



Is Health a Human Right? The European Perspective

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Short Introduction: Neni Panourgiá, ICLS, Director of Program on Health as a Human Right

After a short introduction where Mr. Panayotis Yatagantzidis will present some tentative definitions of the concept of human rights as delineated in different schools of thought, he will move towards a constitutional cartography of the right to health in nations-members of the European Union. From within that perspective he will examine the international protection provided by the Treaty of the EU and the European Declaration of Human Rights and he will analyze the existing international legal discourse. He will locate the limits of protection provided by the existing legal framework in the EU, and with a commitment to the social welfare state and the principles of Democracy, he will arrive at a number of conclusions that will envelope within them the protection of health.

FOREWORD

Thank you very much, Neni, for this introduction and many thanks to the Program “Perspectives on Health as a Human Right” for addressing to me this exceptionally honoring invitation to be at this academic stand today, and for inviting me to deliver the inaugural address for what promises to be a most important and influential research program. I would also like to thank profoundly the Heyman Center for the Humanities and Professor Gillooly in specific for their generous hospitality. My thanks also go to the Institute for Comparative Literature and Society, the Program in Hellenic Studies, The Center for Justice at Columbia University, and the Institute for the Study of Human Rights. On this occasion, I would also like to sincerely thank from this stand two of my colleagues, Mrs. Aikaterini Fereti and Dr. Dimitrios Tsarapatsanis, for their valuable assistance in the preparation of this talk. Last, but by no means least, I would like to thank Professor Downey for kindly agreeing to offer her thoughts and comments on what I am about to present here today. Finally, I wish to thank all of you for coming.

Dear members of the Professoriat, dear students, Fellows, ladies and gentlemen,

I could not hide from you the fact that the topic I will elaborate today is the follow-up of a conversation I had some months ago with Professor Panourgia, during a walk under the Acropolis of Athens. The conversation was about the gloomy economic crisis that Greece has been undergoing in recent years and the traumatic impact it has had on human health. Indeed, there appears to be reliable evidence to the effect that the economic crisis is correlated with a recent spike in suicide rates. So the question of the significance and limits of the human rights to health and to life came immediately to the fore. I would therefore like once again to warmly thank Professor Panourgia not only for having invited me here today, but also because her deep concern encouraged me to delve into the core of the

concept of human rights, in search of potential legal grounds as well as of limits to a putative human right to health. As we shall see, many national jurisdictions and international instruments consider this as a fundamental right, on a par with the human rights to life and to dignity. However, is such recognition sufficient in order to classify health as a human right? And what exactly could such a classification entail?

I. INTRODUCTION

With regard to scope, my research regarding the recognition of the right to health is restricted to the European legal landscape and, more specifically, to a complex of superimposing legal structures that comprise the national level, the EU legal order, the Council of Europe and the international legal order. This is so for two reasons. First, this landscape constitutes the natural and familiar field of my scientific and professional activity for many years now. Second, and perhaps more importantly, Europe, which traditionally preserves such intimate historical and organic ties with the United States, appears to have developed a complex and multilevel model of protection of health, which could prove to be suitable for different kinds of productive comparisons with federal systems such as the American one.

I must, however, explain in a nutshell what I mean here by “*multilevel*” protection. In essence, I am referring to the fact that many legal systems, which encompass the right to health in their scope of application and collectively define the legal status of the European citizen vis-à-vis this right, overlap in their protective ambit. The provisions of these legal systems tend to apply either jointly or independently, which results in the reinforcement and extension of the scope of protection of the right to health. At the same time, the coexistence and parallel functioning of these legal systems also reflects the current complex institutional structure of Europe.

Within this framework, the first level of protection rests upon the State, to wit, the Member State of the European Union. This is the main institutional unit of protection, which carries with it the primary responsibility for the effective implementation of the right to health. As we shall see, this responsibility stems in part from national constitutional and legislative provisions. But it is also the case that the national level is crucial insofar as it is responsible for the effectiveness of the provisions of European and international law, which depends to a large extent on the national legal order and the actions of national authorities. The second level concerns the protection granted to citizens, directly or indirectly, by way of provisions of European Union law. A third source of law and a parallel level of protection to European Union law is the one stemming from the European Convention of Human Rights. The Convention system establishes a number of institutions comprising the Council of Europe, the most important of which, from the point of view of our research, is the European Court of Human Rights. Despite the fact that the Convention does not explicitly enshrine a human right to health, the jurisprudence of the Court constitutes a major guarantee and a guide for the protection of such a right. Lastly, health-related protective guarantees also flow

from a fourth source of law: the complex grid of international law instruments and provisions. These include Covenants of the United Nations, Acts and Resolutions of International Bodies and international treaties, bilateral or multilateral, signed and ratified by the Member States of the European Union.

Allow me, now, before proceeding to the main discussion of my topic, to note that the title of my talk turns on two crucial terms, whose content might not be as clear as it would seem, at least from a first glance. The first is the term “*health*”. What do we actually understand by that? The answer to this question is particularly important because the protection that the individual may enjoy or claim as a matter of right depends on whether we adopt a narrow or a wide interpretation of the term. The second concerns the term “*human right*”. Under which conditions can we specifically use it to refer to the protection of someone’s health? And what does such protection entail with regard to the actions and omissions of state authorities? It is evident that the determination of the nature of this right also commands its legal reach regarding the protection of health.

As far as the first question is concerned, I must highlight, from the very beginning, the difficulties mentioned by many international commentators when it comes to providing a general definition of the concept of health that could be adopted systematically by ‘*legal science*’ (as we traditionally call it in Continental Europe). How could a notion like that of health, that is to do with all aspects of human life, be defined i.e. *circumscribed* in a non question-begging way? Still, we should not be skeptics by default. After all, it is a fact of international legal reality that we are familiar with a host of national health-protection systems. These do provide approximate definitions of the term “*health*”, which are further determined by reference to the special characteristics akin to each such system. We observe that this principally occurs in cases where a social security regime is established: in these cases, the relevant specifications aim at covering the insurance risk of a disease. So, one approach could consist in comparing these national systems, eventually spotting areas of conceptual overlap in the definition of health.

On the other hand, and insofar as human health is also considered by many as a fundamental universal value, a particularly useful methodological starting point to the present analysis could consist in taking into account the definition of health provided by the Preamble of the World Health Organization’s Constitution. This document defines health as the “*state of complete physical, mental and social well-being and not merely the absence of disease or infirmity*”. Despite its vagueness, it is clear that this definition is not restricted to biological and mental criteria: deferring to the findings of social sciences, it penetrates into the relations of the individual with society and connects health with the concept of ‘*complete well-being*’. The idealized aspects of the definition and their abstract character should not be understood as undercutting its fundamental importance as a guiding thread for comparing current healthcare regimes.

As far as the second question is concerned, I should note the following about the notion of human right. First of all, I would like to stress that the protection of

health is a politically contested subject in the public sphere. On the one hand, conservatives aim at guaranteeing the individual's integrity through interventions that are conceived as the individual's sole responsibility. On the other hand, liberals assume that the protection of health is a responsibility of the community as a whole. What is at stake, among other things, is the role of the state vis-à-vis the market, and the extent of the regulation of the latter. As a characteristic example, I mention here that the Greek Statutory Law establishing the National Health System states at the outset: "*health is a social good that does not obey to rules of profit*". Therefore, the degree of protection of the right to health in different countries is, largely, the result of the tension between social rights guaranteed by the state and the workings of the free market. No one, of course, can ignore that the protection of the right to health, as a public good, and the scope and intensity of provision of health services depend to a great extent on available resources. In this sense, the right is also directly linked with the wider policy of the government and the management of public resources. At a first glance, then, the purpose of the right to health is the promotion of healthcare and the protection of health. As far as its legal dimension is concerned, it is two-sided:

On the one hand, it has the character of a *negative* (classical "*civil and political*") right, which is enforceable *erga omnes*. As such, it entails an obligation on the part of the state and every other agent, whether public or private, to abstain from any conduct that offends the physical and mental well-being of the citizen, or to restrict their freedom to decide on their own about issues concerning their personal health. From this perspective, it is a classical "*first generation*" right, as international legal doctrine traditionally classifies it. On the other hand, the right to health is also considered as one of the most important *positive* rights (i.e. a socio-economic right), grounding the power to claim the provision of state services that promote, maintain or restore health. From this perspective, the right to health can be dubbed as a "*second generation*" right.

I should note, in addition, the trend of the last decades to conceptualize the right to health as a third generation right. These rights are generally characterized as "*solidarity rights*". Rights belonging to this category consider the individual as a reference point for collectives or even for humanity as a whole and constitute a response to the phenomenon of globalization. The peculiarity of this right lies in the fact that, in certain cases, the satisfaction of a civil (first-generation) negative right requires the protection not just of an individual, but also of a group of persons. Last, and independently of the above conceptualizations, the right to health can also be analyzed as an overarching label that bundles together a series of already recognized legal rights, such as the right to medical care, to social security, etc.

From the aforementioned aspects of the right to health, we will primarily focus on its dimension as a *positive* right (or, differently put, as a socio-economic right) for our analysis. This is because the negative ("*civil and political rights*") dimension has been widely recognized and is explicitly found in constitutional texts and international human rights instruments. Also, the 'third generation' aspect of the

right seems to be in a premature stage of recognition, if at all. Therefore, we must examine the scope of the protection of the right to health as a positive right (social right) and the effectiveness of this right. These issues are to do with the long-standing doctrinal debate in public law about whether the positive or socio-economic rights are *justiciable* rights, to wit, about whether they grant enforceable individual claims against the state, or not. According to the traditional picture of positive rights, these are simply statements of policy objectives that ground various state duties, but are not justiciable as such. The kinds of justiciable claims the citizen can raise under the law are limited to civil and political rights.

However, this approach is now being challenged. Some support in favor of the justiciability thesis is provided, among other things, by recent and important case law of various national supreme courts. According to this newer line of thought, the “*functional*” importance of certain social rights, which include rights such as the right to health or the right to a (clean) environment, places these rights among the prerequisites of democracy. As a result, their “*objective*” component cannot be separated from its justiciable counterpart. On this view, and even in the absence of an explicit *ad hoc* constitutional provision, the social right to health can be inferred through interpretation in a number of ways, either from the content of general constitutional provisions pertaining to democracy, or as a further normative consequence of the right to life. However, these different positions, which delimit the rough boundaries of the dialogue concerning the scope of protection and the effectiveness of the right to health, must be examined on the basis of the positive law now in force in Europe, so as to assess the legal status of the European citizen with regard to this right.

On the basis of this methodological approach, I propose that we examine different aspects of the aforementioned “*multilevel*” protection. In particular, firstly, we shall compare the constitutional provisions and, where these are absent, other statutory provisions relating to the protection of health, of a representative number of Member States of the European Union. Then, we shall study the protection provided to health within the framework of the European Union legal order. Our attention shall then focus on the European Convention of Human Rights and, in particular, on the way the case law of the European Court of Human Rights interprets the Convention with respect to the right to health. The last source of law that we will take into account consists of the rules of international law, which are binding both on Member States and on the European Union itself. In the end of our research, we shall draw a series of conclusions in order to prompt further discussion.

II. THE RIGHT TO HEALTH IN THE CONSTITUTIONS AND STATUTORY PROVISIONS OF EUROPEAN UNION MEMBER STATES

A country’s constitution is the natural and primary normative ground for establishing where the country stands with respect to health protection and for recognizing the legal status enjoyed by the bearers of the right to health. In view of

this consideration, we proceed to the following comparative analysis of the legal framework akin to a number of key European countries.

1. France

Let us begin by examining France. The French Constitution of 1958, unlike the 1946 one, makes no explicit reference to a ‘right to health’. However, the French Constitutional Council (France’s constitutional court, which was created in 1958) has made it clear through its case law that the Constitution of 1958 has conferred constitutional status on a number of provisions that are to be found *outside* the Constitution’s text itself, insofar as that text makes reference to them. It follows from the Council’s case law that these provisions include the Preamble of the 1946 Constitution, as well as the 1789 Declaration of Rights of Man and Citizen, which are now considered as part of French constitutional law and form together what has been called ‘the constitutionality bloc’ (i.e. all the texts that are the sources of positive constitutional law).

For the purposes of the present argument, this means that the 1946 Preamble is one of the authoritative sources of French constitutional law. Indeed, and in relation to the right to health, paragraph 11 of this Preamble states the following: “*The Nation guarantees to each one [...] the protection of [his/her] health*”. With regard to the interpretation and institutional implementation of this provision, three observations are in order. *First*, paragraph 11 is not understood as enshrining a justiciable constitutional right, but merely as setting out a goal that should inform public policy.

Second, and concomitantly, it is the legislature (which includes, in bicameral fashion, a National Assembly and a Senate), which has the primary responsibility for implementation of the right to health through the adoption of appropriate (usually codified) legislation. Implementation of the ‘right to health’ has thus historically been the result of the adoption, post-1945, of a two-tier social security system. On the one hand, statutory health insurance (SHI) came into being with the Ordinance of 4 October 1945. It consists of compulsory universal protection, with four branches covering health (disease, maternity, incapacity, death), work-related illness and injuries, family allowances, and retirement (pension and widowhood). Today, three main SHI schemes cover 95% of the population: the general health insurance scheme, which covers employees in commerce and industry and their families and civil servants; the agricultural scheme; and the national insurance fund for self-employed people. The state has responsibility for the financial and operational management of SHI (for example, setting premium levels and the prices of goods and services).¹ On the other hand, voluntary health insurance (VHI) pertains to the coverage of the costs (standardly about 20%) that are not covered by SHI.

Third, the Constitutional Council had generally been reluctant and deferential when it comes to reviewing the health-related decisions made by legislatures and other

¹ See *Health Systems in Transition, France* (2010)

public bodies, providing ample leeway to primary decision-makers. Thus, and to take just one particularly characteristic example, in its Decision n°2004-504 DC of 12 August 2004, the Council considered that the imposition of a compulsory private participation of a cost of 1 euro with respect to a certain number of medical procedures did not violate the aforementioned paragraph 11 of the 1946 Constitution. However, the generally deferential attitude of the Council does not automatically entail that gross violations of the right to health on the part of state authorities would be accepted as constitutional. In fact, the whole system is based on a *bona fide* institutional cooperation of various actors, with the political branches enjoying ample room for maneuver against a background of already undertaken substantive commitments (the SHI system described above).

2. Germany

The German legal system displays, in general, a certain skepticism towards justiciable entrenched social rights. The Basic Law's that is to say the Federal Constitution's catalogue of constitutionally guaranteed rights is on the face of it silent on the matter of economic and social rights. Moreover, whereas provincial constitutions (the constitutions of the *Länder*) as well as federal legislation generally contain provisions setting out certain social rights, some of them even going as far as expressly guaranteeing a fundamental 'right to health', they are not interpreted as instituting judicially enforceable individual entitlements. As a result, an overarching 'right to health' is unknown, as such, to German Constitutional law. However, this is far from being the end of the story in relation to this right.

Article 20(1) of the German Federal Constitution states that "*The Federal Republic of Germany is a democratic and social federal state*". Courts interpret this provision as implying that the state has a formal duty to care for its citizens. This general duty derives from a combined interpretation of Art. 20(1) in conjunction with Art. 1(1), which refers to the inviolability of human dignity, Art. 2(2), referring to the right to life, and Art. 104(1), referring to the protection of the individual's physical and psychological integrity.² This duty of care includes, according to the Federal Constitutional Court, the provision of the *material minimum* necessary to sustain a dignified existence.³ Thus, despite the fact that the Basic Law itself does not further elaborate on what it means, specifically, to claim that Germany is a 'social state', this concept has traditionally been understood as encompassing an abstract commitment to social justice, social equality, and social protection. As a result, the non-justiciability of social rights *qua* individual entitlements simply entails that the task of implementing social rights falls primarily on legislatures, and *not* that social rights are placed completely outside the responsibilities of government.

² See Decision of the Federal Administrative Court (Bundesverwaltungsgericht) of 24 June 1954, published in BVerwGE, Vol 78, 159 [161], June 24, 1954; Decision of the Federal Constitutional Court (Bundesverfassungsgericht) of 18 June 1975, published in BVerfGE 15, 121 [133].

³ See BVerfGE 7, 187 [228], of 21 June 21 1977.

The above reading is supported by the history of healthcare legislation in Germany. Germany's state healthcare system is the oldest one in Europe, with its creation dating back to the 1880s. In 1881 social insurance was implemented on a national level. In 1883, Chancellor Otto von Bismarck submitted the Health Insurance Act, integrating all then existing health insurance plans into one overarching national law. Accordingly, all plans were uniformly regulated and premiums, the cost of which was to be shared between employers and workers, were assessed according to income and guaranteeing a decent minimum of access to healthcare. In addition to prepaid medical care, coverage included sick pay and maternity benefits. The act was part of a comprehensive national social insurance system also covering workers' compensation, disability and retirement plans. It is noteworthy that Bismarck's seminal system of health insurance has lasted to the modern day, though various changes and reforms have taken place to modify specific needs of the general population.

In general, the healthcare system Germany has in place nowadays is a highly complex one, combining public and private aspects. *Länder* receive and distribute sickness funds and the role of the federal government becomes one of regulating how *Länder* operate. In reality, more than 750 sickness funds operate simultaneously, providing healthcare to about ninety percent (90%) of the population. Their services include unlimited ambulatory physician care without co-payment and unlimited hospital care limited to a 10-day stay. All these services aim at establishing a decent minimum of care, in tune with the constitutional principle of the 'socially responsible' state and are included as part of the system's structure with a view to remaining economically viable. The other 10 percent of Germans receive access to health care through private voluntary insurance.

In this respect, it could be argued that Germany has a health service aligned with the notion that access to health care is a *limited (in content and normative force) but nonetheless existent legal right*. However, unlike the National Health Service (NHS) of the UK, *it does not offer universal access as a matter of principle*. Persons that, for various reasons, are unable to access healthcare services are excluded from the system. Since employment, through both the private and public sectors, is the way the German system is funded, access is given solely to those that contribute to the financing of the system.

3. Italy

The Italian 1948 constitution stands out in comparison to other European constitutions because it *entrenches (positive) socio-economic rights*. Under the prevailing interpretation, social rights are traditionally understood as rights of citizens that the State and its agents provide certain services, through the mediatory role of the legislature. Legislative organs thus play a crucial role in the implementation of social rights. On the other hand, the reasonableness of the legislature's choices with respect to such implementation is scrutinized by the Italian Constitutional Court, which reviews the balance struck between these rights and other primary interests guaranteed by the Constitution, in view of the

resources available to the State. In this vein, the Italian Constitutional Court has consistently affirmed that the existence of social rights must be balanced against considerations stemming from the availability of the State's economic resources as well as from its economic policy, provided that an essential *minimum level of services*, which corresponds to the 'core' of the protected social right, is always guaranteed.

Within this wider context, the right to health in Italy, enshrined in Article 32 of the Constitution, insofar as it is a social right, does not entail only a 'negative', but also a 'positive' component, namely the right to receive health care and medical treatment. Article 32 section 1 of the Italian Constitution identifies health as a fundamental right, but guarantees *free* health care only for those of low income or no income at all. As already highlighted, the enforcement of the right is subject to the existence of appropriate resources, with the exception of the services that correspond to the 'core' of the right (essential healthcare services). These must be provided to all individuals, with no discrimination as to citizenship or income.⁴ Moreover, since the seventies the Court of Cassation and the Constitutional Court have considered that, in cases of infringement to the right to health, individuals may claim compensation by means of tort actions.⁵ As was the case with other social rights, the right to free or affordable healthcare, as set out in Article 32 of the Constitution, has often been interpreted as a '*programmatic objective*', and the Constitutional Court has always attempted to strike a balance between the principles of the Constitution, the independence of Parliament and budgetary requirements.

The main legislative implementation of the right to health in force is Law 833/1978, which established the Italian National Health Service (*Servizio Sanitario Nazionale*, SSN), underpinned by the principles of equity and universality. The objectives of SSN, operating through Local Healthcare Units which subsequently became Local Healthcare Enterprises under Legislative Decree 502/1992, extend beyond the requirements of the Constitution: access to healthcare services and the right to health are guaranteed to all citizens, and the service is free of charge for certain specified categories of individuals, beyond these with no or low income. Ruling No. 455 of 16 October 1990 by the Constitutional Court sought to strike a balance between the right to public provision of health care and the availability of sufficient state financial resources, and identified criteria of 'reasonableness' against which to assess the provision of healthcare against other "*values and interests of equal importance*". More recently, the Court identified within the constitutional right to health an "*irreducible core protected by the Constitution as an inviolable component of human dignity*" that must be afforded more weight than the sheer need to reduce public spending.⁶ The Constitutional Court has held that the legislature must enact the rules necessary to ensure that everyone, throughout the country, can access and

⁴ Constitutional Court Ruling no. 423, 2 December 2005.

⁵ Constitutional Court Ruling no. 88, 26 July 1979.

⁶ See Constitutional Court rulings no. 509, 20 September 2000; no. 309, 16 July 1999; no. 267, 17 July 1998; no. 2473, June 1992.

utilize healthcare services and that regional legislation cannot impose limitations on the enjoyment of such services.⁷ Finally, a combined reading of Articles 3, 32.1, and 117.2.m of the Constitution led the Constitutional court to an understanding of the notion of an ‘*essential level of healthcare*’ which comprised the level needed to ensure a free and dignified existence to anyone in need of treatment and to their family.⁸

4. United Kingdom

The first important consideration to point out is that in the UK there is no entrenched ‘right to health’, because, rather famously, the UK does not have an entrenched, codified and written constitution. Under traditional constitutional doctrine, which is always prevailing, Parliament is sovereign and its decisions are supreme. In this vein, until 1998, when the Human Rights Act was adopted, incorporating the European Convention of Human Rights into UK law, no possibility existed for courts to review the compatibility of legislation with human rights norms and standards. The doctrine of parliamentary supremacy entailed that Parliament, consisting of the House of Commons and the House of Lords, was the main source, along with judicially created common law, of enforceable rights. Since 2000 though, when the Human Rights Act came into force, courts have the power to review the compatibility of primary legislation with the rights contained in the European Convention of Human Rights. They have two kinds of power, specified, respectively, in Sections 3 and 4 of the Human Rights Act. They can either proceed to a Convention-compatible interpretation of legislation (under Section 3) or, if that is not possible, they can issue a declaration of incompatibility (under Section 4), leaving it to Parliament to finally settle the issue.

Bearing these points in mind, it is no accident that the traditional legal ground of a ‘right to health’ in the UK is almost entirely statutory. The National Health Service (NHS), which was created in 1948, was originally conceived as a comprehensive health service free at the point of delivery. Despite the fact that since then there has been an intense wave of deep reforms with regard to the NHS’ mode of governance, the comprehensive provision of healthcare remains at the core of the system’s normative logic. This is clearly set out in the latest version of the NHS Constitution, which was published in 2012, and which comprises the principles, rights and pledges that relate to the normative framework governing the provision of healthcare in the UK. The very first principle contained in its Constitution, at paragraph 1, suggests that ‘*[t]he NHS provides a comprehensive service, available to all irrespective of gender, race, disability, age, sexual orientation, religion or belief*’.⁹ The first paragraph also highlights the importance of respecting human rights, by stating that the NHS ‘*[...] has a duty to each and every individual that it serves and must respect their*

⁷ See Constitutional Court ruling no. 282, 26 June 2002.

⁸ See Constitutional Court rulings no. 162, 8 May 2007 and no. 134, 31 March 2006.

⁹ NHS, *The NHS Constitution* (2012), p.3 (emphasis in the original).

human rights'.¹⁰ Last, the paragraph underpins the redistributive and egalitarian function of the NHS, which '[...] *has a wider social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping in pace with the rest of the population*'.¹¹ The next paragraph makes it clear, moreover, that '*access to NHS services is based on clinical need, not on an individual's ability to pay*'.¹² NHS services are thus provided free of charge, except in limited circumstances sanctioned by Parliament.¹³ Hence, despite the fact that there is no constitutionally entrenched 'right to health' in the UK, the central normative logic of the main public health provider is organized around the idea of the recognition of a social right to health on the basis of individual need and irrespective of the individual recipient's economic situation.

This, however, should not be understood as being equivalent to the proposition that individuals receive healthcare services on the basis of their individual wants, desires or needs. In this regard, the NHS Constitution explicitly states that its resources *are limited*, which implies that rationing will be unavoidable. The NHS Constitution thus provides the following message to patients: whilst the NHS intends to provide a comprehensive and free service to all based on need, patients must also understand that resources are finite and, therefore, not everything can be funded.¹⁴ The main source of litigation in the field of healthcare thus involves patients challenging particular choices of resource allocation by hospitals and health authorities either on traditional judicial review grounds or, post-2000, on human rights grounds.

In relation to the first category of challenges, complainants generally seek to argue that allocation decisions taken were unreasonable in the *Wednesbury*¹⁵ sense. Despite some interesting relatively recent developments in the case law¹⁶, the threshold for potential complainants generally remains particularly high. As a result, only a small fraction of challenges succeeds. Accordingly, findings of unreasonableness are rare and courts are, for the most part, deferential to health authorities.¹⁷ Likewise, with respect to the second category of challenges, judges have usually rejected arguments invoking the ECHR (especially Articles 2, 3, 8 or 14) to challenge particular funding decisions. As Hoppe and Miola put it: '*cases where the claimant has*

¹⁰ Loc.cit.

¹¹ Loc.cit.

¹² Op.cit. at para. 4.

¹³ Loc.cit.

¹⁴ Loc. cit.: '*You have the right to expect local decisions on funding of other [i.e. non-approved by a committee] drugs and treatments to be made rationally following a proper consideration of the evidence. If the local NHS decides not to fund a drug or treatment you and your doctor feel would be right for you, they will explain that decision to you*'.

¹⁵ *Associated Provincial Picture Houses Ltd. v. Wednesbury Corp* [1947] 2 All ER 680. The principle derived from that seminal English administrative law case states that a decision from a public body may be challenged if it is 'so outrageous in its defiance of logic or of accepted moral standards that no sensible person who had applied his mind to the question to be decided could have arrived at it'.

¹⁶ See, especially, *R v. North West Lancashire HA, ex p. A and others* [2000] 1 WLR 977, where the Court of Appeal found that blanket bans on certain forms of treatment without adequate justification of the pertinent decisions can be deemed unreasonable.

¹⁷ Hoppe and Miola (2014) *Medical Law and Medical Ethics*, CUP, p.148-150.

attempted to use the Human Rights Act as its principal point have invariably failed in what might be called 'classic' resource allocation scenarios.¹⁸ In less 'classical' cases, however, and with a number of notable exceptions¹⁹, the courts have remained extremely reluctant when it comes to considering claims by patients to the effect that particular resource allocation decisions are in breach of the Human Rights Act.

5. Spain

The constitutional protection of healthcare in Spain is marked by the specific historical circumstances of the transition from Francoism to democracy. The right for all Spanish citizens to enjoy health protection and care is laid down in the Spanish Constitution of 1978. Section 43 of the Constitution recognizes the right to the protection of health and it establishes that it is the responsibility of public authorities to promote public health through preventive measures and the provision of necessary services. Moreover, the Spanish Constitution of 1978 established a territorial structure that allowed devolution to the Autonomous Communities of powers in the area of health. As a result, all the Autonomous Communities have gradually taken on such powers.

The basic regulation for the Spanish National Health System emanates from the General Health Law of 1986 (Law 14/1986 of 25 April 1986), which pushed forward and integrated most of the piecemeal reforms introduced since 1977 under a unified legislative framework. In particular, the act laid out the National Health System scheme, bringing all publicly administered health services under one roof. Amongst the principles that govern the exercise of the right to health is the provision of public funding, with universal, free health services at the point of use. Coverage-wise, the statutory National Health System is universal, funded from general taxation and predominantly operating through the public sector. Provision is free of charge at the point of delivery and user co-payments are restricted to pharmaceuticals. The General Health Law provides for the devolution of health affairs to the Autonomous Communities. As a result, the National Health System comprises both the Central Government Administration and the autonomous regions' public healthcare administrations, working in coordination to cover all the healthcare duties and benefits for which public authorities are legally responsible.

The General Health Law was complemented in 2003 by the Law of Cohesion and Quality of the National Health System (Law 16/2003), which maintained the basic lines of the General Health Law but also included benefits related to public health, primary care, specialized care, long-term care and pharmaceuticals. This law also guarantees the right of all citizens to access to a second medical opinion, the right to receive medical assistance in their Autonomous Community of residence in a maximum time and the right to receive by that Health Care Service the medical

¹⁸ *Op.cit.*, p.153.

¹⁹ E.g. *Price v. UK* (2001) 34 EHRR 1285; *Savage v. South Essex Partnership NHS Foundation Trust* [2008] 1 WLR 977, where the House of Lords held that if a mentally ill patient was known to be a suicide risk, Article 2 of the ECHR provided a duty to take positive steps to help to prevent the risk from materializing.

assistance of the defined benefits of the National Health System, with the same conditions and guarantees as those enjoyed by citizens resident in that Autonomous Community. However, under the impetus of the financial crisis and subsequent austerity programs, the Spanish Government recently approved Royal Decree-Law 16/2012, which came into force on 20 April 2012 and introduces severe cuts in the Spanish National Health System. More importantly, it provides for the exclusion of undocumented immigrants, an increase in co-payments, and the privatization of a number services.

6. Sweden

In the Swedish constitution, health is only mentioned as a ‘goal’ to be promoted in Chapter 1 Article 2 (2) of the Instrument of Government, which is one of the fundamental laws that make up the Constitution of Sweden of 1974. Over the last 2 decades, there has been an extensive debate over the legal right to health in the Swedish medical system. Sweden first began to establish broad access to healthcare after 1946, when the government set up a system in which all working Swedes contributed to and were covered by social health insurance. However, at that time not all Swedes were covered. In 1969 the government undertook further reforms of the healthcare system, aiming at expanding healthcare coverage.

At the present, Swedish healthcare is financed from general taxation and is heavily subsidized at the point of use. A ‘localist’ rather than a centralist approach with respect to the delivery of healthcare characterizes the system. As a result, both financing and provision of services lie with the regional and municipal levels of government. However, it is notable that although health services in the Swedish health system were once entirely publicly provided, since the 1990s Sweden has seen the expansion of private sector provision within the public system on a scale unmatched with many other traditional public provision health systems. Nevertheless, all kinds of service provision remain taxpayer-funded and broadly accessible to all residents. More specifically, the legislative framework for the regulation of healthcare services in Sweden is the Swedish Health and Medical Services Act of 1982, which states the overall objective of health and medical care: “*Good health and care for the whole population on equal terms*”. The Act also states that healthcare shall be of a high standard and satisfy the patient’s need for security, be easily accessible, be based on respect for the patient’s right to self-determination and integrity, and promote good communication between the patient and health care personnel.

The 1982 Health and Medical Services Act provides for universal coverage to all legal residents. About 4 percent of the population has supplementary private voluntary health insurance. Moreover and as already stated, the responsibility for the provision of health and medical care in Sweden is shared by the central government, county councils and municipalities. The Health and Medical Services Act regulates the responsibilities of county councils and municipalities, and gives local governments more freedom in this area. The role of the central government is

to establish principles and guidelines, and to set the political agenda for health and medical care.

7. Finland

In Finland, the state's responsibility to promote health is enshrined in the Constitution. In particular, Section 19 of the Finnish constitution enshrines the right to social security. Healthcare is also mentioned in the same section.²⁰ Section 19 makes an important distinction between *urgent* healthcare, which is recognized as a subjective right owed to everyone according to section 19 para. 1 of the Constitution, and *non-urgent* healthcare, which is mentioned in section 19 para. 3 and is not construed as a subjective justiciable right. The Finnish health system resembles those of other Nordic countries in that it offers universal coverage of a comprehensive range of publicly funded health services paid for mainly out of general taxation and relies mainly on public provision of care. The main provisions on health care are set out in the Health Care Act 1326/2010, which is a merger of the Primary Health Care Act 66/1972 and the Act on Specialized Medical Care 1062/1989. The latter Act previously regulated the provision of public sector health services. According to Section 2 of the Health Care Act 1326/2010, its provisions aim to reduce health inequalities between different population groups and ensure universal access to the services required by the population and improve quality and patient safety.

Universal public healthcare is in practice the responsibility of the municipalities, and available to all permanent residents in Finland regardless of their financial situation. Municipal health centers provide primary health care services. In particular, the 2010 Act states that every municipality must have a health center providing primary health services. Secondary care is provided through district hospitals where more specialist care is available.

8. Romania

After the fall of the communist regime in 1989, Central and Eastern European countries have been undergoing major social changes, switching from a centralized planning to a market-oriented economic system. Their health care systems also went through fundamental reforms. In this context, it is noteworthy that by 1990 the Romanian health system was based on principles of universal coverage, state financing, central planning and free access to health care at the point of delivery. After 1990, there were major pressures for a change from the

²⁰ Section 19 of the Finnish constitution provides that: “Those who cannot obtain the means necessary for a life of dignity have the right to receive indispensable subsistence and care. Everyone shall be guaranteed by an Act the right to basic subsistence in the event of unemployment, illness and disability and during old age as well as at birth of a child or the loss of a provider. The public authorities shall guarantee for everyone, as provided in more detail by an Act, adequate social, health and medical services and promote the health of the population. Moreover, the public authorities shall support families and others responsible for providing for children so that they have the ability to ensure the well being and personal development of children.”

taxpayers, users, doctors, medical institutions, and also the administrative authorities, although all medical services were still free. This was due to the fact that the quality of health services in some areas of the country was poor and there was progressive deterioration of health state due to under-funding and lack of competition through a system of private health and individual initiative.

Specific constitutional provisions guarantee access to healthcare. Article 20 of Romania's 1965 Constitution had already declared "*the right to be insured for old age, illness, or disability*", but it was only after 1991 that Article 34 of the Constitution (1991) recognized that the right to protection of health is individually enforceable by further explicitly stating that "*the state shall be bound to take measures to ensure public hygiene and health*".²¹ The main act of legislation governing health care in Romania nowadays is Law 95/2006 on healthcare reform, as amended and supplemented. The law imposes a number of rules for all relevant activities, whether publicly or privately funded. It also sets out the responsibilities of the main actors in the field, namely the Ministry of Health and its decentralized services, the National Health Insurance House and County Health Insurance Houses. Health care in Romania is dominated by a public system, financed mainly through mandatory social health insurance contributions. Public health services are free of charge for those insured, but limited funding will result in a paradox situation where people often have to pay for the theoretically free service, like lab tests, X-rays or scans.

9. Greece

The right to health is enshrined in Greece's Constitution and is further specified by an important number of statutory provisions. In particular, the Greek Constitution guarantees the right to health both as a negative (classical civil and political) right and as a positive (social) one. On the one hand, article 5 para. 5 of the Constitution, reading, "*All persons have the right to the protection of their health and their genetic identity*", provides for a *classical negative* right to health. On the other hand, article 21 para. 3 of the Constitution, which declares that "*The State shall care for the health of citizens*", provides for a *positive (social)* right to health. The latter establishes social claims for appropriate public health structures to be provided by the State, first and foremost in the form of a national health system. However, one cannot help but notice the generality of the wording of this particular constitutional provision. Nevertheless, it should be mentioned that other constitutional provisions refer also to health, like for example articles 18 para. 3 and 22 para. 4 of the Constitution. This allows us to conclude that health has developed into a constitutional good of fundamental importance.

²¹ **ARTICLE 34**

(1) The right to the protection of health is guaranteed.

(2) The State shall be bound to take measures to ensure public hygiene and health.

(3) The organization of the medical care and social security system in case of sickness, accidents, maternity and recovery, the control over the exercise of medical professions and paramedical activities, as well as other measures to protect physical and mental health of a person shall be established according to the law.

The main statutory legislation concerning healthcare provision in Greece is Law 1397/1983, which established the National Health System. Pursuant to its provisions, health services are provided equally to all citizens, regardless of their economic, social and professional status, through a unified and decentralized national health system organized according to the law's provisions. In general, the Greek health system could be characterized as *mixed*. The National Health System and the existing sickness funds provide public health services. The former is funded by general taxation and provides secondary hospital care in public hospitals to all citizens. The latter are funded by their members' contributions and provide primary healthcare provisions to them. In parallel, healthcare services are also provided by the private sector. I should also mention that by virtue of two very recent ministerial decisions (No. 48985/03.06.2014 and No. 56432/28.06.2014, respectively), all Greek citizens who are uninsured as well as any other lawfully residing person who is uninsured are entitled to free hospital and pharmaceutical care.

Nonetheless, it is worth mentioning the ongoing debate between Greek constitutional scholars and judges about whether the social component of the right to health is legally enforceable without legislative intervention (i.e., whether it is, to use a technical legal term, 'self – executing') or not. More specifically, the debate is about whether citizens can raise justiciable claims against the state and thus, whether the extant legal framework requires positive state action to be taken in order to guarantee the effective exercise of people's right to health.

I should note beforehand that the wording of art. 21 para. 3 of the Greek Constitution is rather vague and general, which precludes it from being directly applicable by courts. Therefore, the thesis that generally prevails is that the enactment of the positive (social) right to health depends principally on legislatures and not on the judiciary. However, any legislative choice concerning health can be scrutinized for its constitutionality by courts, pursuant to the principle of "*relative social acquis*". According to this principle, the Constitution and statutory health legislation together form a unified protective body of law. Whereas the legislature may not be legally compelled to proceed in the provision of social benefits, once these are provided it may not subsequently retract them, doing away with the body of law that has been created or arbitrarily limit it. Consequently, according to this principle, abolition of institutions implementing the state's duty to provide healthcare, such as the National Health System, is constitutionally forbidden. Nevertheless, as a matter of governmental policy, the legislature may amend the organizational form of the Health System or limit the resources granted to it, on condition that the choices made do not distort the *ratio* of the proclamation of a social right to health in Constitution.

10. Other European States

Finally, a brief reference should be made to a number of other European Union Member States, which have introduced the right to health in their national

constitution. **Portugal's** (1976)²², and Belgium's (1994)²³ Constitutions explicitly grant a legal right to health to their citizens. The **Dutch** Constitution (art. 22) merely recognizes health as an important value of the country, stating that: "*the authorities shall take steps to promote the health of the population*". The **Polish** Constitution (1997) clearly divided social rights into two categories: the judicially enforceable rights and other non-enforceable rights. Article 68 of Constitution recognizes an individually enforceable constitutional right to health.²⁴ Finally, in **Denmark and Norway**, there are no constitutional provisions on the right to health. In these countries, the right to health is only protected through national legislation and international human rights treaties.

Conclusions

As aforementioned, the right to health embodies both positive and negative rights. The right to health in its negative component is guaranteed constitutionally by all Member States. Here, my focus was on the positive component of the right to health. Whilst most Member States have introduced a positive right to health in their national constitution, this is not always the case. In addition, considerable differences exist with respect to the form and wording chosen of the constitutional provisions. All Member States have shaped a public health system based on a variant funding. The categories of the persons entitled to access their health services, differ among Member States. The absence of an explicit constitutional provision does not deter the Member States from establishing a publicly funded health care system. However, the inclusion of the right to health in the Constitution reinforces the protection of the right insofar as national constitutions are the supreme laws of countries. Consequently, the legislative and executive branches of the State have the duty to respect, protect and fulfil this right.

²² Article 64 of the Portuguese Constitution states that "*Everyone shall possess the right to health protection and the duty to defend and promote health. 2. The right to health protection shall be fulfilled: a) By means of a national health service that shall be universal and general and, with particular regard to the economic and social conditions of the citizens who use it, shall tend to be free of charge; b) By creating economic, social, cultural and environmental conditions that particularly guarantee the protection of childhood, youth and old age; by systematically improving living and working conditions and also promoting physical fitness and sport at school and among the people; and by developing both the people's health and hygiene education and healthy living practises. 3. In order to ensure enjoyment of the right to the protection of health, the state shall be under a primary duty: a) To guarantee access by every citizen, regardless of his economic situation, to preventive, curative and rehabilitative medical care; b) To guarantee a rational and efficient nationwide coverage in terms of healthcare units and human resources; c) To work towards the public funding of the costs of medical care and medicines; d) To regulate and inspect corporate and private forms of medicine and articulate them with the national health service, in such a way as to ensure adequate standards of efficiency and quality in both public and private healthcare institutions; e) To regulate and control the production, distribution, marketing, sale and use of chemical, biological and pharmaceutical products and other means of treatment and diagnosis; f) To establish policies for the prevention and treatment of drug abuse. 4. The national health service shall possess a decentralised and participatory management system*".

²³ Article 23 of the Belgian Constitution recognizes "*the right to social security, to health care and to social, medical and legal aid*".

²⁴ Article 68 of the Polish Constitution states that "*Equal access to health care services, financed from public funds, shall be assured by public authorities to citizens, irrespective of their material situation. The conditions for, and scope of, the provision of services shall be established by law.*"

Moreover, to the extent that health is enshrined as a right in Member States' constitutions, it provides strong textual support for health care rights.

However, the constitutional right to health has not yet been recognized by the Member States (with the exception of urgent health care provisions in Sweden) as a right enforceable by individuals. In particular, the bearers of the right cannot force the State to comply with its obligation because the right to health is too resource – intensive and too vague to be justiciable. Indeed, the wording chosen in the respective constitutional provisions limits its scope to what is provided for by the law. So implementation of the right to health depends on the legislature. Nevertheless, the lack of enforceable state constitutional right does not necessarily undermine the importance of health as a constitutional objective.

III. THE PROTECTION UNDER EUROPEAN UNION LAW

1. Introduction – Fundamental Rights Protection in the European Union

In order to explore the issue of the legal status of the right to health in EU law, it is necessary to begin by some preliminary general observations. *First*, the addition of a Charter of Fundamental Rights to supplement EU policies when it comes to human rights protection is a relatively recent development. The stated aim of the Treaty of Rome (signed in 1957) was confined to the creation of a common market through the free movement of goods, persons, services and capitals, and the question of the protection of human rights arose much later. *Second*, and concomitantly, social policy remains within the ambit of Member States. This means that the realization of social rights through redistributive taxation occurs at the national, not the EU level. Basically, that's also the level responsible for the financing of national healthcare systems. *Third*, the role of the CJEU has been instrumental in integrating human rights in EU law. The Court gradually developed a fundamental rights case law, which made reference to the national constitutional traditions of Member States and to the ECHR. *Fourth*, the whole process resulted in the formal recognition of the above human rights sources in the Maastricht Treaty, and culminated, forty years later, with the adoption of the Treaty of Lisbon, which came into force on 1 December 2009.

For the first time since the Union's inception, the Lisbon Treaty made fundamental rights contained in the Nice Fundamental Rights Charter of 2000 a binding part of primary EU law. The Union thus now has its own catalogue of *justiciable fundamental rights*. Moreover, Article 6(2) TEU says that the Union shall formally accede to the ECHR, though formal accession raises a host of complex and potentially controversial legal issues, and has yet to materialize. Finally, Article 6(3) TEU follows the Maastricht Treaty in making reference to the ECHR and to the constitutional traditions of Member States.

2. The Right to Health in Primary EU Law

a. Article 168 TFEU

Before I proceed, though, to an examination of the health-related Article 35 of the Charter, I want to place emphasis on the fact that health has been recognized as a policy objective by the Union as early as the 1980s. I can mention here, for example, the Europe against Cancer Program, Decision 88/351/EEC, which encompassed anti-tobacco campaigns. While the legal basis for health measures was rather unclear, numerous commentators suggested that health had become one of the objectives of the Union even in the absence of an express provision. In any event, though, the formal recognition of a legal basis for a health policy of the Union, once again, came with the Maastricht Treaty.

Article 168(1) TFEU provides that ‘*A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities*’ (emphasis added). It also makes encouragement of cooperation of Member States in various public health areas a Union aim. The matters covered by the Article have a number of features. *First*, they adopt what in legal theory has been called a ‘*mainstreaming*’ approach, to the effect that health protection must be considered in the implementation of all other Union policies and activities. As a result, health interests must be taken into account when pursuing potentially competing goals in other areas. *Second*, Article 168 TFEU provides that the Union shall not just ‘*contribute*’ to ensuring a high level of health protection but will directly ‘*ensure*’ it. Moreover, Union activities are no longer limited to preventing disease, but have expanded to include *promotion* of good health. *Third*, the wording suggests a move away from a solely ‘*public health*’ conception towards a concern with the health of individuals through the implantation of measures granting specific rights. *Fourth*, the division of tasks and powers between the Member States and the EU institutions is governed by the *principle of subsidiarity*. EU institutions are entitled to act only if ‘added European value’ will result from their action. Overall, the Article is an important step towards the recognition of a distinctive health policy of the EU, which offers an additional guarantee to European citizens, compared with the means of protection of health deployed by their Member States.

b. Provisions of the Charter Related to the Right to Health

The aforementioned developments are corroborated and strengthened by the adoption of the Charter. How, then, is the Charter placed in respect of the right to health? There are four things to note at the outset. *First*, the Charter explicitly mentions in its Preamble the constitutive values of the Union, referring to human dignity, freedom, equality, solidarity, democracy and the rule of law. It also claims to be placing the individual ‘*at the heart of its activities*’. These values are particularly important with regard to the axiological framework, which shapes the Union’s policies, including those related to human health. *Second*, the Charter contains seven different titles (dignity, freedoms, equality, solidarity, citizens’ rights, justice and general provisions involving interpretation and application), which can be of

interest when it comes to formulating a right to health. *Third*, the Charter's Preamble distinguishes between 'rights, freedoms and principles', implying that some of the articles contained should be interpreted as being merely aspirational ('principles') rather than as enshrining justiciable rights ('rights' or 'freedoms'). *Fourth*, it is important to stress that the Charter is applicable only insofar that EU law is implemented, either by the organs of the EU or by national organs.

Article 35 of the Charter would be the first and most obvious (and important!) candidate towards the recognition of a right to health. However, several other EU Charter provisions could also be relevant to such a right. These could be the following. *First*, Chapter I, which is headed '*Dignity*' and Article 1, which refers to the fundamental principle of human dignity. *Second*, Article 2, which makes explicit reference to the right to life and which, combined with Article 35, may be used in a situation in which access to health care has been denied on the basis that resources are limited. *Third*, Article 3, which refers to the *integrity* of the person.²⁵ *Fourth*, Article 7 in Chapter II, entitled '*Freedoms*', guarantees the right to private life.²⁶ *Fifth*, Chapter III of the EU Charter concerns '*Equality*'. Article 20 states that all people are equal before the law. Article 21 includes the prohibition of discrimination on grounds of sex, race, color, ethnic or social origin, genetic features, language, religion or belief. These Articles could become potentially important in litigation involving access to healthcare. *Sixth*, a number of provisions could become relevant when it comes to constructing a right to health protecting particularly vulnerable groups like the elderly or persons with disabilities.²⁷ However, it goes without saying that, from the point of view of the protection of a fundamental right to health, the most important provision is contained in Chapter IV of the Charter, entitled '*Solidarity*'. The provision, which enshrines a right of access to healthcare, is in turn based on Article 11 of the European Social Charter. Article 35 provides that: '*Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured by the definition and implementation of all Union policies and activities.*'

²⁵ Article 3 states that: '2. *In the fields of medicine and biology the following must be respected; (a) The free and informed consent of the person concerned according to the procedures laid down by law; (b) The prohibition of eugenic practices, in particular those aiming at the selection of persons; (c) The prohibition on making the human body and its parts as such a source of financial gain; (d) The prohibition of the reproductive cloning of human beings.*' The drafting of this particular provision echoes that of the Council of Europe Convention on Human Rights and Biomedicine. Reference to the integrity of the person is also to be found in the constitutions of a number of EU Member States (Article 2, Basic Law of the Federal Republic of Germany: '[e]veryone has the right to life and to physical integrity'; Article 15, Constitution of the Kingdom of Spain: '[e]veryone has a right to life and physical and moral integrity'; Article 25, Constitution of the Portuguese Republic: '[t]he moral and physical integrity of the person is inviolable').

²⁶ This provision has been interpreted in the ECHR context, as well as by a number of Constitutional and supreme courts, as not only being applicable to the privacy of personal information but, in addition, as conferring respect for individual decision-making autonomy and requiring consent to any medical activity that involves an assault on the physical or psychological integrity of a person.

²⁷ Thus, Article 24 concerns the rights of the child and provides that children should have the ability to freely express their views and that these should be taken into account in accordance with their age and maturity. Provision is made for the rights of the elderly in Article 25, which include their right to lead a life of dignity and independence, and Article 26 calls for the integration of persons with disabilities into the life of the community on several levels (e.g., political, social).

Various commentators have forcefully suggested that this article entails two elements. *First*, the article enshrines a *social right* and is an expression of an individual entitlement to health care. So it introduces a robust ‘*subjective*’ element in comparison to Article 168 TFEU. *Second*, this element of the Charter may be seen as a kind of ‘super-mainstreaming’ expression of the values that should underpin EU law and policy. Article 35 may be used in free movement claims in the context of an individual who travels to another Member State to receive treatment and then claims reimbursement of the cost of that treatment. Indeed, in²⁸, the Advocate General commented the following: *‘[A]lthough the case-law takes as the main point of reference the fundamental freedoms established in the Treaty, there is another aspect which is becoming more and more important in the Community sphere, namely the right of citizens to health care, proclaimed in Article 35 of the Charter of Fundamental Rights of the European Union since “being a fundamental asset health cannot be considered solely in terms of social expenditure and latent economic difficulties. This right is perceived as a personal entitlement unconnected to a person’s relationship with social security and the Court of Justice cannot overlook that aspect.’*

c. The Construction of an Internal Market and the ‘Four Freedoms’

As is well known, the construction of a ‘*single*’ or ‘*internal*’ market was the hallmark of European integration and formed a substantial part of the endeavors of the EU. The internal market is founded on the so-called ‘*four freedoms*’ (the free movement of goods, the freedom to provide services, the freedom of establishment and the free movement of capital). These freedoms form a part of primary Union law. In virtue of the principle of primacy of EU law, they have a higher legal status than national law and policy. The authoritative interpretation of these freedoms is the task of the CJEU. As we shall shortly see, the Court played a particularly important role in interpreting the freedom to provide health services among Member States in favor of individuals that wanted to move from one Member State to another in order to receive those services.

3. Health in Secondary EU law – An Overview

Secondary EU law, which mainly takes the form of regulations and directives, has frequently been used in areas relating to the protection of health in the implementation of other EU policies and objectives, pursuant to Article 168 TFEU. The terrain is vast, and I will provide no more than a very brief overview.

a. Pharmaceuticals

The EU’s responsibilities for free movement of goods entail that the EU has a dense regulatory structure for pharmaceuticals, medical equipment, and medical devices. Legislation, decisions, and guidance date back to the 1960s. The EU has used both regulation and competition law to pursue its aims of opening up markets

²⁸ AG Opinion, Case C-444/05, Stamatelaki [2007] ECR I-3185.

for these products, while seeking to ensure safety for patients. No pharmaceuticals or medical devices can be sold anywhere in the EU without compliance with this law, although the processes involved differ for drugs and devices. EU laws seek to balance innovation and safety in new health technologies, such as the products of biotechnology and nanotechnology.²⁹

b. Blood, Organs and Human Tissue

The EU also regulates blood, organs, and human tissue. EU legislation concerned with quality and safety of such products requires Member States to set up risk assessment and monitoring institutions, and to collect and share information. In particular, it exhorts Member States to seek non-market models, although such models are not made compulsory.

c. Social Security

The EU's responsibility for ensuring free movement of people means that it coordinates the social security entitlements of migrant labor. Secondary legislation to that effect was originally adopted in the 1970s. This includes access for patients to EU health-care systems beyond the country in which they live..

d. Other Health-related EU Policies

The EU has been particularly active in a number of policies involving the protection and promotion of public health. These include its policies on the production and distribution of tobacco, food, alcohol, cars, or other consumer products affecting health. However, in other areas, the power of industry lobbies in the Commission, Parliament, and Member States has restrained the potentially vast power of the EU to only a few policy approaches.

4. The Case Law of the CJEU

While there is no significant case law of the Court in relation to the Charter and Article 35, the Court's role in the construction of a right to health within the EU has been instrumental, on the basis of the freedom to receive services provisions of primary EU law. In particular, the Court has significantly extended the right of individuals to be reimbursed by statutory social security of their home state for health services they receive in another Member State.

²⁹ It is important to stress that the EU is regularly criticized for stifling innovation by industry and for paying insufficient attention to the needs of patients. The European Medicines Agency, based in London, UK, has come under much scrutiny. In particular, it has been accused that it places the interests of the pharmaceutical industry above those of the patient. A particular concern relates to its refusal to report the data on which it makes its decisions. A particularly shocking example involved the almost 4 year struggle by the Nordic Cochrane Centre to obtain data for two drugs intended to assist weight loss. The agency repeatedly refused to release the data, despite demands to do so by the EU's Ombudsman.

Before proceeding further, though, I would like to stress a point of information. The decisions of the Court of Justice of the EU are an important source of EU law. The Court acts when the meaning or applicability of secondary legislation or of the Treaties that set up the EU, including the Charter, are unclear. The result of the Court's case law is frequently a series of interventions that resolve individual cases and prompt more systematic legislative action by other organs of the EU. As we shall see, this is exactly what happened in the domain we are examining.

EU's responsibility for ensuring free movement of people and services meant that the Union has the responsibility to coordinate social security entitlements. Simply put, someone who moves from one Member State to another to provide a service has to be covered by social security while providing the service. So, this includes access for patients to EU healthcare systems beyond the country in which they live. Most of this law is uncontroversial, because the home Member State authorizes the terms on which migrant patients are entitled to receive benefits in a host country. However, in the 1990s the Court of Justice of the EU extended that traditional possibility by deciding a high-profile series of cases involving patients using their rights to free movement of services in EU law to claim treatments in another Member State. Those patients claimed a right to be reimbursed by their home health system. A brief overview of that case law follows:

(a) The first case which is important in this respect is the *Luisi and Carbone* judgment of 1984³⁰. In that case the Court held that: '*the freedom to provide services includes the freedom, for the recipients of services, to go to another Member State in order to receive a service there, without being obstructed by restrictions, even in relation to payments and that tourists, persons receiving medical treatment and persons travelling for the purpose of education or business are to be regarded as recipients of services*'. It is widely accepted that this seemingly minor judgment actually transformed the whole perspective of the Treaty of Rome on services. After this judgment, it was no longer just the freedom of the provider of services which was protected by the provision on services. The *freedom of recipients of services* was also considered to be protected as a judicially enforceable individual right. The judgment thus paved the way to entirely new developments in the provision of healthcare services.

(b) The possibility opened up with *Luisi and Carbone* materialized in 1998, with the Court's judgments in *Decker*³¹ and *Kohll*³². In *Decker* and *Kohll* the Court confirmed that social security is not excluded from the purview of the free movement rules. This was despite the fact that Member States had seemingly retained their competences to regulate their social security systems. The Court said that prior authorization systems are incompatible with the free movement rules insofar as they concern non-hospital treatment or the acquisition of health goods. In such cases, the Member State of affiliation must reimburse the patient on the same terms as if the health goods had been bought or the treatment had been received within its territory. Moreover, the Court insisted that a prior authorization

³⁰ (ECJ, Joined Cases 286/82 and 26/83 *Luisi and Carbone* [1984] ECR 377).

³¹ Case C-120/95 *Decker* [1998] ECR I-1831.

³² Case C-158/96 *Kohll* [1998] ECR I-1931.

condition couldn't be justified by the need to preserve the financial balance of the medical and hospital system of the Member State. So the individuals concerned were not seen only as economic actors, but also as citizens who want to move to receive health services in another Member State. These citizens have a right, subject to justified limitations, to receive such services under the same conditions as if they had not moved.

(c) The next significant step towards the same direction came only 3 years later, in July 2001, when the Court handed down the *Vanbraekel*³³ and the *Smits–Peerbooms*³⁴ cases. The Court confirmed its expansive approach. In particular, it classified the health services provided by hospitals as an '*economic activity*'.

(d) A particularly important turning point in the case law we are here considering is the *Watts* case³⁵. That case was decided in May 2006 and concerned the United Kingdom and its National Health Service (NHS). Unlike the other systems examined by the Court in previous cases, the NHS is a completely public system, both with respect to its organization and in the way it is financed. The system makes no provision for reimbursements. Its functioning is conceived as being entirely outside the purview of the logic of the market. Also, importantly, the case concerned hospital services. Even though the CJEU accepted that Member States could demand prior authorization for reimbursement of hospital services provided abroad, their discretionary power was restricted. The Court underlined that prior authorization could not be used arbitrarily. It should be based on objective, non-discriminatory criteria that are knowable in advance. Likewise, it must be based on a procedural system that is, first, easily accessible and, second, capable of ensuring that a request for authorization will be dealt with objectively and impartially within a reasonable time. Last refusals to grant authorization can be challenged in judicial or quasi-judicial proceedings.

Even this cursorily review of the case law makes some important points stand out. *First*, the Court interpreted primary EU law expansively and applied it to healthcare services in a very wide way. *Second*, the Court's case law made it clear that individuals have justiciable and enforceable rights to receive health services in another Member State and be reimbursed by their home state. *Third*, the case law aimed at forcing openings into the national health systems, whose closure is considered to be problematic from the perspective of the freedom of patients to receive their treatments throughout the Union. It created a procedure for the reimbursement of health care costs generated outside the Member State of affiliation that is directly based on the EU Treaty. It also maintained the pre-authorized procedure, as included under the social security coordination regime. *Fourth*, it remains to be seen whether article 35 of the Charter will make a difference in the Court's reasoning with regard to the interstate provision of healthcare and, if so, what its potential impact will be.

³³ Case C-368/98 *Vanbraekel and others* [2001] ECR I-5363.

³⁴ Case C-157/99 *Smits and Peerbooms* [2001] ECR I-5473.

³⁵ Case C-372/04 *Watts* [2006] ECR I-4325.

The case law of the Court prompted a legislative response on the part of the Union. The development of an EU-wide Directive was seen as necessary to clarify the new rights of citizens across the EU. This new legislation³⁶ reflects existing rights under the Treaty on the Functioning of the European Union, the principles confirmed by established CJEU case law and applies best practice in providing access to these rights. Its main objectives are the following:

- Clarify and simplify the rules and procedures applicable to patients' access to cross-border healthcare;
- Provide EU citizens with better information on their rights;
- Ensure that cross-border healthcare is safe and of high-quality;
- Promote cooperation between Member States.

The Directive sets out the information Member States must provide for patients from other states considering coming to the country to purchase healthcare. It also sets out the arrangements that a Member State must provide to allow its own citizens to access their rights to reimbursement of the costs of cross-border healthcare, if they choose to seek such healthcare in another Member State. Most importantly, the home state retains responsibility for deciding what healthcare it will fund on a cross-border basis. So the Directive is not a way for a patient to obtain reimbursement for the costs of a treatment which they obtain in another EU member State if the same or equivalent treatment would not be made available to that patient in their circumstances under their home health service. However, it can provide significant benefits, such as shorter waiting lists or recourse to a specific kind of medical experts. At the same time, Member States are required to be clear and transparent in home legislation or administrative processes as to what entitlements to healthcare home patients have within their national health system.

Conclusion

As I already said at the beginning, the EU does not have the powers and competences to harmonize social policy. Concomitantly, it is up to Member States to create, sustain and finance healthcare systems. Still, the impact of EU law on the right to health of individuals has been significant. On the one hand, major new provisions and, above all, the Charter, hold the promise of further development of an effective and justiciable social right to health. Moreover, the EU's policies are imbued with health goals, with the help of the mainstreaming provision of Article 168 TFEU. The EU also implements a number of important policies that aim at promoting and protecting health. On the other hand, examination of the seminal case law of the Court in relation to inter-state provision of healthcare services showed that an entirely new possibility was opened up for individual patients. This possibility was formally enshrined in the 2011 Directive. Citizens in the EU are now in principle free to seek any health care, where they want and from whatever provider available. The new procedure not only has a

³⁶ Directive 2011/24/EU of the European Parliament and of the Council of 9 March 2011 on the application of patients' rights in cross-border healthcare (OJ No. L88, 4.4. 2011, p.45)

different legal base than the traditional social security coordination mechanism, it also applies a different concept of equal treatment. Whereas under the latter cross-border patients are treated as though they were insured in the country of treatment, under the new route they are treated as though the treatment were provided in the country of affiliation. Overall, this is an important development that can make the enjoyment of the right to health much more effective.

IV. THE PROTECTION OF THE RIGHT TO HEALTH UNDER THE EUROPEAN CONVENTION OF HUMAN RIGHTS

Following on from the survey of national provisions, I should mention firstly that the European Convention of Human Rights (ECHR), signed in 1950, is the main human rights treaty of the Council of Europe, which comprises forty seven states parties. All the Member States of the European Union are Contracting Parties to the Council of Europe. This Convention, in force for more than sixty years now, constitutes the main pillar for the protection of the human rights in Europe and the case law of the European Court of Human Rights (ECtHR) has a universal reach.

The first thing to note is that the European Convention of Human Rights (ECHR) is primarily a civil and political rights document that focuses on the protection of these traditional rights and is much less friendly to social and economic rights. As a result, the Convention does not include social and economic rights within its reach³⁷. The protection of such rights falls primarily under the scope of the European Social Charter (ESC), adopted by the Council of Europe in 1961, whose aim is to serve as the economic and social rights counterpart to the European Convention of Human Rights (ECHR). As it is well known, the European Social Charter (ESC) is a separate treaty, with entirely distinct monitoring mechanisms, the details of which shall not be examined here.

Nevertheless, early enough, the European Court of Human Rights (ECtHR) accepted that the distinction between two categories of rights, i.e. civil and political rights, on the one hand and social and economic rights, on the other hand, was not watertight. In *Airey v. Ireland*, the Court was faced with a situation whereby a woman could not afford legal representation in order to initiate divorce proceedings before the Irish High court. Ireland replied that the claim of right to access a court was one for civil legal aid, which had resource implications, and that the Convention should not be interpreted so as to protect social and economic rights within a Contracting State. Nonetheless, the Court stated that: “*Whilst the Convention sets forth what are essentially civil and political rights, many of them have implications of a social or economic nature. The Court therefore considers, like the Commission, that the mere fact that an interpretation of the Convention may extend into the sphere of social and economic*

³⁷ There are exceptions in the ECHR, certainly like, for instance, Article 8 which covers family life, Article 11 which includes the right to form unions, and Protocol 1 which provides both the right to property and a right to education. Even as regards these rights, only the right to education is unquestionably a social right.

*rights should not be a decisive factor against such an interpretation; there is no water-tight division separating that sphere from the field covered by the Convention*³⁸.

Progressively, the European Court of Human Rights developed a more activist approach, implying judicial intervention, among other things, in what were traditionally conceived as socio-economic areas. In particular, the Court proceeded to interpretation of the admittedly vague clauses of the text of the European Convention of Human Rights in ways that managed to extend the potential reach of the Convention into various socio-economic spheres and, thus, to cover cases that could not conceivably have been within the intention of the drafters of the Convention (such as environmental protection, housing, etc.). However, the Court continues to emphasize that: “*although many of the rights it contains have implications of a social or economic nature, the Convention is essentially directed at the protection of civil and political rights*”.³⁹

In this section, we shall examine the extent to which the jurisprudence of the Court can be used to promote the social dimension of the right to health. Specifically, although particularly mindful of concerns about legitimacy when it comes to intervening in domains of allocation of national resources, the Court, through an autonomous interpretation of the notions included in the Convention, has identified and developed a number of *positive state obligations* regarding the right to health. The most critical articles of the Convention in this regard are Articles 2 (which protects the right to life), Article 3 (which is to do with the prohibition of torture, and inhuman or degrading treatment or punishment) and Article 8 (which enshrines a right to respect for private and family life).

1. The protection of the right to health in the context of compulsory detention

A first and important positive duty to provide medical care for vulnerable individuals has most frequently been found in the context of people detained by the state. In these cases, and in the light of the responsibility of state authorities vis-à-vis detainees, the Court has held that, among other things, detainees have a right to health care provision. In this specific respect, the Court has made clear that although Article 3 of the Convention cannot be construed as laying down a general obligation to release detainees on health grounds, it nonetheless imposes an obligation on the State to protect the physical well-being of persons deprived of their liberty, for example by providing them with the requisite medical assistance.⁴⁰ According to the Court’s case law, persons in detention cannot protect their own health and so are entitled to medical care⁴¹ by virtue of Article 3 ECHR. Moreover, particular *conditions of detention* may amount to a violation of Article 3 if prisons and other detention centers are unhealthy or

³⁸ *Airey v. Ireland*, application No. 6289/73. judgment of 09.10.1979, para. 26.

³⁹ *N. v. the United Kingdom*, application No. 26565/05, judgment of 27.05.2008, par. 44

⁴⁰ *Hurtado v. Switzerland*, judgment of 28 January 1994, Series A no. 280-A, opinion of the Commission, pp. 15-16, § 79

⁴¹ *Mouisel v. France*, application No. 67263/01, judgment of 21.05.2003), *Kudla v. Poland*, application No. 30210/96, judgment of 26.10.2000.

overcrowded⁴², or deprive the person of natural light.⁴³ Also, the Court has found that the provision of Article 2 encompasses an obligation on the part of prison authorities to take appropriate and reasonable steps to guard against the risk of death or injury suffered in custody⁴⁴.

2. Positive obligations to provide health to aliens in a state party's jurisdiction

According to the Court's case law, states parties may be liable for breaching Article 3 of the Convention in cases of *extradition or expulsion of aliens*. This line of cases demonstrates the Court's willingness to extend the concept of a state's responsibility beyond its borders.

In *D. v. the United Kingdom*⁴⁵, to take a characteristic example, the applicant, originally from St Kitts (in the Caribbean), was arrested in the United Kingdom and was sentenced to imprisonment for six years. It was subsequently discovered that he was suffering from AIDS. Before his release, an order was made for his deportation to St Kitts. He claimed that his deportation would reduce his life expectancy, as no treatment of the kind he had been receiving in the United Kingdom was available in St Kitts. The Court emphasized that aliens who had served their prison sentences and were subject to expulsion could not, in principle, claim any entitlement to remain in the territory of a Convention State in order to continue to benefit from medical, social or other forms of assistance provided by the expelling State during their stay in prison. However, the Court, in view of the "*exceptional circumstances*" of the case, concluded that his deportation would be in breach of Article 3 of the Convention. Nonetheless, it should be noted that the threshold established by that case law to benefit from the protection afforded by Article 3 ECHR, namely the "*very exceptional circumstances of this case and given the compelling humanitarian considerations at stake*", is particularly high. Accordingly, the case should be considered as rather exceptional.

This line of reasoning was reaffirmed in the similar case of *N. v. the United Kingdom*.⁴⁶ In this case, the applicant, a Ugandan national, was admitted to hospital days after she arrived in the UK, as she was seriously ill and suffering from AIDS -

⁴² *Kehayov v Bulgaria*, application No. 41035/98, judgment of 18.04.2005.

⁴³ *Peers v. Greece*, application No. 28524/95, judgment of 19.04.2001.

⁴⁴ *Keenan v. the United Kingdom* (03.04.2001) where the Court held that "*Bearing in mind the difficulties in policing modern societies, the unpredictability of human conduct and the operational choices which must be made in terms of priorities and resources, the scope of the positive obligation must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities. Accordingly, not every claimed risk to life can entail for the authorities a Convention requirement to take operational measures to prevent that risk from materialising. For a positive obligation to arise, it must be established that the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual from the criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk (see Osman, cited above, pp. 3159-60, § 116). In this case, the Court has to consider to what extent this applies where the risk to a person derives from self-harm*" (par. 90).

⁴⁵ *D. v. the United Kingdom*, application No. 30240/96, judgment of 02.05.1997.

⁴⁶ *N. v. the United Kingdom*, cited above.

related illnesses. Her application for asylum was unsuccessful. She claimed that she would be subjected to inhuman or degrading treatment if compelled to return to Uganda, because she would not be able to receive the necessary medical treatment there. However, the Court found no violation of Article 3 of the Convention, ruling that “*the Convention did not place an obligation on States parties to account for disparities in medical treatment in States not parties to the Convention by providing free and unlimited medical treatment to all aliens without a right to stay within their jurisdiction*”. The Court thus reiterated the principle to the effect that the decision to remove an alien who was suffering from a serious mental or physical illness to a country where the facilities for the treatment of that illness were inferior to those available in the Contracting State might raise an issue under Article 3, but only in very exceptional circumstances, in which the humanitarian grounds against the removal were found to be particularly compelling, such as those of the *D. v. the United Kingdom* case.

3. Right to a healthy environment

The Court has made clear in *Janina Furlępa v. Poland*⁴⁷ that “*there is no explicit right in the Convention to a clean and quiet environment*”, while also noting: “*but where an individual is directly and seriously affected by noise or other pollution, an issue may arise under Article 8.*” Thus, environmental degradation *per se* does not violate the European Convention.⁴⁸ However, the Court has also acknowledged in *Önerıldiz v. Turkey*⁴⁹ that the positive obligation on States to take appropriate steps to safeguard the lives of those within their jurisdiction, for the purposes of Article 2, also applied in relation to environmental issues. In that case, the applicant’s dwelling was built without authorization on land surrounding a rubbish tip used jointly by four district councils. A methane explosion occurred and the applicant lost nine close relatives. The applicant complained that no measures had been taken to prevent an explosion. The Court found a violation of Article 2, as the Turkish Government had not provided the slum inhabitants with information about the risks they ran by living there; moreover, even if it had had, it remained responsible, insofar as it had not taken the necessary practical measures to avoid the risks to people’s lives.

Besides, the right to respect for private and family life, enshrined in Article 8 of the Convention has given rise to a substantial amount of litigation with respect to the protection of the right to a healthy environment. To take a handful of characteristic

⁴⁷ *Janina Furlępa v. Poland*, application No. 62101/00, judgment of 18 March 2008.

⁴⁸ *Kyrtatos v. Greece*, application No. 41666/98, judgment of 22.08.2003. The applicants complained that urban development in the south-eastern part of the island of Tinos had led to the destruction of their physical environment and had negatively affected their private life. In particular, they claimed that the area had lost all of its scenic beauty and had changed profoundly in character from a natural habitat for wildlife to a tourist development. The Court found no violation of Article 8 as the applicants had not been directly affected. Even assuming that the environment had been damaged by the urban development of the area, the applicants had not shown that the alleged damage to the birds and other protected species living in the swamp was of such a nature as to directly affect their own rights under Article 8. It might have been otherwise if the environmental deterioration complained of had consisted in the destruction of a forest area in the vicinity of the applicants’ house, a situation which could have affected more directly their own well-being.

⁴⁹ *Önerıldiz v. Turkey*, application No. 48939/99, judgment of 30.11.2004.

examples, in *Guerra v. Italy*⁵⁰, the failure to provide information about pollution from a chemical factory was found in violation of Article 8. Likewise, in *Fadeyeva v. Russia*⁵¹, the failure to deal with the impact of pollution from a steel plant was found to be in violation of Article 8. Moreover, in *Hatton v. the United Kingdom*⁵², the Court extended the scope of Article 8 to cases dealing with *noise* pollution.

4. Health and living conditions

The extension of the scope of Article 3 of the Convention so as to encompass standards of living is evident in *Moldovan and Others v. Romania*⁵³, which is to do with whether denial of adequate living conditions amounts to a ‘degrading treatment’ within the meaning of Article 3 of the Convention. Here, the applicants’ homes had been destroyed, as a result of which they lived in appalling conditions for ten years, suffering particularly detrimental effects on their health and well being. In conjunction with the racial discrimination that they suffered, this constituted an interference with the applicants’ human dignity and amounted to degrading treatment and a breach of Article 3. The Court stressed several factors in arriving at this decision: the living conditions, the involvement of the state in the original destruction, the unhelpful state attitudes since then, and finally the negative effect on the applicants’ health.

5. Cases concerning the alleged inadequacy of State financing of medical treatment

As already noted at several points, one of the main characteristics of social and economic rights is that their effective exercise requires positive state action. Usually, such positive action requires an allocation of national resources. In this context, the European Court of Human Rights has repeatedly stressed that the question whether States have complied with their positive obligations depends on balancing the requirement to protect the fundamental rights of the individual and the general policy interests that are being served.

Thus, in *Cyprus v. Turkey*⁵⁴, the applicant Government argued that the restrictions on the ability of the enclaved Greek Cypriots and Maronites to receive medical treatment and the failure to provide or to permit receipt of adequate medical services gave rise to a violation of Article 2 of the Convention. The Court accepted that an issue may arise under Article 2 of the Convention where it is shown that the authorities of a Contracting State *put an individual’s life at risk through the denial of health care which they have undertaken to make available to the population generally*. However, it did not find a violation in this case, as it had not been established that the lives of any patients were put in danger on account of delays in individual cases. Consequently, the Court avoided to rule on the extent to which Article 2 of the Convention may

⁵⁰ *Guerra and Others v. Italy*, application No. 14967/89, judgment of 19.02.1998.

⁵¹ *Fadeyeva v. Russia*, application No. 55723/00, judgment of 09.06.2005.

⁵² *Hatton v. United Kingdom*, application No. 36022/97, judgment of 08.07.2003.

⁵³ *Moldovan and Others v. Romania*, judgment of 12.07.2005.

⁵⁴ *Cyprus v. Turkey*, application No. 25781/94, judgment of 10.05.2001.

impose an obligation on a Contracting State to make available a certain standard of health care.

In *Nitecki v. Poland*⁵⁵, the applicant, who had a very rare and fatal disease, alleged that he did not have the means to pay for his medical treatment. He complained before the Court of the authorities' refusal to refund the full cost of his treatment (under the general sickness insurance scheme only 70% of the costs were covered). The Court accepted that the positive obligation under Article 2 could be engaged in such cases, but having reviewed the facts, ruled that the application was inadmissible.

The scope of the obligation under Article 8 of the Convention to take positive measures to permit disabled people to enjoy autonomy and independence in the wider community has been the focus of *Sentges v. the Netherlands*.⁵⁶ In this case, the Court stated that the margin of appreciation afforded to states in balancing ECHR rights against collective goals is wider when, as in that case, the issues involve an assessment of the priorities in the context of the allocation of limited State resources. It also accepted that national authorities are in a better position to assess health care priorities. The Court doubted that the situation complained of touched the essential core of the applicant's private life. However, it also stressed that, even if it did, this complaint fell squarely into the type of resource allocation disputes where a wide margin of appreciation was left to the authorities themselves to strike a fair balance between the competing interests of the individual and the interest of the wider community. This meant, in this particular case, that there was no positive obligation to provide the applicant with a robotic arm, which he arguably needed to lead an autonomous life in dignity.

In *Pentiacova and Others v. Moldova*⁵⁷, the alleged inadequacy of State financing of medical treatment, putting the lives of patients at risk and causing them suffering, was not found in violation of Articles 2, 3 or 8 of the Convention. The Court justified its reluctance to interpret the Convention as requiring the provision of certain forms of free health care by stating that "*The margin of appreciation referred to above is even wider when, as in the present case, the issues involve an assessment of the priorities in the context of the allocation of limited State resources*". It went on to express its concern about requiring all state parties to provide a certain form of health treatment. Nevertheless, the Court was of the opinion that "*in the circumstances of the present case it cannot be said that the respondent State failed to strike a fair balance between the competing interests of the applicants and the community as a whole*".

In 2009, in *Budina v. Russia*⁵⁸, the Court stated that a denial of social assistance might reach *a level of severity* such, that it can amount to a violation of Article 3 ECHR. In particular, the applicant's complaint was that the State pension on which she depended for her subsistence and livelihood was not sufficient to satisfy her

⁵⁵ *Nitecki v. Poland*, judgment of 21.03.2002.

⁵⁶ *Sentges v. the Netherlands*, application No. 27677/02, judgment of 08.07.2003.

⁵⁷ *Pentiacova and Others v. Moldova*, application no. 14462/03, judgment of 04.01.2005.

⁵⁸ *Antonina Dmitriyevna Budina v. Russia*, judgment of 18.06.2009.

basic human needs. The Court did not rule out the possibility that the State's responsibility could be engaged on account of the treatment meted out to the applicant, who was wholly dependent on State support and found herself faced with official indifference despite living in a state of great hardship incompatible with human dignity.

Conclusions

The above analysis shows that a significant body of jurisprudence is emerging in the domain of socio-economic rights. Applicants before the European Court of Human Rights (ECtHR) have attempted, with various degrees of success, to argue that the right to life, the prohibition on inhuman and degrading treatment and the right to private and family life, have socio-economic implications for States. In the cases surveyed, the focus was on health-related areas.

These claims have only been moderately successful. As already argued, *only in exceptional circumstances* does the Court accept that States are under a positive obligation to act using their resources in certain ways to guarantee the enjoyment of a minimum of healthcare protection. In particular, the Court has set a high threshold in the form of the “*minimum level of severity*” test, which must be met in order for positive obligations to arise. As long as this is not the case, the Court will not easily find fault with national authorities and it will not intervene in the choices they make in relation to the use of their resources. The situation is different, however, with respect to individuals finding themselves within the direct responsibility of the State, in particular if these are detained. In those cases, the positive obligations on States are much more robust and the Court is much less deferential towards States, even if budgetary considerations are still considered relevant.

V. THE RELEVANT INTERNATIONAL INSTRUMENTS

This section is concerned with the protection of the right to health in international instruments. In particular, we shall examine whether international sources of law may provide a legal ground for a right to health. As things currently stand, the right to health has evolved rapidly under international law and is enshrined in a number of different human rights treaties. A review of these international instruments shall be particularly helpful in identifying the scope of the right at issue.

1. The main international provisions

Firstly, as far as *occupational health* is concerned, the International Labor Organization's (ILO) documents are especially important. The ILO was created in 1919 with the aim to promote social justice as a contribution to universal peace⁵⁹.

⁵⁹ According to ILO's constitution of 1919: “*Whereas universal and lasting peace can be established only if it is based upon social justice; And whereas conditions of labour exist involving such injustice; hardship and privation to large numbers of people as to produce unrest so great that the peace and*

The right to decent, safe and healthy working conditions was enshrined in the Declaration of Philadelphia of 10 May 1944 of the International Labor Organization⁶⁰, which recognized ILO's obligation to further among the nations of the world programs that will achieve the extension of social security measures to provide a basic income to all in need of such protection, as well as comprehensive medical care. Nevertheless, these measures chiefly aimed at ameliorating *workers' health*. Consequently, it cannot be concluded that the Declaration guaranteed the protection of health beyond the scope of specific social security purposes. In this context, the ILO Social Security (Minimum Standards) Convention of 1952 (No. 102) is also relevant. Article 7 of this Convention states that "*Each Member for which this Part of this Convention is in force shall secure to the persons protected the provision of benefit in respect of a condition requiring medical care of a preventive or curative nature in accordance with the following Articles of this Part*". Articles 8 to 10 clarify the content of the provision of full medical care.

Secondly, there are the various *United Nations Treaties*. The United Nations Charter, adopted as a binding treaty on 26 June 1945, contains the seeds of protection of a number of basic human rights, including economic, social and welfare rights. In addition to establishing the Economic and Social Council, the Charter provides for the promotion of rights and economic development. In its preamble, the U.N. Charter articulates the determination of the international community "*to reaffirm faith in fundamental human rights, [and] in the dignity and worth of the human person*". Article 55 provides that the United Nations shall promote solutions of international economic, social, *health*, and related problems. However, the Charter only commits the United Nations to promote solutions to health problems and does *not* explicitly declare a right to health for particular individuals. Nonetheless, the inclusion of the reference to seeking solutions to "*international . . . health . . . problems*" in the basic document of the United Nations, indicates the fundamental, deeply rooted nature of this right.

Furthermore, the Preamble of the World Health Organization's Constitution of 1946 enshrines the highest attainable standard of health *as a fundamental right of every human being*⁶¹ and enumerates some principles pertaining to this right, such as healthy child development, equitable dissemination of medical knowledge and its

harmony of the world are imperiled; and an improvement of those conditions is urgently required ; as, for example [...] the protection of the worker against sickness, disease and injury arising out of his employment".

⁶⁰ "*The Conference recognizes the solemn obligation of the International Labour Organization to further among the nations of the world programmes which will achieve: (a) [...] (f) the extension of social security measures to provide a basic income to all in need of such protection and comprehensive medical care; (g) adequate protection for the life and health of workers in all occupations*".

⁶¹ "*THE STATES Parties to this Constitution declare, in conformity with the Charter of the United Nations, that the following principles are basic to the happiness, harmonious relations and security of all peoples: Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. 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*".

benefits and government-provided social measures to ensure adequate health. The critical importance of this provision is that it recognizes explicitly the provision of health services *as a fundamental right*.

In 1948, the United Nations adopted the Universal Declaration of Human Rights (UDHR), which was based upon the ideals of the United Nations Charter. Although this Declaration is not a binding treaty, but rather a statement of policy and a call for action, it explicitly enshrines a human right to health. Article 25 (1) specifically states that “*Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control*”. This provision thus recognizes a right to a certain standard of living, which covers basic needs including “*health and well-being*”. Health is thus treated as a way to measure the extent to which the right is being met. However, it should be noted that the right is to a certain minimal standard of living, not to health directly. The United Nations Declaration is not legally binding on Member States. However, it is arguable that, insofar as an increasing number of States have often applied and accepted its provisions, many, if not most, of its principles have attained the status of customary international law.

In this respect, the International Covenant on Economic, Social and Cultural Rights of 16 December 1966 (ICESCR) is also of great importance, when it comes to protecting the right to health. Article 12 of the Covenant⁶² stipulates that States Parties recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health. Moreover, a textual analysis of this article allows us to conclude that the right is not understood as the mere result of a promulgation or adoption on the part of States, but recognized as if it were a natural or inherent right.

The UN Committee on Economic, Social, and Cultural Rights (CESCR) specified the meaning and implications of this provision in General Comment 14 on the concept of the “*highest attainable standard of health*”, as set out in Article 12 of the Covenant, adopted in 11 May 2000. While not legally binding strictly speaking, it gives an authoritative and comprehensive overview of the meaning and implications of the right to health. According to the General Comment, the right to health has a core content, which refers to the minimum essential level of the right. Although this level cannot be determined in the abstract, its specification being

⁶² “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”.

primarily a national task, key elements are set out to guide the priority setting process.

In particular, General Comment 14 sets out the content of the right, which comprises obligations on the part of States to respect and fulfill the right, the elements of international cooperation relevant to implementation of the right, as well as acts constituting violations. General Comment 14 states that health is a fundamental human right indispensable for the exercise of other human rights. It also makes clear that the reference to Article 12(1) of the Covenant to “*the highest attainable standard of physical and mental health*” is not confined to the right to health care and that the wording of Article 12.1 acknowledges that the right to health embraces a wide range of socio-economic factors that promote conditions in which people can lead a healthy life, thus extending 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. Likewise, it clarifies that the notion of “*the highest attainable standard of health*” contained in article 12.1 of the Covenant takes into account both the individual’s biological and socio-economic preconditions and a State’s available resources. In addition, a human right to health is also recognized in numerous other international human rights treaties that establish prohibitions against governmental conduct that is detrimental to health, such as the Convention on the Elimination of All Forms of Discrimination against Women of 1979 and the Convention on the Rights of the Child of 1989.

Thirdly, and quite apart of the specific case of the ECHR which has already been extensively dealt with, there are various other Council of Europe Treaties. In this respect, the provisions of the 1961 European Social Charter (ESC –subsequently revised in 1996) of the Council of Europe are of prime importance. It must be noted at the outset that the Charter is in no sense a protocol to the European Convention of Human Rights (ECHR). On the opposite, it is an entirely separate treaty, with entirely distinct monitoring mechanisms of enforcement, insofar as there is no provision for a Court adjudicating on disputes of alleged violations. Enforcement mechanisms are thus characteristically ‘soft’ and they comprise a reporting mechanism as well as a collective complaint mechanism, which empowers certain organizations to make complaints about a general situation where state law or practice inadequately respects the Charter. Article 11 of the Charter provides for an elaborated framework of measures required to ensure the right to health, namely the removal of the causes of ill health, the establishment of advisory and educational facilities for the promotion of health and for the encouragement of individual responsibility and the prevention of accidents, epidemic, endemic and other diseases.

However, it is evident that the European Charter adopted a relatively restrictive approach, insofar as it does not protect the right to health as such. Instead, it only requires the taking of “*appropriate measures*” for the “*protection of health*”. Also, the Charter does not contain a definition of health. Nonetheless, the European Social Charter does reinforce the notion that the right to health is more than a right to

medical care, including within its scope a whole range of causes of ill health. The Charter also reinforces the focus on preventative measures and education, as opposed to merely responding to medical or other health problems and emergencies.

In this vein, another health-related convention of the Council of Europe is the European Convention on Human Rights and Biomedicine of 1997 (or Oviedo Convention), regarding various aspects of bioethics. These include provisions on informed consent and the protection of the human genome. According to Article 3 of the Convention, States Parties are required to take appropriate steps to achieve the aim of equitable access to health care of appropriate quality as far as the available resources permit it.⁶³ However, according to the Explanatory Report of the Convention the purpose of this provision is not to create an individual right on which each person may rely in legal proceedings against their State, but rather to prompt the latter to adopt the requisite measures as part of its social policy, in order to ensure equitable access to health care. In this context, “*equitable*” means here first and foremost the absence of unjustified discrimination. Although not synonymous with absolute equality, equitable access implies effectively obtaining a satisfactory degree of care.

Lastly, the 1993 Vienna Declaration on Human Rights is also of interest because it emphasizes the fundamental interrelation of political and civil human rights, on the one hand, and economic, social and cultural human rights on the other hand.⁶⁴

Conclusions

An attempt has been made to illustrate that a large range of international human rights instruments, declarations and resolutions affirm that good health is a precondition for the enjoyment of all other human rights and for participation in socio-economic and political life. Most countries in the world have become States parties to one or more international human rights treaties. To this extent, there now exists an international obligation owed by States towards some form of realization and enforcement of the right to health. Arguably, the above provisions impose a number of core obligations on contracting parties. Yet, implementation and enforcement of the international right to health is particularly complicated, since it requires affirmative action on the part of States, implicating various degrees of intervention in the internal domestic affairs of nations. Further, given the diverse cultures and economic levels of the nations of the world, it is

⁶³ “Parties, taking into account health needs and available resources, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality”.

⁶⁴ “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 and cultural systems, to promote and protect all human rights and fundamental freedoms”.

hard to envision a set of one-size-fits-all requirements that would be appropriate to all nations.

VI. GENERAL CONCLUSIONS

I believe that the overview of the four different legal orders that I just canvassed, centred as it was on the European citizen, puts us in a position to discern the nature of the right to health in the European Union, as well as its scope of protection:

1. An initial remark consists in saying that, with few exceptions, the citizen of a Member State enjoys a right to health based directly on explicit constitutional provisions. Moreover, even in the absence of explicit provisions, the right to health is frequently ‘deduced’ or ‘inferred’ from other provisions (protection of life and of dignity) or from general constitutional principles.
2. The negative aspect of the right to health, as already underlined, is a palpable normative reality. It is also constantly corroborated by the case law of the European Court of Human Rights. With respect to it, individuals enjoy justiciable and fully enforceable claims.
3. Now, in its most interesting socio-economic aspect that could potentially ground positive obligations on the part of the State, the constitutional right to health is not considered as generating, at least *pro tanto* and with some notable exceptions, enforceable claims to the benefit of individuals. As a general rule, constitutional provisions protecting health are addressed to legislatures or, from the point of view of international law, to States. However, one should take into account the emerging case law of a number of constitutional and supreme Courts that challenge a clear-cut distinction between constitutional rights and constitutional aims or goals. To give just one example, the Italian Constitutional Court recognizes the core of the right to health as a subjective right. Likewise, the CJEU has granted citizens of Member States of the EU, on the basis of primary Union law, enforceable individual rights with a wider protective ambit. By making use of their freedom to receive services, enshrined in the Treaties, they can move to another Member State to receive healthcare, and claim reimbursement from their home State.
4. Soft law international norms define a ‘*minimal standard of living*’ (see, for example, the Universal Declaration of Human Rights and General Comment 14 of the UN Committee on Economic, Social and Cultural Rights). These norms are implemented *de facto* by EU Member States (see, especially, the constitutional jurisprudence of Italy and Germany) and are confirmed by the case law of the European Court of Human Rights.
5. European citizens are not (yet) the beneficiaries of a fully justiciable right to health. As a result, they cannot force their state to provide them with healthcare services. However, all Member States of the EU have established robust national healthcare systems, which are mainly funded through state budgets. Many of them

function on the basis of universal free provision of health services at the point of contact (most famously the British NHS).

6. Moreover, the general theory of law tells us that not all rights have to correspond to individually enforceable claims to actually count as *legal* rights. In this vein, we may plausibly argue that in Europe, citizens have a legal right to health, which enjoys the multilevel protection of a *‘fundamental human right’*, both as a negative and as a socio-economic right.

EPILOGUE

At the end of this talk let me try to take a glimpse of the future. The EU Charter of Fundamental Rights is a seminal text for future generations. The text observes that “the Union places man at the Heart of its Action”. This is, undoubtedly, a Declaration that puts the threshold of expectations very highly. In so doing, the Charter reconnects today’s Europe with the political rededications of the era of enlightenment and of the various Declarations of the Rights of Man that followed it. Indeed, the slogan of the French Revolution “Liberté, Egalité, Fraternité” is well known. This moral and spiritual Heritage of Europe, a continent that has known for the last two centuries the disaster of total war and the annihilation of Human Dignity, anxiously brings back the historical Dilemmas of our Societies as well as their prospects for progress.

The Right to Health is the deepest expression of the principle of solidarity and a central component of social cohesion, social justice and sustainable development. Together with equality and Liberty, these principles inform the Universal values of Democracy and of the distinctively European Civilisation, that we are called to safeguard and promote.

Thank you kindly for your attention!

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