect to the comprehensiveness public health measures were expected to have. The issue was neither whether a specific group of people was deprived of an important good, nor whether such a deprivation did not affect their lives, nor whether they were poor. The point at stake concerned whether the government's restrictions on nevirapine could be considered reasonable and whether the government was obliged to have a comprehensive policy plan to prevent the mother-to-child transmission of HIV throughout the country.[148] In this way all the involved actors were reflecting from the perspective of public health, including whether the challenged statute affected public health, and whether granting the nevirapine treatment would or would not involve sacrificing other programs already in place. In this respect, it was regarded as unreasonable not to provide nevirapine to the medical facilities outside the research and training sites considering that the provision of the drug would not involve extra costs.[149]

The *TAC* judgment complies with the non-individual nature of social rights. It shifts from an adjudication based on individual concerns, to one based on public health concerns. It thus ratifies the shift of paradigm adopted in *Soobramoney*. Still, the rather exceptional circumstances of the case must be noted. Usually, the administration of a treatment comes with, not without, costs. This made it simple for the Court to decide on the unconstitutionality of the government policy. The exceptionality of the lack of costs had the effect of ruling out the omnipresent background of scarcity in which social rights usually take place. And with that, it took out of the equation the polycentric dimension inherent in social rights adjudication. In those circumstances, the lessons derived from the *TAC* case and the reasonability standard may be more limited than what scholars have been suggesting.

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[146] '27(1) Everyone has the right to have access to – (a) health care services, including reproductive health care … (2) The State must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights.'; '28(1) Every child has the right – … c) to basic nutrition, shelter, basic health care services and social services.'

[147] In relation to the positive obligations, the Court stated that: 'sections 26 and 27 must be construed as imposing two positive obligations on the State: one an obligation to give effect to the 26 (1) and 27 (1) rights; the other a limited obligation to do so progressively through "reasonable legislative and other measures, within its available resources"'. Concerning the negative obligation, the Court cited *Grootboom* arguing that there was 'at the very least, a negative obligation placed upon the State and all other entities and persons to desist from preventing or impairing the right of access to adequate housing'. Such a negative obligation applied equally to s 27(1) on 'the right of access to "health care services, including reproductive health care"'. *TAC* (n 124) paras 29, 46.

[148] *Minister of Health and Others v Treatment Action Campaign and Others* [2002] ZACC 16, 2002 (5) SA 703, paras 4-5.

[149] *TAC* (n 124) para 71.

3.3. PORTUGAL'S *39/84* CASE

In this case,[150] Portugal's Constitutional Court not only abided by the non-individual approach of social rights under solidarity, but it also interpreted the positive obligations deriving from the right to health in a way that seems to address the distinctive obligations of the right to health as described in the second half of chapter four.

The Court had to deal with a situation where the government attempted to regulate Portugal's National Healthcare Service (*Serviço Nacional de Saúde*, SNS). The government's regulation consisted in practically revoking the service. The Court established that the right to health had both a negative and a positive dimension. The negative dimension entailed that the State had to abstain from any act capable of threatening the health of the individual. The positive dimension involved an entitlement to several State measures related to the prevention and treatment of illnesses.[151] The SNS was the main means of realizing the positive dimension of the right of access to health.[152] The Court added that it was not just any means of realization but 'the first'. In that sense, it stated that the creation of the SNS was a constitutive element of the right to health, and a State duty.[153] Thus, the Court struck down Article 17 of Decree-Law Number 254/82 of 29 June 1982, which had amended Act of Parliament No 56/79 of 15 September 1979, which had in turn established the SNS. The Court held that the amendment was equivalent to eliminating the SNS.[154]

When facing the question of whether the SNS could have been abolished, the Court stated that that depended on the nature of the constitutional duty imposed by the constitution on the State, in the sense of establishing a national healthcare service as means of realization of the right to health.[155] Further, the Court stated that the abolition of the SNS would create a situation of lack of compliance by the State with a concrete constitutional duty. Insofar as such an action would entail revoking the implementation of a fundamental right, the abolition of the SNS would involve a State violation of the constitutional right to health.[156] By the same token the Court stated that an amendment of an institution, service or legal body cannot take place by means of it being abolished. This conclusion would flow naturally from understanding this service as a guarantee for the realization of this right.[157] Following the same line of argument, the Court

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[150] *Case 39/84* Acórdão do Tribunal Constitucional nº 39/84, 11 April 1984 in 'Acórdãos do Tribunal Constitucional', 3º Vol (1984) 95ff (Portugal's Constitutional Court).
[151] ibid para 2(2)(1).
[152] ibid 2(1)(a).
[153] ibid (2)(3)(1).
[154] ibid (2)(1).
[155] ibid (2)(1)(c)(2).
[156] ibid para (2)(3)(3).
[157] ibid.

stated that the SNS, once created, could not be abolished. Once created, the SNS became part of the right to health. As such, it was irreversible (except by a constitutional amendment).[158]

In contrast with *Soobramoney*,

a) Portugal's Constitutional Court questioned the government's decision of interpreting the constitutional right to health through a statute that was in fact revoking Portugal's single-tiered healthcare system, and
b) While the court did not actively *come up* with a different arrangement, it did re-install a legislative provision that permitted the maintenance of a more extended form of healthcare provision where access was arranged based on citizenship and medical need (as opposed to ability to pay).

This case shows that the judiciary has on some rare occasions taken up on the challenge to directly protect and fulfil the right to health under the perspective of solidarity. Unlike the Paraguayan cases, the *legal effect* of this decision consisted in directly striking down an act to maintain access to healthcare for all, and not just a group.

In *39/84*, the court reasoned from the perspective of the constitutional right to health and its interpretation of what this right required for its realization. The court:

a) applied both the non-individualistic approach of social rights while at the same time derived positive obligations from the right to health in line with solidarity;
b) did not base its decision on a mere activism but protected the right to health within the contours of a negative legislator. While the court's ruling was a reaction to Decree-Law Number 254/82, its effect consisted in reinstating Act of Parliament No 56/79; and
c) decided exclusively based on the narrative of constitutional rights. Yet, the decision can also be understood as a choice between two standards of healthcare de-commodification: the one from Act of Parliament No 56/79 and the one from Decree-Law Number 254/82. That process involved that the Court assessed the situation *ex-ante* and *ex-post* the entry into force of Decree-Law Number 254/82. Although not explicit in the judgment, since after the entry into force of Decree-Law Number 254/82 the SNS would be abolished and access to healthcare in Portugal would get much closer to a commodity, the judiciary preferred a less commodified access to healthcare. The decision of the Court distributes scarcities among all members of society not on the condition of ability to pay but accoring to citizenship and medical need.

Finally, this perspective may sound similar to the prohibition of retrogression developed by General Comment 3.[159] This provision establishes that 'deliberately retrogressive' measures are required to be 'fully justified by reference to the totality of the rights provided for in the Covenant and in the context of the full use of the maximum available resources'.[160] While there may be a

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[158] ibid.
[159] UNCESCR, 'General Comment 3: The Nature of States Parties' Obligations (Art 2, Para. 1, of the Covenant)', UN Doc E/1991/23, 14 December 1990, para 9.
[160] ibid.

certain overlap with that view, the notion of non-retrogression does not reproduce the non-individualistic nature of the right to health as a social right. Potentially, shrinking the amount or quality of any individual or group entitlement could involve retrogression.[161] Such a remedial development would not be in line with the non-individual notion of social rights defended in the second half of chapter four. A justification of judicial powers of review in line with the solidarity-based concept of social rights focuses on the distributive standards (of economic nature) based on which the solidarity of the healthcare system is construed. This standard does not entail a discussion about the coverage of more or fewer healthcare treatments, but a discussion concerning the principles or logic on which scarcity is distributed: either due to legitimate trade-offs or due to inability to pay.

Non-retrogression could refer to the individual benefits that either a person or a group of persons may end up losing because of legitimate trade-offs. Such a focus would not necessarily be aligned with the principles of distributive justice that solidarity helps to put forward. Any individual treatment that is cut due to a legitimate prioritization could hence be regarded unlawful. Social rights would be identified based on whether they allow securing more or less goods or services on the hands of one or more individuals. As stated previously, what defines social rights is a democratic standard that turns the given human right into a protected public good so that it can be assigned equally to all.[162]

4. CONCLUSIONS

1. The invigoration of judicial powers is often seen as a development that automatically leads towards a better protection of rights. The chapter critically addresses this assumption in the context of the protection of the right to health. Looking at salient cases in the field of access to healthcare, the research goal of this chapter consisted in determining whether this predominant trend was protecting this right's distinctive components from the perspective of solidarity. The study looked at two important ways for courts to address the right to health, as an individual right (through both direct and indirect protections), and in the non-individualistic approach promoted by solidarity.
2. Concerning the direct protection of the right to health, the chapter looked at extended understandings of the principle of human dignity. Cases such as *Meza Garcia* or *T-737*,

[161] In the context of the Spanish doctrine, Juli Ponce Sole has interpreted that retrogression is linked with the idea of a core individual minimum of rights. When in combination with human dignity, those retrogressions are regarded as unconstitutional at all events. Juli Ponce Solé, *El Derecho y la (Ir)reversibilidad Limitada de los Derechos Sociales y de los Ciudadanos. Las Líneas Rojas Constitucionales a los Recortes y la Sostenibilidad Social* (Instituto Nacional de Administración Pública 2013) 24, 61, 66.

[162] Ricardo García Manrique, *La Libertad de Todos: Una Defensa de los Derechos Sociales* (El Viejo Topo 2013) 34.

showed a rather essentialist protection which in the context of polycentric legal problems appears hard to place.

3. The study also analysed so-called *absolute* approaches. Here, the right to health is explicitly protected as an autonomous individual legal right. While a step forward in terms of taking the right to health seriously, these approaches can lead to vertical interventions and medicalised approaches of healthcare where the accent is placed on curative care. It is unclear how these approaches could integrate the diverse and opposed needs and trade-offs embedded in healthcare systems. As the financial sustainability of healthcare systems may become threatened, the study was critical of this focus.
4. The chapter also assessed critically the assumption that the legal rights discourse necessarily leads to the advancement of the right to health. Considering the *Chaoulli* case, the study showed how legal rights have in some cases entertained processes of privatization and compromised the integrity of public healthcare systems. Caution should replace the overenthusiastic faith in legal rights manifested by the promoters of the predominant interpretation. Understood in connection with solidarity, the protection of social rights cannot be considered satisfied by simply making them positive law. The challenge is more complex. As showed in the Introduction of the thesis, human rights law is rarely understood as something other than legal rights. Hence, the integrity of the healthcare system is likely to remain reduced to an aggregated political interest that must bow to the fundamentality of classical rights and liberties. As individual rights cannot grasp the collective claims the right to health originates under solidarity, should courts wish to protect the right to health in its distinctive components, they should go beyond the construct: 'as A has human dignity and is in a vulnerable position, his right to access healthcare must be protected in order not to violate his dignity', or 'A's right to access healthcare is separated from B's right to access healthcare'. Under solidarity, courts should not disconnect A's right of access healthcare from B's.
5. Concerning the indirect protection of the right to health the chapter looked at what it called the *collateral* effort: a link with other rights in ways that promise the realization of the right to health. In some cases this approach is driven by widening the scope of positive obligations deriving from classical human rights. Yet, the analysis showed that the collateral link does have the ability of attaining the protection of the right to health when defined within the contours of the predominant interpretation. This is because vulnerability can be detrimental to the foundational concept of individual autonomy upon which this interpretation is construed. Reaching the right to health under the purview of solidarity, the collateral interpretative effort appears less promising. Neither dignity nor collateral interpretations seem to lead towards the obligations to protect and to fulfil when conceived under solidarity. A set of cases of the Inter-American Court of Human Rights reflected that rather than this focus, the right to health becomes sub-species or an appendix of other rights. Analysis of

some reparations confirmed that while a more collective approach in line with solidarity is needed and has been used, its protection under an individualistic approach is incongruous.

6. In what I consider an approach closer to the perspective of solidarity, I also addressed a further set of right-to-health cases. What courts do here is to consider the right to health in a more collective way. Various cases from South Africa's Constitutional Court were assessed. Unlike the collateral effort or the direct appeal to human dignity, this case law gives a qualitative shift as it identifies social rights' non-individualistic nature. The right to health goes beyond an individual or group entitlement and appears strongly connected to public health. The study is critical of the reasonability standard, however. Not only is this view focused on vulnerability and human dignity, which raises the concerns expressed above; its ability to lead to a non-partisan outcome is also unconvincing. On the contrary, the regressive tendencies with which the predominant interpretation of the right to health proved to be compatible may be also reproduced.
7. The *39/84* case before Portugal's Constitutional Court is of a different kind, however. Besides implicitly identifying the non-individualistic and non-marketed nature of the right to health, the judiciary engaged in an effort that on the one hand combined respect for social rights' democratic pedigree and, on the other, characterized the essence of this human right in line with the conclusions of chapter three. The Constitutional Court identified the protection of this collective right with the defence of the public nature of the entitlements created by the national healthcare system. Thus, solidarity can take the idea of the progressive realization of the right to health to the legal fore. In the judicial sphere, solidarity is a standard through which courts materialize the idea of the progressive realization of the right to health.[163] In this respect solidarity means the ever-increasing path towards the de-commodification of access to healthcare to attain the goal of equal access to healthcare for all.
8. Considering the open terms of paragraph 9 of General Comment 3, the chapter took the view that the prohibition of non-retrogression as presented in this instrument overlaps only potentially with this second line of case law. The reason is that non-retrogression can be instrumental to the protection of individual entitlements that do not necessarily coincide with solidarity, a principle that can only be driven by collective concerns.

[163] ICESCR (n 65) art 2(1).

CHAPTER SIX
SOLIDARITY AND THE RIGHT TO HEALTH: PROVISION AND FINANCING OF HEALTHCARE

1. INTRODUCTION

So far, I have outlined a critique of the predominant interpretation of the right to health and of an alternative interpretation of this right from the perspective of the principle of solidarity and their implications for judicial review. As I have pointed out, the proper place to situate the right to health is the intersection of law and politics, social justice and human rights law, as well as the effort of combatting two distinct problems: poverty and inequality in a context of scarcity of resources. The implications of an alternative interpretation of this human right touch on the organization of healthcare, on which I had already occasion to make a few remarks in passing in the previous chapters. In order to make sense, I devote some attention to these organizational aspects in the broader context of healthcare (and access to it) within the overall health system of a country. Such an organizational analysis in light of the principle of solidarity requires a more profound empirical study of healthcare systems than can be offered in this thesis. I therefore limit myself to a set of remarks concerning the implications that the perspective of solidarity sheds on the right to health for the organization of healthcare systems. Nearly all these remarks should be understood to formulate points for further research which may corroborate or falsify the normative claims that each of them makes. This further research, which is largely empirical, is beyond the scope of this thesis, if only for reasons of time and resources.

Chapters three and four addressed the substance of solidarity and its connection with the right to health. Moreover, chapter four showed that the right to health could not be understood disconnected from legislative standards. This is not only insofar as health systems are *made* of legislation, but also insofar that only legislation has the general aptitude needed to address the social justice conundrum involved in the goal of equal access to healthcare for all. Furthermore, chapter five showed that to operationalize the distinctive goals of social rights such as the right to health the role of the judiciary had to be mainly reactive and circumscribed to the enforcement of the collective goal of solidarity.

Consistent with these conclusions, the present chapter asks for the role that solidarity plays in the context of health systems. In this regard – it should be clarified at the outset – healthcare entails only a fragment of what health systems do. In its 2007 report *Strengthening health systems to improve health outcomes*,[1] the WHO defined health systems as:

> [A]ll organizations, people and actions whose *primary intent* is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities. A health system is therefore more than the pyramid of publicly owned facilities that deliver personal health services. It includes, for example, a mother caring for a sick child at home; private providers; behavior change programmes; vector-control campaigns; health insurance organizations; occupational health and safety legislation. It includes inter-sectorial action by health staff, for example, encouraging the ministry of education to promote female education, a well known determinant of better health.[2]

As I noted previously, solidarity gives insight to the question of how the community bears the costs of healthcare. Chapters three and four have answered that solidarity promotes the shifting of the rules according to which the scarcity in access to healthcare is distributed: from individual ability to pay, to citizenship and medical need.[3] What solidarity does is link the question of access to healthcare to the institutional features of the health system, financing in particular. In doing this, solidarity not only contributes to the realization of the universality of human rights ('equal liberty'[4]), but it also operationalizes a *legal* interconnection between human rights and social justice. This process has been also called 'vertical equity'. According to the European Health Management Association, vertical equity:

> [I]s concerned with the extent to which system finance is progressive, proportional or regressive. In progressive systems affluent people spend a greater proportion of their income on health care than the poor. In proportional systems affluent and poor people pay equal proportions relative to their income. Regressive systems cause the poor to spend proportionately more of their income on health care compared to the rich.[5]

The concerns of solidarity reflect in the way entitlements are structured (who is covered and to what extent) but also on the features of health-financing systems. Health financing systems deal with the problem of who should pay for health services as well as when and how.[6] The simplest

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1 WHO, *Strengthening Health Systems to Improve Health Outcomes: WHO's Framework for Action* (WHO 2007).

2 ibid 2.

3 ch 3, s 3.3.

4 ibid.

5 Nicoline Tamsma and Philip Berman, *The Role of the Health Care Sector in Tackling Poverty and Social Exclusion in Europe* (European Health Management Association 2004) 26.

6 WHO, *The World Health Report. Health Systems Financing: The Path to Universal Coverage* (WHO 2010) 4.

way of dealing with this problem consists in a direct payment that the consumer of the service pays to the provider in return for the good or service (out-of-pocket payments).[7] Yet, according to the WHO this is also the most regressive form of financing healthcare.[8] This agency holds that 'direct payments are the least equitable form of health funding. They are regressive, allowing the rich to pay the same amount as the poor for any particular service'.[9]

Due to their ability to subsidizing the poor, sick funds are preferable than direct payments. Yet, not all sick funds have been supported by the WHO. This agency has held that the bigger the risk pools, the better.[10]

> [A] single pool offers several advantages, including greater efficiency and capacity for cross-subsidization within the population. There is strong evidence that fragmented pooling systems without risk equalization can work against equity goals in financing, because each pool has an incentive to enroll low-risk people and the parts of the population that receive more benefits are unwilling to share their pooled funds with the parts of the population that are worse off.[11]

Finally, there is strong evidence that health-financing systems based on tax-revenue facilitate redistribution.[12] Here, however, the possibility of redistribution depends on to what extent is taxation progressive. The WHO recommends direct taxation − such as income or property − by opposition to indirect forms, such as trade or sale taxes.[13]

As detailed in chapter three, solidarity has been advanced in important documents such as the Alma-Ata Declaration, and public health views around social medicine such as the WHO's strategy of 'Health for All'[14] and 'Health Promotion'.[15] Lately, along the lines of its new strategy of 'Universal Healthcare Coverage',[16] the WHO has limited itself to state that good financing of

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7 Elias Mossialos and Anna Dixon, 'Funding Health Care: an Introduction' in Elias Mossialos and others (eds), *Funding Health Care: Options for Europe* (Open University Press 2002) 2-3.

8 WHO, Report (n 6) 5; WHO, *Making Fair Choices in the Path to Universal Health Coverage: Final Report of the WHO Consultative Group on Equity and Universal Health Coverage* (WHO 2014) 40; Tamsma, *Poverty* (n 5) 30.

9 WHO, *Report* (n 6) 42.

10 ibid 77.

11 ibid 47.

12 Akiko Maeda and others, *Universal Health Coverage for Inclusive and Sustainable Development: A Synthesis of 11 Country Case Studies* (The World Bank 2014) 37.

13 Commission on Social Determinants of Health (CSDH), *Closing the Gap in a Generation. Health Equity through Action on the Social Determinants of Health: Final Report of the Commission on Social Determinants of Health* (WHO 2008) 123.

14 WHO, 'Global Strategy for Health for All by the Year 2000' (WHO 1981).

15 WHO, 'Ottawa Charter for Health Promotion' (17-21 November 1986) WHO/HPR/HEP/95.1; Benjamin Mason, 'Advancing Health Rights in a Globalized World: Responding to Globalization Through a Collective Human Right to Public Health' (2007) Global Health Law, Ethics and Policy 545, 547.

16 According to a WHO report, the definitions of 'universal health coverage' and 'universal coverage' vary. The

healthcare requires systems to raise 'adequate funds for health, in ways that ensure people can use needed services, and are protected from financial catastrophe or impoverishment associated with having to pay for them'.[17] I am critical of this vision insofar as it points out a problem that in my view had been long ago identified, while leaving aside all the advancements concerning how to tackle it. I will not be able to address these challenges in the field of global health, and what I intend to do here is to exclusively focus on the problem of solidarity, the right to health and health financing systems at the domestic level.

Health systems have developed in ways in which a third party offers protection to the population against the financial risk of falling ill.[18] One historically relevant distinction is between Bismarckian (based on social health insurance), and Beveridgean (tax-based) health financing systems.[19] Since nowadays health financing relies on multiple sources (taxes, social health insurance, private individuals and donors) and resources are pooled in various ways, this distinction appears to have become less relevant.[20] For example, while the Bismarckian model had its origins in Germany, this country no longer relies purely on such a scheme.[21] Perhaps with the notable exception of Cuba, where almost the total amount of health expenditure comes from the State,[22] the vast majority of health systems in the world rely heavily on private spending. The Canadian health system for example − usually known as a single payer health-financing system − records a significant 30% of the total amount of healthcare spending from private sources.[23]

2005 58th World Health Assembly indirectly defined universal coverage as 'access to key promotive, preventive, curative and rehabilitative health interventions for all at an affordable cost'. WHO, 'Social Health Insurance: Sustainable Health Financing, Universal Coverage and Social Health Insurance, Report by the Secretariat, Provisional Agenda Item 13.16' (Fifty-Eighth World Health Assembly 2005). Somewhat differently, the World Health Report 2010 specified 'universal coverage' as a goal according to which 'all people have access to services and do not suffer financial hardship paying for them', and the report generally focused on 'access to needed services' and 'financial risk protection'. WHO, *The World Health Report 2010: Health Systems Financing: The Path to Universal Coverage* (WHO 2010). Since then, most definitions have had a similar structure with some variation in wording. Although these variations may appear minor, at least four types of variation should be acknowledged. First, some definitions assert that everyone must have 'access' to services as opposed to 'receiving' services. Second, some definitions refer to 'needed services', 'key services', or 'necessary services', as opposed to 'services that meet [people's] needs' ... Third, some definitions refer to 'financial catastrophe', 'financial ruin', or 'poverty' rather than 'financial hardship'. Fourth, not all definitions explicitly link the financial harm to payment for services. WHO, *Report* (n 6) 1[ii].

17 WHO, *Strengthening* (n 1) vi.

18 Mossialos (n 7) 3.

19 ibid.

20 ibid.

21 WHO, *Report* (n 6) 51.

22 In 2010, this country registered 96.2% of public spending in healthcare, see Pan-American Health Organization (PAHO), *Health in the Americas 2012 Edition,* country volume (PAHO 2012) 251.

23 Colleen Flood, 'Litigating Health Rights in Canada. A White Knight for Equity?' in Colleen Flood and Aeyal Gross (eds), *The Right to Health at the Public/Private Divide: A Global Comparative Study* (CUP 2014) 79.

No health financing system is 100% *pure*; nevertheless, predominant features can still be identified.

Any health financing system requires making the distinction between healthcare payers and healthcare providers. Payers carry the burden of healthcare costs. They can involve the State, individuals, workers and employers' contributions or payments from insurance companies (which can be either for- and non-for-profit). Healthcare providers are 'a person or place that is trained to give health care'.[24]

The way in which healthcare systems are financed depends on the content of the legal rules determining whom, when and how pays for the services offered by healthcare providers.[25] This, in turn, may give origin to various ways of providing healthcare services. According to the WHO, this can be done in three main ways. One way is for the government to directly fund a healthcare service through a budgetary contribution (sometimes also through income-dependent employer contributions automatically deducted). The second way is by means of funding an institutionally separate agency that purchases services on behalf of the population. The third way is for individuals to directly pay the providers through out-of-pocket expenses or self-provision of services.[26] What usually happens is a combination of the three. Yet, depending on the most distinctive feature, it is still possible to make a classification between:

a) *Single-tiered*, *single-payer* or *publicly financed* health systems. These are systems where 'public financing based on tax revenues is a defining feature of the health care system';[27]
b) *Social health insurance* systems. These are systems that include mechanisms of redistribution but which are mainly financed 'through mandatory contributions from employers and employees to either non-profit social health insurers or competing private not-for-profit or for-profit insurers (managed competition)',[28] and
c) *Two-tiered* or *mixed* healthcare systems. In these systems, a 'private health system fulfils a central role alongside a public system.'[29]

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24 Encyclopedia of Health Care Management (2004) 249.

25 According to the WHO, 'health financing is much more than a matter of raising money for health. It is also a matter of who is asked to pay, when they pay, and how the money raised is spent. Revenue collection [involves] the way money is raised to pay health system costs ... Pooling is the accumulation and management of financial resources to ensure that the financial risk of having to pay for health care is borne by all members of the pool and not by the individual who fall ill ... Purchasing is the process of paying for health services'. WHO, *Report* (n 6) 4.

26 ibid 4.

27 Colleen Flood and Aeyal Gross, 'Introduction: Marrying Human Rights and Health Care Systems. Contexts for a Power to Improve Access and Equity' in Colleen Flood and Aeyal Gross (eds), *The Right to Health at the Public/Private Divide: A Global Comparative Study* (CUP 2014) 5.

28 ibid 5-6.

29 ibid 6.

In this sense, the Organisation for Economic Cooperation and Development concludes that:

> [M]ulti-payer systems − i.e. systems that allow for publicly as well as privately financed options − can make it difficult to maintain equity in access and financing compared to systems that feature just a single payer.[30]

In this chapter I look a little closer at this assumption. I tackle this issue looking at three different health-financing systems. My aspiration is that by looking at the financing structure of these systems I will be able to shed light on the extent these systems promote solidarity.

I shall begin by assessing the question of solidarity in the context of focus studies that look at three different ways of organizing health financing systems. The purpose of these focus studies is not to develop a detailed comparison between these different systems of financing, but to understand the way these different systems tackle solidarity as an element of the right to health. The selected countries have the virtue not only of representing different health-financing structures; they also greatly differ in terms of their socio-political understanding of social rights: from socialist Cuba to Chile's neoliberal approach, but also including the Dutch attempt of combining market and solidarity considerations.

In this respect, I find it necessary to justify my addressing of Cuba, a country that does not abide to the liberal hegemon. I have not regarded the flaws Cuba's polity has from a human rights perspective, a reason not to look at an exemplary health system, so useful in allowing me to contrast and illustrate the points I raise in this thesis.[31] Moreover, I think it would be very

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[30] Cited in Tamsma (n 5) 27.

[31] As argued by Cooper, Kennelly and Orduñez-García, 'Cuba remains an enigma to North Americans and Europeans alike. Two generations ago there was no society with the exception of Canada that was more tightly integrated into the US cultural and economic sphere. After the revolution of 1959, however, Cuba acquired the pariah status of a wayward child and has been variously vilified in rhetoric, attacked militarily and economically, and consigned to cultural oblivion. Within the US academic community, Cuban dialogue has been maintained primarily by social scientists and historians, many of whom are second-generation Cubans. Despite occasional 'discovery pieces' the biomedical literature in English has been almost entirely silent on the Cuban experience and US government policy temporarily forbade publication of articles from Cuba by US journals or their foreign subsidiaries. The historical context that explains the absence of Cuba from the global conversation on public health and medicine is self-evident. This absence cannot be dismissed as passive acquiescence of the health professions to the demands of real politik, however. The raison d'etre of the health sciences is the discovery of new knowledge and the use of that knowledge to improve health. Both the professional and commercial reward structures within the discipline insure that evidence of a major advance will attract further sustained attention. This dynamic, however, is conspicuously absent from the debate on international health. While the undisputed priority in public health from a global perspective is the need to rescue the populations of poor countries from diseases we have been able to prevent or cure for many decades, nothing is said of one of the most striking examples where that challenge has been most effectively met. This silence stands in stark contrast to the impassioned rhetoric of the many conferences, declarations and gatherings of world leaders where the imperative to find a solution is so often reiterated. The

hard to carry out comparative research if one would leave out countries whose governments have been questioned from a human rights perspective. Such a standard would certainly pose the most formidable obstacle to carry out legal research on the United States, China or Russia, countries with a record of grave human rights violations at both the domestic and international level, none of which prevents the most conspicuous academic circles from doing so. Cuba, among its many other notable efforts, has received the praise of the WHO for its focus on health research and its response before the Ebola outbreak.[32]

2. SINGLE-TIERED HEALTH FINANCING SYSTEMS: CUBA

In what follows, a salient example of a single-tiered health-financing system will be discussed − the Cuban system. The defining feature of single-tiered health-financing systems is that most health costs are centralized in a single state agency. While this model benefitted from the experience of the Soviet Union's nationalized health system organized in the 1920s under Health Commissar Nikolai Semashko, as well as the British National Healthcare Service organized by Aneurin Bevan, the Cuban healthcare system was forged in the context of the specific experiences of the Cuban revolution.[33]

2.1. HISTORICAL BACKGROUND

In 1959, after a guerrilla-armed conflict, the revolutionaries led by Fidel Castro seized power in Cuba, forcing the end of Fulgencio Batista's dictatorship. In 1959, the country only had a single

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unwillingness to take account of the Cuban experience, or to even view it as an alternative route through which some societies can move toward the universal goal of health promotion, represents an important oversight. The achievements in Cuba thereby pose a challenge to the authority of the biomedical community in countries that define the scientific agenda. This assertion by no means rests exclusively in Cuba's success in climbing the vital statistics charts. In virtually every critical area of public health and medicine facing poor countries Cuba has achieved undeniable success; these include most prominently - creating a high quality primary care network and an unequalled public health system, educating a skilled work force, sustaining a local biomedical research infrastructure, controlling infectious diseases, achieving a decline in non-communicable diseases, and meeting the emergency health needs of less developed countries'. Richard Cooper, Joan Kennelly and Pedro Orduñez-García, 'Health in Cuba' (2006) 35 International Journal of Epidemiology 817, 817-818.

[32] Salimi Lamrani, 'Cuba's Health Care System: A Model for the World' The Huffington Post (8 October 2014) <www.huffingtonpost.com/salim-lamrani/cubas-health-care-system-_b_5649968.html> accessed 23 June 2017.

[33] Anne-Emanuelle Birn and Laura Nervi, 'Political Roots of the Struggle for Health Justice in Latin America' (2015) 385 (9974) The Lancet 1174, 1175.

university hospital, a dominant private health sector and a rudimentary public health system.[34] The new government addressed health determinants with redistributive policies, and set up a comprehensive health system.[35] In the early stages, 'emphasis was placed on basic public health improvements, such as sanitation and immunization, and medical care was extended to the rural areas. A system of regional polyclinics and hospitals subsequently evolved, complemented in the 1980s by a reorientation of the entire system toward primary care and the education of large numbers of family doctors'.[36]

2.2. MAIN FEATURES

The Cuban healthcare system is characterized by a strong focus on the following areas: prevention,[37] primary attention (80% of the health problems of the population are addressed at this level[38]), a strong health working force with the highest doctor per-patient ratio in the world,[39] and a great emphasis on medical research and education,[40] including its own pharmaceutical industry.[41] For its 11 million inhabitants, the country has 90,000 doctors, which is 'eight for every 1,000 citizens − more than double the rate in the US and in the UK (the US has 2.5 doctors per 1,000, the UK 2.7 per 1,000 according to the World Bank).'[42] This takes place in a context where the *First Global Forum on Human Resources for Health*, held in March 2008, concluded that the global shortage of health workers reaches an estimated 4 million.[43]

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34 Sarah Conover, Stephen Donovan and Ezra Susser, 'Reflections on Health Care in Cuba' (1980) 316 (8201) The Lancet 958; Cooper, *Cuba* (n 31) 818.

35 Pol de Vos and Patrick Van der Stuyft, 'The Right to Health in Times of Economic Crisis: Cuba's Way' (2009) 374 (9701) The Lancet 1575.

36 Cooper, *Cuba* (n 31) 818.

37 Edward Campion and Stephen Morrissey, 'A Different Model - Medical Care in Cuba' (2013) 368 (4) The New England Journal of Medicine 297, 297-298; Fiona Hill, 'Prevention Better than Cure in Cuban Healthcare System' BBC News (London, 13 December 2015) <www.bbc.com/news/health-35073966> accessed 23 June 2017.

38 Programa de las Naciones Unidas para el Desarrollo (PNUD), 'Cuba' (PNUD) <www.cu.undp.org/content/cuba/es/home/ourwork/hiv_aids/in_depth/> accessed 23 June 2017

39 Lucia Newman, 'The Truths and Tales of Cuban Healthcare' Aljazeera English (18 June 2012) <www.aljazeera.com/indepth/features/2012/06/201265115527622647.html> accessed 23 June 2017.

40 This aspect was applauded by Margaret Chan, Director-General of the WHO, in her visit to Havana in July 2014, see Cooper, *Cuba* (n 31) 819; De Vos, *Economic* (n 35) 1575; Campion, *Different* (n 37) 298; Lamrani (n 32).

41 Campion, *Different* (n 37) 298.

42 Hill (n 37).

43 John Yudkin and others, 'Global Health-Worker Crisis: the UK Could Learn From Cuba' (2008) 371 (9622) The Lancet 1397.

In spite of the imposition of the United States' trade embargo in the 1960s,[44] the health standards of the population in Cuba have strongly improved from the 1950s.[45] Cuba's health indicators not only rate as one of the highest in the Caribbean and Latin America regions,[46] but in many respects they are equal or superior to those of developed countries.[47] For example, 'the infant mortality rate in Cuba has fallen from more than 80 per 1,000 live births in the 1950s to less than 5 per 1,000 − lower than the US rate'.[48] This makes Cuba rank with 'the second lowest infant mortality [rate] in the Americas,'[49] and puts it 'among the lowest in the world'.[50]

Unlike the austerity measures that have characterized Europe's response to the economic financial crisis of 2008,[51] Cuba's achievements in the health and social plane have

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[44] According to De Vos and colleagues: '[T]he USA should end its embargo against Cuba, which for more than 40 years has infringed international and humanitarian law, and has been condemned by numerous resolutions of the United Nation's General Assembly. Cuba will be much more prosperous, stable, and healthy from the day the USA decides to respect its sovereignty'. Pol De Vos, Mariano Bonet and Patrick Van de Stuyft, 'Health and Human Rights in Cuba' (2004) 364 (9452) The Lancet 2177; the UNGA has condemned the United States' embargo on Cuba on 26 occasions. In the voting of 2015, 193 countries voted against the embargo except for the United States and Israel. In 2016 the United States acknowledged its policy of isolation towards Cuba and abstained for the first time since the beginning of this policy (UN News Centre, 'US Abstains for First Time in Annual UN Vote on Ending Embargo Against Cuba' (United Nations, 26 October 2016) <www.un.org/apps/news/story.asp?NewsID=55404> accessed 23 June 2017).

[45] Richard Garfield, 'Health Care in Cuba and the Manipulation of Humanitarian Imperatives' (2004) 364 (9438) The Lancet 1007; Pol de Vos and colleagues state that the embargo has been in line with a US policy that for more than four decades isolated, undermined or invaded the island, damaging the Cuban economy for more than US$ 79 billion. They also state that the embargo has had serious consequences on all socioeconomic sectors. With respect to the health sector 'it led to a rise in mortality in those aged 65 years and older ... and also to an increase in the proportion of low birth weight infants ... and in the tuberculosis incidence ... From 1995 onwards the economy grew, and health indicators started to recuperate quickly'. De Vos, *Cuba* (n 44); Cooper, *Cuba* (n 31) 820.

[46] Commission on Social Determinants of Health (CSDH), 'Action on the Social Determinants of Health: Learning from Previous Experiences: A Background Paper Prepared for the Commission on Social Determinants of Health' (WHO 2005) <www.who.int/social_determinants/resources/action_sd.pdf?ua=1> accessed 23 June 2017, 14.

[47] ibid.

[48] Campion, *Different* (n 37) 298.

[49] Cooper, *Cuba* (n 31) 819.

[50] Lamrani (n 32).

[51] Christoph Hermann and Brigit Mahnkopf, 'The Past and Future of the European Social Model' (Institute for International Political Economy Berlin, Berlin School of Economics and Law, Working Paper no. 05/2010) 7-8; Alexander Kentikelenis and others, 'Health Effects of Financial Crisis: Omens of a Greek Tragedy' (2011) 378 (9801) The Lancet 1457; David Stuckler and others, 'Effects of the 2008 Recession on Health: a First Look at European Data' (2011) 378 (9786) The Lancet 124; Frank Connolly, 'The EU "Austerity" Deal Won't Work - Irish Workers Face a Grim Future' in Nicolas Pons-Vignon and Phumzile Ncube (eds), *Confronting Finance: Mobilizing the 99% for Economic and Social Progress* (International Labour Organization 2012) 11-12; Amalia Ifanti and others, 'Financial Crisis and Austerity Measures in Greece:

been attained despite the 1990s-economic crisis resulting from the discontinuation of economic support from the Soviet Union after its collapse.[52] By the same token, Cuba's healthcare achievements have been attained spending a fraction of what developed countries invest in health. The World Bank reports Cuba spends US$ 431 per head per year compared with the US$ 8,553 that are spent in the US.[53]

At the same time, the country has made great efforts in helping to improve the health sector of other countries.[54] At present 50,000 Cuban medical personnel are working in 66 countries around the world;[55] the country provides training for thousands of young foreign students;[56] it has built a hospital for the child victims of the Chernobyl nuclear disaster;[57] and has received the praise of the Director General of the WHO's for its quick response after the Ebola outbreak.[58] The WHO notes that the lack of access to care in the world arising from a lack of resources is by no means a foregone conclusion. It reflects, instead, a lack of political will on the part of leaders to protect their most vulnerable populations. The organization cites the case of the Caribbean island as the perfect counter-example.[59]

Largely the result of the isolation imposed against the country, many aspects of Cuba's healthcare system are complex. The Cuban healthcare system does not fit the idea of consumer choices.[60] Physician's salaries are on average between US$ 30 and US$ 50 a month,[61] while the government has been accused of retaining the income of those working abroad.[62] By the same token, annual check-ups − one of the cornerstones of the integrated and preventive-based Cuban

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Their impact on Health Promotion Policies and Public Health Care' (2013) 113 (1-2) Health Policy 8, 10; Marina Karanikolos and others, 'Financial Crisis, Austerity, and Health in Europe' (2013) 381 (9874) The Lancet 1323, 1325; Achim Truger, 'Austerity in the Euro Area: The Sad State of Economic Policy in Germany and the EU' (Institute for International Political Economy Berlin, Berlin School of Economics and Law, Working Paper, No. 22/2013) 17; Christoph Hermann, 'Crisis, Structural Reform and the Dismantling of the European Social Model(s)' (Institute for International Political Economy Berlin, Berlin School of Economics and Law, Working Paper no. 26/2013) 5-12; Carlos Lema, 'La Erosión del Derecho a la Salud en el Reino de España: el Ataque a la Universalidad' in María José Bernuz y Manuel Calvo (eds), *La Eficacia de los Derechos Sociales* (Tirant lo blanch 2014) 224.

52 Cooper, *Cuba* (n 31) 818; De Vos, *Economic* (n 35) 1575.

53 Hill (n 37).

54 Some cases are referred in Eduardo Gómez, 'Cuba's Health Diplomacy in the Age of Ebola' BBC News (London, 14 November 2014) <www.bbc.com/news/world-latin-america-29984688> accessed 23 June 2017.

55 ibid.

56 De Vos, *Economic* (n 35) 1398.

57 Newman (n 39).

58 Gómez (n 54).

59 Lamrani (n 32).

60 Campion, *Different* (n 37) 298.

61 Newman (n 39).

62 Octavio Gómez Dantés, 'Health in Cuba: The Other Side of the Story' (2015) 385 (9972) The Lancet 944.

model − while acceptable within Cuba may seem too intrusive in other contexts.[63] Other criticisms have pointed to the difference in treatment between top-level government and Communist Party officials by comparison to ordinary people, as well as hygiene problems inside hospitals.[64]

2.3. PROVIDERS

The National Health System works on the basis of a completely 'integrated network of services based on primary care and the family physician and nurse model. It is oriented toward health promotion as well as disease prevention, cure, and recovery at all care levels'.[65] The basic law is the Public Health Act (*Ley de Salud Pública*) of 13 June 1983.[66]

According to the report from the Pan-American Health Organization:

> [T]he Ministry of Public Health is responsible for implementing health policies and regulations, and for managing health programs and services. The health system is structured at three territorial levels − national, provincial, and municipal − and at three levels of care based on a network of specialized, decentralized, and regionalized services beginning at the primary care level and covering the entire population. The primary health care model is based on family medicine and on general practitioners who are capable of promoting health, carrying out preventing and protective action, and providing diagnosis, treatment, recovery, and rehabilitation for the population for which they are responsible. They do this through a system of comprehensive health monitoring and care that is ongoing and sectorized, and that utilizes teams and involves community participation.[67]

The provision of healthcare is differentiated, 'according to the needs for each territory, community, population group, family and individual, to guarantee equity and efficiency based on an assessment of the health situation in each area'.[68] A key health authority is the 'Regulatory Bureau for the Protection of Public Health'. This body oversees 'compliance with regulations regarding medical products and equipment. At the same time, the Bureau monitors practices and accredits and certifies the country's health units'.[69]

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63 Hill (n 37).
64 Newman (n 39).
65 PAHO (n 22) 238.
66 Public Health Act 13 June 1983, Cuba's Ministry of Public Health <http://legislacion.sld.cu/index.php?P=FullRecord&ID=2> accessed 23 June 2017.
67 PAHO (n 22) 251.
68 ibid.
69 ibid.

2.4. PAYERS

The Cuban healthcare model relies on a universal healthcare system completely free for the population.[70] The system is funded via tax revenues and the main health authority is the Ministry of Health.[71]

In Cuba, 'access to all health and education services is universal, and free for the country's citizens. Cubans also have the right to a job and access to the country's solid social security and assistance system'.[72] This is the result of a constitutional right. In Cuba, the Constitution 'establishes health care and protection as a duty of the State and a right of all citizens.[73] The Public Health Act and its regulations establish legal provisions governing the sector's operation in correspondence and harmony with the development of the national health system'.[74] According to a report of the Pan-American Health Organization, 'total health spending as a percentage of the GDP increased from 7.7% in 2006 to 11.9% in 2010. Public spending on health as a percentage of total health spending rose from 92.2% in 2006 to 96.2% in 2010'.[75] The costs of the system are distributed in the following way: 'hospital institutions implement 42.3% of the budget, polyclinics 31.6%, stomatologic clinics 2.4%, and maternity homes 1.5%. [This reflects an emphasis on] ambulatory and community-based health care'.[76]

3. MIXED OR TWO-TIERED HEALTH FINANCING SYSTEMS: CHILE

The two-tiered nature of these healthcare systems is linked to its two main sources of financing − public and private. In Chile's health system, the private tier is to a large extent run on a marketed basis and the public tier, although more regulated, still has a strong commercial component.

3.1. HISTORICAL BACKGROUND

Under the 1980 Constitution, a series of constitutional provisions related to health were enshrined: a right to the protection of health, a State's correlative duty to protect and supervise

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70 Campion, *Different* (n 37) 297.
71 Conover (n 34) 958.
72 WHO and PAHO (n 22) 237.
73 Cuba's Constitution 1992, art 50.
74 PAHO (n 22) 251.
75 ibid.
76 ibid.

this right and, conspicuously, the freedom to choose a healthcare regime of either a public or private nature.[77] In doing so, the Chilean regime pioneered in connecting social rights with 'a right to choose'. The first constitutional provisions were the ones established in paragraphs 4 and 5 of Article 19(9) on the right to health,[78] and paragraph 3 of Article 19(18) on the right to social security.[79] These provisions reflect a stark contrast between a strong protection of choice and a weak protection of duties. In the case of the right to health, while it was true that the duties protecting this right were given the status of 'preferential',[80] choice was protected in a much more effective way, namely:

a) Unlike the duties of the right to health, which could not be claimed in court, the provisions concerning the right to choose a healthcare system were explicitly shielded with the writ of protection (*recurso de protección*);[81]
b) The right to engage in any economic activity (in this case, the 'economic' activity of providing private healthcare services) was given explicit constitutional recognition in Article 19(22) of the Constitution;[82]
c) The right to embark in an economic activity (which covers healthcare businesses) was explicitly shielded with the writ of protection,[83] and
d) A special procedure granted this right an extra shield: it afforded 'popular' legal standing, ie, the complainant does not need a specific legal interest to be able to file a legal suit in these cases.[84]

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77 The constitutional provision on the right to health states: '[I]t is the preferential duty of the State to guarantee the execution of the health actions provided either through public or private institutions in the way and under the conditions determined by statutory law, which may establish obligatory contributions. Each person will have the right to choose the health system of his or her preference, either of the State or private'. Political Constitution of the Republic of Chile (consolidated text of 22 September 2005) Chile's National Congress <www.leychile.cl/Navegar?idNorma=242302> accessed 23 June 2017, art 19(9)[4-5].

78 The Military Junta, through Decree Law No 3,464 of the Ministry of Interior, dictated Chile's Constitution on 11 August 1980. The Constitution has been in force ever since. Yet, important amendments have been introduced. The most significant ones were introduced in 1989 and 2005. At the moment, Chile is in the process of discussing a new constitution (Chile's Ministry Secretary General of the Presidency, 'Proceso Constituyente Abierto a la Ciudadanía' (Chile's Ministry Secretary General of the Presidency) <http://datos.gob.cl/dataset/proceso-constituyente-abierto-a-la-ciudadania> accessed 23 June 2017).

79 This provision states: '[T]he action of the State will be directed to guarantee the access to all the inhabitants to the provision of uniform basic entitlements, provided either by public or private institutions. Statutory law may establish obligatory contributions.' Constitution (n 77) art 19(19)(3).

80 *Sentencia Rol 1710-10*, 6 August 2010, para 121 (Chile's Constitutional Court).

81 Constitution (n 77) art 20.

82 ibid art 19(22).

83 ibid art 20.

84 Act of Parliament 18,971 (10 March 1990) Chile's Ministry of Economy, '<www.leychile.cl/Navegar?idNorma=30339> accessed 23 June 2017.

3.2. MAIN FEATURES

The regulations concerning the provision of medical care date back to Decree Law No 2,763 of 1979,[85] which was the first comprehensive body of law concerning the organization of healthcare issued during the military government. This decree established the 'National System of Health Services' (*Sistema Nacional de Servicios de Salud*). This norm did four things: it merged the former National Healthcare Service to the 'National Medical Employees Service' (*Servicio Médico Nacional de Empleados, SERMENA*), it dissolved both services, and it further transformed them into autonomous, regional, state-funded healthcare services. At the same time, primary care was left to municipalities in what became the 'Municipal System of Primary Care' (*Sistema Municipal de Atención Primaria*).[86] Currently, the norm consolidating the bulk of the healthcare regulations is Decree with Force of Law No 1 of 2005 of the Ministry of Health.[87]

Obligatory health insurance for occupational diseases and accidents at work is dealt with by specific acts of Parliament (Act of Parliament 16,744 of 1968[88]), as well as the healthcare system of the armed forces and their families (Decree Law No 1,468 of 1976[89] for the police forces − *Carabineros de Chile* − and Act of Parliament 19,465 of 1996[90] for the Armed Forces). The police and the armed forces, who accounts for approximately 3% of the population, are an exception to the whole system. This is not only because of the universal and comprehensive nature of the healthcare protection these civil servants get (fully funded based on tax revenues), but also because they can make use of a well-equipped network of exclusive healthcare providers.

3.3. PROVIDERS

The public tier of Chile's healthcare system covers approximately 83%[91] of Chile's population. The Ministry of Health oversees its supervision. The abovementioned National System of Health

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85 The text of Decree Law No 2,763 has been further consolidated with other norms, see Decree with Force of Law No 1 (24 April 2006) Chile's Ministry of Health <www.leychile.cl/Navegar?idNorma=249177&idParte=&idVersion=2006-04-24> accessed 23 June 2017) art 2.

86 Manuel Gárate, *La Revolución Capitalista de Chile (1973-2003)* (Ediciones Universidad Alberto Hurtado 2012) 272-273.

87 Decree with Force of Law No. 1 (n 85) art 16(11).

88 Act of Parliament 16,744 (1 February 1968) Chile's National Congress <www.leychile.cl/Navegar?idNorma=28650&buscar=16744> accessed 23 June 2017.

89 Decree Law No 1,468 (16 June 1976) Chile's Ministry of National Defence <www.leychile.cl/Navegar?idNorma=6627> accessed 23 June 2017.

90 Act of Parliament 19,465 (2 August 1996) Chile's Ministry of National Defence <www.leychile.cl/Navegar?idNorma=30832> accessed 23 June 2017.

91 Víctor Becerril-Montekio and others, 'Sistema de Salud en Chile' (2011) 53 (Supp 2) Salud Pública de

Services consists of an extended network of hospitals, specialized medical centres and primary healthcare services. Medical services can be provided in two ways: the *institutional modality*[92] and the *free choice modality*.[93] The institutional modality has lower individual co-payment levels but it does not allow the beneficiary to choose the healthcare provider. The free choice modality has higher individual co-payment levels but it allows beneficiaries to choose the healthcare provider. As the services from the private sector can be hired, providers of the public sector do not need to be state-funded. Furthermore, the public sector is also in charge of CENABAST (*Central National de Abastecimiento*), a governmental agency in charge of acquiring medicines,[94] and the Institute of Public Health (*Instituto de Salud Pública*[95]), a body that advises the Ministry of Health in the fields of microbiology, immunology, bromatology, pharmacology, imaging, radiotherapy, blood banks, clinical laboratory, environmental contamination and occupational health.

The private sector is comprised of private companies − clinics that sell their healthcare services to two kinds of patients: either people who directly pay for them in exchange of a direct sum (the richest portion of the population), or to specialized healthcare insurance companies denominated 'Health Contributory Institutions' (*Instituciones de Salud Previsional,* ISAPRES). Through this modality, private providers assist 16.8% of the population.[96] I shall make a few more remarks about them in the next section.

3.4. PAYERS

The public tier of Chile's healthcare system is funded via State tax revenues, compulsory contributions, municipal contributions and out-of-pocket payments.[97] The compulsory contributions require that irrespective of the sector where the contributor is enrolled (public or private), he or she must supply a monthly tax deduction of 7% from their taxable income.[98] Those enrolled in the public sector contribute to the 'National Fund for Healthcare' (*Fondo Nacional de Salud,* FONASA).[99] Out of 83% of the population that receives State-funded

México 132, 134.

92 Decree with Force of Law No 1 (n 85) art 141.

93 ibid art 142.

94 ibid art 68.

95 ibid art 57.

96 According to the Association of Health Contributory Institutions (ISAPRES), by 2012 the total number of contributors was 1,629,196 inhabitants making a total of 3,064,719 beneficiaries, see ISAPRES de Chile, *ISAPRES 1981-2016: 35 Years Supporting Chile's Private Health System* (ISAPRES de Chile 2016) <http://www.isapre.cl> accessed 23 June 2017, 33.

97 Becerril-Montekio (n 91) 136.

98 Decree Law No 3,500 (consolidated text of 13 November 1980) Chile's Ministry of Labour and Social Security <www.leychile.cl/Navegar?idNorma=7147> accessed 23 June 2017, art 85.

99 ibid arts 49, 50(b).

healthcare, 74%[100] are FONASA contributors. At the same time, contributors need to *co-pay* a percentage of the fee[101] for the specific medical treatment that they or their dependents receive. Around 7% of the population does not contribute to any healthcare system (indigents). They are assisted free of charge through the institutional modality at healthcare providers belonging to the public network.[102]

The private tier is organized based on the abovementioned ISAPRES − specialized health insurers covering a spectrum of medical treatments under healthcare contracts signed with individuals in exchange of a monthly premium. These healthcare contracts are indefinite,[103] and they are subject to a series of legal rules limiting freedom of contract.[104] Beyond these

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[100] As of December 2012, Chile's Ministry of Health estimated that out of a total population of 17,479,723 inhabitants, beneficiaries of the National Health Fund, FONASA, were 13,377,082 (76.5%), see National Health Fund, 'Statistic of Beneficiaries of the Public Health System and their Participation with Respect to Other Systems. Number of Persons. Years 1990-2013' (National Health Fund) <https://www.fonasa.cl/sites/fonasa/institucional/archivos> accessed 23 June 2017.

[101] Decree Law No 2,763 works in a way where although FONASA proposes the fees of the various medical interventions, these are finally fixed by the Ministry of Health acting together with the Ministry of Finance. Contributors to FONASA pay higher or lower fees according to their socio-economic level. Four socio-economic groups are established: Group A comprises indigents and persons receiving social assistance pensions; Group B comprises affiliates whose monthly income is not higher than the minimum monthly income (in 2012, the minimum monthly income was $193,000 Chilean pesos – approximately €286 (Datos Macroeconómicos, 'Salario mínimo en Chile' (DatosMacro) <www.datosmacro.com/smi/chile> accessed 23 June 2017); Group C comprises affiliates whose monthly income is somewhere between the minimum monthly income and a sum which does not exceed 1.46 times this amount, but only provided that the number of dependents does not exceed two persons. In the contrary case the contributor shall be considered under Group B; Group D comprises affiliates whose monthly income is more than 1.46 times the minimum monthly income, provided that the number of dependents does not exceed two persons. In the contrary case the contributor shall be considered under Group C. The State contributes to the fees in percentages that differ according to the specific group to which the contributor or his or her dependents belong. Concerning groups A and B, the State provides 100% cover. Group C is covered to a percentage that is never below 75%. Group D is covered to a percentage that is never below 50%. The individual co-payment level shall be the gap between the FONASA contribution and the cost of the fee. Chile's Ministry of Health, Decree with Force of Law No 1 (n 85) arts 159-161.

[102] ibid art 147.

[103] Gárate (n 86) 275.

[104] One such element is the price of the health contract. To configure it, two elements enter into play: the 'base price' and the 'table of factors'. The 'base price' refers to the price ISAPRES charge for each of its health-plans. The base price of each plan must be the same for all subscribers. The final price is calculated by multiplying the base price by the specific factor corresponding to the affiliate or beneficiary, in conformity with the table of factors. Article 170 (n) establishes that the 'table of factors' is made by the ISAPRES. These factors describe the relation of prices of the health-plan divided by group of people on the basis of the age, gender, and status of the contributor or dependent. This table establishes a variation mechanism for the price of the health-plan for the lifespan of the contributor and his/her dependents at the time the contract is signed or incorporated, and which cannot be modified as long as the person remains attached to that plan. Decree

limitations, parties can freely agree upon the conditions of the contract.[105] For-profit healthcare providers offer the healthcare services, but State-paid providers with which an ISAPRE has contracted services can also offer them. In some cases, private companies ensure the medical treatment of their employees at 'Benefit Societies' (*Mutuales de Empleadores*), mainly covering occupational diseases and accidents at work.

Act of Parliament 19,966 of 2004[106] established a 'System of Healthcare Guarantees' (*Régimen de Garantías en Salud* AUGE-GES). This system obliges both FONASA and ISAPRES to ensure the treatment of a set of illnesses.[107] Pursuant to Article 190 of DFL1, ISAPRES users shall have the same levels of co-payment for these illnesses as users under the FONASA free-choice modality. The treatments guaranteed by this statute apply to the access, quality, financial protection and opportunity of the given benefits.[108]

The supervision of the services granted by ISAPRES, FONASA and the healthcare providers, is overseen by a supervisory authority (*Superintendencia de Salud*).[109]

4. SOCIAL INSURANCE HEALTH FINANCING SYSTEMS: THE NETHERLANDS

The main feature of social health insurance systems is the guarantee of access to healthcare by means of a social insurance that both the State and the private sector contribute to in different proportions.[110] This is developed by means of two basic features: insured people pay a regular

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with Force of Law No 1 (n 85) art 170(m).

105 ibid arts 189, 197, 198.

106 Act of Parliament 19,966 (3 September 2004) Chile's Ministry of Health <www.leychile.cl/Navegar?idNorma=229834&buscar=19966> accessed 23 June 2017.

107 The system began providing coverage to 56 illnesses. By January 2016, a total of 80 illnesses were covered, see Superintendence of Health, 'Guaranteed Illnesses "AUGE-GES"' (Superintendence of Health) <www.supersalud.gob.cl/difusion/572/w3-propertyname-501.html> accessed 23 June 2017.

108 Act 19,966 (n 106) art 2.

109 Decree with Force of Law No 1 (n 85) art 106.

110 The German social insurance system was described in the late 1960s in the following way: 'West Germany has one of the most comprehensive social security systems in the world. The roots reach back almost a century to the social insurance laws of Imperial Germany, which served as models for subsequent legislation in other countries. Government policies determine who is covered against what risks, who contributes and how much, and who is to receive what, when, and for how long. Federal regulations to that effect are implemented by the Social Security Administration and other public agencies; disputes over claims are adjudicated by the Federal Social Courts. As in the United States and other countries, most social security contributions represent enforced savings through payroll deductions. In West Germany, all wage and salary earners are required by law to pay up to 18 percent of such income toward health, maternity, work injury and disablement, and retirement and survivor insurance. In addition, both private and public employers must

contribution, and a set of quasi-public bodies manage the system while paying the costs of healthcare.[111] Several countries have adopted this system, incorporating compulsory social insurance covering a set of interventions at an affordable price. How comprehensive the provision of health services is varies from country to country. The State often exerts important regulatory functions.

4.1. HISTORICAL BACKGROUND

In 2006, the Dutch healthcare system was reformed, shifting from a two-tiered social insurance system, to a multiple private health insurers system. André den Exter characterizes the Dutch system as 'an interesting marriage of tensions in that while it moved to expand insurance to all citizens, it simultaneously introduced a much greater role for the private sector in terms of relying on competing private for-profit health insurers'.[112]

The Netherlands has had a system of competing funds since the early 1990s.[113] Den Exter describes the main features of the old system as a dual system of social (compulsory) and private or voluntary health insurance. Den Exter explains how people who were too wealthy to qualify for social insurance (around 30% of the population) were free to purchase private health insurance. However, most of the population (65% except for 5% of public servants that had access to their own insurance scheme) accessed social insurance based on the Health Insurance Act (*Ziekenfondswet*) of 1966.[114] This statute established an insurance scheme covering curative

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make a proportionate "fringe benefit" contribution. Self-employed individuals, including farmers, pay the entire premium for their compulsory social insurance. All told, working people may pay as much as a fifth of their earned income for mandatory social insurance. The size of contributions is much higher than in the United States, but the range of benefits is also more extensive. In West Germany, too, so-called unearned personal incomes from sales, investments, rents, and savings are not subject to social security taxes. Consequently, the more an employed individual gets from such exempted sources, the smaller will be the bite which these taxes take out of total income and the less onerous are across-the-board increases in the rate of personal contributions. Moreover, since benefit payments are based on entitlement, the more an individual has previously earned under the social security system, the more he or she will receive on becoming eligible for disbursements. The same holds for the qualified dependents and survivors of the insured. In effect, these measures place a proportionately heavier burden on the lower than the higher income groups and provide them with smaller financial payoffs. ... The question of who should pay for the steeply rising health care expenses of insured persons is now once again a major political issue. It has also become increasingly apparent that the seeds for similar controversies are embedded in the unemployment and the old age insurance laws'. Lewis Edinger, *Politics in West Germany* (Little, Brown and Company 1977) 326-328.

111 Charles Normand and Reinhard Busse, 'Social Health Insurance Financing' in Elias Mossialos and others (eds), *Funding Health Care: Options for Europe* (Open University Press 2002) 60.

112 André den Exter, 'Health Care Access in the Netherlands. A True Story' in Colleen Flood and Aeyal Gross (eds), *The Right to Health at the Public/Private Divide: A Global Comparative Study* (CUP 2014) 188.

113 WHO, *Report* (n 6) 47.

114 '*Ziekenfondswet*' 15 October 1964 <http://wetten.overheid.nl/BWBR0002460/2005-12-29> accessed 23

care. Its administration was carried out by private non-profit entities that contracted the services of healthcare providers.

While these two tiers of healthcare protection were private, Den Exter explains that equity was still an important feature of the system since both waiting times for medical treatment and the tariffs charged by hospitals did not depend on the private or social nature of the insurance where people were enrolled.[115]

The goals pursued by the establishment of the new Health Insurance Act (*Zorgverzekeringswet*) became effective in 2006.[116] According to Den Exter, the main contribution from the perspective of the right to health consisted in the elimination of the divergence in judicial interpretations derived from the different two tiers, hand in hand with the provision of universal access to healthcare in a competitive insurance market context.[117]

4.2. MAIN FEATURES

After the entry into force of the new system, a few for-profit healthcare insurers started to compete one against another. Every person is obliged to take out health insurance,[118] while at the same time healthcare insurers are under the obligation to accept every resident in their area of activity and to provide a basic health insurance package that has been designed by the government.[119] Health insurance agreements are private law contracts and are therefore based on the principle of freedom of contract. Certain restrictions are imposed by the legislature to protect the principle of equal access to healthcare. Den Exter states that the prohibition of risk selection by health insurers can be considered an example of this.[120] This prohibition impedes denying coverage to individuals deemed to be 'high risk' on grounds of age, gender or health profile.[121] By the same token, a system of risk equalization is included. This system permits that individuals with higher risk profile receive greater funding from insurers. In this way, risk selection is prevented.[122] The law defines entitlements covered by health insurers, but

June 2017.

115 Den Exter, *Netherlands* (n 112) 190.

116 The Netherlands Ministry of Health, Welfare and Sports, 'Health Insurance Act' (16 June 2005) <http://wetten.overheid.nl/BWBR0018450/2016-08-01> accessed 23 June 2017.

117 Den Exter, *Netherlands* (n 112) 190.

118 The Netherlands' Ministry of Health, Welfare and Sports, Health Insurance Act (n 116) art 2.

119 Brigit Toebes, 'Taking a Human Rights Approach to Healthcare Commercialization' in Patricia Cholewka and Mitra Motlagh (eds), *Health Capital and Sustainable Socioeconomic Development* (CRC Press 2008) 444.

120 Den Exter, *Netherlands* (n 112), 196.

121 Anne-Laure Macherey, 'Legal Report on Access to Healthcare in 12 Countries' (MdM International Network 2015) 79.

122 ibid 196.

contracting parties can agree about where and who will deliver the insured health services.[123] Freedom of contract is non-existent in case of emergency care and highly specialized care.[124]

4.3. PROVIDERS

As explained by Den Exter, before the reform, the government had a strong planning capacity, making provincial health authorities responsible for implementing the plan. The government could regulate the supply of hospitals, but such a process was criticized for its complexity and lack of flexibility.[125]

The major revision to this process came by means of the Health Facilities Admission Act (*Wet Toelating Zorginstellingen,* WTZi).[126] This statute introduced decentralization, and a demand-driven system where the role of the government was limited to set the general conditions governing hospital planning. These conditions attempted to ensure public interests such as accessibility, quality, and efficiency of inpatient care. Den Exter comments that the rationale is that consumer demand and market competition will determine the requirements of hospital capacity with the aspiration of achieving equilibrium between demand and supply.[127] In practice, as Toebes and San Giorgi comment, hospitals and other healthcare providers are under the obligation of competing against each other to obtain the funding from healthcare insurers.[128] The effect of this regulated competition is that healthcare providers have started to offer non-essential treatments that make them more attractive in the eyes of the patients while at the same time healthcare providers are merging into larger-scale organizations in order to increase efficiency and increase the strength of their position before the insurers.[129] Under the new rules, in order to receive a license to provide healthcare, hospitals guarantee the quality of care, accessibility of emergency services, financial transparency and sound management. The Dutch Health Care Inspectorate, an independent advisory body to the Ministry of Health, supervises whether health care institutions comply with the law. If not, the ultimate sanction imposed is withdrawal of admission.

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123 ibid.
124 ibid.
125 ibid 191.
126 Health Facilities Admission Act (18 September 2009) The Netherlands' Ministry of Health, Welfare and Sports <www.wtzi.nl/Media/Default/PDF/Beleidsregels WTZi.pdf> accessed 23 June 2017.
127 ibid 191-192.
128 Brigit Toebes and Maite San Giorgi, 'Dutch Realities: Evaluating Health Care Reform in the Netherlands from a Human Rights Perspective' in Brigit Toebes and others (eds), *The Right to Health: A Multi-Country Study of Law, Policy and Practice* (Springer 2014) 14.
129 ibid.

As Den Exter comments, the WTZi also introduced a for-profit category of outpatient healthcare entities for certain medical services including dental, pharmaceutical, obstetrics and transportation services.[130]

An important element is that the insured may opt for a benefits-in-kind or reimbursement model or a combination of both models. Although both models guarantee a standard insurance policy, under the reimbursement model, the insured has free choice of provider. Under the benefits-in-kind variant, the insured are limited to a set list of health providers who have entered contracts of delivery with the patient's chosen health insurer. In exceptional cases under this model, the insured may opt for a non-contracted provider abroad, if there is a long waiting period.[131]

4.4. PAYERS

As Den Exter describes, the new Health Insurance Act (*Zorgverzekeringswet*) establishes the obligation of paying a flat-rate premium together with an automatically deducted income-dependent employer contribution. On top of that, a compulsory 'own-risk' payment was introduced for primary and secondary care providers. To this, a flexible system of voluntary own-risk payment may be added.[132] Lower income groups are partly compensated by means of a healthcare allowance. In exchange 'all insurance providers offer the same standard package. This package includes GP visits, outpatient treatments in hospital, hospitalization, emergency treatment, transport to the hospital, antenatal, delivery and postnatal care and mental healthcare (individual psychological consultations). Contraception is not included in the basic package'.[133]

Concerning the financing of long-term, disability care and mental diseases, they are covered by a separate health insurance program − the AWBZ scheme. This scheme derives from the general health insurance programme, but also from income-related contributions, and a complicated means-tested system of payment by users.

The Health Care Authority (NZa) regulates the prices of healthcare. This public authority ensures that the healthcare market is of high quality and efficient to the consumer. Without the approval of the NZa, it is forbidden to charge another tariff. Yet, on an experimental basis, the NZa liberalized tariffs on some health services. As expected, free hospital prices grew 50-70% in one year (2011-2012). Den Exter comments: 'To what extent, such a measure will contribute to cost reduction and more efficient purchasing of inpatient health care remains to be seen'.[134]

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[130] Den Exter, *Netherlands* (n 112), 192.
[131] Toebes, *Commercialization* (n 119) 196.
[132] Den Exter, *Netherlands* (n 112), 190.
[133] Macherey, *Report* (n 121) 79.
[134] Den Exter, *Netherlands* (n 112), 193.

Finally, there is a Voluntary Health Insurance scheme, which may cover non-evidence-based health care services. Here, health insurance companies are free to set the premium and have the possibility to refuse potential beneficiaries for nonmedical reasons.

By 2006, in a figure that did not include people without legal residence status, it was calculated that in the Netherlands 1.5% of the population (approximately 241,000 Dutch residents including 40,000 children) were uninsured.[135]

5. CONCLUSIONS

1. The organization of health financing is crucial for the understanding of the right to health as a social right. This is because health-financing systems can either promote or militate against solidarity. This chapter looked at three major forms of organization with different degrees of State involvement.
2. The majority if not all healthcare systems contemplate State involvement. This, however, should not be considered a synonym of solidarity. Most healthcare systems today are *prima facie* market-based. Namely, State action on healthcare is only subsidiary. Individuals attempt to arrange the provision of social rights to the extent of their individual ability while the role of the community consists in guaranteeing a minimum for those unable of affording the costs by themselves. This action takes place either through social insurance schemes or via the action of the public tier in two-tiered healthcare systems. In these schemes, everyone obtains healthcare coverage on a set of treatments at an affordable price. In two-tiered healthcare systems such as Chile's, the State arranges different regimes to access healthcare depending on economic capacity. In the systems where the State is involved, assistance is on average the same. What can vary are the contributions to the system, which depend on individual economic capacity. The AUGE-GES programme has allowed standardizing the costs for the provision of a set of critical treatments. Yet, the provision of healthcare is non-comprehensive. Coverage not falling in AUGE-GES treatments remains compartmentalized by socio-economic group in the several layers and tiers of the system. A critical characteristic of two-tiered healthcare systems is that the public healthcare system can function in parallel with a fully private system run based on ability to pay. Here, individuals can even obtain healthcare services by directly purchasing them from healthcare providers. As it has been noted in chapter two, human rights law has critically approached the gap between this form of provision and public healthcare systems. Yet, this has been done by means of recommendations issued in Concluding Observations of the Committee. While this is much less intense than mechanisms based on the prohibition of non-discrimination and

[135] Directorate-General for Employment, 'Quality in and Equality of Access to Healthcare Services' (European Commission 2008) 33.

subsequent use of judicial review, these tools appear only effective when it comes to striking down legislation that does not abide to the idea of subsidiary State action in favour of the vulnerable.[136] A human rights mechanism aimed at protecting the essence of the right to health from the perspective of solidarity, namely, the universality and integrity of national public healthcare systems, is rare.

3. Chile and the Netherlands both show substantive State involvement in healthcare. Both schemes concede that social rights are a matter of public concern. Not only that, both systems take redistribution seriously, something that they do ensuring coverage to certain pathologies, limiting reliance on out-of-pocket payments, direct protection of the poor, and favouring of risk pooling.[137] In this way both the most deprived members of the community but also the majority of the population are protected either through a comprehensive package of insured treatments, by impeding to discriminate against on health pre-conditions or by not connecting waiting lists to the quality of the premium that is paid. In the Netherlands, while individual discrimination has been eradicated and waiting lists are not linked to socio-economic status, it remains that the system fails to cover everyone. This is a matter of concern, even more in the context of the present migration crisis.
4. Integrating the commercial delivery of healthcare services is a way of expressing that healthcare is only partially a problem of public concern. In the Netherlands and especially in Chile, the community is concerned only to a certain extent with these needs. In contrast, it does not seem that a mere range of needs is sufficient when it comes to protecting civil and political rights. Accordingly, the implementation of the duties protecting these rights are placed out of the market. As discussed in chapter three, this is what happens with electoral systems, where the right to vote cannot be commercialized. Unlike this regime, when it comes to healthcare systems such as Chile's, the focus is placed on minimal protection and choices. Such an asymmetry (equality versus minimums) is far from politically neutral.
5. Healthcare systems such as the Cuban one, which rely on solidarity, do not lead to an individual entitlement to claim the services of physicians, hospital beds, or the technology healthcare comprises. Conceived under solidarity the right to health concerns the designation of an area that due to its fundamental importance is placed outside the market and guaranteed to all. In Cuba, the National Health System performs this function. The right to health

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[136] Brigit Toebes, *The Right to Health as a Human Right in International Law* (Intersentia 1999) 105-106; Maite San Giorgi, *The Human Right to Equal Access to Health Care* (Intersentia 2012) 46; UNCESCR, 'Consideration of Reports Submitted by States Parties under articles 16 and 17 of the Covenant [on Economic, Social and Cultural Rights]: Concluding Observations of the Committee on Economic, Social and Cultural Rights: India', UN Doc E/C.12/IND/CO/5, 8 August 2008, para 78; UNHRCL, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Paul Hunt', UN Doc. A/HRC/7/11, 31 January 2008, para 43.

[137] WHO, *Strengthening* (n 1) 21-22; WHO, *Report* (n 6) xv, 47.

translates into an equal right of access to a public service as guaranteed by the Constitution. In this respect, Cuba's understanding of the right to health entails to respect, protect and fulfil ideas of solidarity discussed in the second half of chapter four. By avoiding understanding healthcare purely or fundamentally as an individual challenge, by constitutionalizing the right to health and effectively granting it to every citizen free-of-charge based on medical need and not on ability to pay, and by seriously addressing primary healthcare, popular participation, prevention and health promotion, Cuba's healthcare system is compatible with the principles put forward in the Alma-Ata Declaration and the former strategy of *Health for All* of the WHO. Healthcare, as well as other basic social services is seen, from an ethical point of view, as linked to the satisfaction of the needs that are regarded pre-requisite for liberty. This allows basic needs and services such as healthcare to be accessed not in exchange of privilege, but as an entitlement attached to the status of citizenship, with limitations and priorities organized from the perspective of medical need and public health. Legally speaking the effect of social rights is to limit any arrangement conflicting with the universal provision of these rights. For this reason, this perspective limits property rights, the market and freedom of enterprise by declaring access to healthcare a *non-commodity*.[138] While Cuba may seem less interesting as not just healthcare but many other areas are also socialized, this is not a reason to dismiss the argument altogether. Similarly, it does not pose an obstacle for market economies to socialize or de-commodify access to healthcare.

6. Despite its limited economic resources, Cuba has given multiple proofs of its serious commitment towards the protection of the right to health. This coincides with what this thesis regards as the international obligations derived from the right to health. This obligation, the thesis has argued, is consistent with the Declaration on the New International Economic Order and has its source in Article 28 of the Universal Declaration of Human Rights.
7. The political agenda of austerity, a context where the biomedical approach remains to dominate the healthcare discussion, and the constant rise in the costs of healthcare, are all interrelated. Cuba's social medicine model based on participation, primary healthcare and interconnected policies, teaches lessons to all countries, rich and poor, that efficiency can coexist with equality and universality. As stated by Asa Laurell, a single, universal, free-of-charge public healthcare system, financed with public resources is the most humane option because it values equally the health of everyone; it is the fairest, because those that are most in need receive proportionally more; it is the most equitable because everyone has equal

[138] Ricardo García Manrique, *La Libertad de Todos: Una Defensa de los Derechos Sociales* (El Viejo Topo 2013) 240; Rutger Classen, 'Introduction. Public Services on the Market: Issues and Arguments' 3 (2) Public Reason 3, 5.

access to the existing services before the same needs, and it is the cheapest because it does not have to generate profits while keeping the lowest administrative costs.[139]

[139] Asa Cristina Laurell, '¿Pueden los seguros garantizar el acceso universal a los servicios de salud?' (2010) 5 (3) Medicina Social 184, 184-185.

CHAPTER SEVEN
CONCLUSIONS

In this study I explored what it would mean to interpret the international human right to health by means of the principle of solidarity. The hypothesis was that solidarity entails a different way of informing the duties that correlate with this human right. Also, it was hypothesized that solidarity entails a more coherent way of interpreting this principle by comparison to the authoritative views that have guided the interpretation of this right in recent years.

In chapter two, the study began by showing that the predominant interpretation of the right to health conceived this human right as an individual legal right, namely, a subjective entitlement, justiciable in court, and which is to a large extent informed by the notion of vulnerability. We also noted that this interpretation is operationalized by means of a few particular doctrines and legal techniques. At least three of these can be pointed out: the minimum core of rights doctrine, non-discrimination, and a special focus on people at disadvantage such as minority groups.

Regarding the minimum core, this doctrine demarcates the material content, legal subjects and effects of the obligations of the State under the ICESCR. Several public health measures are accompanied by an individual entitlement to access primary healthcare and emergency care. Making it easier to grasp the right to health at the judicial level, the minimum core doctrine also opens the door to the notion of violations, an important element within this interpretation. As to non-discrimination, we saw showed that this principle shapes all the net of health services, including access to healthcare. Non-discrimination means placing the attention not on the organizational aspects of the provision of healthcare, but on the fact that whatever mix of public or private services, their provision must be delivered without discrimination. Finally, a special focus on vulnerable persons and groups such as children, women, minorities such as the Roma people and others, reinforce the idea of the right to health as a legal right. This is because the protection of this right appears intrinsically targeted to persons and groups in conditions of vulnerability.

At the end of chapter two, the study laid out two main problems with this interpretation. Firstly, the limited ability and prospects of this interpretation to actually focus on the needs of the vulnerable and, secondly, the limited ability and prospects of this interpretation to connect with the social justice roots of social rights, which in the case of the right to health is the goal of guaranteeing equal access to healthcare for all.

These problems appeared linked to issues of both a theoretical and practical nature. Theoretically, the main problem is that conceiving the right to health as a legal right impedes deploying appropriate mechanisms to address the structural nature of the problems social rights raised to combat. Social rights emerged as an answer to a number of social malaises. These include poverty and social inequality among other forms of deprivation and marginalization. Conceived as a legal right, the right to health necessarily connects with the needs of the isolated individual. This is why, as chapter five showed, this technique finds itself more at ease when activating legal concepts such as human dignity, which are limited in tackling the intrinsically collective conundrums social rights posit. Due to its individualistic point of reference, the predominant interpretation has difficulties in recognizing the elements that the second half of chapter four described as social rights' inherent elements: their democratic pedigree, the principles of distributive justice that these rights uphold, the trade-offs that describe these rights' background and the collective nature of the remedies that best address their social nature (see the second half of chapter four).

The predominant interpretation understands the asymmetries between so-called first and second-generation rights in connection with the lack of justiciability of the latter. This view stems from this perspective's individualized conceptualization of social rights and its non-substantive nature, namely, the lack of a theoretical definition of the essence and distinctiveness of social rights. When looking at the notion of solidarity, we noted that for Post-War liberals the equal universalization of social rights did not require the judicialization of access-related questions (chapter three). Insisting on a judicial approach only confirms the asymmetry affecting social rights. This becomes clear when assessing political rights such as the right to vote, of which judicialization is not the primary function (irrespective of the fact that some of its dimensions may be susceptible of judicialization). The distinctive features of this right emerge from its ability to assert the universality and equality of outcome of the entitlement in the public arena. This takes place first of all by means of the requirement that electoral systems must enact the principle of one person, one vote. This principle is affirmed not just against the State but also against any other power, including private actors. Conceived in this fashion, electoral systems not only put an end to the institution of census suffrage but they also became incompatible with the commodification of the vote (despite some recent contrary tendencies such as *Citizens United*). This is not to say that judicial remedies do not have any role to play, for example in addressing discrimination. Yet, it would be wrong to identify the asymmetry between both sets of rights as an issue of discrimination or court justiciability. That perspective would fail to look at what each right seeks to protect (which in any case cannot be done from the moment that the definition of social rights is non-substantive), but also at what its most fundamental effects on society are. The predominant interpretation's definition of the right to health precludes it from seeing where the real asymmetry lies, namely, the limited extent the duties protecting social rights have been structured in the public domain by comparison to those of civil and political rights. As much as the sole declaration of political rights has led to an equal right to vote, the

right to health should put the State under the obligation to exclude the commercialization of healthcare so that access can be truly universalized. If the goal is to treat both sets of rights equally, as the Human Rights World Conference promised in Vienna in 1993, State action cannot be limited to subsidize the private sector. If at best this human right translates in a State subsidy to have the expenses of the healthcare industry covered when it addresses the financially unattractive health services to the public, the degree access to healthcare is a public good by comparison to the right to vote is certainly humbler. While the principle one person, one vote protects the right to vote in the public domain *equally* (in the sense that market considerations cannot make the entitlement of one individual weigh more than that of any other), the public expressions of the right to health are of lower intensity than those generated by classical rights.

Although the predominant interpretation regards legislative and administrative measures a primary way of realizing this human right (see chapter two), it places much more focus on and has higher expectations of the work of the judiciary. Legislative and administrative measures, although more suited to relate to the abovementioned elements of social rights, are relegated to a secondary place by the predominant interpretation. In this view, the justiciability of social rights places economic, social and cultural rights on an equal footing with civil and political rights. As a consequence, most of the attention is paid to individualized tools operated by the judiciary. These include the minimum core doctrine, the prohibition of discrimination and focuses on the vulnerable. Contrarily, insufficient attention goes to the rules regulating the access, financing and provision of healthcare, and the institutions in charge of carrying out that enterprise. The result is that under the predominant interpretation of the right to health: a) the provision of healthcare services can be either public, private or mixed, b) no State institution is *per se* under the duty of delivering healthcare services, c) commercialization is not *per se* opposed to human rights, and d) healthcare services must not necessarily be free-of-charge.

Moreover, the predominant interpretation advances the right to health through a set of legal mechanisms (see chapter four). These include the prohibition of discrimination, an affordable provision of healthcare services and their regulation. Non-discrimination has done a great deal for human rights, but it cannot possibly be expected to structurally shift the market so that everyone gets the same. Asking non-discrimination to *correct* the market fails to appreciate that the principles of distribution according to which the market operates are not accountable from the point of view of distributive justice. Rather, irrespective of the practical reality, market principles describe an interaction which is regarded as commutative, and where all individuals relate to one another via relations of supply and demand. Under those principles, it is not 'unjust' not to give something in exchange for anything less than its market price. This does not make the market an immoral form of distribution. What is simply not conducive is to expect that such principles will allow everyone attain the same.

Moreover, by establishing limits to the market provision and financing of healthcare services, affordability and regulation, rather than distinguishable instantiations of human rights duties, are the tools that attempt to curb the intrinsically unequal distribution logic of market

principles. While admittedly their involvement may lead to a limited public good – one where certain minimums are guaranteed for all – it is not less true that positioning those tools at the core of authoritative human rights interpretations has the effect of legitimizing the market delivery of healthcare services. Under this logic, the market not only becomes the default way of providing healthcare services, but also the inability to purchase healthcare services in the market becomes the very indicator determining when human rights are called to intervene. This renders the role of the market nothing less than crucial for current human rights-based approaches to health. In doing so, human rights, far from halting is giving green light to the most formidable source of health inequities.

To constantly revolve around the protected (vulnerable) legal subjects only partially realizes the right to health's task. The vulnerable may get a minimum, but from the moment that the market provision of healthcare services becomes acceptable to human rights, a parallelism emerges: the divide between the institutions serving those who can purchase these services in the market *vis-a-vis* the institutions serving those that cannot. In such a divide, the political priority attached to those that are served by the latter institutions pales by comparison to the political priority afforded to those that are served by the former. Moreover, as the right to health was already regarded as compatible with the market, the predominant interpretation can do little to counter this trend. Of not much relevance is the fact that the ECOSOC Committee notices with concern, in multiple Concluding Observations, the existence of a divide in the extension and quality of the commercial provision of healthcare services *vis-a-vis* their public counterpart. While the Committee describes the completely expectable disparities of access generated by healthcare commercialization, going as far as opposing that phenomenon is never presented as a task the right to health would be able to mandate. Well embedded in a set of frameworks defining what human rights should be about, it is hard for the right to health to reconnect with its social justice roots. The motto of 'Health for All' of the Alma-Ata Declaration, as raised once by the WHO, and still supported by grassroots international health movements such as the People's Health Movement, are not the focus of the predominant interpretation.

Without further characterization of the right to health's duties, without identifying the inherent characteristics of social rights such as the right to health, and without attempting to explicitly tackle the menaces that social rights were born to eradicate, the prospects of the right to health are not bright. Moreover, if the elements that the predominant interpretation defines as inherent to the right to health can be predicated from any other human right, to what extent are both sets of human rights placed on the equal footing that the Human Rights World Conference held in Vienna promised? Getting back to the research question that motivated the present study, can solidarity provide an alternative interpretation of this human right and if so, *how does solidarity inform the right to health?*

Justifying the duties of the right to health in line with the principle of solidarity has more potential to reconnect with the inherent elements of social rights. I explored the contents of solidarity and the relationships between this principle and health issues. Looking at various legal

instruments within international human rights law but also in the context of domestic bills of rights and other constitutional provisions, it turns out that the history of social rights has a great deal of connection with the principle of solidarity (see chapter three). A major way for solidarity to protect social rights consists in de-commodifying the areas identified by social rights. That finding proves that the history of social rights is more closely linked to solidarity and de-commodification, than to the justiciability of legal rights.

Furthermore, by galvanizing the idea that every member of the community has duties to one another, solidarity is inherently a communitarian notion. As such, solidarity fits social rights' democratic pedigree, or the idea that the communitarian nature of social rights is most appropriately expressed in the generality of legislative standards.

However, solidarity should not be stretched to the point of being made a synonym with anything the community decides. Solidarity's most important contribution is to inform the principles of distributive justice that apply to social rights (see chapter three). Solidarity strives to gradually replace the principles that lead to an inequitable distribution of the goods and services of social rights, into principles of distribution able to ensure universal access. In this respect, the principle of distribution preferred by solidarity is citizenship, as opposed to the unequal logic of market principles which distribute goods and services in accordance to ability to pay. As discussed in the second half of chapter four, this input from solidarity manifests itself on the level of the right to health's positive obligations. Under solidarity, these give shape not to a legal but to a non-marketed right. This is achieved by an obligation to protect and an obligation to fulfil. This obligation to protect primarily discourages and ultimately prohibits the marketed provision of healthcare services. In turn, the obligation to fulfil ensures a free-of-charge provision of those services. Moreover, in the judicial sphere, solidarity gives insight to the Covenant's notion of the progressive realization of social rights. This should be interpreted as the judiciary's ability to shift back the commodification of access to healthcare. The interplay of these various aspects allows ensuring the legal protection of a much more comprehensive public good. One where access to healthcare does not depend only from the position of vulnerability of specific individuals. As showed in chapter three, vulnerability is certainly a constitutive component of solidarity, but it does not fully cover it. As chapter three showed, what marks the beginning of social rights is the idea that solidarity would replace charity as a source of legal obligations. Further developed by thinkers such as T H Marshall, social rights would complete a project of emancipation that would come in waves, and where the social rights layer would be added to the already gained conquests that civil and political rights entailed.

I argued that under solidarity citizenship should not be regarded as the only principle of distribution guiding the provision of healthcare services. While indeed the history of solidarity allows the establishment of a natural connection with the idea of citizenship, solidarity can also relate to the idea of medical need. That was in fact one of the fundamental principles in the provision of social rights under institutions such as the British National Health Service. This idea is consistent with the ICESCR, which in Article 12(2)(d) considers medical need a principle of

distribution for the right to health. Yet, when read in combination with the prohibition of discrimination on national grounds as established by Article 2(2) of the same treaty, this idea reflects the most ambitious emancipatory horizons of the Bill of Human Rights, which according to Article 28 of the Universal Declaration of Human Rights, should be understood along with the lines of the right to an equitable international order. In this understanding, solidarity appears as the natural principle orienting the construction of a cosmopolitan project of citizenship, where the legal scope of the right to health is not limited by territorial considerations. In the present situation, this understanding means that the State is certainly obliged to realize the right to health in favour of its citizens, but also in favour of every person in the globe in a situation of medical need. Consequently, regarding non-citizens within the State's jurisdiction, the State should realize the right to health without discrimination. I argued that regarding the right to health of non-citizens located beyond its borders, following Cuba's example, the State should help the realization of their right to health through international cooperation.

A further point of contact between solidarity and social rights' inherent elements concerned trade-offs. Since under solidarity the right to health is not conceived as an individual legal right, solidarity fits more naturally with this requirement. In this sense, I have shown that the point is not to deny the trade-offs inherent in the ineradicable scarcity of economic resources, but to take issue with trade-offs opposed to citizenship and medical need as principles of distribution. The predominant interpretation, with its insistence on reducing the right to health to an individual legal right, becomes dangerously compatible with essentialist adjudications, which by failing to give room to the ineradicable trade-offs of social rights, are likely to put the judiciary at the service of those with more economic resources. By the same token, by failing to safeguard the financial sustainability of healthcare systems, the predominant interpretation may compromise the rights of the most vulnerable as the poor heavily rely on public services.

Furthermore, solidarity also provides insight when it comes to the collective remedies better fitting the multiple needs in a context of scarce resources that describe social rights. In this respect, following a now classical decision from Portugal's Constitutional Court and the remarks of the Special Rapporteur for the Right to Health, the national healthcare system is a completely ineluctable institution without which this human right cannot be conceived. What solidarity adds in this respect are the positive obligations of the right to health. On the one hand the obligation to protect this human right by ultimately prohibiting the commercial provision of healthcare services. On the other, the obligation to fulfil the right to health by means of the in principle free-of-charge provision of healthcare services. Thus, ensuring a solidarity-based alternative to the unequal logic of market distribution principles requires understanding that the State discharges its obligations by instituting a free-of-cost national healthcare system accessible to all persons situated under the State's jurisdiction.

Important overlaps can be detected between health-financing systems that rely on the market and the predominant interpretation of the right to health (see chapter six). The individualistic perspective of the right to health, so prone to protect the 'deserving poor', fits

well with systems that are mainly built around market principles and where the action of the State is a subsidizer for those unable to purchase social rights in a market context. This contrasts with Cuba's tax-funded healthcare system. Under solidarity, the unavoidable trade-offs are not carried out sacrificing the weakest but in accordance to principles of distributive justice and sound public health evidence. Furthermore, the equality and universal focus of Cuba's healthcare system not only entail the basic presuppositions for a human rights-based discussion of efficiency. The impressive achievements of Cuba's healthcare system reached with its limited resources, show that justice is not necessarily opposed to economic efficiency.

States that have signed the Covenant are free to interpret the legal obligations derived from this treaty in a way that is not necessarily in line with the predominant interpretation of the right to health. Despite the authority and widespread recognition enjoyed by the bodies that defend that understanding, I conclude that the predominant interpretation of the right to health has several flaws that require careful assessment. The inability of the authoritative bodies to identify the commercialization of healthcare as the greatest threat to this human right is a fundamental part of the problem. Furthermore, the main asymmetry between social rights such as the right to health and classical rights comes not from the lack of justiciability of this right in court, but from the incapacity of human rights to put aside the market, property, entrepreneurialism and search for profits, which threatens the goal of equal access to healthcare for all. This asymmetry keeps assigning so-called second generation rights a lower status. Healthcare commercialization, that defines the present era, is also illustrative of the crossroads where the human rights project presently stands. The future will teach us whether the human rights project is in fact as fundamental as its most conspicuous advocates constantly proclaim. Either it will triumph by overmastering our political economy or, submissive to market imperatives, it will become less relevant as a narrative of emancipation.

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SUMMARY IN ENGLISH

Since the World Conference on Human Rights held in Vienna in 1993, the idea that all human rights are universal, indivisible, and interrelated has become standard. However, this thesis argues that this goal has not been attained because social rights such as the right to health have not been granted what is inherent to them. Social rights need to be protected in their distinctive normative content and not be conflated with classical rights.

This thesis explores the distinctive normative content of one particular social right, namely the right to health. From the perspective of international human rights law, the *lex lata* element of this right is based on Articles 12 and 2(1) of the International Covenant on Economic, Social and Cultural Rights. In the borderline between what the right to health *is* and what the right to health *should be*, lie a series of interpretations. This study analyses what it calls calls *the predominant interpretation of the right to health*. This interpretation fundamentally comprises the contributions of two UN bodies: the Committee on Economic, Social and Cultural Rights − consisting specifically of this Committee's General Comments and Concluding Observations − and the reports of the Special Rapporteur for the Right to the Highest Attainable Standard of Health. Yet, what this study also does is to explore another interpretation. In this case, what this thesis considers to be a philosophically coherent standpoint that permeates social rights in general, and the right to health in particular: the principle of solidarity.

The goal of this thesis is to explore whether solidarity can teach us something about the limitations, challenges and contradictions involved in an individualized understanding of the right to health while at the same time exploring what it means to link solidarity with the duties and institutions that make the right to health possible. In this way, the study's research question can be formulated as follows: *How does the principle of solidarity inform the right to health?* In answering this question, the study's hypothesis is that it is solidarity and not the over-expansion of legal rights what gives this social right its distinctiveness.

In chapter two, the predominant interpretation of the right to health is analyzed. After outlining the work of the relevant treaty bodies, the study shows that, for the most part, these bodies do not conceive of the right to health in a substantive way. Rather, the right to health is fundamentally interpreted as a legal right, namely, a judicialized mechanism to claim a particular treatment. This interpretation of the right to health leaves a number of challenges unsolved. The most important problem is whether an individualized or group focus is able to move forward equity in access to healthcare. Can this view help articulate equal enjoyment of access to

healthcare for all? Is judicialization of the right to health an effective way towards the reach of that objective?

Chapter three explores a critical notion for the right to health, namely the principle of solidarity. From a historical point of view, the distinctive nature of social rights originates in a republican and socialist vision linked to the concept of solidarity. Research on this conceptual history allowed to demarcate the boundaries of this principle with a certain level of specificity and distinctiveness. In connection with social rights, solidarity means the universalization of the access to the material conditions that make liberty and communal life possible. This is corroborated when looking at the institutional implications of social rights. Under solidarity, social services are created in order to meet collective rather than individual needs. Private dynamics are replaced by public dynamics where the areas covered by social rights are *socialized*. In this way solidarity limits the principle of competence of the modern liberal State (freedom understood as 'autonomy' or 'non-interference').

Chapter four unfolds the main claim of this study, namely that the idea that solidarity, as understood in the abovementioned terms, should be used to consistently interpret the legal nature of the right to health. The first half of this chapter casts criticism on the predominant interpretation of the right to health. The main critique is that the predominant interpretation shifts the right to health from the declared goal of *equal access to healthcare for all* to the goal of *a justiciable minimum for those unable to buy healthcare services*. The study claims that this latter view struggles to fulfil the same equality of treatment classical rights achieve. This, the thesis argues, is what gives social rights their second class status by comparison to civil and political rights. To come to this conclusion, this section discusses a number of issues. A particularly important one is legal non-discrimination, which in the case of the right to health has been driven by the misconception that the principle can deliver equal access to healthcare for all. The appropriate inquiry – it is argued in the thesis – should also measure equality by looking at how much equality of outcome the provision of healthcare services deliver, namely, whether access to healthcare services are or not provided in exchange of economic resources.

In the second half of the chapter, building on the conclusions of chapter three, an alternative way of interpreting the right to health is put forward. This section argues that the right to health should be applied in line with solidarity and explores how that could be achieved in the light of the legal duties and institutions solidarity helps to identify. The chapter proposes an alternative interpretation of the right to health. One that does not rely on vulnerability as the notion that justifies the duties protecting social rights, but one that is grounded on solidarity, a principle that contemplates situations of vulnerability, such as childhood or motherhood, but which goes beyond, in a more comprehensive and transformative sense.

To say that the right to health is grounded in solidarity means that the goal of this right consists in the ever-increasing path towards equal access to healthcare for all. From access conditioned by social privilege, to access based on citizenship and medical need. The main idea behind solidarity consists not in proclaiming an individual legal right for one or more individuals,

but in understanding the right to health as a public good in constant need of promotion through obligations to respect, protect and fulfil. While the obligation to respect is not different from the predominant interpretation, the thesis addresses in more detail the obligations to protect and to fulfil. Concerning the obligation to protect, the chapter describes it as the discouragement or prohibition of the for-profit provision of healthcare. The obligation to fulfil entails the establishment of a non-marketed right of access to public healthcare services free-of-charge based on citizenship and medical need.

While chapter four provides an alternative explanation of the meaning of the right to health under solidarity, chapter five explores whether that understanding has been supported in salient access-to-healthcare judicial decisions. The purpose of this inquiry is to find out how courts have ruled in access-to-healthcare cases, what salient case law trends can be detected, and whether any of these protects the right to health in line with the alternative understanding provided in the second half of chapter four.

Two case law trends are identified in this respect. The first one conceives the right to health as an individual legal right. Namely, this trend affirms the legitimacy of the judiciary's action to step in and challenge legislative arrangements that limit individual or groups' access to healthcare. In this perspective courts have protected the right to health both directly and indirectly.

Concerning the direct protection, the analysis focuses mostly on the legal connection with the value of human dignity. Here, the study assesses the ability of a legal right to protect the integrity of the public healthcare system. As it is not a classical right, this interest automatically attains the lower status of an aggregated demand. As such, it can never counter the protected interests that coincide with the scope of classical rights.

The study also analyses indirect efforts of protection, namely, cases where the right to health has been protected via other human rights. This section shows that there can indeed be a number of overlaps between the right to health and the normative elements of other rights. Yet, while medically speaking it makes sense to relate poor health to the curtailment of life, the study looks at the reasons of why a *legal* interrelation between these two rights remains unclear.

The study also identifies a second trend in the case law on access to healthcare. This perspective is not based on the rationale of individual legal rights, but it fits the concept of solidarity. As chapter four clarified, solidarity leads primarily to a legislative understanding of the right to health – what everyone in the community owes to everyone else. Yet, the thesis argues that the *outlawing* of legislative healthcare provisions by the judiciary are also a possibility within this trend: courts can strike down an administrative act or legal statute to respect, protect or fulfil the right to health under solidarity. This happens when the statute challenges the solidarity embedded in the healthcare system. In this sense, courts can put back in place a former healthcare provision that better aligns with solidarity. Courts can use solidarity as a guideline that operationalizes the progressive realization of the right to health. Namely, courts can vetoe attempts of conditioning access to healthcare to economic privilege. Because of

social rights' democratic pedigree, the judiciary cannot operate actively but only reactively. It can only review a legislative decision, not generate new policy.

Chapter six asks for the role that solidarity plays in the context of health systems. Taking the premise that what solidarity does is to link the question of access to healthcare to the institutional features of the health system, financing in particular, the chapter looks at different models of healthcare delivery. By means of case studies, the chapter looks at the healthcare systems of Cuba, Chile and the Netherlands. While the majority if not all healthcare systems are premised on different degrees of State involvement, this should not be considered a synonym of solidarity. Chile and the Netherlands both show substantive State involvement in healthcare. Both schemes concede that social rights are a matter of public concern. Yet, in both cases, the community is concerned only to a certain extent with these needs.

Healthcare systems such as the Cuban one, which rely on solidarity, do not lead to an individual entitlement to claim the services of physicians, hospital beds, or the technology healthcare comprises. Conceived under solidarity the right to health concerns the designation of an area that due to its fundamental importance is placed outside the market and guaranteed to all. In Cuba, the National Health System fulfils this human right. The right to health translates into an equal right of access to a public service as guaranteed by the Constitution. In this respect, Cuba's understanding of the right to health entails to respect, protect and fulfil ideas of solidarity discussed in the second half of chapter four.

States that have ratified the International Covenant on Economic, Social and Cultural Rights are bound to the treaty but not necessarily to the predominant interpretation of the right to health. Despite the authority and widespread recognition enjoyed by the bodies that defend that understanding, this thesis concludes that the predominant interpretation of the right to health has several flaws that require careful assessment. The inability of the authoritative bodies to identify the commercialization of healthcare as the greatest threat to this human right is a fundamental part of the problem. Furthermore, the main asymmetry between social rights such as the right to health and classical rights comes not from the lack of justiciability of the right to health in court, but from the incapacity of human rights to put aside the market, property, entrepreneurialism and search for profits, which threatens the goal of equal access to healthcare for all. This asymmetry keeps assigning so-called second generation rights a lower status. The healthcare commercialization, that defines the present era, is also illustrative of the crossroads where the human rights project presently stands. The future will teach us whether the human rights project is in fact as fundamental as its most conspicuous advocates constantly proclaim. Either it will triumph by overmastering our political economy or, submissive to market imperatives, it will become less relevant as a narrative of emancipation.

SUMMARY IN DUTCH

Sinds de in 1993 in Wenen gehouden Wereldconferentie over Mensenrechten is de gedachte dat alle mensenrechten universeel, ondeelbaar en onderling samenhangend zijn gemeengoed geworden. In dit proefschrift wordt echter gesteld dat dit doel niet is bereikt, omdat de sociale grondrechten, zoals het recht op gezondheid, niet de aan dezen toekomende erkenning hebben gekregen. De sociale grondrechten moeten worden beschermd conform hun kenmerkende normatieve inhoud en mogen niet samenvallen met de klassieke grondrechten.

Het onderzoek in dit proefschrift richt zich op de kenmerkende normatieve inhoud van één specifiek sociaal grondrecht, te weten het recht op gezondheid. Vanuit het perspectief van het internationale recht inzake de mensenrechten is het *lex lata* element van dit recht gebaseerd op art.12 en art.2 lid 1 van het Internationaal Verdrag inzake economische, sociale en culturele rechten. Er zijn diverse interpretaties van wat het recht op gezondheid *is* en wat het recht op gezondheid *zou moeten zijn.* Dit onderzoek bevat een analyse van de zogenaamde *heersende interpretatie van het recht op gezondheid.* Deze interpretatie omvat in essentie de bijdragen van twee VN-instellingen: het Comité voor economische, sociale en culturele rechten - meer specifiek de algemene en afsluitende opmerkingen (*General Comments* en *Concluding Observations)* - en de rapporten van de Speciale Rapporteur voor het recht op een zo goed mogelijke gezondheid. In dit proefschrift wordt echter ook een andere interpretatie aan de orde gesteld. Deze betreft een filosofisch coherent gezichtspunt, waarvan de sociale grondrechten in het algemeen en het recht op gezondheid in het bijzonder zijn doordrongen: het solidariteitsbeginsel.

Het doel van dit proefschrift is om te onderzoeken of solidariteit ons iets kan leren over de beperkingen, uitdagingen en contradicties die samenhangen met een geïndividualiseerde opvatting van het recht op gezondheid, terwijl tegelijkertijd wordt onderzocht wat het betekent om solidariteit te koppelen aan de verplichtingen en instellingen die het recht op gezondheid mogelijk maken. De onderzoeksvraag van deze studie kan daarom als volgt worden geformuleerd: *Hoe geeft het solidariteitsbeginsel vorm aan het recht op gezondheid?* Bij de beantwoording van deze vraag wordt uitgegaan van de hypothese, dat solidariteit, en dus niet het eindeloos oprekken van juridische rechten, aan dit sociale grondrecht een eigen karakter verleent.

Hoofdstuk twee bevat een analyse van de heersende interpretatie van het recht op gezondheid. Na een overzicht van het werk van de desbetreffende verdragsorganen, laat het

onderzoek zien dat deze organen het recht op gezondheid in het algemeen niet inhoudelijk benaderen. Het recht op gezondheid wordt veeleer geïnterpreteerd als een juridisch recht, te weten een gejudicialiseerd mechanisme voor het claimen van een specifieke behandeling. Deze interpretatie van het recht op gezondheid biedt voor een aantal problemen geen oplossing. Het belangrijkste vraagstuk is of het mogelijk is om met behulp van een geïndividualiseerde- of groepsfocus gelijke toegang tot de gezondheidszorg te bevorderen. Kan deze opvatting bijdragen tot het verwoorden van gelijke toegang tot de gezondheidszorg voor iedereen? Is de judicialisering van het recht op gezondheid een effectieve manier om dit doel te bereiken?

In hoofdstuk drie wordt aandacht besteed aan een cruciaal begrip in het kader van het recht op gezondheid, te weten het solidariteitsbeginsel. Historisch gezien is het kenmerkende karakter van de sociale grondrechten gebaseerd op een republikeinse en socialistische visie op het solidariteitsconcept. Onderzoek naar de geschiedenis van dit concept maakte het mogelijk om de grenzen van dit beginsel meer specifiek en onderscheidend af te bakenen. In het kader van sociale grondrechten betekent solidariteit het universeel maken van de toegang tot de essentiële voorwaarden die vrijheid en gemeenschapsleven mogelijk maken. Dit wordt bevestigd wanneer wij kijken naar de institutionele implicaties van de sociale grondrechten. Conform het solidariteitsbeginsel worden sociale voorzieningen eerder ter voorziening in collectieve-, dan in individuele behoeften ingericht. Een publieke dynamiek vervangt de particuliere dynamiek wanneer de terreinen waarop de sociale grondrechten betrekking hebben, worden *gesocialiseerd.* Solidariteit beperkt zo het principe van de competentie van de moderne, liberale staat (vrijheid opgevat als 'autonomie' of 'non-interventie').

In hoofdstuk vier wordt de hoofdstelling van dit onderzoek gepresenteerd, te weten de opvatting dat solidariteit, zoals in het voorgaande uiteengezet, dient te worden gebruikt voor een consistente juridische interpretatie van het recht op gezondheid. Het eerste deel van hoofdstuk vier bevat kritiek op de heersende interpretatie van het recht op gezondheid. Het belangrijkste punt van kritiek is, dat in de heersende interpretatie het doel van het recht op gezondheid wordt verlegd van het erkende doel van *gelijke toegang tot de gezondheidszorg voor iedereen* naar het doel van *een justitiabel minimum voor diegenen, die niet in staat zijn om gezondheidszorgdiensten te kopen.* Gesteld wordt, dat men in deze laatste visie tracht om te komen tot dezelfde gelijke behandeling als bij de verwezenlijking van de klassieke rechten. Dit is volgens het proefschrift de reden voor de tweederangspositie van sociale grondrechten in vergelijking met de burgerlijke en politieke rechten. Deze conclusie volgt uit een aantal in dit deel besproken onderwerpen. Een uiterst belangrijk onderwerp is in dit verband het beginsel van juridische non-discriminatie, dat in het geval van het recht op gezondheid berust op de misvatting, dat het gelijke toegang tot de gezondheidszorg voor iedereen zou kunnen bewerkstelligen. Voor een correct onderzoek dient men -aldus de argumentatie in het proefschrift- gelijkheid ook te meten door te kijken naar de mate van gelijkheid bij de door de gezondheidszorgdiensten geleverde diensten, namelijk of toegang tot de gezondheidszorgdiensten al dan niet wordt verleend in ruil voor economische middelen.

In het tweede deel van hoofdstuk vier wordt, voortbouwend op de conclusies van hoofdstuk drie, een alternatieve interpretatie van het recht op gezondheid gepresenteerd. In dit onderdeel wordt gesteld dat het recht op gezondheid dient te worden toegepast conform het solidariteitsbeginsel, en wordt onderzocht hoe dit kan worden verwezenlijkt in het licht van de via dit beginsel vastgestelde juridische verplichtingen en instellingen. In hoofdstuk vier wordt een alternatieve interpretatie van het recht op gezondheid gegeven. Deze berust niet op het concept van kwetsbaarheid ter rechtvaardiging van de plichten ter bescherming van sociale grondrechten, maar is gebaseerd op solidariteit, een beginsel dat rekening houdt met situaties van kwetsbaarheid, zoals kind-zijn of moederschap, maar deze overstijgt, in een meeromvattende en transformerende zin.

De stelling dat het recht op gezondheid is gebaseerd op solidariteit houdt in, dat dit recht zich richt op een toenemende mate van gelijkheid bij de toegang tot de gezondheidszorg voor iedereen. Van toegang bepaald door sociale voorrechten tot toegang op basis van staatsburgerschap en medische behoefte. Solidariteit bestaat in essentie niet uit het verkondigen van een individueel juridisch recht voor één of meer individuen, maar erkent het recht op gezondheid als een publiek goed, dat continue aandacht vereist via verplichtingen om dit te bevorderen, te beschermen en te verwezenlijken. Bij de verplichting tot bevorderen is er geen verschil met de heersende interpretatie; daarentegen komen de verplichtingen tot bescherming en verwezenlijking in het proefschrift uitgebreid aan de orde. De verplichting tot bescherming wordt in het hoofdstuk gedefinieerd als de ontmoediging van of het verbod op het verlenen van gezondheidszorg met winstoogmerk. Uit de verplichting tot verwezenlijking volgt het vaststellen van een niet vermarktbaar recht van toegang tot gratis publieke gezondheidszorgdiensten op basis van staatsburgerschap en medische behoefte.

Terwijl hoofdstuk vier een alternatieve uitleg bevat van de betekenis van het recht op gezondheid conform het solidariteitsbeginsel, wordt in hoofdstuk vijf onderzocht of deze opvatting steun vindt in opvallende rechterlijke uitspraken inzake toegang tot de gezondheidszorg. Dit onderzoek beoogt te achterhalen, hoe rechters hebben geoordeeld in zaken over de toegang tot de gezondheidszorg, welke opvallende trends in de jurisprudentie waarneembaar zijn, en of er uitspraken zijn die het recht op gezondheid beschermen conform de in het tweede deel van hoofdstuk vier gepresenteerde opvatting.

In dit verband kunnen er twee trends in de jurisprudentie worden vastgesteld. In de eerste trend wordt het recht op gezondheid beschouwd als een individueel juridisch recht. Deze trend bekrachtigt de legitimiteit van het optreden van de rechterlijke macht, die vraagtekens zet bij wetgevingsmaatregelen ter beperking van de toegang van individuen en groepen tot de gezondheidszorg. Gezien in dit perspectief heeft de rechterlijke macht het recht op gezondheid zowel direct als indirect beschermd.

Wat de directe bescherming betreft, ligt de focus van de analyse vooral bij het juridisch verband met de waarde van de menselijke waardigheid. In de studie wordt geëvalueerd of een juridisch recht de integriteit van het publieke gezondheidszorgsysteem kan beschermen.

Aangezien het geen klassiek grondrecht betreft, verkrijgt dit belang automatisch de lagere rang van een geaggregeerde vraag. Als zodanig kan het nooit weerwerk bieden aan de beschermde belangen die vallen onder de reikwijdte van de klassieke grondrechten.

De studie bevat ook een analyse van pogingen tot indirecte bescherming: zaken waarin het recht op gezondheid werd beschermd via andere mensenrechten. Hieruit blijkt, dat het recht op gezondheid en de normatieve elementen van andere rechten elkaar deels kunnen overlappen. Terwijl het vanuit medisch oogpunt voor de hand ligt om een verband te leggen tussen slechte gezondheid en verkorting van de levensduur, wordt in de studie gekeken naar de redenen, waarom een *juridisch* verband tussen deze beide onduidelijk blijft.

In de jurisprudentie over toegang tot de gezondheidszorg is tevens een tweede trend waarneembaar. Dit perspectief is niet gebaseerd op de ratio van individuele juridische rechten, maar past bij het concept van solidariteit. Zoals in hoofdstuk vier is toegelicht, leidt solidariteit in de eerste plaats tot een juridisch begrip van het recht op gezondheid: wat iedereen in de gemeenschap is verschuldigd aan ieder ander. Toch wordt in het proefschrift gesteld dat in deze trend ook de mogelijkheid bestaat dat de rechterlijke macht *wetsbepalingen* inzake gezondheidszorg *onwettig verklaart*: rechters kunnen een bestuurshandeling of wet ter bevordering, bescherming of verwezenlijking van het recht op gezondheid terzijde stellen met een beroep op solidariteit. Dit gebeurt wanneer de wet in strijd is met de in het gezondheidszorgsysteem besloten solidariteit. Aldus kan de rechter een eerdere bepaling inzake de gezondheidszorg die beter strookt met het solidariteitsbeginsel weer in ere herstellen. Rechters kunnen solidariteit hanteren als een richtlijn ter operationalisering van de toenemende verwezenlijking van het recht op gezondheid. Rechters kunnen namelijk hun veto uitspreken in geval van pogingen om de toegang tot de gezondheidszorg te laten afhangen van economische privileges. Gezien de democratische oorsprong van de sociale grondrechten kan de rechterlijke macht niet actief, maar slechts reactief optreden. Zij kan een wetgevende beslissing enkel toetsen, maar geen nieuw beleid maken.

In hoofdstuk zes komt de vraag aan de orde welke rol solidariteit speelt binnen de context van gezondheidssystemen. Op basis van de premisse dat solidariteit de vraag naar toegang tot gezondheidszorg koppelt aan de institutionele kenmerken van het gezondheidssysteem, in het bijzonder financiering, wordt gekeken naar verschillende modellen voor het leveren van gezondheidszorg. Aan de hand van casestudy's wordt in het hoofdstuk gekeken naar de gezondheidszorgsystemen van Cuba, Chili en Nederland. Ofschoon de meeste, zo niet alle gezondheidszorgsystemen verschillende gradaties van staatsbemoeienis kennen, mag dit niet worden beschouwd als synoniem aan solidariteit. Zowel Chili als Nederland kennen een hoge mate van staatsbemoeienis in de gezondheidszorg. In beide stelsels erkent men dat sociale grondrechten een zaak zijn van publiek belang. Toch is in beide gevallen de gemeenschap slechts tot op zekere hoogte begaan met deze behoeften.

Systemen van gezondheidszorg, zoals het Cubaanse systeem, die zijn gebaseerd op solidariteit resulteren niet in een individueel recht tot het claimen van diensten van artsen, van

ziekenhuisbedden of van de technologie in de gezondheidszorg. Conform het solidariteitsconcept heeft het recht op gezondheid betrekking op het aanwijzen van een gebied dat, gezien het fundamentele belang ervan, buiten de markt wordt geplaatst en aan allen wordt gegarandeerd. Op Cuba wordt dit grondrecht verwezenlijkt door het nationale gezondheidssysteem. Het recht op gezondheid wordt vertaald in een gelijk recht op toegang tot een in de grondwet gegarandeerde publieke dienst. Cuba's visie op het recht op gezondheid leidt er dus toe, dat de in het tweede deel van hoofdstuk vier behandelde solidariteitsgedachte wordt bevorderd, beschermd en verwezenlijkt.

De landen die het Internationale Verdrag inzake economische, sociale en culturele rechten hebben geratificeerd, zijn wel gebonden aan het verdrag, maar niet noodzakelijkerwijs aan de heersende interpretatie van het recht op gezondheid. Ondanks het gezag en de wijdverbreide erkenning van de organen die deze opvatting voorstaan, is de conclusie in dit proefschrift dat de heersende interpretatie van het recht op gezondheid diverse gebreken vertoont, die zorgvuldig moeten worden beoordeeld. Een fundamenteel onderdeel van het probleem is het onvermogen van de gezaghebbende organen om in te zien dat de commercialisering van de gezondheidszorg de grootste bedreiging vormt voor dit grondrecht. Tevens komt de belangrijkste asymmetrie tussen de sociale grondrechten, zoals het recht op gezondheid, en de klassieke grondrechten niet voort uit het ontbreken van de afdwingbaarheid in rechte van het recht op gezondheid, maar uit de onmacht van de mensenrechten om zaken als markt, bezit, ondernemerschap en winstbejag te negeren, hetgeen een bedreiging vormt voor het doel van gelijke toegang tot gezondheidszorg voor iedereen. Deze asymmetrie leidt ertoe dat aan de zogenaamde tweede-generatie rechten nog steeds een lagere status wordt toegekend. De voor de huidige tijd kenmerkende commercialisering van de gezondheidszorg, illustreert tevens het kruispunt, waarop het mensenrechtenproject zich momenteel bevindt. De toekomst zal ons leren of het mensenrechtenproject echt zo fundamenteel is als de meest markante voorvechters ervan voortdurend beweren. Het zal ofwel zegevieren door onze politieke economie te overmeesteren, ofwel, onder invloed van marktimperatieven, als emancipatoir narratief aan belang inboeten.

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Eduardo Arenas Catalán studied law at *Universidad Católica del Norte* in Chile, graduating with distinction in 2008 and becoming entitled to practice the legal profession in 2012. In 2011, he graduated with the highest distinction from the Legal Research Master's Programme at Utrecht University. In 2012, he began his PhD at Utrecht University under the supervision of Professor Leonard Besselink.

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