The Human Right to Equal Access to Health Care

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The Human Right to Equal Access to Health Care

Het fundamentele recht van de mens op
gelijke toegang tot gezondheidszorg

Proefschrift

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In memory of my father
to Jan Willem
with love

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Maite San Giorgi

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LIST OF ABBREVIATIONS

AP ESC	Additional Protocol to the ESC
CAT	Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CEDAWCee	Committee on the Elimination of Discrimination Against Women
CERD	Convention on the Elimination of all forms of Racial Discrimination Women
CERDCee	Committee on the Elimination of Racial Discrimination
CoE	Council of Europe
Committee	Committee on Economic, Social and Cultural Rights
Convention on Human Rights and Biomedicine	Convention for the protection of human rights and Dignity of the Human Being with regard to the Application of Biology and Medicine
CRC	Convention on the Rights of the Child
CRCCee	Commitee on the Rights of the Child
CRPD	Convention on the Rights of Persons with Disabilities
CRPDCee	Committee on the Rights of Persons with Disabilities
ECHR	Convention for the Protection of Human Rights and Fundamental Freedoms
ECtHR	European Court of Human Rights
ESC	European Social Charter
ECOSOC	UN Economic and Social Council
GC	General Comment
GDP	Gross Domestic Product
HRCee	Human Rights Committee
ICCPR	International Covenant on Civil and Political rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
ILO	International Labour Organization

OECD	Organisation for Economic Co-operation and Development
OP ICCPR	Optional Protocol to the ICCPR
OP ICESCR	Optional Protocol to the ICESCR
RESC	Revised European Social Charter
UDHR	Universal Declaration of Human Rights
UN	United Nations
UNFPA	UN Population Fund
UNICEF	UN Children's Fund
WHO	World Health Organization

PART A

GENERAL INTRODUCTION AND LEGAL FRAMEWORK

CHAPTER I
GENERAL INTRODUCTION

1 INTRODUCTION AND STATEMENT OF THE PROBLEM

Health care reform has found its way to the top of many policy agendas. Escalating health care costs, an ageing population and the increasing use of expensive health care goods and services give reason for the momentum towards change of health care systems. The human rights perspective, however, is largely absent in the debate on health care reforms. Most of the proposals for changing health care systems focus on economic reforms in which market-oriented and cost-benefit approaches are considered to resolve the problems health care systems are facing.[1] Human rights experts claim that the implementation of such proposals in health care systems in practice adversely affects health outcomes, accessibility of health care and can lead to arbitrary discrimination against certain groups. This in turn would constitute a violation of the human right to equal access to health care.[2]

The right to equal access to health care is a fundamental principle that is part of the human right to health care. The human rights approach perceives health care as a means to serve the health and well-being of human beings, which is indispensable to exercise other human rights.[3] By virtue of being a human being, all individuals are equally entitled to their corresponding inalienable human rights, including the right to health care. The human right to equal access to health care consists of a right to equal treatment in accessing health care and responds to the special needs of vulnerable and disadvantaged people. As discrimination violates the principle of equality, the prohibition of discrimination seeks to ensure that all persons can enjoy and exercise their right to equal access to health care.[4]

It is common knowledge that some persons or groups of persons have more problems in attaining health care than others. This for example accounts for women and girls, members of ethnic minorities, people with a poor health status, those with

[1] Chapman 1994, p. vi; Leary 1994, p. 94.
[2] Leary 1994, p. 92, 96.; Mackintosh and Koivusalo 2005, p. 8.; Gómez Isa 2005, p. 15.
[3] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 1.
[4] Hendriks 1994a, p. 156.

a low socio-economic status, and other vulnerable persons.[5] This is at odds with the human right to equal access to health care.

For victims of a violation of the human right to equal access to health care it is important that a judicial or quasi-judicial body can adjudicate their complaint in this regard. Justiciability contributes to the protection and realisation of the right to equal access to health care and further determines the meaning of this right. However, the justiciability of the human right to equal access to health care is complex.

The human right to equal access to health care is an economic, social and cultural human right. In many human rights instruments and documents a distinction is made between civil and political rights – *e.g.* the right to life, the right to a fair trial and the prohibition of torture and inhuman and degrading treatment - on the one hand and economic, social and cultural rights on the other. Economic, social and cultural rights include the right to education, the right to food, and the right to adequate housing. Traditionally, economic, social and cultural rights are perceived to entail positive State obligations, whereas civil and political rights impose a negative obligation on States. Negative rights comprise an abstention of the State so that every individual can freely exercise his or her rights and freedoms. Positive rights require active measures and government programs, which have financial implications for a State.

The separation between these rights also found expression with regard to the historical evolution of the justiciability of human rights. It is more complex for economic, social and cultural rights to be justiciable than for civil and political rights. The amount of human rights bodies with which a complaint concerning an alleged violation on economic, social and cultural rights can be lodged directly is limited and the establishment of new bodies is subject to political resistance. Nevertheless, the separation between economic, social and cultural rights on the one hand and civil and political rights on the other is not so strict in practice. Over the last two decades several adjudicatory human rights bodies have dealt with elements of economic, social and cultural rights *via* civil and political rights. This protection of elements of economic, social and cultural rights under the notion of civil and political rights is designated as the 'integrated approach'.

The human right to equal access to health care has thus far not been dealt with by these bodies. The body entitled to deal directly with a complaint of economic, social and cultural rights, *i.e.* the European Committee of Social Rights, has adjudicated only a few cases on unequal access to health care. Therefore, their approach with regard to the application of the principle of equality and non-discrimination in relation to the human right to health care needs further elaboration and clarification. Moreover, although the right to equal access to health care is

[5] A/66/254, 3 August 2011, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover*; Hendriks 2001a, p. 59; Vasey 2009, p. 61.

discussed by various authors, its justiciability is not extensively dealt with in human rights literature.

2 Research Objectives, Research Questions and Structure of the Present Study

This research is directed at the analysis of the justiciability of the human right to equal access to health care. Its objective is to examine how cases concerning unequal access to health care would be dealt with by judicial and quasi-judicial human rights bodies and to provide the elements that can be expected to play a role in the assessment of such cases. For this reason, the present study is divided into three parts, each dealing with one separate research question and consisting of several Chapters.

Part I focuses on the legal human rights framework of the right to equal access to health care and its definition. It will answer the following research question: *What is the human right to equal access to health care and how is it enshrined in human rights law?*

The human right to equal access to health care is an essential element of the right to health care, which in its turn is part of the broad framework of the right to health. The human rights framework providing for the right to health and the right to health care and their corresponding entitlements will be set out in Chapter II. The provisions providing for the right to health care are primarily directed at the Signatory States of the various human rights instruments. The extent to which the right to health care has to be implemented, the different ways in which this right can and sometimes must be realised by States and the criteria that have to be met before there is actual access to health care shall be discussed in Chapter III. Recurring elements in the various human rights provisions on the right to health and the right to health care, and the corresponding State obligations relate to the accessibility of health care on an equal and non-discriminatory basis. Chapter IV will analyse these elements and presents the definition of the human right to equal access to health care adopted in this study. The principle of equality and non-discrimination is vital for the justiciability of the human right to equal access to health care. By virtue of a provision prohibiting discrimination, the right to health care can be justiciable by a judicial or quasi-judicial human rights body. Therefore, the human rights framework of these provisions is also included in this Chapter.

Part II of this research aims at answering the following research question: *What arguments are brought forward with regard to the justiciability of economic, social and cultural rights and how are these rights, including the human right to health care, adjudicated in practice by the various judicial and quasi-judicial human rights bodies?*

Chapter V will set out the debate on the justiciability of economic, social and cultural rights. In addition, it will describe the justiciability of economic, social and cultural rights in practice by the various judicial and quasi-judicial human

rights bodies. How these bodies adjudicate complaints concerning the right to health care and dimensions of the right to health care shall be analysed in Chapter VI. As becomes obvious from the cases discussed in Chapter V and VI, both the Human Rights Committee (HRCee) and the European Court of Human Rights (ECtHR) adopt an integrated approach. By this integrated approach these human rights bodies took into account dimensions of economic, social and cultural rights, including elements of the right to health care in their task to afford protection to civil and political rights. The integrated approach is of great importance for the justiciability of the human right to equal access to health care. This phenomenon is set out in Chapter VII together with several normative explanations of the integrated approach.

Part III of the present study focuses on the justiciability of the human right to equal access to health care. The case law of three human rights bodies – the European Committee of Social Rights, the ECtHR and the HRCee – will be examined in detail in order to analyse how these bodies assess cases concerning discrimination and how elements of economic, social and cultural rights are taken into account under the various equality and non-discrimination provisions. Subsequently, the different criteria and elements that can be expected to play a role in the justiciability of cases concerning the human right to equal access to health care shall be considered. The European Committee of Social Rights is a quasi-judicial human rights body entitled to directly receive complaints with regard to the right to health care. Hitherto it is the only body that actually has dealt with complaints with regard to unequal access to health care. The ECtHR adopts an integrated approach to economic, social and cultural rights. It is the only truly judicial human rights body and therefore its adjudicatory practice in relation to the application of the prohibition of discrimination to dimensions of economic, social and cultural rights serves as a highly relevant basis for the analysis of it dealing with a possible future case about unequal access to health care. The HRCee is another human rights body with the power to assess complaints with regard to the implementation of civil and political rights, that adopts an integrated approach. It applies the provision on equality and non-discrimination enshrined in Article 26 of the International Covenant on Civil and Political rights (ICCPR) directly to rights protected by other treaties, including those providing for economic, social and cultural rights.[6] Hence, the examination of the adoption of this provision to economic, social and cultural rights can provide for different elements that can play a role in a future case concerning unequal access to health care assessed by the HRCee.

The research question that will be answered by the examination of the adjudicatory practice of these three bodies in light of the right to equal access to health care is: *What elements can be expected to play a role in the justiciability of*

[6] Adopted and opened for signature, ratification and accession by General Assembly Resolution 2200 A (XXI) of 16 December 1966.

cases with regard to the human right to equal access to health care at the European Committee of Social Rights, the European Court of Human Rights and the Human Rights Committee?

The European Committee of Social Rights is subject of research in Chapter VIII. The adjudicatory practice of the ECtHR with regard to cases concerning discrimination in general and in cases dealing with dimensions of economic, social and cultural rights are set out in Chapter IX. Chapter X gives an assessment of the cases under the autonomous non-discrimination provision of Article 26 ICCPR by the HRCee. Finally, in Chapter XI the main findings of this study will be presented.

3 METHOD OF ANALYSIS

The purpose of the first part of the research is to achieve a detailed picture of the legal framework of the right to health care, *i.e.* a description of the norms currently applied in this field. Therefore, this part of the research includes a literature research as well as a study of relevant human rights norms and doctrines. Relevant legal sources that will be discussed include, *inter alia*, treaties and conventions, and documents of human rights bodies. A distinction in legal sources will be made between the level of international human rights law and regional human rights law by which is referred to the United Nations (UN) level and the Council of Europe (CoE) level, respectively. The body overseeing the implementation of the human right to health care at international human rights level is the Committee on Economic, Social and Cultural Rights (the Committee). At regional level this role is assigned to the European Committee of Social Rights. The compliance of the various States in relation to the human right to health care is supervised by these bodies, *inter alia* on the basis of a periodical State reporting procedure. The conclusions issued since 2003 in reply to these State reports are taken into account in this first part of the research as well, as these provide further clarification of the nature and content of the right to health care.

The methodology applied in the second and third part of the research includes a literature research, a study of existing human rights law, and an extensive case law analysis. The investigation conducted in the second part of the present study with regard to the justiciability of economic, social and cultural rights and the right to health care is mainly based on a research of literature and on the case law of several human rights bodies. This approach – here too – follows from the purpose of the research as a whole. The third part of the present study is based on a thorough examination of the case law of the three bodies that stand central to this part of the study. For the analysis of how the human right to equal access to health care is justiciable, all cases dealt with by the European Committee of Social Rights have been analysed. Due to the quantity of rulings of the HRCee and the ECtHR, a selection is made of cases in which both bodies dealt with complaints under the provisions of equality and non-discrimination. For the HRCee a selection has been made, based on the volumes of the *Selected Decisions of the Human Rights*

Committee under the Optional Protocol. The analysis of the adjudicatory practice of the ECtHR is based on its database and the cases selected by the *European Human Rights Cases* journal and the covering annotations of various leading scholars.

CHAPTER II
THE RIGHT TO HEALTH AND THE RIGHT TO HEALTH CARE IN HUMAN RIGHTS LAW

1 INTRODUCTION

Health is special. Health is among the most important conditions of human life and central to our well-being. Moreover, health has been proclaimed as the object of the human right to the enjoyment of the highest attainable standard of health by the international community since the adoption of the Constitution of the World Health Organization in 1946.[1] It is well entrenched within international and regional human rights law and the various instruments have been supplemented and clarified through additional instruments and through the practice of monitoring bodies.[2] The language of each of these documents varies widely, but in general the right is referred to as the "right to health".[3]

The right to health is not a right to be healthy.[4] It is a right to a number of entitlements and underlying determinants of health, such as potable water, adequate sanitation, housing, healthy occupational conditions and healthy environmental conditions. These entitlements and underlying determinants are provided for by the different human rights provisions in which the right to health is enshrined. Paragraph 2 sets out this human rights framework of the right to health at international and regional level and provides for a delineation of its entitlements and underlying determinants.

Although the right to health is firmly embedded in a substantial number of international and regional human right laws, most of its provisions are broadly and fragmentarily defined. To provide for more conceptual clarity with regard to the content of this right, the entitlements and underlying determinants are set out in a classification of the scope of the right to health, the core content of the right to health, and the overlapping elements of the right to health in paragraph 3.

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[1] Adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States (*Off. Rec. Wld Hlth Org*., 2, 100), and entered into force on 7 April 1948; Leary 1994a, p. 25.
[2] Chinkin 2006, p. 9.
[3] Leary 1994a, p. 26; Hendriks 1998, p. 389-408.
[4] Roscam Abbing 1979, p. 104-105.

The right to health care is the subject of the present study. It is an essential aspect of the entitlements and underlying determinant of the right to health, which can be considered as the broad framework of the right to health care. In paragraph 4, the right to health care is set out in more detail on the basis of the classification provided for in paragraph 3.

2 THE RIGHT TO HEALTH IN INTERNATIONAL AND REGIONAL HUMAN RIGHTS LAW

2.1 Introduction

This paragraph sets out the human rights framework of the right to health, including a delineation of the entitlements and underlying determinants of this right. The provisions at the international human rights level and regional human rights level are being dealt with separately in the following subparagraphs.

2.2 The Right to Health in International Human Rights Law

The right to health was for the first time laid down in the Constitution of the World Health Organization (WHO) of 1946. The WHO is the directing and coordinating authority for health within the system of the UN. Its Constitution is the basic legal document of the WHO and sets out the overall objective of the organization, its legal status, its organizational structure, and its co-operative relationships between the UN and other organizations.[5] The rights enshrined in the Constitution are described in the 9 principles of the Preamble that declare the right to health 'as a right of every human being without distinction of race, religion, political belief, economic or social condition'. The first principle defines health as 'a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity'. This definition was rather revolutionary at the time of the adoption of the Constitution of the WHO.[6] Nowadays, it is well-known and referred to and seen as the 'broad definition' of health.[7]

The other principles of the Preamble of the Constitution of the WHO emphasize the importance of the promotion of health and the control of diseases and lay down what is perceived as being part of the right to health. This is a healthy development of the child, mental health, and health related information and knowledge. The principles therefore address preventive health efforts, as well as curative health care.[8]

[5] Roscam Abbing 1979, p. 103.
[6] Roscam Abbing 1979, p. 103.
[7] Boot and Knapen 2005, p. 5.
[8] Roscam Abbing 1979, p. 104.

The Constitution of the WHO was a breakthrough in the field of international health and human rights and inspired the further elaboration of a right to health in human rights documents.[9] Shortly after its adoption, the right to health was laid down in the 1948 Universal Declaration of Human Rights (UDHR).[10] Article 25, paragraph 1 UDHR formulates the right to health as '[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family'. Paragraph 1 of this provision provides that the right to health includes, but is not limited to, underlying determinants of health such as food, clothing, housing, medical care and necessary social services. Moreover, the right to 'security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control' is also included in this provision on the right to health.[11] In paragraph 2 of Article 25 UDHR the special care and assistance for motherhood and childhood is determined as being part of the right to health. In addition, it provides for an equal enjoyment of this special care and assistance by all children, whether born in or out of wedlock.

In 1966 the provisions of the UDHR were laid down in two legally binding International Covenants that cover the civil and political rights and economic, social and cultural rights enshrined in it: the ICCPR and the International Covenant on Economic, Social and Cultural Rights (ICESCR).[12] Together with the UDHR, these two covenants form the international Bill of Human Rights which constitutes the foundation of the international normative regime for human rights. The right to health is laid down by the ICESCR and is the most authoritative interpretation of the right to health in international human rights law.[13] It is enshrined in Article 12 ICESCR which defines the right to health as 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.

Article 12 ICESCR prescribes that State parties have to take steps to achieve the full realisation of the right to health. Such steps include those necessary for the reduction of the stillbirth-rate, of infant mortality and to enhance the proper development of the child, environmental and industrial hygiene, the prevention, treatment and control of epidemic, endemic, occupational and other diseases, and to ensure to for all people medical service and medical attention in the event of sickness.

In addition to Article 12 ICESCR, the Committee has developed further guidance on the full realisation of the right to health in its General Comment No. 14 (GC No. 14).[14] The Committee is the independent expert monitoring body

[9] Toebes 1999a, p. 36.
[10] Adopted and proclaimed by General Assembly Resolution 217 A (III) of 10 December 1948.
[11] This is closely related to Article 22 UDHR on the right to social security.
[12] Adopted and opened for signature, ratification and accession by General Assembly Resolution 2200 A (XXI) of 16 December 1966.
[13] World Health Organization, *25 questions and answers on health and human rights,* 2002, p. 9.
[14] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*.

overseeing the implementation of the ICESCR. This supervisory task was delegated to it by the Economic and Social Council of the UN (ECOSOC) under ECOSOC Resolution 1985/17 of 28 May 1985.[15] One of the entitlements of the Committee is that it can issue a General Comment on a specific right enshrined in the ICESCR to clarify the nature and content of a specific right. Is has done with regard to the right to health enshrined in Article 12 ICESR. Moreover, the rights set forth by the ICESCR are supervised by the Committee on the basis of a periodically State reporting procedure. In its Concluding Observations, the Committee sets forth its findings on the basis of these reports on the compliance of Member States with their obligations under the ICESCR.

Considering Article 12 ICESCR, as well as GC No. 14, the right to health as set forth by the ICESCR includes various elements. Firstly, it provides for both freedoms, such as the right to control one's health and body, and the right to be free from interference (torture, non-consensual medical treatment and experimentation), as well as entitlements. These entitlements are: preventive, curative, primary, rehabilitative health services, treatment and care and include maternal, child, and reproductive health, mental health, provision of essential drugs, prevention, treatment, and control of epidemic, endemic, occupational and other diseases and care for chronically and terminally ill persons.[16] Secondly, the Committee interprets the right to health as an inclusive right extending not only to these freedoms and entitlements. It has underscored that the right to health also extends to the underlying determinants of health, such as: nutrition, housing, access to safe and potable water, adequate sanitation, safe and healthy occupational conditions, healthy environment and access to health-related education and information, including on sexual and reproductive health.[17] Finally, the Committee recognizes in GC No. 14 that the right to health is closely related to and dependent on the realisation of other human rights. Examples of these rights are the right to food, housing, work, education, human dignity, life, privacy and access to education. These rights and freedoms form an integral component of the right to health.

In addition to the above-mentioned instruments, a number of other UN Conventions include the right to health. These conventions protect the rights of special groups within society or in a specific area of health. Examples are the Convention on the Elimination of all forms of Racial Discrimination (CERD), Convention on the Elimination of all forms of Discrimination Against Women

[15] ECOSOC Resolution 1985/17 of 28 May 1985, *Review of the composition, organization and administrative arrangements of the Sessional Working Group of Governmental Experts on the Implementation of the International Covenant on Economic, Social and Cultural Rights.*

[16] Pillay 2008, p. 2006; E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*. Reproductive health includes measures to reduce the stillbirth-rate and the rate of infant mortality, and to improve child and maternal health, sexual and reproductive health services, including access to family planning, pre- and post-natal care and emergency obstetric services.

[17] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*.

(CEDAW), Convention on the Rights of the Child (CRC), and the Convention on the Rights of Persons with Disabilities (CRPD).[18]

The CERD prescribes the right to equal treatment and non-discrimination in relation to the right to health.[19] In the CEDAW, the areas where women need additional protection in relation to health are highlighted. Article 12 CEDAW prescribes that the right to health encompasses access to health care services, including those related to family planning and services in connection to pregnancy. Also the right to protection of health in working conditions of which the safeguarding of the function of reproduction is part of, and the right to access to educational information to ensure the health and well-being of families are enshrined in the CEDAW.[20] The CRC is directed at the legal protection of the rights of the child, before as well as after birth. It provides for a broad protection of the right to health of children, including underlying determinants. The provisions put forward by the CRC correspond to the elements of the right to health as defined in the above mentioned human rights instruments. In addition, it includes the prohibition of traditional practices harmful to the health of the child, special attention for access to health care services for disabled children, primary health care, and mental health.[21] Finally, the CRPD emphasizes the importance of the enjoyment of the highest attainable standard of health without discrimination on the basis of disability.[22] This right includes access to health services on an equal basis with others, health-related rehabilitation, services designed to minimize and prevent further disabilities, sexual and reproductive health, and public health programmes.

2.3 The Right to Health in Regional Human Rights Law

Similarly, at regional level and within the framework of the CoE, human rights instruments provide for a right to health.[23] The main documents in which this right is embedded are the European Social Charter (ESC) and the Revised European Social Charter (RESC).[24] As set forth by its Preamble, '[e]veryone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable'. This right is further laid down and specified in different Articles.

[18] CERD: Adopted and opened for signature, ratification and accession by General Assembly Resolution 2106(XX) of 21 December 1965; CEDAW: Adopted and opened for signature, ratification and accession by General Assembly Resolution 34/180 of 18 December 1979; CRC: Adopted and opened for signature, ratification and accession by General Assembly Resolution 44/25 of 20 November 1989; CRPD: Adopted and opened for signature, ratification and accession by General Assembly Resolution A/RES/61/106 of 13 December 2006.
[19] Article 5, paragaph e, sub iv CERD.
[20] Articles 10, 11, and 14 CEDAW.
[21] Articles 17, 23 paragraph 23, 24 paragraph 2, sub b, and paragraph 3, 25 CRC.
[22] Article 25 CRPD.
[23] Chinkin 2006, p. 52.
[24] European Social Charter, 18 October 1961, entry into force: 26 February 1965, E.T.S. 35; European Social Charter (Revised), 3 May 1996, entry into force: 1 July 1999, E.T.S. 163.

For example, in Article 11 ESC and RESC the right to health has been laid down as 'the right to protection of health'. This includes the removal of causes of ill-health, information and education for the promotion of health and prevention of epidemic, endemic, and other diseases, as well as accidents. Moreover, in other Articles of the ESC and RESC further elements of the right to health are laid down: the right to access to health care for elderly persons, healthy working conditions and occupational health services, measures to encourage the health at work of pregnant workers, and the right to housing.[25]

Another important document drafted within the framework of the Council of Europe is the Convention for the protection of human rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (The Convention on Human Rights and Biomedicine).[26] This Convention is directed at protecting human dignity and human rights in both longstanding and developing areas concerning the application of biology and medicine such as medical research, organ transplantation and the provision of health care.[27] Therefore, it is less directed at the 'broad-based right to health' that sets out or explains what elements form part of the right to health than the provisions of the ICESCR and ESC and RESC.[28] Nevertheless, the Explanatory Report to the Convention on Human Rights and Biomedicine does provide further clarification on what is included in the right to health. In paragraph 24, the Committee on Bioethics interprets as being part of health care: diagnostic, preventive, therapeutic and rehabilitative interventions.

3 THE SCOPE, CORE CONTENT AND OVERLAPPING ELEMENTS OF THE RIGHT TO HEALTH

3.1 Introduction

The right to health is firmly embedded in a substantial number of international and regional human rights instruments. These instruments include the right to health care and comprise other underlying determinants as being part of the right to health. Most of the provisions concerned are however, broadly and fragmentarily defined. Toebes (1999) uses a classification of different elements of the right to health to provide for more conceptual clarity with regard to the content of this right.[29] This classification consists of three components; the scope, core content, and

[25] Articles 3, 19, 23 ESC and RESC.
[26] Convention for the protection of human rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, Oviedo, 4.IV.1997 (DIR/JUR (96) 14), E.T.S. No. 164.
[27] Goffin et al. 2008 p. 223.
[28] Toebes 1999a, p. 69.
[29] Toebes 1999a, Chapter 5.

overlapping elements of the right to health.[30] This classification is set out in the following three sub-paragraphs together with the entitlements and determinants that fall under each component.

3.2 The Scope of the Right to Health

The scope of the right to health is the general content of this right as embedded in the different human rights provisions that lay down the right to health.[31] The elements that form part of the scope of the right to health have been set out in the previous paragraph. The following overview provides a clear outline of all these elements. A distinction is made between the right to entitlements and underlying determinants of the right to health and the right to health care for the purpose of the present study.

Underlying determinants of the right to health	*Treaty*
– health related information and education	Preamble WHO, ICESCR, CEDAW, ESC
– nutrition	UDHR, ICESCR, CRC
– clothing	UDHR, CRC
– housing	UDHR, ICESCR, CRC, ESC
– social services	UDHR
– freedom from interference	ICESCR
– abolishment harmful traditional practices	CRC
– safe and potable water	ICESCR
– adequate sanitation	ICESCR, CRC
– safe and healthy occupational conditions	ICESCR, CEDAW, ESC
– healthy environment	ICESCR, CRC

Underlying determinants of the right to health care	*Treaty*
– health care goods and services	Preamble WHO, UDHR, ICESCR, CEDAW, CERD, CRC, CRPD, ESC, Convention on Human Rights and Biomedicine
– child health care	Preamble WHO, UDHR, ICESCR, CRC

[30] This classification is also used in relation to other human rights, see for example: A.P.M. Coomans, *Identifying the key elements of the right to education. A focus on its core content,* London: Childs Right Information Network (CRIN) 2007, p. 10.
[31] Toebes 1999a, p. 243.

– mental health care	Preamble WHO, ICESCR, CRC
– preventive health care	Preamble WHO, ICESCR, ICESCR, CRC, CRPD, ESC, Convention on Human Rights and Biomedicine
– curative health care	Preamble WHO, ICESCR, CRC
– primary health care	ICESCR, CRC
– rehabilitative health care	ICESCR, CRC, CRPD, Convention on Human Rights and Biomedicine
– family planning services	ICESCR, CRC, CEDAW, CRPD
– pre- and post-natal health care	UDHR, ICESCR, CRC
– provision of essential drugs	ICESCR
– palliative care	ICESCR

3.3 The Core Content of the Right to Health

The core content of the right to health encompasses the essence of the right and therefore contains the minimum entitlements of the scope of the right to health.[32] There are situations in which the realisation of rights is not achieved, or is even limited. This can for example be necessary for reasons of general welfare, when rights are in conflict and in times of emergencies (*e.g.* in case of armed conflicts, natural disasters).[33] Therefore, human rights are rarely absolute.[34] It should, however, be stressed that the possibility to impose limitations on the enjoyment of human rights is intended to protect the rights of individuals rather than to permit the impositions of limitations by Signatory States.[35] Moreover, laws imposing limitations on the exercise of economic, social and cultural rights should not be arbitrary, unreasonable or discriminatory.[36] The possibility of limiting human rights is discussed in more detail in Chapter III on State Responsibilities. For now, it is sufficient to point out that human rights, such as the right to health may not be limited beyond its core content as without that it loses all significance.[37]

But what exactly is the core content of the right to health? GC No. 14 on Article 12 ICESCR is about the only document that clearly defines the core content

[32] Toebes 1999a, p. 244.
[33] Müller 2009. p. 558-560.
[34] Müller 2009, p. 559.
[35] UN doc. E/CN.4/1987/17, The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, para. 46.
[36] UN doc. E/CN.4/1987/17, The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, paras. 48- 51.
[37] Toebes 1999a, p. 244.

of the right to health.[38] It states that States parties have to 'ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups'.[39] Moreover, it defines that the core obligation is to 'ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including primary health care'.[40] This primary health care includes:
– access to health facilities, goods and services on a non-discriminatory and equitable basis;
– the provision of essential drugs.

Furthermore, it states that other obligations of comparable priority are:
– reproductive, maternal (pre- and post-natal) and child health care;
– immunization against important infectious diseases;
– measures to prevent, treat and control epidemic and endemic diseases.

The underlying determinants of health that are defined to be part of the core content of the right to health are:
– minimum essential food;
– basic shelter;
– housing;
– sanitation;
– safe and potable water;
– a national public health strategy;
– access to health education and information.[41]

Solely realising the core content of a right is not sufficient. The core content of a right is to be perceived as 'an expanding floor' and not as a 'fixed ceiling.[42] As provided for by Article 2, paragraph 1 ICESCR, a State has the obligation to realise the rights enshrined in the ICESCR progressively and to the maximum of its resources. Thus, in case the core content of a right has been realised, Member States have to strive for the realisation of the full spectrum of that right.[43] The State's

[38] Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September
1978, para. VII.
[39] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 43.
[40] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 43.
[41] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, paragraph 43 (f). A national public health strategy and plan of action should be based on epidemiological evidence and address the health concerns and needs of the whole population and requires States to realise progressively their full obligation of the right to health.
[42] Coomans 2007, p. 2.
[43] Chapman 1997-1998, p. 409; Coomans 2007, p. 2.

obligation of realising progressively the right to health and the right to health care is discussed in more detail in Chapter III.

3.4 The Overlapping Elements of the Right to Health

The right to health consists of various elements that overlap with other human rights.[44] As such, the right to health is not only covered by those provisions explicitly directed at the right to health. The right to health is also protected by other provisions that are part of the entitlements and determinants of the right to health. A violation of these human rights may result in ill-health and can thereby affect the right to health.[45]

Several examples of overlapping elements of the right to health and health-relevant elements covered by other human rights provisions can be given. Firstly, the civil and political right to life (Art. 6 ICCPR, Art. 2 Convention for the Protection of Human Rights and Fundamental Freedoms (ECHR)) that eminently prohibits the deprivation of life and therefore health, and provides for the right to protection against malnutrition and epidemics to prevent infant mortality and increase life expectancy.[46] Secondly, the right to physical and mental integrity that is covered by the prohibition of torture, inhuman and degrading treatment (Art. 7 ICCPR, Art. 3 ECHR) and the right to privacy (Art. 17 ICCPR, Art. 8 ECHR). This right protects individuals against deprivation of medical treatment, food, water, adequate sanitary circumstances, and mental damage and sickness, *e.g.* in case of detention and stay in a medical institution.[47] Moreover, it explicitly prohibits medical and scientific experimentation without free consent of the person involved, which can lead to cruel, inhuman or degrading treatment.[48] The prohibition of harmful traditional practices, such as female circumcision that is covered by Article 12 ICESCR as well as Article 24 CRC is understood to be part of the prohibition of torture, inhuman and degrading treatment and the right to privacy.[49] Thirdly, the right to education and information (Art. 13 ICESCR, Art. 10 CEDAW, Art. 28 CRC, Art. 2 ECHR) is part of the overlapping elements of the right to health, not only as there is a strong relationship between the level of education and people's health, but also as it is part of the obligation of a State to provide health-related

[44] Toebes 1999a, p. 243-244, 259.
[45] World Health Organization 2002, p. 8.
[46] A/37/40, General Comment 6 (1982), 30 April 1982, *Right to life*, para. 5; Article 12, paragraph 2, sub a ICESCR.
[47] A/37/40, General Comment 7 (1982), 30 May 1982, *Torture or cruel, inhuman or degrading treatment or punishment*, para. 2.
[48] Toebes 1999a, p. 265-267; A/37/40, General Comment 7 (1982), 30 May 1982, *Torture or cruel, inhuman or degrading treatment or punishment,* para. 3; Article 5 Convention on Human Rights and Biomedicine.
[49] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 21.

information and education.[50] Finally, food, housing, access to work and healthy working conditions are also important underlying determinants of a person's health and form part of the adequate living conditions covered by different human rights provisions.[51]

The aforementioned provisions are directed to protect health-related issues or contain elements of the scope of the right to health care. This illustrates that the right to health is closely related to and dependent on the realisation of other human rights.[52] Moreover, these provisions play an important role in the justiciability of the right to health. For example, the right to health is considered as being non-justiciable in a direct manner under the ECHR. It can only be effectively effectuated within the framework of other recognized rights, such as the rights dealt with in this subject on the overlapping elements of the right to health. As such, the rights to health and health care have been brought before the ECtHR at Strasburg under the notion of the right to life (Art. 2 ECHR), the prohibition of torture (Art. 3 ECHR) and the right to privacy and family life (Art. 8 ECHR).[53] The justiciability of the right to health is further discussed extensively in Chapter VI.

4 THE CORE CONTENT AND SCOPE OF THE RIGHT TO HEALTH CARE WITHIN THE BROAD FRAMEWORK OF THE RIGHT TO HEALTH

4.1 Introduction

The right to health is an inclusive right to various freedoms and entitlements that together form the underlying determinants of health. Some examples of these determinants are: nutrition, housing, access to safe and potable water, adequate sanitation and safe and healthy occupational conditions. The right to health care is another and essential aspect that forms part of the broad framework of the right to health.

In the previous paragraph, the scope and core content of the right to health care are set out. The scope of the right to health care includes health care services, including child health care, mental health care, preventive health care, curative health care, primary health care, rehabilitative health care, family planning services, pre- and post-natal health care and palliative care, and provision of essential drugs. The core content of the right to health care entails access to health care on a non-discriminatory basis and *inter alia* includes as a minimum the right to primary

[50] Toebes 1999a, p. 269; as enshrined in Article 11 ESC, Article 24 CRC, and Article 10 CEDAW.
[51] The right to housing: Article 11 ICESCR, Article 31 ESC and RESC; The right to food: Article 11 ICESCR, Article 12 CEDAW, Article 24 CRC; The right to work and safe and just working conditions: Articles 6, 7 ICESCR, Articles 1, and 3 ESC and RESC; Convention concerning Occupational Safety and Health and the Working Environment, ILO Convention 155, adopted 2 June 1981.
[52] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 3.
[53] *E.g. D.* v. *the United Kingdom*, Application No. 30240/96, 2 May 1997, para. 37.

health care, and access to essential drugs. Other entitlements of comparable priority are: i) reproductive, maternal (pre- and post-natal) and child health care; ii) immunization against important infectious diseases, and iii) measures to prevent, treat and control epidemic and endemic diseases.[54]

In this paragraph, the right to health care is addressed in more detail. The elements that are part of the right to health care are set out according to the classification of the scope of the right to health care and the core content of the right to health care. The scope and the core content of the right to health are set out on the basis of the various international and regional human rights instruments and documents that supplement the provisions enshrined in the instruments that have been described in paragraph 3. Moreover, the documents and conclusions with regard to State reports of the various supervisory bodies of the ICESCR and the ESC and RESC are examined as well as these provide for more concrete guidance on the elements that are part of the right to health care. As attention is only paid to the right to health care at this point, the overlapping elements will not be taken into account.

4.2 The Scope of the Right to Health Care

States should strive for the realisation of the full spectrum of the right to health, including the right to health care. Only complying with the core content is not sufficient. The health care, *i.e.* its scope, remains to be realised progressively and therefore, steps should be taken towards the full enjoyment of this right.[55] It is not possible to determine on a very detailed level to what kind of health care individuals should have access to nor to what extent. The spectrum of the progressive realisation of this right is *inter alia* dependent of the specific situation and health needs in a State and its financial resources. Nevertheless, various instruments and documents can help to further concretize the elements covered by the right to health in addition to the list of scope elements as described in paragraph 3.2 of this Chapter.

Interesting is the role of the Committee and the European Committee of Social Rights[56] in detecting what other elements individuals should have access to as part of their right to health care.[57] The Committee sets up Concluding Observations on the compliance of the Member States of the ICESCR with their obligations under this Convention. A comparable supervisory role is assigned to the European Committee of Social Rights that sets out Conclusions on the basis of the State reports submitted by the Member States of the ESC and the RESC.

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[54] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 44.
[55] Toebes 2001, p. 176.
[56] Previously named the Committee of Independent Experts.
[57] Schoukens 2008, p. 32.

From the Concluding Observations that were set up by the Committee between 2004 and 2009, different elements can be distinguished that can be considered to be part of the right to health care. These elements are enlisted in an overview at the end of this paragraph together with the elements of other sources that provide the elements that are part of the right to health care. In several Concluding Observations, the Committee also touched upon the subject of access to abortion. It urged various States to review their legislation if abortion was illegal in all cases under law. It recommended them to consider exceptions to this general prohibition of abortion for cases of therapeutic abortion, *e.g.* where the mother's life is in danger, or if the pregnancy is the result of rape or incest.[58] One of the reasons the Committee gave for this recommendation, is the prevention of clandestine and unsafe abortions that in some countries form the principal cause of death among women.[59]

In comparison to the Concluding Observations of the Committee in which the Committee made specific recommendations or urged States rather concretely to change a certain situation, the analysis of the European Committee of Social Rights is more restrained. In its analysis of Article 11 ESC and RESC it set out in general the situation in the State under examination and argued whether that situation was or was not in conformity with the ESC and RESC.[60] Moreover, it repeatedly demanded in several Conclusions for further information on the situation in the State under scrutiny. In some Conclusions however, it does make concrete statements on what should be included in the right to health care. The elements that can be discerned from the Conclusions that were set up between 2003 and 2009 by the European Committee of Social Rights too are included in the overview at the end of this paragraph.

The right to health care is also addressed in instruments on social security of the International Labour Organization (ILO) and the Council of Europe. The ILO was set up in 1919, and is 'devoted to advancing opportunities for women and men to obtain decent and productive work in conditions of freedom, equity, security and human dignity'.[61] The ILO formulates binding international labour standards in the form of Conventions and Recommendations of which various deal with work-related health issues, as well as with work-related health care. Although only directed to workers, these cover a large part of the population of a Member State.

[58] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Malta, E/C.12/1/Add.101, paras. 23, 41; Azerbaijan, E/C.12/1/Add.101, para. 56; Chile, E/C.12/1/Add.105, para. 53; Monaco, E/C.12/MCO/CO/1, para. 23; Nicaragua, E/C.12/NIC/CO/4, para. 26; El Salvador, E/C.12/SLV/CO/2, para. 44. Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: The United Kingdom, E/C.12/GBR/CO/5, para. 25 the Committee also mentioned the criteria of foetal abnormality in the case of the Abortion Act of Northern Ireland, contrary to the other statements.

[59] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: El Salvador, E/C.12/SLV/CO/2, paras. 25, 43.

[60] Toebes 1999a, p. 156.

[61] Source: website ILO: www.ilo.org.

The ILO Convention on Medical Care and Sickness Benefits (C130) states to what level and types of health care workers have access to by means of insurance, ILO Convention C102 on the Social Security Convention deals with the minimum standards of social security, and ILO Convention C103 on Maternity Protection also provides for the access to different types of health care in case of pregnancy and confinement.[62] The elements of the right to health care set out in these ILO Conventions are also included in the list at the end of this paragraph.

Furthermore, there is the European Code of Social Security that is part of the legal framework of the Council of Europe.[63] According to Article 9, it protects a specific group of the population of a Member State that constitutes of i) employees, forming at least 50 per cent of all employees, and their wives and children, or ii) at least 20 per cent of all economically active persons, as well as their wives and children, or iii) at least 50 per cent of all residents. For the States that ratified the Addition Protocol to the European Code of Social Security, these percentages have been raised to 80 per cent, 30 per cent and 65 per cent respectively. This protected group, which forms a large part of the population, is entitled to have access to medical care of a preventive or curative nature that includes different elements as set out in the overview at the end of this paragraph.

4.2.1 Overview of Scope of the Right to Health Care

In comparison to the list that was set out in paragraph 3.2 on the scope of the right to health, the documents and instruments that have been analysed in this paragraph do not provide for new elements as part of the scope of the right to health care. Nonetheless, they provide for a more detailed description of what elements of health care encompass. They are listed in the following overview. This list is not exhaustive as States should strive for full realisation of the right to health care, which has to be realised progressively.[64]

The scope of the right to health care includes:
– health care services (primary health care, preventive health care, curative health care, mental health care, and rehabilitative health care)[65], *inter alia* including:

[62] Convention concerning Minimum Standards of Social Security, ILO Convention 102, adopted 28 June 1952; Convention concerning Maternity Protection, ILO Convention 103, adopted 28 June 1952; Convention concerning Medical Care and Sickness Benefits, ILO Convention 130, adopted 25 June 1969.
[63] European Code of Social Security, adopted 16 April 1964, E.T.S. 048.
[64] See *e.g.* E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 13; The Digest of the Case Law of the European Committee of Social Rights, 1 September 2008, p. 99.
[65] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: China, E/C.12/1/Add.107, para. 47; Bolivia, E/C.12/BOL/CO/2, para. 34; Angola, E/C.12/AGO/CO/3, para. 36; Hungary, E/C.12/HUN/CO/3, paras. 46, 48; Serbia and Montenegro, E/C.12/1/Add.108, para. 60; Uzbekistan, E/C.12/UZB/CO/1, paras. 60, 66; Republic of Korea, E/C.12/KOR/CO/3, para. 24;

– general practitioners care;[66]
– in-patient and out-patient specialist care at hospitals;[67]
– dental care;[68]
– ambulatory mental health services.[69]

– screening for all diseases that constitute the principal causes of death, including cancer screening for women;[70]
– hospitalization if necessary;[71]
– supply, maintenance and renewal of prosthetic and orthopedic appliances;[72]
– care for elderly, *inter alia* including:
– home care and nursing;[73]
– health care services;[74]

Lativa, E/C.12/LVA/CO/1, para. 54; India, E/C.12/IND/CO/5, para. 73; The United Kingdom, E/C.12/GBR/CO/5, para. 35;

[66] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Bolivia, E/C.12/BOL/CO/2, para. 34; Angola, E/C.12/AGO/CO/3, para. 36; Hungary, E/C.12/HUN/CO/3, para. 46; Serbia and Montenegro, E/C.12/1/Add.108, para. 60; Uzbekistan, E/C.12/UZB/CO/1, para. 60; Convention concerning Minimum Standards of Social Security, ILO Convention 102, adopted 28 June 1952, Art. 10; Convention concerning Medical Care and Sickness Benefits, ILO Convention 130, adopted 25 June 1969, Art. 13; European Code of Social Security, adopted 16 April 1964, E.T.S. 048.

[67] Convention concerning Medical Care and Sickness Benefits, ILO Convention 130, adopted 25 June 1969, Art. 13; European Code of Social Security, adopted 16 April 1964, E.T.S. 048.

[68] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Bolivia, E/C.12/BOL/CO/2, para. 34; Angola, E/C.12/AGO/CO/3, para. 36; Hungary, E/C.12/HUN/CO/3, para. 46; Serbia and Montenegro, E/C.12/1/Add.108, para. 60; Uzbekistan, E/C.12/UZB/CO/1, para. 60; Convention concerning Minimum Standards of Social Security, ILO Convention 102, adopted 28 June 1952, Art. 10; Convention concerning Medical Care and Sickness Benefits, ILO Convention 130, adopted 25 June 1969, Art. 13.

[69] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Nepal, E/C.12/NPL/CO/2, para. 45; Ukraine, E/C.12/UKR/CO/5, para. 51; Zambia, E/1990/5/Add.60, para. 53; El Salvador, E/C.12/SLV/CO/2, para. 44; Kenya, E/C.12/KEN/CO/1, para. 32; Republic of Korea, E/C.12/KOR/CO/3, para. 24; Uzbekistan, E/C.12/UZB/CO/1, para 66; Lativa, E/C.12/LVA/CO/1, para. 54; India, E/C.12/IND/CO/5, para 73; The United Kingdom, E/C.12/GBR/CO/5, para. 35.

[70] Conclusions of the European Committee of Social Rights with regard to: Albania (2007); XV-2 Belgium, XVII-2 Denmark.

[71] Convention concerning Minimum Standards of Social Security, ILO Convention 102, adopted 28 June 1952, Art. 10; Convention concerning Medical Care and Sickness Benefits, ILO Convention 130, adopted 25 June 1969, Art. 13. European Code of Social Security, adopted 16 April 1964, E.T.S. 048.

[72] Convention concerning Minimum Standards of Social Security, ILO Convention 102, adopted 28 June 1952, Art. 10; Convention concerning Medical Care and Sickness Benefits, ILO Convention 130, adopted 25 June 1969, Art. 13.

[73] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Norway, E/C.12/1/Add. 109, para. 35; Italy, E/C.12/1/Add.103, para 51; Serbia and Montenegro, ,E/C.12/1/Add.108, para. 55; Conclusions of the European Committee of Social Rights with regard to: XVII-2 Denmark; Digest of case law of the European Committee of Social Rights, 1 September 2008, p. 149.

[74] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Norway, E/C.12/1/Add. 109, para. 35; Italy, E/C.12/1/Add.103, para. 51; Serbia and Montenegro,

  - mental health care;[75]
  - palliative care.[76]
- family planning services, including maternal and child health care, *inter alia* including:
  - pre-natal and post-natal health care;[77]
  - emergency obstetric services;[78]
  - gynaecological and counseling services;[79]
  - screening of pregnant women and children;[80]
  - contraception methods.[81]
- provision of essential drugs, *inter alia* including:

E/C.12/1/Add.108, para. 55. Digest of case law of the European Committee of Social Rights, 1 September 2008, p. 149.

[75] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Norway, E/C.12/1/Add. 109, para. 35; Italy, E/C.12/1/Add.103, para. 51; Serbia and Montenegro, E/C.12/1/Add.108, para. 55; Digest of case law of the European Committee of Social Rights, 1 September 2008, p. 149.

[76] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Norway, E/C.12/1/Add. 109, para. 35; Italy, E/C.12/1/Add.103, para. 51; Serbia and Montenegro, E/C.12/1/Add.108, para. 55.

[77] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Kuwait, E/C.12/1/Add.98, para. 43, 40; Ecuador, E/C.12/1/Add.100, para. 54; Malta, E/C.12/1/Add.101, para. 42; Zambia, E/1990/5/Add.60, para. 53; China, E/C.12/1/Add.107, para. 100; Kenya, E/C.12/KEN/CO/1, para. 32; Tajikistan, E/C.12/TJK/CO/1, para. 68; Benin, E/C.12/BEN/CO/2, para. 46; The former Yogoslav republic of Macedonia, E/C.12/MKD/CO/1, para. 46; Conclusions of the European Committee of Social Rights with regard to: Albania (2007); Conclusions of the European Committee of Social Rights with regard to: Albania (2007); Convention concerning Minimum Standards of Social Security, ILO Convention 102, adopted 28 June 1952, art 10; European Code of Social Security, adopted 16 April 1964, E.T.S. 048.

[78] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Kuwait, E/C.12/1/Add.98, para. 43, 40; Ecuador, E/C.12/1/Add.100, para. 54; Malta, E/C.12/1/Add.101, para. 42; Zambia, E/1990/5/Add.60, para. 53; China, E/C.12/1/Add.107, para. 100; Kenya, E/C.12/KEN/CO/1, para. 32; Tajikistan, E/C.12/TJK/CO/1, para. 68; Benin, E/C.12/BEN/CO/2, para. 46; The former Yogoslav republic of Macedonia, E/C.12/MKD/CO/1, para. 46; Convention concerning Minimum Standards of Social Security, ILO Convention 102, adopted 28 June 1952, art 10.

[79] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Kuwait, E/C.12/1/Add.98, para. 43, 40; Ecuador, E/C.12/1/Add.100, para. 54; Malta, E/C.12/1/Add.101, para. 42; Zambia, E/1990/5/Add.60, para. 53; China, E/C.12/1/Add.107, para. 100; Kenya, E/C.12/KEN/CO/1, para. 32; Tajikistan, E/C.12/TJK/CO/1, para. 68; Benin, E/C.12/BEN/CO/2, para. 46; The former Yogoslav republic of Macedonia, E/C.12/MKD/CO/1, para. 46; Convention concerning Minimum Standards of Social Security, ILO Convention 102, adopted 28 June 1952, Art 10.

[80] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Azerbaijan, E/C.12/1/Add.101; Conclusions of the European Committee of Social Rights with regard to: Albania (2007).

[81] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Chile, E/C.12/1/Add.105, para. 54; Nepal, E/C.12/NPL/CO/2, para. 45; Angola, E/C.12/AGO/CO/3, para. 37; The Committee even urged the Netherlands to reconsider continuing the allowance for contraception under the National Health Service for women over the age of 21, The Netherlands, E/C.12/NLD/CO/3, para. 31.

  - generic medicines;[82]
  - pharmaceutical supplies.[83]
- drugs for the treatment and prevention of sexually transmitted diseases such as AIDS;[84]
- immunization and vaccination;[85]
- preventive and rehabilitative services for physical and sexual abuse.[86]

4.3 The Core Content of the Right to Health Care

GC No. 14 on Article 12 ICESCR is about the only document which clearly defines the core content of the right to health care. In specifying what is part of the core content reference is made to two documents in GC No. 14.[87] The first document is the Declaration of Alma-Ata (USSR 1978).[88] In the 1970s a need was felt by the WHO and its members for a thorough discussion on how to ensure the health of all people. This resulted in the International Conference on Primary Health Care that was held in 1978 in Alma-Ata, under auspices of the WHO and the United Nations Children's Fund (UNICEF) out of which this declaration came forth.[89] The Declaration of Alma-Ata expressed as the main task of governments, international organizations and the whole world community the attainment by all people of the world by the year 2000 of a level of health that will permit them to lead a socially and economically productive life. Moreover, it states that the key to attaining that objective is the development of national health care systems, which should at least provide access to primary health care. In the declaration, primary health care is defined as 'essential health care based on practical, scientifically sound and socially

[82] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Ecuador, E/C.12/1/Add.100, para. 55.
[83] Convention concerning Medical Care and Sickness Benefits, ILO Convention 130, adopted 25 June 1969, Art. 13; European Code of Social Security, adopted 16 April 1964, E.T.S. 048.
[84] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to:Nepal, E/C.12/NPL/CO/2, para. 45; Ukraine, E/C.12/UKR/CO/5, para. 51; Zambia, E/1990/5/Add.60, para. 53; El Salvador, E/C.12/SLV/CO/2, para. 44; Kenya, E/C.12/KEN/CO/1, para. 32; Conclusions of the European Committee of Social Rights with regard to: XVIII-1 Croatia.
[85] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Madagasgar, E/C.12/MDG/CO/2, para. 29; Conclusions of the European Committee of Social Rights with regard to: Italy (2003). According to WHO guidelines, more than 95% of babies under 24 months should be vaccinated against diphtheria, tetanus, poliomyelitis, and more than 99% vaccinated against measles, mumps, and rubella', see: Conclusions of the European Committee of Social Rights with regard to: Italy (2003).
[86] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Zambia, E/C.12/1/Add.106, para. 46.
[87] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 43.
[88] Alma-Ata Declaration, Report of the International Conference on Primary Health Care, Alma-Ata, 6-12 September 1978, in: World Health Organization, Health for All Series, No. 1, WHO, Geneva, 1978. Now Almaty, Kazakhstan.
[89] Venediktov 1998, p. 79-81.

acceptable methods and technology'. In its description of the entitlements of individuals, the Declaration of Alma Ata determines that primary health care should at least include: access to promotive, preventive, curative and rehabilitative services; maternal and child health care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; appropriate treatment of common diseases and injuries; and provision of essential drugs.[90]

The second document, to which reference is made in GC No. 14 in relation to the core content of the right to health care, is the Program of Action of the International Conference on Population and Development (ICPD).[91] The ICPD was a UN conference, organized principally by the United Nations Population Fund (UNFPA) and the Population Division of the UN Department for Economic and Social Information and Policy Analysis. The Program of Action that resulted from this International Conference concentrates on the linkages between population and development with a special emphasis on empowering women by providing them *inter alia* with extended access to health care services.[92] The report of the Program of Action mainly focuses on reproductive health care as part of primary care. According to this report, an individual has a right to, *inter alia*:

– family-planning care;
– pre-natal care; pregnancy and post-natal care for the mother and the child;
– treatment of reproductive tract infections, sexually transmitted diseases and other reproductive health conditions;
– active discouragement of harmful practices;
– diagnosis and treatment for complications of pregnancy, delivery, abortion, infertility, reproductive tract infections, breast cancer and cancers of the reproductive system, and sexually transmitted diseases, including AIDS and the complications of sexually transmitted diseases, such as infertility;
– contraceptives, including treatment for side effects of contraceptive use;
– treatment and rehabilitation for girls and women who have suffered genital mutilation;

[90] Alma-Ata Declaration, Report of the International Conference on Primary Health Care, Alma-Ata, 6-12 September 1978, in: World Health Organization, Health for All Series, No. 1, WHO, Geneva, 1978, Articles VII2 and VII3. At the International Conference on Primary Health Care that was held in Alma-Ata, the report on The Primary Health Care Strategies of the WHO were also issued subsequently promulgated in the Declaration of Alma-Ata of 1978; Toebes 2001, p. 13. These strategies also reflect the core content of the right to primary health care by formulating maternal and child care, including family planning; immunization against the major infectious diseases; prevention and control of locally endemic diseases; and appropriate treatment for common diseases and injuries as essential basic health care services. See: World Health Organization, *Primary Health Care: Report of the International Conference on Primary Health Care,* Alma-Ata, USSR, 6-12 September 1978, Health For All Series No. 1, 1978, Chapter 3, para. 50.

[91] Report of the International Conference on Population and Development, Cairo, 5-13 September 1994, A/CONF.171/13: Report of the ICPD (94/10/18).

[92] Introduction of the Summary of the Program of Action of the International Conference on Population and Development, see: http://www.un.org/ecosocdev/geninfo/populatin/icpd.htm#intro.

– long term care for the elderly, those with disabilities, and those infected with HIV and other endemic diseases.

Moreover, access to generic drugs has been further concretized in this report. It comprises access to vaccines and antibiotics; condoms and drugs for the prevention and treatment of sexually transmitted diseases, such as AIDS.[93]

4.3.1 Overview of Core Content of the Right to Health Care

The consultation of the documents set out above has provided further guidance on the core content of the right to health care. Primary health care and access to essential medicines are the basic standards of the core contents of the right to health care. Furthermore, within the context of the core content of the right to health care, much emphasis is placed on access to family planning and maternal and child care. These elements have to be ensured on a non-discriminatory basis as this criterion is also part of the core content of the right to health care.[94]

An elaborate list of health care goods and services that are part of the right to primary health care and drugs that has been derived from these documents can be summarized in the following overview:

– Primary health care, *inter alia* including:
  – promotive, preventive, curative and rehabilitative health care service, *inter alia* including:
    – appropriate treatment of common diseases and injuries;
    – long term care of the elderly, those with disabilities, and those infected with endemic diseases such as AIDS;
    – prevention and control of locally endemic diseases;
    – active discouragement of harmful practices.
  – family planning, including maternal and child health care, *inter alia* including:
    – prenatal and post-natal care;
    – diagnosis and treatment of infertility, reproductive tract infections, sexualyl transmitted diseases, including AIDS and other reproductive health conditions, breast cancer and cancers of the reproductive system;
    – condoms and other contraceptives, including treatment for side effects of contraceptive use.
  – treatment and rehabilitation for girls and women who have suffered genital mutilation;

[93] Report of the International Conference on Population and Development, Cairo, 5-13 September 1994, A/CONF.171/13: Report of the ICPD (94/10/18), paragraph 7.2, 7.6, 7.23, 7.40, 8.9, 8.17, 8.22, 8.25, 8.31, 8.33, 8.35.

[94] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 43.

– provision of essential drugs:
  – immunization against major infectious diseases;
  – antibiotics;
  – condoms;
  – drugs for the prevention and treatment of sexual transmitted diseases, such as AIDS.

5 CONCLUSIONS

It is clear that the right to health is well entrenched within international and regional human rights law. It is an inclusive right to various freedoms and entitlements that together form the underlying determinants of health. Most of the provisions are broadly and fragmentarily defined. The classification adopted by Toebes (1999a) provides for more conceptual clarity with regard to the content of this right.[95] This classification includes the scope of a right, its core content and the overlapping elements of a right.

Examples of the scope of the right to health are the entitlements and underlying determinants, such as potable water, adequate sanitation, housing, healthy occupational conditions, and healthy environmental conditions. The core content of the right to health encompasses the essence of the right and therefore contains the minimum entitlements of the scope of the right to health. Examples of the core entitlements of the right to health are minimum essential food, basic shelter, safe and potable water, primary health care, access to health facilities, goods and services on a non-discriminatory and equitable basis, and the provisions of essential drugs. Examples of the overlapping elements provided for in other international and regional human rights instruments than those specifically providing for the right to health, are the right to life, the right to physical and mental integrity, the right to privacy, the right to housing, the right to food, and access to work.

The right to health care is one of the essential aspects of the broad framework of the right to health. The scope of the right to health care includes various entitlements, including the right to health care services, screening, hospitalization if necessary, care for elderly, family planning services, including maternal and child health care, and provision of essential drugs. The core content of the right to health care includes primary health care and the provision of essential drugs. Moreover, an important criterion for the provision of this core content is that these elements have to be ensured on a non-discriminatory basis. Access to health care on a non-discriminatory basis is a recurring element of the right to health care and it is part of the right to equal access to health care. This will be set out in further detail in Chapter IV. As the various international and regional human rights

[95] Toebes 1994a, Chapter 5.

instruments set out in this Chapter are primarily directed at the concerning Signatory States, Chapter III will primarily focus on the various State obligations resulting from the right to health care.

CHAPTER III
STATE OBLIGATIONS RESULTING FROM THE RIGHT TO HEALTH CARE

1 INTRODUCTION

The human rights instruments providing for the right to health and the right to health care are primarily directed at their Signatory States. They impose the obligation on their Member States to take measures in order to make sure that the right to health and the right to health care can be enjoyed by all. In addition to the instruments that set out the elements that are part of the right to health and the right to health care there are general clauses that define to what extent measures have to be taken by the Signatory States. These prescribe that rights have to be realised progressively beyond their core contents and to the maximum of available resources. However, there are situations in which the realisation of rights is not achieved, or is even restricted or derogated from. Numerous provisions regulate State obligations in these situations as well. The general clauses regulating the realisation of human rights are set out in paragraph 2. As the subject of the present study is the right to health care, these shall be applied to this human right.

States can comply in different ways with their obligations in realising human rights in general and the right to health care *in concreto*. These actions can range from refraining from action to taking positive action for the enjoyment of these rights.[1] For example, Article 12 ICESCR states that States should *recognize* the right to health and are bound *to take steps*, *inter alia* necessary to secure access to health care. Article 11 ESC and RESC furthermore, sets forth that States should *take appropriate measures* with a view to *ensure* the effective exercise of the right to protection of health and health care. In scholarly writings, different typologies of obligations have been distinguished in an attempt to clarify State obligations in the human rights field. The best-known analytical tool is the tripartite typology developed by Eide.[2] This typology sets out the obligations 'to respect', 'to protect', and 'to fulfill' and will be discussed in detail in paragraph 3 and adopted to the right to health care in paragraph 4.

The right to health care is an empty promise if there is no practical access to health care.[3] In addition to the extent to which the right to health care has to be realised and the various ways in which this right can be realised, there are certain

[1] Arambulo 1999, p. 117.
[2] Eide 1987.
[3] Huls 2004, p. 20.

criteria that can be discerned that have to be met before there is actually access to health care. These can be considered as guiding principles that address the elements that have to be taken into account in realising the right to health care. These criteria are set out in the final paragraph of this Chapter on State obligations resulting from the right to health care.

2 General Clauses Regulating the Realisation of the Right to Health Care by Member States

2.1 Introduction

Several clauses pertain to the obligations of States in respect to realising the rights enshrined in the different international and regional human rights instruments. These clauses not only include provisions in relation to progressively realising human rights, but stipulate conditions concerning limitations of the rights provided for by a State as well. In order to obtain a more complete overview of the various State obligations in relation to the right to health care, these clauses are set out in this paragraph. These include the obligation of immediate and progressive realisation, realisation to the maximum of the available resources, limitations, derogations, and retrogressive measures.[4]

2.2 Progressive Realisation, Immediate Realisation and Realisation to the Maximum of Available Resources

There are two important elements that form part of the obligations of States when realising the right to health and other economic, social and cultural rights. The first element is the level of rights that must be achieved immediately. These include, *inter alia*, the obligation to guarantee that the right to health care can be exercised without discrimination of any kind, the obligation to take steps towards the full realisation of this right, and the obligation to realise the minimum core content. The second element is an obligation of longer term orders and requires States to achieve the full realisation of the right to health care and other economic, social and cultural rights progressively, to the maximum of available resources.

Article 2, paragraph 1 ICESCR provides that State parties are required to take steps to progressively achieve the full realisation of the rights enshrined in the ICESCR, including the rights to health and health care. Moreover, these rights have to be realised to the maximum of the available resources.[5] The European Committee

[4] In this chapter the State obligations as enshrined in the ICESCR and ESC and RESC stand central. Other Human Rights Conventions at international level also contain these State obligations in relation to social, economic and cultural rights and civil and political rights, see *e.g.* part II, III and VI ICCPR; Article 24 CEDAW; Article 4 and Article 7 CERD; Article 4, Article 23 and Article 24CRC; Article 4 CRPD.

[5] Article 2, paragraph 1 ICESCR.

of Social Rights adopts a comparable approach in relation to the realisation of the rights provided for in the ESC and RESC. In relation to Article 11, paragraph 1 ESC the European Committee of Social Rights stated that the indicators reflecting the health status of a population should show a progressive improvement.[6] Moreover, progressive realisation is recognized in relation to the right to social security enshrined in Article 12 ESC and RESC. Furthermore, the European Committee of Social Rights adopted comparable criteria in its case law on the implementation of the rights enshrined in the ESC and RESC by their State parties. In different decisions it stated that measures to achieve the objectives of the Charters must be taken within reasonable time, within measurable progress and with the maximum use of available resources.[7]

The clause of the progressive realisation constitutes the recognition of the fact that realisation of all economic, social and cultural rights generally cannot be achieved over a short period of time.[8] In this sense, this obligation differs significantly from the obligation as laid down in Article 2 ICCPR, which embodies immediate obligations in relation to civil and political rights. It provides for flexibility to take into account the economic realities in a Member State, the time necessary for the realisation of legislation, regulations, and other measures for a proper implementation of the realisation of economic, social and cultural rights.[9]

This flexibility could give the impression that States are provided with 'escape clauses' from their treaty obligations.[10] However, this not the case. These clauses indeed provide for certain flexibility. The concept of progressive realisation of economic, social and cultural rights provides States with a margin of appreciation. States enjoy this discretion in selecting the means for implementing their respective obligations as they are generally expected to have a better understanding of all aspects of a specific situation in their country than international or regional human rights bodies.[11] However, this discretion must not be regarded as an excuse for not fulfilling State obligations.[12] The progressive realisation of a right should not be interpreted as a pretext for non-compliance, or as depriving States' obligations of all meaningful content, nor as implying that States have the right to defer indefinitely their efforts to ensure full realisation.[13] In case a State fails to take

[6] Conclusions of the European Committee of Social Rights with regard to: XVII-2 Latvia.
[7] Complaint No. 13/2002, *Autism Europe* v. *France*, para. 53; Complaint No. 31/2005, *European Roma Rights Centre* v. *Bulgaria*, para. 37.
[8] E/1991/23, General Comment 3 (1990), 14 December 1990, *The nature of State parties' obligations*, para. 9.
[9] Chinkin 2006, p. 55; Courtis 2009, p. 52-60, 382, 379-395.
[10] Toebes 1999a, p. 294.
[11] Müller 2009, p. 565; Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, January 22-26, 1997, Guideline 8.
[12] Asher 2004, p. 23.
[13] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 31; UN doc. E/CN.4/1987/17, The Limburg Principles on the Implementation

all necessary steps to ensure the realisation of a right, it is in violation of the ICESCR, especially if it deliberately retards, obstructs or halts the progressive realisation of a right protected by it.[14] Examples of failures of a State in relation to the rights to health and health care are the failure to adopt or implement a national health policy that ensures the right to health care for everyone, the failure to monitor the realisation of that right at national level, and the failure to take measures to reduce an inequitable distribution of health care.[15]

The obligation of a progressive realisation of the right to health care also includes the criterion of realising this right to the maximum of available resources.[16] As set out in the following paragraph, the Committee as well as the European Committee of Social Rights have repeatedly urged States to increase their spending on health care in order to increase the availability of health care for their citizens.

The obligation of progressive realisation applies to the so-called substantive economic, social and cultural rights, such as the right to food, the rights to health and health care, the right to education, and the right to work. In addition to these substantive rights, there are rights that are not subject to the progressive realisation clause. These rights can be determined as procedural rights.[17] They apply irrespective of adverse conditions to all human rights and require immediate compliance. These obligations are known as 'immediate State obligations'.[18]

Various rights are determined as obligations of immediate effect, *inter alia* the obligation to guarantee that the rights will be exercised without discrimination, and the obligation to take steps.[19] Both obligations are enshrined in Article 2 ICESCR. Immediate State obligations imply that the steps necessary for the realisation of a right must be taken immediately, *i.e.* within a reasonably short time after the entry into force of the ICESCR.[20] In addition, in General Comment No. 3

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of the International Covenant on Economic, Social and Cultural Rights, para. 21, Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, January 22-26, 1997, Guideline 8.

[14] UN doc. E/CN.4/1987/17, The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, para. 72; Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, January 22-26 1997, Guideline 14 (f). This does not apply in case the State is acting within a limitation permitted by the ICESCR or it does so due to a lack of available resources or *force majeure*. This will be discussed in paragraph 4.3.2 of this Chapter.

[15] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 52.

[16] UN doc. E/CN.4/1987/17, The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, para. 72. The European Committee for Social Rights found various States in violation of their obligations in relation to Article 11, paragraph 1 ESC due to spending a too small proportion of their GDP on health care. See paragraph 3.3.1 of this Chapter.

[17] Green 2001, p. 1071; Courtis 2009, p. 384.

[18] Asher 2004, p. 22-23.

[19] E/1991/23, General Comment 3 (1990), 14 December 1990, *The nature of State parties obligations*, paras. 1-2; UN doc. E/CN.4/1987/17, The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, paras. 16, 22.

[20] E/1991/23, General Comment 3 (1990), 14 December 1990, *The nature of State parties obligations*, para. 2; Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, January 22-26, 1997, Guideline 15(h).

on the nature of States parties obligations the Committee has stipulated as being of an immediate nature Article 3 (equal right for men and women), Article 7(a)(i) (equal remuneration for work of equal value), Article 8 (right to form trade unions and the right to strike), Article 10, paragraph 3 (protection of children and young persons, Article 13, paragraph 2(a) (compulsory and free primary education), Article 13, paragraph 3 (liberty of parents to choose the school of their children), Article 13, paragraph 4 (freedom to establish educational institutions), and Article 15, paragraph 3 (freedom of scientific research and creative activity).[21] Finally, GC No. 3 emphasized that also the minimum core contents of economic, social and cultural rights form part of these immediate obligations.[22]

The provisions in relation to immediate State obligations also apply to the realisation of the right to health care. States have the immediate obligation to take steps toward the full realisation of the rights enshrined in Article 12 ICESCR and have to guarantee that these right will be exercised without discrimination of any kind. Such steps must be deliberate, concrete and targeted towards the full realisation.[23]

In addition to what was elucidated in GC No. 14, the Committee provided for further clarification on the obligations in relation to the right to health care that have an immediate effect in its Concluding Observations. Recently it defined several entitlements of the right to health care that are part of the immediate obligations for which States have to take steps.[24] These entitlements all form part of the core content of the right to health care as set out in Chapter II, paragraph 4.3, and with that the Committee adhered to its earlier positioning in GC No. 3 on the core content of economic, social and cultural rights.

With the core content of the right to health care being part of the immediate State obligations, the policy freedom that is inherent to the progressive realisation of this right is restricted.[25] Nevertheless, an escape clause to this obligation is provided for.[26] This is the requirement of realising economic, social and cultural rights to the maximum of available resources. Therefore, it provides that resource constraints applying within a Member State must be taken into account when assessing whether a State complies with the requirement of progressively realising the right to health care. Nevertheless, this provision is strictly defined. As stated by the Committee in GC No. 14, 'a State which is unwilling to use the maximum of its available resources for the realisation of the right to health is in violation of its

[21] E/1991/23, General Comment 3 (1990), 14 December 1990, *The nature of State parties obligations*, para. 5.
[22] E/1991/23, General Comment 3 (1990), 14 December 1990, *The nature of State parties obligations*, para. 10.
[23] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 30.
[24] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Kenya, E/C.12/KEN/CO/1.
[25] Den Exter and Hermans 1998, p. 265.
[26] Nolan, Porter and Langford 2007, p. 30.

obligations under Article 12. If resource constraints render it impossible for a State to comply fully with its Covenant obligations, it has the burden of justifying that every effort has nevertheless been made to use all available resources at its disposal in order to satisfy, as a matter of priority, the [core obligations]'.[27]

2.3 Derogations, Limitations, and Retrogressive Measures

States must take steps to progressively realise, economic, social and cultural rights, amongst which the right to health care. There are however situations in which the realisation of rights cannot be achieved, and may even be restricted or derogated from. Various provisions regulate State obligations in these situations. These are dealt with in this paragraph.

2.3.1 Derogations

A derogation from a right is its complete or partial elimination which is generally only seen in exceptional circumstances such as in times of a public emergency that threatens the life of a nation.[28] Human rights standards could be different during these times, especially as in most cases this will affect the resources available for spending on human rights. As it can be the case that not all aspects of these rights may be attainable in times of emergency, a State could be granted the possibility to derogate from a right in order to protect the public order.[29]

The ICESCR does not comprise a general clause on derogations.[30] The Committee only clarified in GC No. 14 that States cannot, under any circumstances whatsoever, justify non-compliance with the obligations concerning the core content of the right to health and the right to health care as this is non-derogable.[31] Whether this implies that the entitlements that are part of the scope of the right to health care beyond its core content are derogable, is unclear. Nevertheless, it could be argued that derogating from rights enshrined in the ICESCR is far less justified and necessary than, *e.g.* rights enshrined in the ICCPR and the ECHR which provides for different clauses on derogations. For example, it is hard to imagine a situation in which it is necessary that in order to restore the public order, people should be denied their right to health care. Another argument against permitting derogations from the ICESCR rights is based on the fact that as the general

[27] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 10, Insertion added MSG.
[28] Müller 2009, p. 561.
[29] Müller 2009, p. 592-593; Obviously under specific conditions, which is dealt with later in this paragraph.
[30] However, Article 5 ICESCR disapproves of derogations from restrictions of the rights enshrined in the Covenant that are fore example due to national legal instruments that recognize them to a lesser extent.
[31] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 47.

limitation clause enshrined in Article 4 ICESCR enables States to respond flexibly to emergency situations, the inclusion of a provision on derogations seemed unnecessary.[32]

The ESC and RESC do provide for a general derogation clause. Both Charters perceive derogations as inadmissible, except in times of war and other public emergencies threatening the life of the nation, provided that certain criteria are met.[33] These criteria include that the derogation should be strictly required by the exigencies of the situation and should not be inconsistent with other State obligations under international law. Moreover, in case of a derogation of a right, the Secretary General of the Council of Europe should be fully informed of the measures taken, the reasons to do so, and when such measures have ceased to operate.[34] Nevertheless, thus far the European Committee for Social Rights has never received a State report in which derogations were described.[35] Furthermore, in the forms for the State reports to be submitted to the European Commission for Social Rights, contain no general request for reporting on derogations. Only in relation to Article 2, paragraph 1 ESC and RESC information, such as figures, statistics and factual information is requested on measures permitting derogations from legislation regarding working time.[36]

2.3.2 Limitations

Another measure that can be taken in restricting the enjoyment of economic, social and cultural rights and the right to health care is the limitation of these rights. Unlike with derogations, States can limit human rights in normal times, although for a limited number of reasons. According to Müller (2009), limitations are 'a necessary and normal element of the human rights treaty system, since without them there would be an unworkable system of absolute rights of each individual'.[37] Limitations 'are part of the 'oil' of the system' as it can protect the rights and freedoms of others by solving conflicts between different rights.[38] It should, however, be stressed that the possibility to impose limitations on the enjoyment of human rights is intended to protect the rights of individuals rather than to permit the

[32] Müller 2009, p. 594; Unlike the ICCPR and the ECHR, which provide for a general derogation clause but do not provide for a general limitation clause.
[33] Article F RESC.
[34] Article F RESC.
[35] Müller 2009, p. 593.
[36] Form for reports to be submitted in pursuance of the 1961 European Social Charter and the 1988 Additional Protocol, adopted by the Committee of Ministers on 26 March 2008; Form for reports to be submitted in pursuance of the Revised European Social Charter, adopted by the Committee of Ministers on 26 March 2008.
[37] Müller 2009, p.557-601.
[38] Müller 2009, p. 564. See: Article 31, paragraph 1 ESC and RESC.

impositions of limitation by Signatory States.[39] Consequently, prescriptions on limiting the enjoyment of rights serve as an important tool to strengthen the protection of economic, social and cultural rights as they establish safeguards against unjustifiable limitations.[40]

The limitation clause has been recognized in various human rights treaties. With respect to economic, social and cultural rights, Article 4 ICESCR provides for a general limitation clause and the ESC and RESC contain a similar provision.[41] All treaties include the criteria that have to be met before a limitation can be considered legitimate.

First of all, limitations only should be imposed for reasons as set out in the relevant human rights treaty. The reason set out by the ICESCR is general welfare. General welfare should be understood as 'referring primarily to the economic and social well-being of the people and the community'.[42] The ESC and RESC also contain general welfare as providing legitimate aim and also provide for additional grounds, *i.e.* national security, public health and morals, and the protection of the rights and freedoms of others.[43] They seem to allow a wider margin of appreciation to States to impose limitations than the ICESCR does.[44]

Secondly, limitations have to be determined by law. This requirement is fulfilled when a limitation is provided for by national law, which is consistent with international human rights law and is clear and accessible to everyone. Moreover, laws imposing limitations on the exercise of economic, social and cultural rights should not be arbitrary, unreasonable or discriminatory.[45]

Thirdly, limitations in a democratic society and must be necessary and proportional. The inclusion of the component of 'a democratic society' was considered of vital importance to avoid that introducing limitations in a Signatory State can lead to suppression and dictatorship.[46] This does not require a State to be a democratic society in order to become or remain party to a human rights treaty, but does imply that limitations of economic, social and cultural rights 'should be based on some consultation process […], should not be ordered unilaterally and should be subject to popular control'.[47] As was stated by the Limburg Principles on the

[39] UN doc. E/CN.4/1987/17, The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, para. 46; E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 28; E/1991/23, General Comment 3 (1990), 14 December 1990, *The nature of State parties obligations*, para. 42.
[40] Sepúlveda 2003, p. 285.
[41] A general limitation clause is directed to all the rights enshrined in the specific human rights treaty. Specific limitation clauses exist as well, such as enshrined in Article 8, paragraph 2 ICESCR on the right to form and join trade unions and the right to strike.
[42] Müller 2009, p. 573.
[43] Article 31 ESC and RESC and Article G RESC.
[44] Sepúlveda 2003, p. 278; Gomien 2005, p. 215.
[45] The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, para. 48- 51.
[46] Müller 2009, p. 575.
[47] Müller 2009, p. 577.

implementation of the ICESCR; 'a society which recognizes and respects the human rights set forth in the United Nations Charter and the Universal Declaration of Human Rights may be viewed as meeting this definition'.[48]

The criterion that a limitation has to be proportional entails that the means chosen, *i.e.* the limitation, should not excessively restrict the protected right.[49] As such, the more severe the impact of the restriction imposed, the more difficult its justification. Moreover, the limitation should not be such that the essence of a right is eroded. Limitations can never be applied when they suppress or eliminate a right completely, either in fact or in effect.[50] Therefore, what can never be regarded as proportionate is a limitation that is in conflict with the core content of a right as this encompasses the essence of a right.

In relation to health care, there are not many conceivable situations in which it is necessary to restrict individuals their exercise of their right. Normally the access to medical care is not very likely to endanger the exercise of rights by others nor to be in conflict with other rights.[51] However, in relation to limiting the right to health care, one could think of a situation in which the right to enjoy the benefits of scientific progress and its applications (Article 15 ICESCR) could endanger public health. In addition, the imprisonment of a person could be necessary for the protection of general welfare although this might affect the mental health of the imprisoned. This could be permissive, as long as there is no serious infringement of the health of the individual.[52] A limitation may never be interpreted or applied so as to jeopardize the core content of the right to health care. This is impermissible as in case the core content of this right is limited this, first of all is incompatible with the very nature of that right and secondly, cannot be considered as being proportionate.[53] Consequently, a limitation of a human right does not necessarily constitute a violation of that right whereas when the core content of that right is limited, it will always constitute an illegitimate limitation.

Little attention has been paid to reporting and commenting on limitations by the Committee and the European Committee of Social Rights, as well as by the

[48] UN doc. E/CN.4/1987/17, The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, para. 55. It should be noted that this phrase does not require a State to be a democratic society in order to become or remain party to a human rights treaty.
[49] Courtis 2009, p. 391.
[50] Loof 2005, p. 214; Müller 2009, p. 561.
[51] Toebes 1999a, p. 298. This could be conceivable in relation to scarce resources, but that is not a legitimate aim that is provided for by Article 4 ICESCR, nor under Article 31 ESC and RESC or Article G RESC.
[52] Toebes 1999a, p. 298-299.
[53] Non-discrimination is also part of the core content of the right to health care. Laws imposing limitations on the exercise of economic, social and cultural rights shall not be discriminatory, see The Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, para. 49. Also the limitation of economic, social and cultural rights of vulnerable groups as a consequence of certain policies is not justified as this has a disproportionate effect on vulnerable groups which can never be seen as promoting general welfare, Müller 2009, p. 574.

State parties. The guidelines on the State reports that have to be submitted hardly require States to provide information with regard to this matter. Only in the recent guidelines on State reports under the ICESCR, information is requested on the scope of limitations, the circumstances justifying them and the timeframe envisaged for their withdrawal.[54]

2.3.3 Retrogressive Measures

Limitation clauses are not intended to deal with limitations required by situations of limited resource availability.[55] At least Article 4 ICESCR was not meant to apply to such restrictions.[56] Instead, the Committee developed criteria to evaluate restrictions due to a lack of resources under Article 2, paragraph 1 ICESCR, which are determined as 'retrogressive measures'. A retrogressive measure is a step back in the level of protection of a right and reduces the extent to which such a right is guaranteed.[57] For example, a legislation or policy can be adopted that restricts or limits the content of the entitlements already guaranteed by legislation, or that reduces public expenditure devoted to the implementation of economic, social and cultural rights.[58]

For many years, the Committee had a rather flexible approach to the adoption of retrogressive measures and did not strictly monitor such measures as adopted by States. This situation began to change after 1998 following the adoption of the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, and General Comments 13 and 14 ICESCR.[59] The Maastricht Guidelines state that 'the adoption of any deliberately retrogressive measure that reduces the extent to which any such right is guaranteed constitutes a violation of economic, social and cultural rights'.[60] Later on, in General Comment No. 13 on the Right to Education, the Committee included the impermissibility of retrogressive measures.[61] This was repeated in General Comment 14. From these documents it can be concluded that retrogressive measures are *prima facie* incompatible with economic, social and cultural rights and the right to health care *in concreto* in the absence of further justifying evidence.

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[54] HRI/MC/2006/3, 10 May 2006, *Harmonized guidelines on reporting under the international human rights treaties, including guidelines on a common core document and treaty-specific document*, para. 40(c); HRI/GEN/2/Rev.5, 29 May 2008, *Compilation of Guidelines on the Form and Content of Reports to be submitted by State parties to the International Human Rights Treaties*, para. 40(c).
[55] Sepúlveda 2003, p. 279.
[56] Müller 2009, p. 569.
[57] Sepúlveda 2003, p. 323; Nolan, Porter and Langford 2007, p. 35; Courtis 2009, p. 393.
[58] Sepúlveda 2003, p. 234; Courtis 2009, p. 393.
[59] Sepúlveda 2003, p. 324, 326; Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, January 22-26 1997.
[60] Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, January 22-26, 1997, Guideline 14(e).
[61] E/C.12/1999/10, General Comment 13 (1999), 8 December 1999, *The right to education*, para. 45.

For providing justifying evidence, the State party has the burden of proving that the measures have been introduced after the most careful consideration of all alternatives and that they are duly justified by reference to the totality of the rights provided for in the ICESCR in the context of the full use of the State's available resources.[62] Therefore, States have to show that such measures are as indulgent as possible, that the overall enjoyment of economic, social and cultural rights is not disproportionately diminished, and that these are in consistency with other State obligations and other rights.[63] Moreover, as in line with the requirements on derogations and limitations, the core content of the right to health care should not be affected as this would constitute a violation of the ICESCR.[64]

In view of this assessment and in the preface of the adoption of the Optional Protocol to the ICESCR (OP ICESCR), the Committee made a statement in which it indicated how it would evaluate State parties' retrogressive measure for which it uses resource constraints as an explanation. It will do this on a country-by-country basis in the light of objective criteria such as:
(a) the country's level of development;
(b) the severity of the alleged breach, in particular whether the situation concerns the enjoyment of the minimum core content of the Covenant;
(c) the country's current economic situation, in particular whether the country is undergoing a period of economic recession;
(d) the existence of other serious claims on the State party's limited resources; for example, resulting from a recent natural disaster or from recent internal or international armed conflict;
(e) whether the State party has sought to identify low-cost alternatives; and
(f) whether the State party had sought cooperation and assistance or rejected offers of resources from the international community for the purposes of implementing the provisions of the Covenant without sufficient reason.[65]

A survey of Concluding Observations of the Committee and Conclusions of the European Committee of Social Rights discloses different types of retrogressive measures with regard to the right to health care. In the Concluding Observation of Chile (2004) the Committee showed its concern about a planned law that restricted the current law which permitted parents a subsidized leave from work to care for

[62] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 32.
[63] Müller 2009, p. 590.
[64] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 48.
[65] Optional Protocol to the International Covenant on Economic, Social and Cultural Rights adopted by the General Assembly by Resolution A/RES/63/117, 10December 2008; E/C.12/2007/1, 10 May 2007, *An evaluation of the obligations to take steps to the "maximum of available resources" under an Optional Protocol to the Covenant*, para. 10.

children under the age of 1 in case of serious illness.[66] It noted that the planned law constituted a violation of Article 12 ICESCR, as a retrogressive measure affecting the core content of the rights to health and health care and recommended the State party to review its proposed legislation.[67] In its Concluding Observation of the Netherlands (2006) the Committee responded to the plans of the State to limit the age for allowance of contraception under the basic benefit package of the public health insurance. It urged the Netherlands to reconsider continuing the allowance for women over the age of 21.[68] Another example of retrogressive measures in the field of health and health care, is a type often resorted to by States, namely the reduction on spending on public health and public hospitals. In various Concluding Observations, the Committee showed its concern about the fact that this spending has been on the decline and urged States to continue their efforts to improve their health care services, *inter alia* by allocating further resources and taking measures.[69]

The ESC and RESC do not enclose retrogressive measures and neither request for information specifically in relation to such measures in State reports. Although its approach to retrogressive measures is unclear, the European Committee of Social Rights did notice and emphasized that the coverage rate of compulsory vaccinations and the number of hospital beds declined. It declared that the information provided was not sufficient for it to assess the situation. Consequently, it repeatedly requested further information.[70]

3 TRIPARTITE TYPOLOGY OF OBLIGATIONS: THE OBLIGATION TO RESPECT, TO PROTECT AND TO FULFIL

States can comply in different ways with their obligations in realising human rights in general and the right to health care *in concreto*. In scholarly writings, various typologies of obligations have been distinguished in an attempt to clarify State obligations in the human rights field.

There is a general and often used typology that distinguishes between negative obligations and positive obligations. In this typology, negative obligations constitute an abstention of the State from intervening in fundamental rights. Positive obligations require action by the State as it is also obliged to be active in its

[66] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Chile, E/C.12/1/Add.105, paras. 28, 56.
[67] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Chile, E/C.12/1/Add.105, paras. 28, 56.
[68] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: The Netherlands, E/C.12/NLD/CO/3, para. 31.
[69] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: China, E/C.12/1/Add.107, paras. 87,99; Uzebekistan, E/C.12/UZB/CO/1, paras. 30, 61; Tajikistan, E/C.12/TJK/CO/1, paras. 35,67; Azerbaijan, E/C.12/1/Add.104, paras. 29, 52, 55
[70] Conclusions of the European Committee of Social Rights with regard to: Andorra (2009); XVII-2 Denmark; Italy (2007).

role as protector and provider of fundamental rights to ensure that fundamental rights are effective and can actually be enjoyed.[71] It has been suggested that the distinction between negative obligations and positive obligations coincides with the distinction between civil and political rights and social, economic and cultural rights respectively. This suggestion was made to distinguish between the scope of the law of the first generation of human rights (civil and political rights) and the second generation of human rights (social, economic and cultural rights).[72] Civil and political rights are as such considered to impose negative obligations on the Signatory States, whereas economic, social and cultural rights entail positive rights.

However, according to other authors, this point of view cannot be maintained.[73] They deem many fundamental rights to comprise different levels of obligations. For example, the right to life (Art. 6 ICCPR, Art. 3 ECHR) is considered to not merely require the State to abstain from interfering, but also to include the obligation to take measures to protect the life of individuals against violation by other individuals, and to take actions to increase life expectancy, to reduce infant mortality by, *inter alia*, providing health care, and to eliminate epidemics.[74]

In reaction to the dichotomy of positive and negative rights, Asbjørn Eide, former UN Rapporteur on the Right to Food, developed a more detailed typology of State obligations, which today is the best-known typology of State obligations.[75] It originates from the proposal of Shue (1980) which states that for every basic right there are three types of correlative State obligations: 'to avoid depriving', 'to protect from deprivation', and 'to aid the deprived'.[76]

In its so-called tripartite typology, Eide perceives the State's responsibilities concerning fundamental rights to exist at three levels: The obligation to *respect*, the obligation to *protect*, and the obligation to *fulfil*.[77] The first obligation of the tripartite typology, *i.e.* the obligation to respect, entails that the State should refrain from interfering with the enjoyment of human rights. Consequently, it should not only abstain from an act that violates this obligation to respect the enjoyment of human rights by individuals, but a State should also abstain from taking measures that result in a denial of or hindrance to the access to such a right. The obligation to respect clearly contains a 'freedom dimension' as there has to be respect for the freedom and liberty of the right-holders in how they

[71] Eide 1989, p. 37.
[72] Henrard 2008a, p. 33.
[73] Jägers 2002, p. 75.
[74] Jägers 2002, p. 76.
[75] Eide 1987, p.1, paras. 66-69. Eide stated: that we cannot "make a neat distinction around the axis of 'negative/positive' between civil and political rights on the one hand and economic, social and cultural on the other", p. 36. Different proposals were made to come to an analytical approach of State obligations in relation to human rights. For an extensive delineation on this, see: Sepúlveda 2003.
[76] Shue 1980, p. 52 and further.
[77] Eide 1989, para. 64.

want to satisfy their basic needs.[78] The second obligation, the State's obligation to protect, requires the State to actually take measures, *e.g.* by legislation and the provision of effective remedies necessary to prevent the State, its agents or other individuals from violating individual fundamental rights. This entails that the State should ascertain that individuals can freely realise their rights and freedoms. The third obligation, the obligation to fulfil is defined by Eide as requiring 'the State to take the measures necessary to ensure for each person within its jurisdiction opportunities to obtain satisfaction of those needs, recognized in the human rights instruments, which cannot be secured by personal efforts'.[79] Generally, the third obligation will require the most financial efforts of a State.

Over the years, Eide developed his proposal, mainly by refining the tertiary level of his typology. It now includes two sub-categories; 'the obligation to facilitate' and 'the obligation to provide'.[80] The first sub-paragraph includes the obligation to facilitate the actual opportunity to realise a right for those who are not able to. The obligation to provide consists of the actual provision of resources.[81]

Van Hoof (1984) also developed a typology in relation to State obligations. It included the obligations 'to respect', 'to protect', 'to ensure' and 'to promote'.[82] Especially this fourth level, *i.e.* the obligation to promote, was seen as the significant innovation of his typology and as a contribution to the tripartite typology of the obligations to respect, to protect, and to fulfil.[83] The obligation to ensure consists of the duty to ascertain immediate and concrete results, whereas the obligation to promote is less concrete as it consists of an obligation to develop certain policies and therefore has a more long term perspective.

The terms used in the tripartite typology of the obligations to respect, to protect, and to fulfil are not directly based on the exact terminology used in treaty texts. The tripartite typology is an analytical tool to obtain a more nuanced understanding of the normative character of the State obligations that result from human rights.[84] Nevertheless, the contributions of Eide and Van Hoof to the typology of the obligations of States have been adopted in several human right instruments, for example GC No. 14, GC No. 12 on the right to food and GC No. 15 on the right to water.[85] The Committee adopted these contributions in GC No. 14 as

[78] Eide 1987, para. 67; Chirwa 2003, p. 558.
[79] Eide 1987, p. 1, paras. 66-69.
[80] Eide 2001, p. 23.
[81] Eide 1992, p. 388.
[82] Van Hoof 1984, p. 106-108.
[83] Sepúlveda 2003, p. 163.
[84] Koch 2005, p. 82.
[85] E/C.12/1995/5, General Comment 12 (1995), 12 May 1999, *The right to food*; E/C.12/2002/11, General Comment 15 (2002), 20 January 2003, *The right to water*. Although not a legal instrument, it has also been used repeatedly by the Special Rapporteur of Health. See E/CN.4/2004/49, 16 February 2004, *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health Report of the Special Rapporteur, Paul Hunt,* paras. 13, 43, 44; E/CN.4/2005/51, 11 February

three sub-obligations to the obligation to fulfil: to facilitate, to provide and to promote.

4 TRIPARTITE OBLIGATIONS AND THE RIGHT TO HEALTH CARE

4.1 Introduction

The obligations to respect, to protect, and to fulfil also apply to State obligations in relation to the right to health care. Together with the elements of the right to health care as defined in Chapter II, the tripartite typology of the obligations to respect, to protect and to fulfil can provide for a better understanding of what the right to health care includes and what State responsibilities follow from this right. In the subsequent paragraphs these obligations are set out in relation to the right to health care.

4.2 The Obligation to Respect and the Right to Health Care

In the context of the obligation to respect the right to health care, States should refrain from denying, obstructing or limiting access for all persons to the elements of health care as elaborated in Chapter II.[86] In case of a violation of this obligation, it signifies that the access to available health care is not respected. By contrast, in case access is limited due to *e.g.* scarce resources, this could constitute a violation of an obligation to ensure. Access to health care must also not be limited on the basis of discriminatory practices as a result of *de jure* or *de facto* discrimination due to State policy or other State actions.[87] Therefore, no individual or specific group should be denied access to health care. Examples of denial of health care are discriminatory measures in the provision of health care based on race as happened during the Apartheid regime, in access to reproductive health care for those affected with genetic diseases, and on the basis of nationality by excluding unlawfully residing immigrants from health care services that form part of the core content of the right to health care.[88] Moreover, States should refrain from, *inter alia*, engaging

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2005, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt*, paras. 47-50.

[86] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 34. It is even more correct to state that the obligation to respect the access to health care should *at least* include the elements of health care as determined in paragraph 3 of this Chapter as the right to health care is subject to progressive realisation.

[87] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 50.

[88] Chapman 1997-1998 p. 403; Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Azerbaijan, E/C.12/1/Add.104, para. 57; Uzebekistan, E/C.12/UZB/CO/1, para. 65.

in forced sterilization and other coercive medical treatment,[89] from prohibiting or impeding traditional preventive care, healing practices and medicines, from marketing unsafe drugs, from policies encouraging the imposition of harmful traditional practices, and from excluding prisoners from health care services as a way to punish them or to extort information.[90]

4.3 The Obligation to Protect and the Right to Health Care

The obligation to protect is mainly directed at protecting individuals from an infringement of their rights by third parties. Accordingly, States have the responsibility to protect their citizens from damaging acts. In this regard, the State is not the provider, but the protector of a fundamental right. This function can be compared to the role of the State in relation to civil and political rights where it has to protect individuals from an infringement of, *e.g.* their right to life and maltreatment by third parties.[91] The duty to protect requires States to adopt a legal framework and to take other measures to protect the various elements of the right to health care and to assure that people have access to health care on an equal basis.[92] This is of particular importance to prevent other individuals or groups from refraining individuals to freely realise their right to health care.[93]

States can never be relieved from their obligations in the field of health care. Even if a health care system or an insurance system is privatised, the obligation to protect has to be met as privatisation does not discharge States from their obligations in relation to health care.[94] Therefore, the obligation to protect the right to health care can be seen as having an indirect effect on private relations. It imposes a duty on States to take measures, *i.e.* take positive measures concerning the protection of the right to health care, which in turn govern horizontal relations. This might apply to the relation between the health care provider and the patient, or between the health insurer and the consumer. Whether this can be considered as the

[89] Unless on an exceptional basis for the treatment of mental illness or the prevention and control of communicable diseases. This can be regarded as limiting someone's right in the interest of someone's own health or the wellbeing of other people. E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 34.
[90] Toebes 1999a, p. 318, 325; E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 34; E/CN.4/2004/49,16 February 2004, *Report of the Special Rapporteur of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt*, para. 27.
[91] Eide 1992, p. 388.
[92] Toebes 2001, p. 180.
[93] Toebes 1999a, p. 326; Chirwa 2003, p. 559.
[94] Recommendation 1626(2003) Parliamentary Assembly Council of Europe; E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 34; Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Azerbaijan, E/C.12/1/Add.104, para. 57; Uzebekistan, E/C.12/UZB/CO/1, para. 29.

right to health care having an indirect horizontal effect is subject to discussion.[95] According to the author it is arguable that it can be concluded that as the responsibilities of States concerning the protection of the right to health care determine the law and regulations that are applicable between private parties, the fundamental right to health care has a radiating effect on private relations and therefore can be considered as having an indirect horizontal effect.

An example of measures that have to be taken by States to accomplish their obligation to protect is that States should take measures to protect all vulnerable or marginalized groups of society, such as people with disabilities, and women and children.[96] They should prevent third parties from coercing women and children to undergo harmful traditional practices by taking legislative and other measures to abolish such practices as are prejudicial to their health.[97] Furthermore, individuals should be protected against unreasonable prices for essential medicines and against health care insurances that are inclined to exclude patients, such as elderly or women in the reproductive age.[98]

Under their obligation to protect, States not only have the obligation to protect individuals against actions by others. Member States are also required to *e.g.* take measures in relation to the quality of health care, such as in relation to scientifically approved and unexpired drugs and hospital equipment, and an adequate training of health care personnel, including training as regards health care and human rights and ethical codes of conduct.[99] Other examples are the protection of individuals against HIV-contaminated blood in case of blood transfusions and adequate abortion facilities.[100]

4.4 The Obligation to Fulfil and the Right to Health Care

The obligation to fulfil implies that States have a positive duty to make health care accessible to its citizens.[101] They should create conditions to enable and assist

[95] Toebes 1999a, p. 326-327; Koch 2005, p. 94. Toebes rejects the horizontal effect of the obligation to protect, whereas Koch states that the obligation to protect is similar to the notion of *Drittwirkung*.
[96] Chirwa 2003, p. 559; E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 34.
[97] Article 24, paragraph 3 CRC.
[98] Committee on Economic, Social and Cultural Rights with regard to: Azerbaijan, E/C.12/1/Add.104, para. 57; E/C.12/2008/2, 24 March 2009, *Guidelines on treaty-specific documents to be submitted by State parties*, para. 57(f); E/CN.4/2004/49, 16 February 2004, *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health Report of the Special Rapporteur, Paul Hunt*, para. 65.
[99] E/C.12/2008/2, 24 March 2009, *Guidelines on treaty-specific documents to be submitted by State parties*, paras. 56(c), 56(d); General Comment 14 on Article 12, paragraph 12(d); The Committee in its Concluding Obligation on Hungary 2004, paras. 34, 48.
[100] Toebes 1999a, p. 328-329; Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Philippines, E/C.12/PHL/CO/4, para. 31.
[101] Toebes 1999a, p. 333.

individuals and communities to enjoy their right to health care.[102] Consequently, States must give recognise to the right to health care in their national health policies and legal systems and have to make sure a national health system is in place that meets with the obligations imposed. Health insurance systems play a crucial role in such systems. Therefore, a public, private or mixed health insurance system that is affordable to all has to be included.[103]

In case individuals or a group of individuals are unable, for reasons beyond their control, to realise their right to health care themselves by the means at their disposal, States actually have to provide them with health care.[104] Particularly, certain segments of society, such as prisoners and illegally residing immigrants and other vulnerable groups within society that cannot satisfy their own need to health care should be provided for.[105] This pertains at least to the health care that has to be provided free of charge and to the core contents of the right to health care. The failure to provide essential primary health care and drugs to those in need may therefore amount to a violation.[106] Even in times of resource constraints, these responsibilities should not in any way be eliminated.[107]

The Committee has not often required States to provide health care directly. Where it has done so, it has used less direct language by recommending States to take measures to provide access to essential health care services for the entire population, and in particular for vulnerable groups.[108] Nevertheless, it has urged several State parties to increase their allocation of resources to health care in order to increase the availability of health care in that specific State.[109] The Committee has also pointed out mismanagement and misallocation of scarce resources where it compared the expenditure on defense with the expenditure on health care and other social matters.[110]

The obligation to fulfil also includes the obligation to promote, which aims at looking forward into the future and denotes a long-term obligation. The duties in

[102] Toebes 2001, p. 180; E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 36.
[103] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 36.
[104] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 37.
[105] Toebes 2001, p. 181.
[106] Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, January 22-26, 1997, Guideline 6.
[107] Chapman 1997-1998, p. 409.
[108] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Angola, E/C.12/AGO/CO/3, para. 37; Kenya, E/C.12/KEN/CO/1, para. 32; Tajikistan, E/C.12/TJK/CO/1, para. 70; See for further information paragraph 3.3.2 of this Chapter.
[109] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Latvia, E/C.12/LVA/CO/1; India, E/C.12/IND/CO/5; Tajikistan, E/C.12/TJK/CO/1; Albania, E/C.12/ALB/CO/1, Ecuador, E/C.12/1/Add.100.
[110] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Democratic Republic of Congo, E./C.12/COD/Q/5, para. 16.

relation to the obligation to promote are generally more related to the right to health, and not specifically to the right to health care as such. It is directed to maintain and restore the health of the population by, *e.g.* providing health-related information to promote healthy lifestyles.[111] In relation to the right to health care, the obligation to promote requires States to constitute immunization programs against the major infectious diseases and to support medical research for the purpose of improving health care.[112]

4.5 Observations on the Application of the Tripartite Typology of State Obligations and the Right to Health Care

Exploring the State obligations that follow from the right to health care, three things can be noticed. These are i) the overlap of different obligations of the typology, ii) the difference in use of the typology at international level and at regional human rights level, and iii) the difference of the application of the terminology in General Comments and in Concluding Observations by the Committee.

Firstly, the distinction between the three obligations to respect, to protect and to fulfil is not always clear-cut. The different obligations also overlap to a certain extend. For example, the obligation to protect equal access to health care is closely related to the obligation to fulfil. In case health care is privatised, the obligations in relation to health care are part of the obligation to protect, whereas it is an obligation to fulfil if health care is provided by the State.[113] And in case a prisoner needs health care, the State should respect access to this facility but also has the obligation to fulfil the access to health care for the detainee. Moreover, in case health care during detention is provided by private parties, the State has the obligation to protect the prisoner against an infringement of his right to health care by that private party. Another example is the overlap between the obligation to protect and the obligation to fulfil. The obligation to ensure the provision of immunization programs against infectious diseases contains an obligation for States to protect the health of its citizens and the obligation to actually provide such immunization. The overlap between these obligations has also been defined as the interdependence of duties, which indicates that human rights cannot be fully realised by fulfilling merely one of the types of obligations they impose. Consequently, States should comply with every level of obligation for the full realisation of rights.[114]

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[111] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 37.
[112] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 36. It could be stated that this overlaps with the obligation to protect the health of individuals. However, it also overlaps with the sub-obligation 'to promote'.
[113] Koch 2005, p. 91.
[114] Sepúlveda 2003, p. 170-171.

This overlap of the various State obligations has led to criticism. According to Koch (2005), the fact that these obligations can have an overlap and are interdependent leads to a loss in practical applicability of the tripartite typology.[115] As different measures taken in order to comply with the obligation can belong to more than one category, Koch considers the distinction between the categories as blurred. In practice, this leads to great difficulty in distinguishing the various obligations. Therefore, she proposes a 'slope' that encompasses a continuum of obligations that increases for each 'movement uphill', rather than a division into levels.[116] This metaphor is further dealt with in chapter VII on the integrated approach.

Secondly, as mentioned before, at international level the tripartite typology of State obligations has been adopted in various instruments and documents, such as GC No. 14 and the Maastricht Guidelines on Violations of Economic, Social and Cultural rights. However, at regional level, the tripartite terminology is not incorporated in human rights instruments and documents. Not in the ESC or RESC, nor in the Conclusions of the European Committee of Social Rights, has this typology been used as such. The Conclusions only contain the wordings 'the positive obligation to ensure' in relation to 'the effective exercise of the right to protection of health' and the underlying determinants of health, *i.e.* sexual and reproductive health information.[117]

It is not clear why the tripartite typology is not used by the European Committee of social rights in relation to the right to health and the right to health care.[118] Nevertheless, the obligations resulting from this typology are not entirely rejected at regional level. Although the ECtHR does not use the language of the obligations to respect, to protect and to fulfil, it does accept 'negative' and 'positive' obligations within the framework of human rights and has a long tradition of using positive elements in relation to civil and political rights.[119] Moreover, the ECtHR also recognised the notion of an indirect horizontal effect of fundamental rights in its cases where it describes the State obligation of protecting individuals against a violation of their human right by private parties.[120]

Thirdly, although the Committee started applying the tripartite typology in its General Comments since 1999, the Committee used the terminology of the tripartite typology only seldom in its Concluding Observations and never in relation to the rights to health and health care. Where it did explicitly refer to the tripartite

[115] Koch 2005, p. 81-103.
[116] Koch 2005, p. 92-93.
[117] Conclusions of the European Committee of Social Rights with regard to: Azerbaijan (2009); XIX-2 Croatia.
[118] This does not mean that the typology cannot be used as an analytical tool in distinguishing the different State obligations. See for example Cullen 2009 that used the tripartite typology as a framework for human rights in general.
[119] Koch 2005, p. 93; Chinkin 2006, p. 56.
[120] Koch 2005, p. 93.

typology, it only did so in broad terms.[121] According to Koch (2005), the practical implacability of the tripartite typology, *inter alia*, due to the overlap of the different obligations, might be the reason for this.[122]

It would be useful if the Committee would explicitly apply the typology of State obligations in its Concluding Comments, as this could provide for a better understanding of when a given right is implemented and what a State is required to do or not to do in this respect.[123]

5 CRITERIA TO ENSURE ACTUALLY ACCESS TO HEALTH CARE

5.1 Introduction

The right to health care is an empty promise if there is no practical access to health care.[124] Certain criteria have to be met before there is actual access to health care. A number of guiding principles can be discerned which describe how this right to health care is to be fulfilled. In GC No. 14 on Article 12 ICESCR, the Committee adopted a four-fold classification of guidelines.[125] Consequently, health care must be available, accessible, acceptable and of good quality. The European Committee of Social Rights has not adopted such criteria in relation to the right to health care in a separate document. Nevertheless, as will be set out in Chapter VIII, the European Committee of Social Rights applied comparable criteria put forward by GC No. 13 on Article 13 ICESCR in its case law, *i.e.* the criteria of availability, accessibility, acceptability and adaptability. Therefore, it is conceivable that the criteria adopted by the Committee in GC No. 14 on Article 12 ICESC could serve as guiding principles in future case law of the European Committee of Social Rights. In scholarly writing, several comparable terms are being used that overlap with the classification of the Committee.[126] However, the four-fold classification set out in GC No. 14 ICESCR is the most comprehensive. Therefore, this classification is used as a framework in this paragraph in setting out the various guidelines for the provision of health care, and is supplemented with literature and human rights instruments and documents.

5.2 Availability of Health Care

When an individual has a right to health care, obviously this health care should be actually available. This signifies that health care facilities, goods and services have

[121] Sepúlveda 2003, p. 210.
[122] Koch 2005, p. 81-103.
[123] Sepúlveda 2003, p. 247.
[124] Huls 2004, p. 20.
[125] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 12.
[126] *E.g.* Toebes 1999a, p. 114.; Lie 2000 p. 6; Lie 2004, p. 5; Chinkin 2006, p. 56.

to be available in sufficient quantity as necessary for the whole population within a State.[127] This includes *e.g.* hospitals, clinics and other health-related buildings, medical and professional personnel, drugs and other equipment. Concerning the volume of this available quantity, no concrete criteria are prescribed in GC No. 14. Nevertheless, from the conclusions of the Committee and the European Committee of Social Rights in which the provisions of the ICESCR and the ESC and RESC are interpreted, at least three criteria for the assessment of the availability of health care can be detected. These are i) the number of hospital beds and health care providers per inhabitant, ii) the amount of resources allocated to health care, and iii) the length of waiting time for admission to health care services.

These cannot be strict criteria as the assessment depends on various factors, amongst which the developmental level of a State and the demand for health care within that State.[128] Nevertheless, these criteria can function as indicators of the situation of the right to health care, and therefore as guidelines on how to evaluate the available health care in a specific State.

In the conclusions of the European Committee of Social Rights, the number of hospital beds and medical staff per inhabitant in the different States are examined. In assessing whether the quantities can be considered as sufficient, the European Committee used the average of the EU countries as benchmark. The benchmark used for 2005 per 100.000 inhabitants was: 591 hospital beds, 60 psychiatric hospital beds, 330-420 doctors, 50-80 dentists, 600-1420 nurses and midwives, 80-110 pharmaceutical staff. [129] The figures used for the 2007 benchmark are comparable to those of 2005. In case the number of hospital beds or medical staff was below the EU average, the European Committee for Social Rights requested the Signatory State to provide for further information on the measures planned to increase the specific number.[130] In the Conclusions on the situations in Cyprus and Turkey, the European Committee even concluded that these were not in conformity with Article 11, paragraph 1 ESC. There were only 380 hospital and psychiatric beds per 100.000 inhabitants, 230 doctors, and 90 dentists available in the case of Cyprus and 190 doctors per 100.000 inhabitants in the case of Turkey.[131]

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[127] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 12(a).

[128] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 12 (a).

[129] Mentioned in *inter alia* European Conclusions of the European Committee of Social Rights with regard to: Lithuania (2009); XIX-2 Luxembourg; Belgium (2009). In some reports, the European Committee also used the data of Organisation for Economic Co-operation and Development (OECD) as benchmark; Conclusions of the European Committee of Social Rights with regard to: XVII-2 Portugal (OECD average in 2007: 3.1 doctors/1000 inhabitants and 9,6 nurses/1000 inhabitants).

[130] Conclusions of the European Committee of Social Rights with regard to: Albania (2007); Bulgaria (2009); Italy (2009); XVIII-2 Latvia; Romania (2009).

[131] Conclusions of the European Committee of Social Rights with regard to: Cyprus (2009); XVII-2 Turkey; Turkey (2009). The European Committee of Social Rights stated that the density of physicians, dentists, nurses and midwives and pharmaceutical staff was still below the EU average.

For the assessment of the resources spent on health care too, the European Committee of Social Rights used the EU average as benchmark. In the Conclusion on the situation in Italy, the European Committee mentioned an average EU health care expenditure of 8,6% Gross Domestic Product (GDP) for 1999. In 2009 it classified Germany and France as countries spending one of the highest proportions of Europe on health care, with 10,4% and 11,1% of GDP respectively.[132] Where States spent less than 5% of the GDP spent on health care, the European Committee concluded that the situation in that specific State was not in conformity with Article 11, paragraph 1 ESC.[133]

The resources allocated to health care are also discussed in the Concluding Observations of the Committee. In reference to Article 2, paragraph 1 ICESCR and the OP ICESCR, it stated that it evaluates the obligation of each Signatory State to take steps to the maximum of its available resources.[134] Consequently, the Committee urged several State parties to increase the budgetary allocation of resources, to increase the availability of health care in the specific State. The States concerned spent 3,4 % or less of their GDP on the health sector.[135]

The existence of waiting times and waiting lists has also been used as an indicator of the availability of health care, for example when this was the result of a shortage of medical personnel and medical equipment.[136] In the Conclusions of the European Committee of Social Rights, the subject of waiting times and waiting lists has often been addressed. Nevertheless, the European Committee of Social Right hardly provides further guidelines. It often requests the Signatory States to provide for further information in their subsequent State reports on waiting times and the management of waiting lists as it considers the information provided by States on this subject insufficient. Only in the case of Poland, the European Committee considered the situation not in conformity with Article 11, paragraph 1 ESC

[132] Conclusions of the European Committee of Social Rights with regard to: Italy (2003); France (2009); XIX-2 Germany.
[133] Conclusions of the European Committee of Social Rights with regard to: XVII- 2Turkey: 2,43% of GDP in 2003; XVII-2 Poland: it declined from 4.63 in 1999 to 3.96 in 2002; Estonia (2009): 5% GDP; Azerbaijan (2009): 3,4% of GDP in 2006.
[134] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Democratic Republic of Congo, E./C.12/COD/Q/5, para. 16; Cambodia E/C.12/KHM/CO/1, para 27.
[135] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Latvia, E/C.12/LVA/CO/1: it declined: 1998 3,9%, 1999 4,3%, 2000 4,8%, 2001 3,4%; India, E/C.12/IND/CO/5: declined from 1.3 percent in 1990 to 0.9 percent in 1999; Tajikistan, E/C.12/TJK/CO/1: Since independence expenditure on health care has fallen substantially from 6 per cent of GDP in 1992 to under 1 per cent in 2003, and these resources are unevenly distributed. Significantly smaller sums are spent on the development of primary health care despite the priority assigned under the program for reform of the sector; Albania, E/C.12/ALB/CO/1: 2.7 per cent of GDP in 2002; Ecuador, E/C.12/1/Add.100: where in 1998 the percentage of GDP spent on the health budget was 0,91%.
[136] Conclusions of the European Committee of Social Rights with regard to: XIX-2 Croatia.

because of the waiting time for some specialized medical services and because of the lack of appropriate waiting lists.[137]

It should be noted that waiting times and waiting lists are also issues of quality and accessibility and can be a consequence of the management and organisation of health care. This is dealt with as such later in this paragraph.

5.3 Accessibility of Health Care

Human rights grant individuals a right to access to health care. According to GC No. 14, different dimensions of the accessibility of health care can be distinguished; non-discrimination, financial accessibility, and physical accessibility.[138]

5.3.1 Non-Discrimination

A fundamental element of the right to health care is equal access and non-discrimination. As such, it is defined as core content of the right to health care and a central guiding principle in the various health and human rights instruments and documents.[139] According to the principle of equality, all persons, including women,[140] Roma,[141] street children,[142] prisoners,[143] older persons,[144] undocumented persons,[145] refugees and internally displaced persons,[146] persons with disabilities,[147]

[137] Conclusions of the European Committee of Social Rights with regard to: XVI-2 Poland; In XVII-2 Poland, the European Committee noted that there were various measures were taken to tackle these problems, but that due to the absence of any information about the functioning of the new system it could not consider the previous shortcomings as resolved. In the report of Poland in 2009, the European Committee noted that there where different improvements on this point and it therefore reserved its position while awaiting further information in the next report. Conclusions of the European Committee of Social Rights with regard to: XIX-2 Croatia the European Committee described the waiting time as 'long' (*e.g.* one year for hip and knee replacement), but did not involve this in its conclusion on the assessment of Article 11, paragraph 1 ESC.

[138] It also mentions information accessibility. This is an underlying determinant of the right to health, and not specifically to the right to health care. It therefore is not dealt with in this paragraph.

[139] Lie 2004, p. 5.

[140] Article 12 CEDAW, For example in Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: France, E/C.12/1/Add.72, para. 33.

[141] For example in the Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Greece, E/C.12/1/Add.97; The former Yugoslav republic of Macedonia; E/C.12/MKD/CO/1, para. 32; Ukraine, E/C.12/UKR/CO/5, para. 34.

[142] For example Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Ukraine, E/C.12/UKR/CO/5, para. 45; Brazil, E/C.12/BRA/CO/2, para. 24.

[143] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: India, E/C.12/IND/CO/5, para.75; Australia, E/C.12/AUS/CO/4, para. 29.

[144] E./C12/2008/2, 24 March 2009, *Economic and Social Council. Guidelines on treaty-specific documents to be submitted by State parties under Articles 16 and 17 of the international covenant on economic, social and cultural rights,* para. 56.

[145] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Kuwait, E/C.12/1/Add.98, para. 7; Slovenia, E/C.12/SVN/CO/1, para. 32; Latvia, E/C.12/LVA/CO/1, para. 37; Belgium, E/C.12/BEL/CO/3, para. 35; France, E/C.12/1/Add.72, para. 46.

indigenous people,[148] and mentally or physically disabled children[149] should have equal access to health care throughout their complete life cycle and which is adapted to the various accessibility needs.[150] Consequently, there should be no discrimination in access to health care on any of the prohibited grounds, *i.e.* on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation and civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health.[151] Therefore, health care organization should be responsive to the needs of the recipients and be appropriate to the demand, as otherwise this could result in a discriminatory effect on health due to the recipients' health status.[152] For example, elderly persons should receive the health care necessitated by their state of health, State parties should recognize the right of disabled children to special care, and persons with disabilities should be provided with those health services as are needed because of their disabilities.[153] Other examples of cases in which health care should be adapted to special needs are: people living in rural and urban areas,[154] disadvantaged and marginalized groups,[155] street children,[156] elderly,[157] prisoners,[158] people suffering from HIV/AIDS, including the particular needs of widows and orphans.[159]

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[146] For example Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Azerbaijan, E/C.12/1/Add.104; France, E/C.12/1/Add.72, para. 46.

[147] Article 25 Convention on the rights of persons with disabilities, Concluding Comment Committee China 2005, para. 47; Australia 2009, para. 16.

[148] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Ecuador, E/C.12/1/Add.100, para. 34; Nicaragua, E/C.12/NIC/CO/4, para. 11.

[149] Article 2 CRC.

[150] Chinkin 2006, p. 56.

[151] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 18; Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: India, E/C.12/IND/CO/5, para. 52; E/CN.4/2003/58, 13 February 2003 *Report The right of everyone to the enjoyment of the highest attainable standard of physical and mental health Report of the Special Rapporteur, Paul Hunt, submitted in accordance with Commission Resolution 2002/31*, para. 61.

[152] Lie 2004, p. 4.

[153] Article 4 Additional Protocol to the European Social Charter, Strasbourg 5 May 1988, ETS. 128; Article 23 Convention on the Rights of the Child; Article 25 CRPD; See also *e.g* Conclusions of the European Committee of Social Rights with regard to: Albania (2007) on care adapted to the needs of elderly,

[154] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Tajikistan, E/C.12/TJK/CO/1, para. 67.

[155] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: France, E/C.12/FRA/CO/3, para. 46; Cyprus, E/C.12/CYP/CO/5, para. 18. Groups such as asylum seekers and undocumented migrant workers.

[156] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Brazil, E/C.12/1/Add.87, para. 24.

[157] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 25.

In its Conclusions, when dealing with the accessibility of the right to health care, the European Committee of Social and Cultural Rights often referred to the Parliamentary Assembly of the Council of Europe that describes equity as a yardstick against which the success of a health care system can be measured:

> *'…the main criterion for judging the success of health system reforms should be effective access to health care for all without discrimination, which is a basic human right. This also has the consequence of improving the general standard of health and welfare of the entire population.'*[160]

The Parliamentary Assembly argued this in its recommendation "The reform of health care systems in Europe: reconciling equity, quality and efficiency" against the background of health care reforms in different Member States of the Council of Europe due to limited governmental resources and rapid demographic and technological changes. It stated that the pursuit of cost containment and maximizing efficiency may not become at the expense of equality in access to health care.[161]

In other cases too where rationing is due to a disparity between the demand for health care and the availability of resources, the criteria of equity should prevail.[162] For example, the order in which patients are treated or placed on waiting lists should only be governed by medical criteria, which means that priority must be given to patients with the greatest need. The distribution must never be based on discriminatory grounds, such as the ability of individuals to pay, as this could lead to a denial of health care to a particular group or part of the population.[163] This is also promulgated by the Committee of Ministers in their recommendation on criteria for the management of waiting lists and waiting times in health care.[164] Moreover, based on this recommendation, the considerations on the basis of which such a decision is taken, should be based on transparent criteria, agreed at national

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[158] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Australia, Australia, E/C.12/AUS/CO/4, paras. 29, 30.
[159] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Chile, E/C.12/1/Add.105, para. 53.
[160] Recommendation 1626 (2003) of the Parliamentary Assembly of the Council of Europe on "the reform of health care systems in Europe: reconciling equity, quality and efficiency", para. 4.
[161] Recommendation 1626 (2003) of the Parliamentary Assembly of the Council of Europe on "the reform of health care systems in Europe: reconciling equity, quality and efficiency", paras. 2, 5.
[162] 'Although waiting lists and waiting times are not necessarily representative only of the need for health care, but may reflect various aspects of the health care environment and organization' Council of Europe Committee of Ministers, Recommendation No. R (99)21 on criteria for the management of waiting lists and waiting times in health care, September 1999.
[163] Hendriks 2001 p. 377; Lie 2004, p. 5.
[164] Council of Europe Committee of Ministers, Recommendation No. R (99)21 on criteria for the management of waiting lists and waiting times in health care, September 1999, para. 4.

level via an open and consultative process and made clear to the public, the patient and the medical staff.[165]

5.3.2 Financial Accessibility

The second criterion of accessibility to health care is financial accessibility. Financial accessibility requires that health care, including drugs, should be affordable for everyone.[166] This affordability is an important element of the accessibility to health care and forms part of the information that should be provided in the State reports that have to be submitted to the Committee.[167] The cost of health care should not place an excessive financial burden on individuals as access to health care should be based on need and not on ability to pay.[168] Steps must therefore be taken to reduce the financial burden on patients if necessary.

The type of patients for whom special measures should be taken, can firstly be distinguished by their health status or health care need, and secondly according to their social, legal and economic status. According to GC No. 14, the ESC and RESC and several Conclusions of the Committee and the European Committee of Social Rights, the poorest sectors of the population should have access to free, high-quality and universal primary health care, including dental care.[169] The specific health status or health care needs for which free primary health care should be provided include: screening and other services in connection with pregnancy, confinement and the post-natal period for pregnant women and children suffering from HIV/AIDS,[170] medical checks throughout the period of schooling,[171] contraceptives,[172] antiretroviral medication for pregnant women, including during labour, after birth and for their children,[173] special care for disabled children,[174] and testing and treatment for HIV/AIDS.[175]

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[165] Hendriks 2001, p. 337; Council of Europe Committee of Ministers, Recommendation No. R (99)21 on criteria for the management of waiting lists and waiting times in health care, September 1999, paras. 5, 7, 12, and 13.

[166] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para.12; E./C12/2008/2, 24 March 2009, *Economic and Social Council. Guidelines on treaty-specific documents to be submitted by States parties under Articles 16 and 17 of the international covenant on economic, social and cultural rights,* paras. 56(b), 57 (f).

[167] E./C12/2008/2, 24 March 2009, *Economic and Social Council. Guidelines on treaty-specific documents to be submitted by States parties under Articles 16 and 17 of the international covenant on economic, social and cultural rights,* paras. 56(b), 57 (f).

[168] Digest of case law of the European Committee of Social Rights, September 2008, p. 83; Conclusions of the European Committee of Social Rights with regard to: Ireland 2007.

[169] Article 13, paragraph 1 ESC; Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Bolivia, E/C.12/BOL/CO/2, para. 34; Angola, E/C.12/AGO/CO/3, para. 36; Nicaragua, E/C.12/NIC/CO/4, para. 29; Brazil, E/C.12/BRA/CO/2, para. 28.

[170] Article 12, paragraph 2 CEDAW; Digest of case law of the European Committee of Social Rights, September 2008, p. 85.

[171] Digest of case law of the European Committee of Social Rights, September 2008, p. 85.

[172] The Committee on Angola 2008, para. 37.

[173] The Committee on Kenya 2008, para. 32

However, there is no such thing as free health care. Of course, it may be free for the user, but someone has cover the costs.[176] This can be done through health care systems and health care insurances set up by the State by adopting legislative, administrative, budgetary, judicial and other measures for the full realisation of the rights to health and health care.[177] Strengthening health care systems is the best way of meeting health care needs, improving health care equitably and distributing financial contributions.[178]

Setting up health care systems and health care insurances has been frequently advised to the Signatory States of the ICESCR by the Committee as the cost of health care should be borne, at least in part, by the community as a whole.[179] Also, by means of Article 12 ESC and RESC, Member States should protect the right to health care *via* insurance. Article 12 ESC and RESC set out the obligation to establish and maintain a system of social security.[180] This provision covers the right to health care as well since it refers to the treaties of the ILO and the European Code of Social Security that lay down the obligation to set up a medical insurance for workers. Due to these obligations, it has been stated that the right to health care has become synonymous with health care insurance and benefit packages.[181]

Different health care systems and models for the organisation of health care and health care insurance exist. No specific requirements are set by the Committee or the European Committee of Social Rights for the organisation and implementation of such a system. This can be publicly provided or by private organisations as long as this does not constitute a threat to the affordability.[182] The same holds for cost sharing, *e.g.* co-payment, co-insurance, and deductible components, which is a frequently introduced health care policy reform to contain costs. Such measures must be sought without placing an excessive financial burden

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[174] Article 23, paragraph 3 CRC. The inability to pay should not deprive children of access to health care Tomasevski 1995, p. 135.
[175] The Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Tajikistan, E/C.12/TJK/CO/1, para. 70.
[176] Tomasevski 1995, p. 129.
[177] Hendriks 2001, p. 375.
[178] Hendriks 2001, p. 377; World Health Organization, 2002, p. 74.
[179] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: El Salvador, E/C.12/SLV/CO/2, para. 43; Kenya, E/C.12/KEN/CO/1, para. 20; Digest of case law of the European Committee of Social Rights, September 2008, p. 83.
[180] This also forms part of the information that should be provided in the State reports that have to be submitted to the Committee: States should indicate whether they have adopted a national health care policy and whether a national health care system with universal access to primary health care is in place. E./C12/2008/2, 24 March 2009, *Economic and Social Council. Guidelines on treaty-specific documents to be submitted by State parties under Articles 16 and 17 of the international covenant on economic, social and cultural rights,* para. 55.
[181] Den Exter 2002, p. 22.
[182] Toebes 1999, p. 667; E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, paras. 12(b), 26.

on certain individuals or render medical protection too expensive, as this can lead to an unequal accessibility of health care.[183]

5.3.3 Physical Accessibility

In addition to non-discrimination and affordability, physical accessibility is another criterion that has to be fulfilled to comply with the responsibilities in relation to the right to health care. Health care has to be within safe reach and physically accessible for everyone.[184]

In the Conclusions of the Committees supervising the ICESCR and the ESC and RESC, much attention is paid to the geographical distribution of health care.[185] In various countries, there are significant disparities between urban and remote, rural areas in the provision of health care, including the geographical distribution of doctors and other health care professionals.[186] Moreover, geographical inequalities are more than often related to an inequality in access to health care for less developed and economically marginalized regions or persons belonging to racial, ethnic or national minority groups within population.[187] Especially in case of the latter, a difference in physical accessibility can lead to discrimination in the access to health care. This uneven distribution of health care formed a source of concern for both the Committee and the European Committee of Social Rights. As a consequence, they urged several State parties to adopt measures to address the significant disparities in physical access to health care.[188]

Also part of the criteria of physical accessibility to health care is access for specific groups of patients in a literal sense. For example, older persons and persons with disabilities should have adequate access to buildings and other public areas where health care is provided.[189]

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[183] Den Exter and Hermans 1999, p. 7-8; Article 10, 2 European Code of Social Security, adopted 16 April 1964, E.T.S. 048; Recommendation 1626 (2003) of the Parliamentary Assembly of the Council of Europe on "the reform of health care systems in Europe: reconciling equity, quality and efficiency", para. 5.

[184] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 12(b); E./C12/2008/2, 24 March 2009, *Economic and Social Council. Guidelines on treaty-specific documents to be submitted by State parties under Articles 16 and 17 of the international covenant on economic, social and cultural rights,* para. 56(a).

[185] Toebes 1999, p. 667.

[186] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Albania, E/C.12/ALB/CO/1, para. 60; Tajikistan, E/C.12/TJK/CO/1, para. 61; Conclusion European Committee of Social Rights on Azerbaijan 2009; Germany 2009; Lithuania 2009; Turkey 2005.

[187] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: France, E/C.12/FRA/CO/3, para. 21.

[188] *E.g.* Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: Albania, E/C.12/ALB/CO/1, para. 60; Tajikistan, E/C.12/TJK/CO/1, para. 67; Conclusions of the European Committee of Social Rights with regard to: XIX-2 Germany; Lithuania (2009); XVII-2 Turkey.

[189] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 12(b).

5.4 Acceptable Health Care of Good Quality

The last two criteria distinguished in GC No. 14 are the acceptability and quality of health care. According to GC No. 14 acceptable health care signifies that it must be 'culturally appropriate, *i.e.* respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements'.[190] This means that the cultural tradition of persons should be respected. Examples are the refusal of blood transfusions by Jehovah witnesses, the use of traditional preventive care, healing practices and medicines by various indigenous groups and the use of alternative medicines and medical treatments.[191]

Quality implies that the available health care must be scientifically and medically appropriate and of good quality. This requires scientifically approved and unexpired drugs and hospital equipment and an adequate training of health care personnel, including as regards health and human rights.[192] In the conclusions of the Committee and the European Committee of Social Rights that have been studied for the present analysis, no concrete interpretation of the term quality is given. This is probable due to the fact that the quality of health care in a Member State is very difficult to assess within the context of international reporting procedures. Nevertheless, attention was paid to life expectancy and infant mortality rates and the number of health care professionals with secondary or higher education to obtain an impression of the level of quality of the health care provided.

Waiting lists and waiting times are also quality issues.[193] For example, the waiting time for a medical treatment the time within access to health care can be obtained can be medically unacceptable given the condition and clinical need of a patient. Therefore, there has to be an appropriate and uniform management of waiting lists to improve the quality and effectiveness of health care services.[194] In the past, waiting lists formed a serious problem in the Dutch health care system.[195]

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[190] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 12(c) This also deals with medical ethics as part of the appropriateness of health and health care. This is not discussed in this Chapter as it reaches too far, considering the subject and purpose of the present study.

[191] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 27. Alternative medicines include for example homeopathy, acupuncture and herbalism.

[192] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 12(d); E./C12/2008/2, 24 March 2009, *Economic and Social Council. Guidelines on treaty-specific documents to be submitted by State parties under Articles 16 and 17 of the international covenant on economic, social and cultural rights,* paras. 56(c), 56(d).

[193] Council of Europe Committee of Ministers, Recommendation No. R (99)21 on criteria for the management of waiting lists and waiting times in health care, September 1999, para. 3.

[194] Council of Europe Committee of Ministers, Recommendation No. R (99)21 on criteria for the management of waiting lists and waiting times in health care, September 1999, para. 12; Conclusions of the European Committee of Social Rights with regard to: XIX-2 Croatia; XIX-2 Czech Republic.

[195] State report of the Netherlands submitted to the Committee on Economic, Social and Cultural Rights, E/1994/104/Add.30, para. 411.

Consequently, the Committee recommended the Netherlands to take efforts to reduce the waiting time for admission to health care services.[196]

6 CONCLUSIONS

This Chapter has focused on State obligations resulting from the right to health care. As overall conclusion it is observed that non-discrimination and equal access to health care is a recurring element of that right. It is part of the criteria for actual access to health care. In addition, it is part of the core content of the right to health care. As clarified in paragraph 2, States have an immediate obligation to realise the core content of the right to health care. Likewise, limitations, derogations and retrogressive measures should not affect the core content of the right to health care. Moreover, it is also part of the various types of action States have to take in order to realise the right to health care. As such, the obligation to respect includes that States should not take measures or adopt policies that limit access to health care in a discriminatory manner. Also the obligation to protect entails that States have to protect their citizens from discrimination if health care is provided by others than the State in order for them to have access to health care on an equal basis. These recurring elements are
further discussed in Chapter IV where these are defined as the right to equal access to health care.

[196] Concluding Observations of the Committee on Economic, Social and Cultural Rights with regard to: the Netherlands, E/C.12/NLD/CO/3, para. 30.

CHAPTER IV
EQUALITY, NON-DISCRIMINATION AND THE RIGHT TO EQUAL ACCESS TO HEALTH CARE AS A HUMAN RIGHT

1 INTRODUCTION

Important elements of the right to health care are the right to equal access to health care, the right to equitable access to health care and the right to access to health care on a non-discriminatory basis. These relate to the accessibility of health care and are recurring elements in the various human rights provisions on the right to health and the right to health care. These provisions shall be briefly set out in paragraph 2.

The sources that will be set out in paragraph 2 do not clarify how these elements are related to each other; not every element is provided for in every provision and the elements seem to be used intertwined on occasions. In paragraph 3 the definition and concepts of the principle of equality and non-discrimination will be discussed to subsequently clarify the relation between these recurring elements of the right to health care in paragraph 4. As will be set out in paragraph 4, the prohibition of discrimination is a vital element in the definition of the right to equal access to health care, especially in relation to the question of the justiciability of the right to equal access to health care. By virtue of a human rights provision prohibiting discrimination, the right to equal access to health care could be justiciable. Consequently, the general human rights provisions on equal treatment and mainly those on the prohibition of discrimination, shall be out in paragraph 5.

2 RECURRING ELEMENTS OF THE RIGHTS TO HEALTH CARE: EQUAL ACCESS, EQUITABLE ACCESS, AND ACCESS ON A NON-DISCRIMINATORY BASIS

The important elements of the right to health care relate to the accessibility of the rights and entitlements that fall under the right to health care. These include the right to equal access to health care, the right to equitable access to health care and the right to access to health care on a non-discriminatory basis. These are recurring elements in provisions in which the right to health and the right to health care are enshrined.

GC No. 14 elucidates that the right to health and the right to health care are closely related and dependent upon the realisation of other human rights, such as non-discrimination and equality.[1] For example, Article 2, paragraph 2 ICESCR

[1] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 3.

prescribes that the State parties of the ICESCR 'undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status'. This principle of non-discrimination requires that there is equal access to the determinants of the right to health, including the right to health care.[2] Accordingly, States are under the obligation to respect the right to health by *inter alia* refraining from denying or limiting equal access to certain persons or groups of persons.[3] Moreover, States have a special obligation to protect individuals from any discrimination on internationally prohibited grounds in the provision of health care, especially with respect to the core obligation of the right to health.[4] Furthermore, health care must be affordable for all and therefore based on the principle of equity so that certain groups are not disproportionately burdened with health care expenses.[5] The CERD prescribed the responsibility of State parties to prohibit and eliminate racial discrimination in all its forms and to guarantee the right of everyone without distinction to *inter alia* health care.[6] The CRPD provides that the right to health care should be enjoyed without discrimination as regards disability, which implies equal access to health care services for the disabled and able-bodied alike.[7] By virtue of Article E, the RESC proscribes any discrimination in relation to the right to protection of health and the right to social and medical assistance.[8] Moreover, the right to social and medical assistance applies equally to all legally abiding nationals in a Member State, indigenous or other. And finally, the Convention on Human Rights and Biomedicine provides for a right to equitable access to health care in accordance with the person's medical needs, which first and foremost means the absence of unjustified discrimination.[9]

Access to health care on a non-discriminatory basis is also designated as the core content of the right to health and the right to health care.[10] This was set out in Chapter II, paragraph 3.3 and 4.3. Consequently, it is not only the essence of the right the health care it is also one of the immediate obligations of a Member State. Unlike the duties linked to the progressive realisation of economic, social and

[2] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, paras. 12, 22.
[3] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 34.
[4] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 9
[5] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 12.
[6] Article 5(e)(iv) CERD.
[7] Art. 25 CRPD.
[8] Art. E, 11, 13 RESC.
[9] Art. 3 Convention on Human Rights and Biomedicine; Explanatory Report Convention on Human Rights and Biomedicine, para. 25.
[10] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 43(a).

cultural rights, such duties are immediately effective.[11] Moreover, this core content may not be limited or derogated from, and no retrogressive measures may be taken in this regard. As such, according to GC No. 14 on Article 12 ICESCR, the right to health care includes at least the obligation for its Member States 'to ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups'.[12]

Thus, equal access, non-discrimination and equity are established as essential elements of the right to health care. But how are they related to each other? Not every element is mentioned in every provision and occasionally the separate elements seem intertwined. Is there a hierarchy of elements? Is there overlap between the different elements? Are they synonymous?

To help answer these questions, the principles of equality and non-discrimination are discussed in the next paragraph. Subsequently, in paragraph 4, these principles are combined with the elements of equal access, equity and non-discrimination.

3 THE PRINCIPLE OF EQUALITY: DEFINITION OF CONCEPTS

3.1 Introduction

The principle of equality - enshrined in most of international and regional human rights treaties - implies equal treatment by law, before the law and in fact. Together with the principle of non-discrimination it is considered to be one of the most fundamental elements of law in general, and human rights law in particular.[13] Both principles are discussed in the following paragraphs in order to clarify how the various recurring elements of the accessibility of the right to health care are related.

3.2 The Right to Equality: Formal and Substantial Equality

The distinction between a formal and a substantive notion of equality is well-known.[14] The formal juridical notion entails that comparable cases should be treated alike and that the law treats persons equally.[15] This implies that the same standards of rights and obligations must be applied to everyone, regardless of human

[11] Courtis 2009, p. 382.
[12] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 43(a).
[13] Vandenhole 2005, p. 1.
[14] In the conceptual approach of equality, the concepts of equality 'before the law' and 'equality by the law' are also used. Several approaches exist to the relation between those concepts and the concepts of formal equality and substantive equality. In general it can be stated that formal equality corresponds to equality before the law and substantive equality to equality by the law. However, equality before and equality by the law only concentrate on the applicability of the law in a strict and procedural sense whereas formal and substantive equality can deal with applicability of the law and other treatments.
[15] Hendriks 1994, p. 157.

characteristics, such as race, gender or other status.[16] Therefore, in principle no difference is allowed on any ground whatsoever.[17] In an absolute sense, this means that all personal or group characteristics are abstracted and that emphasis is placed on the creation of strict equality.[18] In a less strict and absolute sense, it suffices if personal or group characteristics are compared only on relevant aspects.[19]

It is generally recognised that formal equality could lead to a difference in treatment in effect. As formulated by Gerards (2005): 'What appears at first sight to be equal treatment can bring about a substantive inequality: a *resulting* inequality, caused by the fact that insufficient account is paid to the differences that in fact exists between groups or persons'.[20] Substantive equality, which can be seen as the second component of equality, focuses on such peculiarities and differences and the factual consequences of a treatment or law and allows to create equal opportunities and outcomes for all.[21] Consequently, unequal cases should be dealt with in a manner that reflects their unlikeness.[22] This means that differentiation in fact could be necessary to realise equality in the sense of equal opportunities and equal outcomes on a higher level. However, the difficulty with substantive equality is to define which inequalities are relevant to take into account and to what extent differentiation should be applied to realise equality on a higher level and can at the same time be justified, considering the right to equal treatment and the prohibition of discrimination.[23]

3.3 Discrimination, Direct Discrimination and Indirect Discrimination

In various situations it is conceivable that differentiation is being made between individuals or groups of persons. In principle, such a differentiation is not unacceptable *per se*. Unequal treatment has to be justified and can be justified if the distinction is based on objective and reasonable grounds. On the other hand, a treatment or rule that is not justifiable is per force illegitimate and can be considered as discrimination.[24]

Discrimination is probably the best-known dimension of the principle of equality.[25] It is a *species* of inequality. A difference in treatment does not always amount to discrimination, but discrimination always amounts to unequal

[16] Partsch 1982, p. 69; Gerards 2005, p. 12.
[17] Holtmaat 2004, p. 68.
[18] Hendriks 1999, p. 101; Loenen 1998, p. 20-21.
[19] Gerards 2005, p. 10.
[20] Gerards 2005, p. 12.
[21] Loenen 1998, p. 24; Gerards 2005, p. 12; Henrard 2008a, p. 12.
[22] Wentholt 1999, p. 54.
[23] Loenen 1998, p. 25-26.
[24] Henrard 2008, para. 27.
[25] Holtmaat 2004, p. 67.

treatment.[26] Originally, discrimination meant no more than differentiation or unequal treatment. Later, the term got a negative and pejorative connotation. Here, opinions differ. Some argue that unjustified unequal treatment should be called unjustified discrimination; others simply call it discrimination.[27] In the present study, 'discrimination' refers to an unjustified difference in treatment. This is unequal treatment based on prohibited grounds, or based on a distinction for which no justification can be found.

The groups of discriminatory grounds that are considered suspect or unjustified are not static but subject to development of *inter alia* case law, and are covered by several documents.[28] These are addressed in the third part of the present study. Generally, it can be stated that discrimination is an unequal and disadvantageous differentiation based on characteristics of human value - characteristics of a group or a person - that cannot, or only with difficulty be changed.[29] Examples of discriminatory grounds are sex, race, nationality, and also religion and sexual orientation.

The prohibition of discrimination is generally directed at the unequal treatment itself. However, this prohibition can also cover discrimination that results as an effect of a treatment.[30] This distinction is defined as the concepts of direct and indirect discrimination. Direct discrimination occurs if a difference in treatment is *de facto* based on unjustified and prohibited grounds. In this sense, equal cases are treated unequally and the differentiation is not based on an objective and reasonable justification.[31] In contrast, indirect discrimination is about the unequal effect of the treatment. A treatment can be based on apparently neutral grounds, so no differentiation is being made, or a differentiation is made on non-prohibited or justifiable grounds, but *de facto* leads to what can be considered discrimination.[32] As such, unequal cases are treated equally. This concept corresponds with the concept of substantive equality and substantive inequality.

The development and implementation of the concept of indirect discrimination, created the possibility to detect and remove concealed forms of discrimination and the possible negative effects of societal differences. However, applying the concept of indirect discrimination also has the difficulty of determining what and how disadvantageous, unreasonable and unjustified effects can be defined.[33]

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[26] Alkema and Rop 2002, p. 37. Several authors assert that the terms equality and non-discrimination are often incorrectly used interchangeable and strive for a clear distinction in the use of both terms. See for example: Hendriks 1994, p. 156; Holtmaat, 2004, p. 74.
[27] Garner 2004, para. 500; Gerards 2005, p. 11.
[28] Wentholt 1999, p. 57.
[29] Loenen 1998, p. 34; Alkema and Rop 2002, p. 36-37.
[30] Henrard 2008, para. 32.
[31] Loenen 1998, p. 47.
[32] Alkema and Rop 2002, p. 36-37; Gerards 2005, p. 13; Hendriks 1999, p. 102.
[33] Loenen 1998, p. 50-51.

3.4 Positive Measures and Preferential Treatment

The prohibition of discrimination alone is sometimes perceived as insufficient to obtain equality. Some inequalities are deemed to need positive measures to realise either equal chances or equal outcomes.[34] Positive measures are present in various forms and aim at achieving a level playing field for equal opportunities for a specific disadvantaged group. The grounds on which the distinction is made and the group or individual at whom these measures are directed, are in general relatively neutral.[35] However, some measures that aim at equality are more specific and extensive. They are directed at eradicating a social disadvantage of a particular group or serve as a compensation for past injustice. Such measures can be defined as preferential treatment[36] With preferential treatment, a direct distinction is made, based on criteria that normally would lead to discrimination.[37] Preferential treatments are therefore also described as positive discrimination, although that can be seen as a *contradictio in terminis*.[38]

Positive measures can be perceived as part of the principle of equality or as an exception to it, depending on the formal or substantive perspective on equality. Within the perspective of formal equality, positive measures are seen as an exception to the legal principle of equality whereas in a substantive view it is part of the right to equal treatment as it is perceived as necessary for the achievement of equality.[39] However, in both views positive measures are indisputably a form of unequal treatment. Therefore, in each separate case it has to be examined whether the differentiation made is reasonable in relation to the interests that are impaired and has to be justified on objective and reasonable grounds.[40] As Gerards (2005) states: "[D]iscrimination is difficult or even wholly impossible to justify, while unequal treatment is still capable of being justified".[41]

4 THE RIGHT TO EQUAL ACCESS TO HEALTH CARE, ITS COMPONENTS AND DEFINITION

Based on what was set out in the previous paragraph, the right to equal access to health care can be defined as the right to equal treatment in accessing health care. This equal treatment implies that comparable cases should be treated alike by law

[34] Alkema and Rop 2002, p. 36. Positive measures are sometimes also defined as social policy: Hendriks 1999, p. 103.
[35] Loenen 1998, p. 56.
[36] Loenen 1998, p. 56.
[37] Hendriks 1999, p. 103-104.
[38] Loenen 1998, p. 56.
[39] Wentholt 1999, p. 59; Henrard 2008, p. 239.
As Wentholt (1999) states: "It is important to understand that the formal approach of equality *allows* some kind of preferential treatment but does not *require* it" (p. 55).
[40] Loenen 1998, p. 61.
[41] Gerards 2005, p. 11.

and in practice. Consequently, the same standards of the right to health care must apply to everyone as everybody has the right to equal access to health care. The State not only has the obligation to respect this right, but must also take action in order to protect individuals from the infringement of this right by others, and by adopting positive measures. An example of the latter is the establishment of a health care system that provides everyone with access to health care.

Discrimination is part of the broader framework of the right to equal access to health care. Or to be more specific, it is a species of the opposite to equal access to health care, *i.e.* unequal access to health care. If there is no equal access to health care, this can be considered as discrimination. Unequal access to health care amounts to discrimination only if the difference in treatment is based on prohibited grounds or on a ground for which no justification can be found. Consequently, not every unequal treatment is discriminatory and consequently, not every instance of unequal access to health care can be considered as discrimination.

The principles of substantive equality and indirect discrimination can also be related to what is part of the right to equal access to health care. It does not suffice to only take into account formal equality. In different situations it may be necessary to pay special attention to the health care needs of specific individuals or groups for there to be actual equal access to health care. This is what is also defined as equity or equitable access to health care. For example, in relation to the financial accessibility of health care it could be necessary to pay attention to the specific circumstances of certain groups in society so that they are not disproportionately burdened with health expenses and thus hampered in accessing health care. Another example is geographical inequality in accessing health care which are more than often related to an inequality in access to health care for less developed and economically marginalised regions or persons belonging to racial, ethnic and national minority groups of the population.[42] Positive measures can be considered to fall under this second component as well as taking such measures as are necessary to ensure the actual enjoyment of their right to equal access to health care by disadvantaged groups in society.

If no attention is paid to the peculiarities of and differences between individuals or groups in society this could result in unequal access to health care. If this results in unequal access to health care based on prohibited grounds of distinction for which no justification can be found, it can be considered to constitute an indirect form of discrimination. Consequently, indirect discrimination is also a *species* of unequal access to health care.

Based on the findings set out in Chapters I and II and subsequently in paragraph 2 of this Chapter, the covering definition of equal treatment in relation to the rights and entitlements that are part of the right to health care is established as the right to equal access to health care. This right consists of both a formal

[42] Concluding Observation Committee on Economic, Social and Cultural Rights with regard to: France, E/C.12/FRA/CO/3, para. 21.

conception and a substantive conception of equality in accessing health care. Substantive equality in accessing health care can also be considered to imply equity as it takes into account the specific needs of certain individuals or groups in society in accessing health care. If a specific measure or treatment leads to unequal access to health care - whether directly or indirectly - for which no justification can be found, discrimination arises. Both direct and indirect discrimination fall under the denomination of the opposite to the right to equal access to health care, *i.e.* unequal access to health care. These violate the right to equal access to health care and are therefore prohibited under human rights law. Consequently, the delineation used in the subsequent parts of the present study is: There is a right to equal access to health care that consists of both formal equality and substantive equality. If there is a case of unequal access to health care and a distinction cannot be justified, it amounts to discrimination, whether direct or indirect. However, if there is a justification for such a difference in treatment, it cannot be considered as a human rights violation.

For the concept of the justiciability of the right to equal access to health care this distinction between unjustified and justified unequal access to health care is vital. The human rights provisions on equal treatment and non-discrimination could be applicable to the right to health care.[43] As a prohibited element of unequal access to health care is discrimination, this could be subject to adjudication in case of unequal access to health care. Accordingly, by virtue of a human rights provision prohibiting discrimination, the right to equal access to health care could be justiciable. Therefore, before continuing with the justiciability of the right to equal access to health care in the second and third part of the present study, the human rights framework of the right to equal treatment and the prohibition of discrimination will be set out in the final paragraph of this Chapter.

5 THE LEGAL FRAMEWORK OF THE RIGHT TO EQUAL TREATMENT AND NON-DISCRIMINATION IN HUMAN RIGHTS LAW

5.1 Introduction

The principles of equality and non-discrimination are without doubt among the most fundamental elements of human rights law.[44] They have been recognised as such and are enshrined in most of international and regional human rights treaties. At UN level all treaties, except for the Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT), contain explicit provisions on equality and non-discrimination.[45] The same holds for the treaties existing within the framework of the CoE. In light of the justiciability of the right to equal access to

[43] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 18.
[44] Vandenhole 2005, p. 1.
[45] Adopted and opened for signature, ratification and accession by General Assembly Resolution 39/46 of 10 December 1984.

health care by virtue of the various human rights provisions on equal treatment and non-discrimination, these provisions are set out in the subsequent paragraphs.

5.2 The International Legal Framework of the Human Right to Equal Treatment and Non-Discrimination

At UN level all but one of the human rights treaties contains explicit provisions on equality and non-discrimination. The UDHR that commences its Preamble by stating that 'recognition of the inherent dignity and of the *equal* and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world', includes both a general formulated equality standard and a specific prohibition of discrimination.[46] The general equality standard is laid down by Article 7 UDHR, which is formulated as follows:

> *'All* are *equal* before the law and are entitled without any discrimination to *equal* protection of the law. *All* are entitled to *equal* protection against any discrimination in violation of this Declaration and against any incitement to such discrimination.'[47]

This definition consists of three parts: one part that prescribes an equal right before the law, a second part that prescribes an equal protection by the law and a third part that provides protection against any form of discrimination. This formulation is more general than the definition of the prohibition of discrimination as laid down in Article 2 UDHR, which states that:

> *'Everyone* is entitled to all the rights and freedoms set forth in this Declaration, *without distinction of any kind*, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth *or other status.*'[48]

Article 2 UDHR prohibits discrimination on the basis of a clearly open-ended number of grounds and just like Article 7 UDHR, forms a subordinate equality norm. Subordinate equality norms complement the other provisions laid down in instruments like the UDHR as these are only applicable to its substantive provisions. In addition, the opposite of a subordinate clause is an autonomous or non-ancillary norm, which stands on itself and is not merely applicable in the context of another substantive right or freedom laid down in a specific instrument.[49]

The UDHR recognises two sets of human rights: civil and political rights as well as economic, social and cultural rights. In converting the UDHR's provisions into legally binding obligations, the UN decided to divide its provisions between the

[46] Emphasis added MSG.
[47] Emphasis added MSG.
[48] Emphasis added MSG.
[49] Bayefsky 1990, p. 4.

ICCPR and the ICESCR. Together these constitute the foundation of the international normative regime for human rights.

The prohibition of discrimination enshrined in Article 2 ICESCR and Article 2 ICCPR are the result of Article 2, paragraph 1 UDHR. Article 2, paragraph 2 ICESCR prescribes:

> 'The States Parties to the present Covenant undertake to guarantee that *the rights enunciated in the present Covenant* will be exercised *without discrimination* of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth *or other status.*'[50]

Article 2, paragraph 1 ICCPR is formulated in a comparable manner although instead of the words 'without discrimination of any kind' it includes 'distinction of any kind'. Nevertheless, these designations have the same legal meaning.[51] Article 2, paragraph 2 of the ICCPR and the ICESCR respectively, are subordinate equality norms and define the rights in question in an open-ended manner. As a result, Article 2, paragraph 2 ICESCR is also applicable to Article 12 ICESCR that places emphasis on equal access to health care and minimum guarantees of health care in the event of sickness.[52]

In addition to Article 2, the ICCPR comprises another non-discrimination clause in Article 26. It states that "all persons are equal before the law and are entitled without any discrimination to the equal protection of the law" and adds a prohibition of discrimination on a clearly open-ended number of grounds. Unlike the provisions of Article 2, paragraph 2 ICESCR and ICCPR it provides for an autonomous and free-standing equality and non-discrimination clause that also applies to other human rights than those provided for by the ICCPR. Consequently, this provision too applies to Article 12 ICESCR.

The right to equal treatment and the prohibition of discrimination is furthermore laid down in specific international treaties. The ILO Conventions, the CRC, and the CRPD contain an equality and non-discrimination provision with respect to the rights of particular groups they are concerned with. Two other Conventions are explicitly devoted to a particular form of discrimination: the CERD and the CEDAW.

The Conventions that came about in the framework of the ILO are directed at promoting rights at work, setting minimum standards for working conditions and enhancing social protection. A number of these ILO-Conventions contain

[50] Emphasis added MSG.
[51] Hendriks 1999, p. 107.
[52] E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*, para. 19.

provisions regarding equal treatment and non-discrimination regarding employment and education, social security, remuneration and accident compensation.[53]

The CRC provides that State parties have to respect and ensure the rights set forth in the Convention to each child within their jurisdiction without discrimination of any kind and that they shall take all appropriate measures to ensure that the child is protected against all forms of discrimination.[54] The CRPD provides for a right to the enjoyment of the highest attainable standard of health without discrimination on the basis of disability. The CEDAW is directed at achieving full equality between men and women, and the CERD commits its State parties to condemn racial discrimination and to promote understanding among all races.[55]

5.3 The Regional Legal Framework of the Human Right to Equal Treatment and Non-Discrimination

The ESC, adopted in 1961, provides for economic, social and cultural rights at regional level. In its Preamble, non-discrimination was assigned a modest place. It concerns a limited list of prohibited grounds (race, colour, sex, religion, political opinion, national extraction or social origin) that are not further dealt with separately. Equal treatment and non-discrimination are only mentioned in the context of specific social and economic rights and are specifically applied to, for example, the right to employment and remuneration, the right to organise and the right to social security.

Later on, in the RESC, the position of the principle of equality gained more strength by the general, subordinate and open-ended Article E on non-discrimination that reads:

> 'The enjoyment of the rights set forth in this Charter shall be secured *without discrimination* on any ground such as race, colour, sex, language, religion, political or other opinion, national extraction or social origin, *health*, association with a national minority, birth *or other status*.'[56]

The content of this Article is comparable to Article 2, paragraph 1 ICESCR, although some extra criteria are included, among which health.

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[53] Convention concerning Equality of Treatment for National and Foreign Workers as regards Workmen's Compensation for Accidents, ILO Convention 19, adopted 5 June 1925; Convention concerning Equal Remuneration for Men and Women Workers for Work of Equal Value, ILO Convention 100, adopted 9 June 195; Convention concerning Discrimination in Respect of Employment and Occupation, ILO Convention 111, adopted 25 June 1358; Convention concerning Equality of Treatment of Nationals and Non-Nationals in Social Security, ILO Convention 118, adopted 28 June 1962.
[54] Article 2 CRC.
[55] Article 2, paragraph 1 CERD.
[56] Emphasis added MSG.

Within the context of the CoE, the ECHR was signed in 1950 and took effect in 1953.[57] The ECHR is obviously enlightened and influenced by the UDHR. Just like the first part of the UDHR, the ECHR is directed at the protection of civil and political rights and Article 14 ECHR is almost a restatement of Article 2 UDHR:

> 'The enjoyment of the rights and freedoms set forth in this Convention shall be secured *without discrimination on any ground* such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth *or other status*.'[58]

Article 14 ECHR prohibits discrimination on the basis of an open-ended number of grounds and prohibits discrimination only in the context of the rights and freedoms laid down elsewhere in the ECHR.

The accessory nature of this Article was perceived to lead to a too narrow scope of protection. To amend this, Protocol No. 12 ECHR was set up and opened for signature by the Member States of the ECHR in 2000.[59] Protocol No. 12 provides for an autonomous prohibition of discrimination. Unlike Article 14 ECHR it does not require a link to a substantive provision enshrined in the ECHR. The adoption of this protocol unchained the right to non-discrimination from other rights and just like Article 26 ICCPR, provides for a general prohibition of discrimination with respect to all human rights defined by law.[60] In addition, the adoption of Protocol No. 12 provides Member States with the possibility to take positive measures, such as affirmative actions, "to promote full and effective equality" without *per se* falling foul of the prohibition of discrimination, provided that there is an objective and reasonable justification for such measures.[61]

6 CONCLUSIONS

The right to access to health care on a non-discriminatory basis, and the right to equitable access to health care are essential elements of the right to health care. Moreover, these are recurring components of the various human rights instruments in which the right to health and the right to health care are enshrined, of the various State obligations, and of the criteria that have to be met in order for there to be actual access to health care. The right to equal access to health care is the covering definition of these three elements. This right consists of both a formal conception and a substantive conception of equality in accessing health care. Substantive

[57] European Convention for the Protection of Human Rights and Fundamental Freedoms, 4 November 1950, entry into force: 3 September 1953, E.T.S. 35.
[58] Emphasis added MSG.
[59] Protocol No. 12 to the Convention for the Protection of Human Rights and Fundamental Freedoms, 4 June 2000, entry into force: 1 April 2005, E.T.S. 177.
[60] Petrova 2006, p. 30.
[61] Preamble of Protocol No. 12 ECHR; D. Gomien, *Short guide to the European Convention on Human Rights,* Strasbourg: Council of Europe Publishing 2005, p. 151.

equality in accessing health care also implies equity as it takes into account the specific needs of certain individuals or groups in society in accessing health care. If a specific measure or treatment leads to unequal access to health care - whether direct or indirect - for which no justification can be found, discrimination arises. Direct as well as indirect discrimination fall under the denomination of the opposite to the right to equal access to health care, *i.e.* unequal access to health care. These violate the right to equal access to health care and are therefore prohibited under human rights law.

The definition of the right to equal access to health care used in the subsequent parts of the present study is: There is a right to equal access to health care that consists of both formal equality and substantive equality. If there is a case of unequal access to health care and that distinction cannot be justified, this amounts to discrimination, whether direct or indirect. However, if there is a justification for the difference in treatment, it cannot be considered a human rights violation.

For the concept of the justiciability of the right to equal access to health care the distinction between unjustified and justified unequal access to health care is vital. The human rights provisions on equal treatment and non-discrimination can be applied to the right to health care. As discrimination is a prohibited element of unequal access to health care, this could be subject to adjudication in a case on unequal access to health care. Accordingly, by virtue of a human rights provision prohibiting discrimination, the right to equal access to health care could be justiciable. The justiciability of the right to equal access to health care by virtue of the right to equal treatment and the prohibition of discrimination enshrined in several human rights provisions is discussed in the third part of this research together with what can be considered justified and unjustified differences with regard to the right to equal access to health care.

PART B

PRACTICE AND DISCUSSION OF THE JUSTICIABILITY OF ECONOMIC, SOCIAL AND CULTURAL RIGHTS

CHAPTER V
THE JUSTICIABILITY OF ECONOMIC, SOCIAL AND CULTURAL RIGHTS

1 INTRODUCTION

As set out in Chapter IV, the human right to equal access to health care is a right that consists of both formal and substantive equality. If there is a case concerning unequal access to health care for which no justification can be found, it amounts to discrimination, whether direct or indirect. The next and central question of the present study is whether the right to equal access to health care is justiciable. The definition of justiciability will be given in paragraph 2.

The right to equal access to health care is an economic, social and cultural right. In contrast to civil and political rights, the justiciability of these rights is subject to extensive debate.[1] Ever since the emergence of these rights, its justiciability has been a contentious issue.[2] A number of arguments have been raised against and in support of the justiciability of economic, social and cultural rights. These arguments will be set out in paragraph 3 and paragraph 4 respectively.

Not every human rights treaty based body entitled with adjudicating complaints of individuals or groups of individuals is entitled to deal with claims concerning economic, social and cultural rights. Nevertheless, the separation between economic, social and cultural rights on the one hand and civil and political rights on the other is not so strict in practice. Several human rights bodies dealt with elements of economic, social and cultural rights in adjudicating on complaints with regard to civil and political rights. As such, economic, social and cultural rights were 'read' into civil and political rights. The practice of these monitoring bodies will be set out in paragraph 5.

2 THE TERM JUSTICIABILITY DEFINED

The term 'justiciability' is widely used in the human rights discourse, especially in relation to the discussion about whether a legally binding economic, social and cultural right can be subject to review by a court of law or a quasi-judicial procedure.[3] It is generally understood to refer to whether a judicial or quasi-judicial

[1] Scheinin 2001, p. 29.
[2] Sellin 2009, p. 451.
[3] Leary 1995, p. 90; Scheinin 2005, p. 18; Coomans 2006, p. 4.

body deems the right concerned to be subject to judicial scrutiny.[4] The ECtHR is a judicial body. Examples of quasi-judicial bodies are the Committee, the HRCee, and the European Committee of Social Rights.

Within the context of justiciability, the term enforceability is also used and sometimes employed as a synonym for justiciability.[5] Arambulo (1999)[6] makes a distinction between these concepts. According to her, the term justiciability of human rights is related to whether a human right is open to interpretation by a judicial or quasi-judicial body and therefore whether a complaint concerning an alleged violation can be lodged with such a body. As such, it contributes to the further determination of the meaning of such a right and therefore forms part of the strategy for the implementation, realisation and protection of economic, social and cultural rights.[7] The term enforceability of a human right may have the same connotation but comprises a wider range or effect.[8] It does not necessarily only include a judgement on whether a human rights violation takes place. It additionally means that the decision of a judicial or quasi-judicial body regarding a specific human right can actually be executed and put into effect, for example by specific remedies. Different reparations could be granted as a result of such legal actions, such as monetary compensation for past pecuniary and non-pecuniary loss for aggrieved individuals.[9] Measures of a more preventive character include declarations or injunctions that invite or require positive governmental actions to enhance compliance in the future, *e.g.* by adapting the law.[10]

In the present study, only the justiciability of the right to equal access to health care is addressed as its main purpose is to assess how a complaint concerning unequal access to health care would be dealt with by judicial and quasi-judicial human rights bodies.

3 Arguments against the Justiciability of Economic, Social and Cultural Rights

The justiciability of economic, social and cultural rights is object of continuing debate ever since the emergence of such rights. There is a prevailing opinion that holds that economic, social and cultural rights are not justiciable.[11] A number of arguments have been used to deny the susceptibility of social, economic and

[4] Arambulo 1999, p. 55.
[5] Scheinin 2005, p. 18. 'The notion of 'justiciability' is widely used in the international human rights discourse, especially in the context of discussions on whether economic, social and cultural rights are capable of being enforced through judicial or quasi-judicial procedures', Courtis 2008, p. 6.
[6] Arambulo 2003, p. 57, 111-123.
[7] Arambulo 1999, p. 55.
[8] Arambulo 1999, p. 57.
[9] Clements and Simmons 2008, p. 425.
[10] Roach 2008, p. 46; Courtis 2008, p. 8.
[11] Toebes 1999a, p. 169.

cultural rights to be subject of review by a judicial or quasi-judicial body.[12] These arguments are closely related to the simplified traditional dichotomy between civil and political rights, and economic, social and cultural rights.[13] The opponents proclaim that economic, social and cultural rights are vague and imprecisely determined, which makes it impossible to adequately determine their content and resulting State obligations, resulting in impeding their justiciability.[14] Moreover, they state that economic, social and cultural rights are positive in nature and require active measures and government programmes which are expensive and depend only on the available economic resources of the concerning State.[15] This point also sheds some light on another argument. The argument that encloses the concerns of financial implications for the State in case of justiciability of economic, social and cultural rights is also closely related to arguments of legitimacy of judicial and quasi-judicial bodies.[16] The argument of legitimacy of these bodies suggests that adjudication of economic, social and cultural rights is anti-democratic as it intrudes fundamentally into an area where the democratic process ought to prevail.[17] Adjudicating between scarce and conflicting resources requires choices to be made which, if made through the judicial process, will influence the distribution of these resources and will therefore possibly influence what society looks like.[18] It is argued that it affects the heart of the political process, which alone can properly handle such questions.[19] Consequently, in case of judgements on matters of social policy and resource allocation, the role of the elected representatives of the people is circumvented, which would imply a violation of the principle of separation of powers.[20]

Whether judicial or quasi-judicial bodies have the capacity to deal with economic, social and cultural rights is another point that raises various issues. These bodies, it is said, lack the competence, in particular in terms of information and expertise, to identify and adjudicate on economic, social and cultural rights.[21] Their lack of knowledge of social policy issues and lack of expertise in this field, including complex technical understanding of certain matters, would render them unsuitable.[22] Moreover, the criticism is that judicial and quasi-judicial bodies are

[12] Leary 1995, p. 90; Langford 2008, p. 30.
[13] Sellin 2009, p. 451.
[14] Courtis 2008, p. 15. See for history traditional dichotomy: Scott 1989, p. 769-878.
[15] Leary 1995, p. 91.
[16] Arambulo 2003, p. 114.; Langford 2008, p. 31.
[17] Neier 2006, p. 1; Langford 2008, p. 31; Courtis 2008, p. 83.
[18] Steiner and Alston 2000, p. 279.
[19] Neier 2006, p. 2.
[20] Langford 2008, p. 31. Separation of powers: in relation to law, the legislature makes it, the executive implements it and the judiciary applies it, interprets it and particularises it.
[21] Courtis 2008, p. 89; Langford 2008, p. 35.
[22] Courtis 2008, p. 90.

not able to ensure that judgements comprising orders at governments are adjudicated on. This in its turn could undermine the legitimacy of the judiciary.[23]

4 ARGUMENTS IN SUPPORT OF THE JUSTICIABILITY OF ECONOMIC, SOCIAL AND CULTURAL RIGHTS

In contrast to these objections to the justiciability of economic, social and cultural rights, there is a long-standing movement of those advocating it. They have different arguments that address the criticism of the ability to claim a legal remedy before a judicial or quasi-judicial body. These arguments have on the one hand contributed to several developments, and are on the other hand influenced by the same developments and growing jurisprudence in this field, as will be set out in Chapters VIII, IX, and X.[24]

In reaction to the claim that economic, social and cultural rights are inherently too abstract and imprecisely determined resulting in the impossibility of adjudication, the proponents state that such an argument is not convincing. The broad definition is not a problem exclusively related to economic, social and cultural rights.[25] However, the fact that civil and political rights are also expressed in broad terms has never led to the conclusion that these rights should be denied justiciability.[26] Moreover, the conceptual traditional dichotomy that is used as an argument *contra* justiciability of economic, social and cultural rights is identified as oversimplified. It is perceived as inaccurate and conceptually problematic to state that civil and political rights impose solely negative duties, *i.e.* protecting personal freedoms, and that economic, social and cultural rights demand only positive duties.[27] In contrast, it is argued that all human rights entail some positive and some negative State obligations.[28]

As set out in Chapter III, paragraph 3, several scholars proposed a typology of State obligations to overcome the traditional dichotomy. The tripartite typology of the obligation to respect, the obligation to protect, and the obligation to fulfil is the best known. This typology is also adopted in several human rights documents.[29] The use of such an analytical tool illustrates that every human right requires both active actions from the State and an abstention of the State from interfering.[30]

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[23] Courtis 2008, p. 91.
[24] Langford 2008, p. 29.
[25] Courtis 2008, p. 15.
[26] Courtis 2008, p. 15.
[27] Courtis 2008, p. 10; Langford 2008, p. 30.
[28] Henrard 2009, p. 374.
[29] *E.g.* E/C.12/1995/5, General Comment 12 (1995), 12 May 1999, *The right to food*; E/C.12/2002/11, General Comment 15 (2002), 20 January 2003, *The right to water*.
[30] Koch 2005, p. 85.

Other scholars adopt the notion of the interdependence and indivisibility of human rights.[31] It contests the hierarchies between human rights and presumes the interconnectedness, interdependence and holism within the global paradigm of human rights. It goes to the heart of the concept of universal human rights and proclaims that these rights apply equally, without exception to all human beings.[32]

The notion of indivisibility and interdependence entails that social means are often necessary for the fulfillment of civil and political rights and *vice versa*. For example, medical treatment is sometimes necessary for the observance of the prohibition of inhumane and degrading treatment, and housing contributes to the enjoyment of family life.[33] Therefore, the situation where every human being enjoys civil and political freedoms can only be achieved if conditions are created whereby everyone may enjoy economic, social and cultural rights as well.[34] Koch (2003), which is one of the advocates of the indivisibility of human rights, states that 'the principle of indivisibility is in itself an argument for the justiciability of economic, social and cultural rights'; 'to put economic, social and cultural rights beyond the reach of the courts is […] incompatible with the principle of indivisibility'.[35]

The criticism regarding the traditional dichotomy of human rights and the notion of indivisibility is also related to the argument that the two sets of human rights are substantively different. The argument that positive rights include social policy and resource allocation and should therefore not be left to adjudication is considered weak. The proponents of the justiciability of economic, social and cultural rights note that all human rights have, to a smaller or larger extent, budgetary implications. As Langford (2008) puts it: although it could be 'possible to contend that economic, social and cultural rights require greater public investment than civil and political rights […] it is a matter of degree rather than substance'.[36]

The nature and degree of human rights implications for State obligations and its accessory financial burden vary according to context, not just to their positive or negative nature.[37] Bearing this in mind, the proponents of the justiciability of economic, social and cultural rights argue that the fact that adjudication could result in budgetary implications has never prevented the justiciability of civil and political rights.[38] Therefore, 'the mere fact that a decision has policy implications does not exclude it entirely from the judicial sphere. Arguing that the judiciary should accept any administrative decision just because

[31] Alternative terms are interrelatedness and interconnectedness which allude to the same principle, Arambulo 1999, p. 100.
[32] Otto 2001, p. 54, 66.
[33] Koch 2003, p. 16.
[34] Arambulo 2003, p. 117.
[35] Koch 2003, p. 4, 9.
[36] Langford 2008, p. 31.
[37] Langford 2008, p. 30.
[38] Courtis 2008, p. 84.

the assessment is difficult and because it has budgetary implications would weaken the human rights protection in an unacceptable and unnecessary way.'[39]

This brings us to the rejoinder of the argument of legitimacy of adjudicatory bodies *contra* the justiciability of economic, social and cultural rights. Firstly, in reply to the argument that adjudication of economic, social and cultural rights is undemocratic, it is stated that social rights are seen as a prerequisite for democracy. Furthermore, as governments and majoritarian democracies do not always succeed in ensuring and protecting economic, social and cultural rights, the justiciability thereof is considered necessary to protect and ensure these rights.[40] Secondly, in reply to the argument that the justiciability of economic, social and cultural rights could constitute a violation of the principle of separation of powers it is stated that 'the idea that courts will be 'making up' policy is very much a caricatured version of a reasonable approach of a court to these issues'.[41] Courts, and the same hold for quasi-judicial bodies, do not make law or policy, but *review* it, *i.e.* interpret it, against a set of criteria, namely human rights law.[42] And although judges undeniably make choices that could influence policy directly or indirectly, there is no reason to assume that, when scrutinising a case concerning economic, social and cultural rights the judiciary would not be aware of its position and the fact that resources are limited.[43] It is even so that in practice, judicial or quasi-judicial bodies adopt a restrained position in adjudicating on matters considered to be the domain of political decision-making, which implies reviewing budgetary allocations, in the absence of a firm legal basis to do so. In these cases the margin of appreciation granted to the political bodies tends to be broader.[44]

The final argument contra the adjudication of economic, social and cultural rights as cited in the previous paragraph, questions the competency of judicial bodies to deal with such rights. The main reaction to this argument by the proponents of the justiciability of economic, social and cultural rights relates to the fact that the objections based on this perceived incompetence are not exclusively linked to economic, social and cultural rights. For example, although complex cases can pose problems if it comes down to the justiciability of certain rights, it is not the nature of the rights involved that determines whether proceedings at a adjudicatory body are complex. This rather depends on other factors, such as the number of actors involved, the scope of the violation, and the character of the remedies necessary.[45] Also, the argument of the lack of adequate guarantees regarding the

[39] Koch 2003, p. 35.
[40] Langford 2008, p. 32, 33.
[41] Langford 2008, p. 33.
[42] Langford 2008, p. 34.
[43] Courtis 2008, p. 75; Sellin 2009, p. 453.
[44] Courtis 2008, p. 85.
[45] Courtis 2008, p. 89-90.

enforcement of judicial orders and the corresponding judicial power would apply to any decision regarding State obligations in relation to human rights.[46]

5 THE JUSTICIABILITY OF ECONOMIC, SOCIAL AND CULTURAL RIGHTS IN PRACTICE

5.1 Introduction

It is common knowledge that in practice it is much more difficult for a violation of an economic, social or cultural right to be subject of review by a court of law or a quasi-judicial procedure than it is for a civil or political right. For many years, the inferior status of economic, social and cultural rights has had a negative impact on whether a violated economic, social or cultural right could be subject to review by a judicial or quasi-judicial body. However, over the last two decades several developments at international and regional level have strengthened the justiciability of economic, social and cultural rights.[47] These will be set out in this paragraph.

5.2 The Justiciability of Economic, Social and Cultural Rights at International Human Rights Level

5.2.1 The ICESCR and the Committee on Economic, Social and Cultural Rights

As was briefly mentioned in Chapter II, paragraph 2, the monitoring body of the ICESCR is the Committee. In addition to its entitlement to issue General Comments to clarify the nature and content of the rights enshrined in the ICESCR, it monitors the degree of achievement of these rights by the Signatory States. This is *inter alia* done on the basis of State reports periodically submitted to the Committee on the standard of achievement and the progress made in achieving the observance of the economic, social and cultural rights recognized in the ICESCR. After extensive investigation, the Committee provides an opinion on the degree of achievement in its Concluding Observations. Concluding Observations include, *inter alia* principle issues of concern, which may constitute violations of the rights of the Covenant. In addition, the Committee also puts forward proposals and makes specific recommendations in relation to these issues of concern. These Concluding Observations have been analysed in Chapter II in order to define what elements are part of the right to health care.

By means of these State reports, the Concluding Observations, and the recommendations made by the Committee, an authoritative interpretation of both the treaty provisions and the compliance of the State is given.[48] Consequently, the

[46] Courtis 2008, p. 91.
[47] Coomans 2006, p. 2.
[48] Toebes 1999a, p. 170; Maes 2003, p. 313, 314.

Committee has evolved into a quasi-judicial body.[49] However, the Committee is still deprived of a complaints mechanism. Although the OP ICESCR was finally adopted by the end of 2008, it did not yet enter into force.

The main objective of the OP ICESCR is the establishment of a new quasi-judicial function for the Committee to receive individual complaints for consideration, a function that has to further strengthen the notion that economic, social and cultural rights are justiciable.[50] At UN level, complaints on the enjoyment of rights under the various Conventions are determined as Communications, although there is no difference between a complaint and a communication.[51] In the present study, the term communication is used for the complaints procedures at UN level.

The adoption of the OP ICESCR has been a lengthy process which started in 1990 with formal discussions by the Committee. Finally in 2007 and 2008 the final drafting took place by the open-ended working group and culminated in its adoption by the General Assembly on 10 December 2008. The OP ICESCR opened for signature on 24 September 2009, on which occasion 20 States signed it.[52] As of 10 September 2011 36 States have signed the OP ICESCR and only 3 States, Ecuador, Mongolia and Spain, have ratified it. The OP ICESCR therefore did not yet enter into force as, in accordance with Article 18 OP ICESCR, the protocol shall only enter into force three months after the date of the tenth ratification or accession.

As there is no individual complaints mechanism at force under which complaints can be lodged with the Committee, the ICESCR and its OP ICESCR are not addressed in the Chapters on the justiciability of the right to health care and the justiciability of the right to equal access to health care. Therefore, a brief overview of the OP ICESCR is provided at this point of the present study.

States that are or become party to the OP ICESCR thereby recognise the authority of the Committee to adjudicate communications from individuals and groups of individuals that are subject to their jurisdiction and which claim to be the victim of a violation of their rights laid down by the ICESCR. Individual communications under the OP ICESCR are admissible for adjudication if certain criteria are met. These include *inter alia* the requirement that domestic remedies have been exhausted, the matter has not already been examined by the Committee or has been or is being examined under another procedure of international

[49] Coomans 1997, p. 567.
[50] Wouters and Vidal 2009, p. 12; Sellin 2009, p. 453. In addition, the OP ICESCR also provides for an optional inquiry procedure independently initiated and conducted by the Committee itself and an optional procedure of inter-State communications. Under this procedure of inter-State communications, a State may at any time claim that another State is not fulfilling its obligations under the ICESCR, in case both States have declared to recognise this procedure and the subsequent competence of the Committee, Articles 10, 11, 12 OP ICESCR.
[51] Tomuschat 2007a, p. 193.
[52] Tomuschat 2007a, p. 197-198; Langford and King 2008, p. 514-516; Vandenbogaerde and Vandenhole 2010, p. 208.

settlement or investigation.[53] Moreover, the communication, whether submitted directly by the complainant or by a representative on behalf of the complainant, should clarify that the complainant has suffered a clear disadvantage, unless the violation concerned raises serious issue of general concern.[54]

As set forth in the OP ICESCR, when examining individual communications the Committee will consider the reasonableness of the steps taken by the Member State under consideration in accordance with substantive rights of the ICESCR. Furthermore, the OP elucidates that in doing so, the Committee 'shall bear in mind that the State Party may adopt a range of possible policy measures for the implementation of the rights set forth in the Covenant'.[55] Although the term "margin of appreciation" is not explicitly included in the text of the OP, the reference to "a range of possible policy measures" denotes a margin of appreciation for States in the field of economic, social and cultural rights.[56]

In addition to its ability to construe concrete legal obligations by means of General Comments and Concluding Observations, the OP ICESCR offers a perspective on a more fundamental and firmly rooted protection of economic, social and cultural rights.[57] Navanethem Pillay, UN High Commissioner for Human Rights, stated that with the adoption of the OP ICESCR the General Assembly 'would close a yawning gap in human rights protection, marking a milestone in the history of the universal human rights system'.[58] Nevertheless, the final OP is also subject to criticism. The drafting process was highly influenced by political considerations and ideological prejudices. Although considered as normal in such processes due the resistance against the justiciability of economic, social and cultural rights, the criticism runs that this has resulted in sometimes weak

[53] Article 3 OP ICESCR; Exemptions apply to the admissibility of the communication as under the OP ICESCR; local remedies need not be exhausted in case the application of such remedies is unreasonably long, the communication need not be submitted within one year after that exhaustion in cases where the author can demonstrate that it had not been possible to submit the communication within that time limit, a communication on facts that occurred prior to the entry into force of the OP in the State concerned can be submitted in case those facts continued after the date of the entering into force, seer Article 3 OP ICESCR.

[54] Articles 2 and 4 OP ICESCR.

[55] Article 8, paragraph 4 OP ICESCR.

[56] Vandenbogaerde and Vandenhole 2010, p. 223, 225, 226.

[57] Langford and King 2008, p. 514.

[58] *General Assembly marks 60 years of universal human rights declaration by adopting its own, pledging to enhance dialogue among peoples*, General Assembly GA/10795, press release 10 December 2008.

provisions.[59] Moreover, as a result of this resistance, a low number of signatures or ratifications could lead to an unsuccessful implementation of this new instrument.[60]

As the OP ICESCR provides for procedures that allow for monitoring *ex post*, it will take some time to evaluate the impact and effectiveness of the OP ICESCR with regard to adjudication of human rights violations under the ICESCR, especially since it did not enter into force yet.[61]

5.2.2 The ICCPR and the Human Rights Committee

The HRCee also issues General Comments and receives periodical State reports for examination of the compliance of Member States with their obligations under the sister treaty of the ICESCR: the ICCPR. Moreover, since 1976 the Optional Protocol to the ICCPR (OP ICCPR) entered into force which it possible to lodge an individual communication with the HRCee concerning alleged violations of the rights set forth by the ICCPR. [62]

The individual complaints procedure under the OP ICCPR is set out in the present study as in addition to its adjudication on civil and political rights, the HRCee already in 1987 considered as admissible a case concerning economic, social and cultural rights.

The possibility of submitting individual communications to the HRCee in case of a violation was initially only directed at rights enunciated in the ICCPR.[63] However, in 1987 the HRCee ruled on three cases from the Netherlands, in which it dealt with social security legislation that discriminated on the basis of sex and marital status.[64] In these cases, the HRCee provided that the application of the principle of non-discrimination contained in Article 26 ICCPR is not limited to those rights which are provided for by the ICCPR and hence also applies to discrimination in the field of economic, social and cultural rights.[65] This was later confirmed in General Comment 18 on non-discrimination.[66] This freestanding non-

[59] Vandenbogaerde and Vandenhole 2010, p. 237. The criticism that the wordings of the OP are weak, springs from the fact that, *inter alia*, two out of the three mechanisms established in the OP are simply optional, the collective complaints procedure was deleted from one of the drafts, and the stipulation that only those that can demonstrate to suffer a clear disadvantage from the alleged violation can lodge a communication, which excludes cases that are also important to consider: Vandenbogaerde and Vandenhole 2010, p. 233, 234, 235.
[60] Vandenbogaerde and Vandenhole 2010, p. 231.
[61] Sellin 2009, p. 453; Vandenbogaerde and Vandenhole 2010, p. 231.
[62] Optional Protocol to the International Covenant on Civil and Political Rights adopted by the General Assembly Resolution 2200A (XXI), 21 U.N. GA OR Supp. (No.16), UN Doc. A/63161966, 999 U.N.T.S. 302, 16 December 1966.
[63] Preamble OP ICCPR.
[64] Communication No. 172/1984, *S.W.M. Broeks* v. *the Netherlands*; Communication No. 182/1984, *F.H. Zwaan-de Vries* v. *the Netherlands*; Communication No. 180/1984, *L.G. Danning* v. *the Netherlands*.
[65] Scheinin 2008, p. 541, 542.
[66] A/45/40, General Comment No. 18 (1989), 10 November 1989, *Non-discrimination*, para. 12.

discrimination provision enshrined in Article 26 ICCPR can be of great importance for the justiciability of the right to equal access to health care and will be further discussed in Chapter X of the present study.

The HRCee also contributed to the justiciability of economic, social and cultural rights in its communications on complaints related to other provisions of the ICCPR. These provisions do not have an autonomous application, such as Article 26 ICCPR. Therefore, when referring to justiciability of economic, social and cultural rights under the substantive, non-autonomous provisions of the ICCPR, it is more appropriate to refer to adjudication of *elements* or *dimensions* of economic, social and cultural rights under the provisions of the ICCPR. The same holds for the adjudication of these dimensions by the ECtHR as the provisions enshrined in the ECHR have no autonomous meaning in relation to rights provided in other treaties than the ECHR.

The HRCee articulated and adjudicated on various dimensions of economic, social and cultural rights under other provisions of the ICCPR; Article 6 on the right to life, Article 7 on the prohibition against torture and other inhumane treatment, Article 10 on the treatment of detainees, and Article 17 on the right to privacy, family and home. In addition to the right to social security, these Articles were applied to issues concerning the right to work, the right to form and join trade unions including the right to strike, the right to housing, the right to property, the right to culture, the right to self-determination, and, not least, the right to health, including the right to medical treatment and the right to reproductive health care.[67] By this, the HRCee provided for ample evidence for its view that human rights can be interdependent and that there is no strict division between different categories of human rights.[68]

5.2.3 The CEDAWCee, CERDCee, CRCee, and the CRPDCee

Just like the Committee and the HRCee, the Committee on the Elimination of Discrimination Against Women (CEDAWCee), the Committee on the Elimination of Racial Discrimination (CERDCee), the Commitee on the Rights of the Child (CRCCee), and the Committee on the Rights of Persons with Disabilities (CRPDCee) are assigned with the supervision of compliance of Member States with their obligations under the corresponding Conventions. These committees all receive periodical State reports and decree Concluding Observations on the basis of their examination of these State reports. Moreover, the CERDCee, the CEDAWCee and the CRPDCee can receive individual communications on non-compliance of the Signatory States with the CERD, the CEDAW and the CRPD.[69] The fact that

[67] For an extensive discussion on the cases that dealt with these Articles in relation to economic, social and cultural rights: Scheinin 2008, p. 540-552.
[68] Scheinin 2008, p. 540.
[69] Article 14 CERD; Optional Protocol to the International Covenant on the Elimination of Discrimination against Women, adopted by General Assembly Resolution A/RES/54/4, 15 October

CRC lacks a complaints procedure is considered to significantly weaken the protection of children's economic, social, and cultural rights.[70]

The CERD reviewed several cases on issues such as labour rights, and the rights to health, education, language or culture.[71] The CEDAWCee hitherto received only a few cases, most of which concerned equality rights in social, economic, and cultural rights issues, such as the rights to work, housing, or education.[72] The CRPDCee has thus far not dealt with individual complaints.

5.3 The Justiciability of Economic, Social and Cultural Rights at Regional Human Rights Level

5.3.1 European Committee of Social Rights

The principal body assigned with the supervision of the compliance of States with economic, social and cultural rights at the level of the CoE is the European Committee of Social Rights. This task is *inter alia* fulfilled by the examination of periodic reports submitted by the Member States of the ESC and the RESC. Several of the so-called Conclusions of the European Committee of Social Rights on these State reports have been discussed in Chapter II and Chapter III.

In addition to the system of periodic reporting, the Council of Europe adopted an Additional Protocol to the ESC (AP ESC) providing for a system of collective complaints.[73] This system entered into force in 1998. According to the Explanatory Report of the AP ESC, the introduction of this procedure was designed to increase the efficiency of the supervisory machinery based solely on the submission of State reports and is to be seen as a complement to the examination of these reports.[74]

Under the collective complaints procedure, not individuals but carefully defined organisations are entitled to raise claims alleging non-compliance with the responsibilities of States that are party to the AP ESC. These organisations, defined as the complainant organisation, include international organisations of employers and trade unions, other international non-governmental organisations having consultative status with the Council of Europe, and representative national organisations of employers and trade unions within the jurisdiction of the specific State.[75] The ability of these organisations to initiate collective complaints has

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1999; Optional Protocol to the International Covenant on the Rights of Persons with Disabilities, adopted by General Assembly Resolution A/RES/61/106, 13 December 2006.

[70] Van Bueren 2008, p. 527.

[71] For an elaborate overview, see: Prouvez 2008, p. 517-539.

[72] See for an outline on several of these communications: Farha 2008, p. 564, 565.

[73] Additional Protocol to the European Social Charter Providing for a System of Collective Complaints, adopted 9 November 1995, C.E.T.S. 158.

[74] AP ESC, paragraph 2.

[75] Article 1 AP ESC; In addition, Article 2 of the AP ESC provides that States may also recognise the right of any other representative national non-governmental organisation within its jurisdiction, which

produced a new body of case law.[76] Since the establishment of the collective complaints procedure, 53 were dealt with by the European Committee of Social Rights on their merits.[77]

For the complaints to be considered admissible as a collective complaint, the complaint has to be lodged in writing, has to be signed by a person entitled to represent the complainant organisation, and the complaint has to relate to a provision of the ESC or RESC that is accepted by the State against which the complaint is lodged.[78] There is no victim requirement for the complaints procedure, no requirement to exhaust domestic remedies, nor a time limit.[79]

In case a claim is found admissible, the European Committee for Social Rights proceeds to examine the complaint. Its decision is transmitted in a report to the Committee of Ministers. On the basis of the report, the Committee of Ministers shall adopt a Resolution.[80] In addition, in case the European Committee for Social Rights has found an unsatisfactory application of the ESC or RESC, the Committee of Ministers 'shall adopt, by a majority of two-third of those voting, a recommendation addressed to the Contracting Party concerned'.[81] However, so far the Committee of Ministers has only once been willing to give support to such findings of the European Committee of Social Rights by addressing a recommendation to the State concerned.[82]

The manner of institution of the adoption of recommendations is considered a weakness of the collective complaints system under the AP ESC.[83] This weakness lies in the role of the Committee of Ministers in the collective complaints system. It functions in a procedure where the European Committee of Social Rights makes legal determinations and the Committee of Ministers makes political decisions as to the follow-up of these judgements.[84] Moreover, a State need not have recognised the collective complaints procedure of the AP to the ESC for it

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has particular competence in the matters governed by the ESC and RESC, to lodge complaints against it.

[76] Bell 2006, p. 13.

[77] Up until 12 August 2011; 5 cases were declared inadmissible, 4 were declared admissible but had not yet been decided on their merits and 6 were only registered at the Secretariat. See: http://www.coe.int/t/dghl/monitoring/socialcharter/Complaints/Complaints_en.asp

[78] Article 4 AP ESC; By the end of August 2010, 56 complaints had been registered of which 4 have been declared inadmissible. See: *Collective complaint list and state of procedure* of 6 July 2010.

[79] Cullen 2009, p. 64.

[80] The Committee of Ministers shall adopt a Resolution by a majority of those voting after consideration of the decision of the European Committee for Social Rights. Article 9, paragraph 1 AP ESC.

[81] Article 9, paragraph 1 AP ESC. Otherwise the Committee of Ministers shall adopt a Resolution by a majority of those voting after consideration of the decision of the European Committee for Social Rights, see Article 9, paragraph 1 ESC.

[82] RecChs(2001)1/ 31 January 2001on Complaint No. 6/1999 *Syndicat national des Professions du tourisme* v. *France*.

[83] Khaliq and Churchill 2008, p. 432.

[84] Cullen 2009, p. 67.

to be entitled to vote on a recommendation on the decision of the European Committee of Social Rights. Even more noteworthy, the State against which a complaint is made cannot only be part of the considerations on the report sent by the European Committee for Social Rights, but can also vote on its decision![85]

In relation to this institution of the adoption of recommendations the European Committee of Social Rights itself made a strong statement of its authority. It stated that 'it is clear from the wording of the Protocol providing for a system of collective complaints that only the European Committee of Social Rights can determine whether or not a situation is in conformity with the Charter. This applies to any treaty establishing a judicial or quasi-judicial body to assess contracting parties' compliance with that treaty. The explanatory report to the Protocol explicitly states that the Committee of Ministers cannot reverse the legal assessment made by the Committee of independent experts [*i.e.* the European Committee for Social Rights], but may only decide whether or not to additionally make a recommendation to the State concerned.'[86] 'Admittedly the Committee of Ministers, when it decides to use this power may take account of any social and economic policy considerations in its reasoning, but it may not question the legal assessment.'[87]

One cannot ignore the fact that the European Committee of Social Rights has developed considerable jurisprudence on a broad array of economic, social and cultural rights, which contributes to the justiciability of these rights.[88] As such, the European Committee of Social Rights has established itself as a body that provides for authoritative legal interpretations of economic, social and cultural rights, both in the reporting process and in the complaints procedure.

5.3.2 European Court of Human Rights

The ECtHR is the only judicial human rights body that can make legally binding judgements. Within the framework of the CoE its task is to ensure the observance of the engagements undertaken by the Signatory States of the ECHR. Any person, non-governmental organisation or group of individuals claiming to be the victim of a violation of the rights set forth by the ECHR by one of the State parties of ECHR is entitled to lodge a complaint with the ECtHR.[89] The ECtHR may only deal with a complaint if all domestic remedies have been exhausted, and if the same matter has

[85] Maes 2003, p. 310. Other weaknesses of this collective complaint system under the AP ESC are the fact that individual complaints are excluded and that the European Committee for Social Rights has no power to order remedies, Cullen 2009, p. 66.
[86] Complaint No. 16/2003, *Confédération Française de l'Encadrement (CFE CGC)* v. *France*, para. 20.
[87] Complaint No. 16/2003, *Confédération Française de l'Encadrement (CFE CGC)* v. *France*, para. 21.
[88] Maes 2003, p. 310; Cullen 2009, p. 92. The European Committee for Social Rights found autonomous violations in relation to the rights laid down in the following Articles, but also in relation to Article E on non-discrimination: 1, 2, 3, 4, 5, 6, 7, 11, 12, 13, 15, 16, 17, 19, 21, 22, and 30.
[89] Article 34 ECHR.

not already been examined by it nor has been submitted to another procedure of international investigation.[90] Moreover, the claimant has to prove being a victim of the alleged violation.[91] If the judicial decision is in favor of the applicant, the Court may award compensation and thereby enforce the rights enshrined in the ECHR.[92]

Already in 1979 the ECtHR cautiously opened the door to the approach that an interpretation of the ECtHR may extend into the sphere of economic, social and cultural rights.[93] In the 1979 case of *Airey* v. *Ireland* the ECtHR recognised that there is no watertight division between civil and political rights on the one hand and social, economic and cultural rights on the other.[94] It held that 'the mere fact that an interpretation of the Convention may extend into the sphere of social and economic rights should not be a decisive factor against such an interpretation'.[95]

By showing its willingness to go beyond the wording of the ECHR, the ECtHR has laid the foundations for its jurisprudence on economic, social and cultural rights *via* the rights laid down in the ECHR.[96] Consequently, over the past three decades, individuals and groups of individuals have increasingly often lodged complaints with the ECtHR to test whether governments and public authorities could be held accountable for alleged violations of economic, social and cultural rights within the framework of the ECHR. The ECtHR has not escaped this trend and over time, the ECtHR has addressed fundamental questions concerning the responsibilities of States in relation to elements of economic, social and cultural rights.[97] It mainly did so under Article 3 (prohibition of torture and degrading treatment), Article 8 (right to respect for private and family life), Article 6 (right to a fair trial), and in combination of these rights with Article 14 (prohibition of discrimination), and Article 1 of Protocol No. 1.[98]

Two very general and overlapping categories within the jurisprudence of the ECtHR on the review of dimensions of economic, social and cultural rights can be discerned; infringements which can be attributed directly or indirectly to State action and cases that require State compliance by way of positive obligations.[99] The first category applies to cases in which a State action directly causes such violations, in case a legitimate State action may constitute a disproportionate or unintended negative effect for the victim, or in case a State fails to uphold a recognised economic, social and cultural right in their legal system resulting in

[90] Article 35 ECHR.
[91] Article 35 ECHR.
[92] Clements and Simmons 2008, p. 411.
[93] Langford 2008, p. 6.
[94] *Airey* v. *Ireland*, Application No. 6289/73, 9 October 1979.
[95] *Airey* v. *Ireland*, Application No. 6289/73, A. 032, 9 October 1979, para. 26.
[96] Koch 2003, p. 25; Palmer 2009, p. 398.
[97] Palmer 2009, p. 408.
[98] Protocol to the Convention for the Protection of Human Rights and Fundamental Freedoms as amended by Protocol No. 11, 20 March 1952, E.T.S. 155. Further on several cases of the ECtHR will be discussed, including Protocol No. 12 ECHR.
[99] Clements and Simmons 2008, p. 410.

serious consequences for the complainant.[100] In case of the second category, the State in question has not taken adequate positive measures following from its positive obligations to ensure human rights. This implies that it did not safeguard the complainant from violatons of those rights by its proper agents, nor from acts committed by private persons or entities that impair the enjoyment of Covenant rights.

The fact that the ECtHR takes into account dimensions of economic, social and cultural rights is of great importance for the subject of the present study, *i.e.* the justiciability of the right to equal access to health care. This is mainly explained by the fact that the ECtHR is the only human rights body that can make legally binding rulings in general and on elements of economic, social and cultural rights *in concreto*. Moreover, in contrast to the complaints system at present under the AP ESC, the complaints procedure at the ECtHR is an individual complaints mechanism.

Nevertheless, although the ECtHR did reject the idea of a separation thesis in relation to civil and political rights on the one hand and economic, social and cultural rights on the other and a line of jurisprudence of the Court on cases that cover elements of economic, social and cultural rights can be discerned, the ECtHR is reluctant to determine a liability of States for breach in relation to these rights. Generally, in determining the applicability of the substantive provision to elements of economic, social and cultural rights in the case at issue, the ECtHR adopts a restrained position and consequently a wide margin of appreciation is granted to the respondent State.[101] Especially in relation to obligations that concern questions of the distribution of scarce resources, which is normally more the case with elements of economic, social and cultural rights than with civil and political rights, the ECtHR' tends to defer to the expertise of legislatures and individual governments.[102]

6 CONCLUSIONS

Justiciability of a human right means that it is open to interpretation by a judicial or quasi-judicial body, and therefore whether a complaint concerning an alleged violation can be lodged with such a body. In contrast to civil and political rights, the justiciability of economic, social and cultural rights is subjected to extensive debate. A number of arguments have been raised both against and in support of the justiciability of economic, social and cultural rights. The main arguments against the justiciability of economic, social and cultural rights are the legal nature and vague and imprecise determination of economic, social and cultural rights, and the legitimacy of adjudicators and the capacity of judicial bodies in relation to such

[100] Clements and Simmons 2008, p. 412.
[101] Maes 2003, p. 154.
[102] Clements and Simmons 2008, p. 409, 426; Palmer 2009, p. 404.

rights. In contrast, those advocating the justiciability of economic, social and cultural rights claim that the idea that these rights are non-justiciable is seriously misguided. They reject the idea of the categorisation of human rights in civil and political rights on the one hand and economic, social and cultural rights on the other and argue that adjudication is desirable and already put into practice.

The justiciability of economic, social and cultural rights by judicial or quasi-judicial bodies is possible and has been evolving over the last decades. Therefore, each and every case in which economic, social and cultural rights are used as a basis for review by such bodies is advancement in its realisation and adduces evidence in support of the justiciability of economic, social and cultural rights.

At international human rights level, both the Committee and the HRCee receive periodical State reports for examination on the compliance of Member States with their obligations under the ICESCR and the ICCPR respectively. Moreover, the HRCee contributes to the justiciability of economic, social and cultural rights in its communications. The freestanding non-discrimination provision enshrined in Article 26 ICCPR is designated to apply directly to other rights than those provided by the ICCPR and hence applies also to cases of the HRCee on economic, social and cultural rights. Moreover, the HRCee articulated and adjudicated on several elements of economic, social and cultural rights under the substantive provisions of the ICCPR.

At regional human rights level, the European Committee of Social Rights is assigned with the supervision of the compliance of States with economic, social and cultural rights. This task is *inter alia* fulfilled by the examination of periodic reports submitted by the Member States of the ESC and the RESC and a complaints procedure. This complaints procedure is characterised by a collective complaints system. The ECtHR, the only judicial human rights body that can make legally binding judgements, also contributes to the justiciability of economic, social and cultural rights. In its case law it recognised that there is no watertight division between these rights on the one hand and civil and political rights on the other. Over time, just like the HRCee, it has addressed fundamental questions concerning the responsibilities of States in relation to elements of economic, social and cultural rights.

CHAPTER VI
THE JUSTICIABILITY OF THE RIGHT TO HEALTH CARE

1 INTRODUCTION

From the previous Chapter it can be concluded that it is artificial to hold on to the non-justiciability of economic, social and cultural rights. The right to health care is an economic, social and cultural right. This Chapter shall set out how the human right to health care has hitherto been subject of judicial review.

Paragraph 2 will deal with the justiciability of the right to health care at international human rights level. It will set out how the various quasi-judicial UN treaty based bodies reviewed alleged violations of the right to health care and of elements thereof. The OP ICESCR has not yet entered into force and, no other complaints procedure has been introduced either. Therefore, the justiciability of the right to health care by the Committee will not betaken into account in this part of the present study.

Paragraph 3 will provide an overview of the justiciability of the right to health care at regional human rights level. At this level, the European Committee of Social Rights is the treaty based body which is assigned the supervision of the compliance of States with economic, social and cultural rights. Therefore, the supervision of the compliance of States with the right to health care under the collective complaints procedure of the European Committee of Social Rights will first be set out. Subsequently, the manner in which the ECtHR – the only judicial human rights body that can make legally binding judgements – addresses fundamental questions concerning the responsibilities of States in relation to elements of the right to health care will be discussed.

It should be noted that this Chapter by no means presents an exhaustive overview of the cases in which the right to health care or elements of the right to health care have been subject to review.

2 THE JUSTICIABILITY OF THE RIGHT TO HEALTH CARE AT INTERNATIONAL HUMAN RIGHTS LEVEL: REVIEW BY THE UN TREATY BASED BODIES

The various UN treaty based bodies receive periodical State reports for the examination of the compliance with the conventions by the Signatory States. In addition, as set out in Chapter V, paragraph 5, some of these bodies have the right to consider individual communications under the various conventions. These are the HRCee, the CERDCee, the CEDAWCee, and the CRPDCee. The CRCCee and the

Committee have no possibility to consider communications. The CRC lacks a complaints procedure, and the Optional Protocol to the ICESCR has not yet entered into force as hitherto only 3 States have ratified it. The CERDCee has not dealt with topics related to the access to health care in its communications so far, and under the Optional Protocol to the Convention on the Rights of Persons with Disabilities no complaints have yet been dealt with.

The CEDAWCee has not reviewed many cases on the right to health care. It did however deal with one case, *Ms. A.S.* v. *Hungary*, in which it set out one of the criteria that should be met for a provision of health care to be considered sufficient.[1] In light of the criteria set out in Chapter III, paragraph 5 for there to be actual access to health care, it is worth to mention this piece of jurisprudence of the CEDAWCee. This case of *Ms. A.S.* v. *Hungary*, dealt with the subject of coercive sterilisation of a Roma woman at the moment she underwent an emergency caesarean section because of the dead embryo inside her womb. At the moment she was prepared for surgery, the applicant was made to sign a statement of consent that was handwritten by the doctor, which also included a statement on sterilisation in Latin terms, which she did not understand. In this case, the CEDAWCee noted that according to Article 12 CEDAW State parties have to ensure appropriate health care services to women in connection with pregnancy, confinement, and the post-natal period. Acceptable services are those that are delivered in a way that ensures that a woman gives her fully informed consent. Furthermore, the Committee stated that State parties should not permit forms of coercion, such as non-consensual sterilisation. As Hungary did not ensure that the applicant was able to take a fully informed decision it violated Article 12 CEDAWCee.

Under the complaints procedures under which it is possible to lodge a communication, only the HRCee has formed jurisprudence that covers the right to health care. The vast majority of these decisions dealt with access to health care for persons in detention and one case assessed a case about the sensitive issue of access to abortion.

In cases on access to health care for persons in detention, the HRCee clarified and repeatedly reaffirmed that by arresting and detaining individuals, States take the responsibility to care for adequate medical care during detention.[2] A lack of financial means cannot reduce this responsibility.[3]

As part of the conditions of detention, reference was made to the UN Standard Minimum Rules for the Treatment of Prisoners and the UN Body of Principles for the Protection of All Persons under Any Form of Detention or

[1] Communication No. 4/2004, *Ms. A.S.* v. *Hungary.*

[2] Communication No. 253/1997, *Kelly* v. *Jamaica*, paragraph 5.7; In addition, the HRCee also held that, and thus confirmed its prior jurisprudence, lengthy detention on death row does not per se constitute cruel, inhumane or degrading treatment in violation of Article 7 ICCPR, as long as the conditions under detention are appropriate, Communication No. 527/1993, *Lewis* v. *Jamaica*, para. 6.9.

[3] Communication No. 763/1997, *Yekaterina Pavlovna Lantsova on behalf of her son Vladimir Albertvich Lantsov* v. *the Russian Federation,* para. 9.2.

Imprisonment.[4] These documents determine what the rights of imprisoned persons are, amongst which the right to access to health care. As set out in these documents, health care should *inter alia* include: medical care free of charge that offers treatment for physical as well as mental illnesses or defects. This includes amongst others basic and specialist treatment, dental care, pre-natal and post-natal care and treatment, and psychiatric health care. Moreover, it prescribes that in every institution at least one qualified medical officer has to be available.

In the cases in relation to the access to health care for detainees, the HRCee deals with alleged violations under Article 6 ICCPR, although in most of the cases, the HRCee addresses alleged violations of either Article 7 ICCPR or Article 10 ICCPR. Article 6 ICCPR protects the right to life, Article 7 ICCPR lays down the prohibition of torture or cruel, inhumane or degrading treatment or punishment, and Article 10 ICCPR covers the rights of persons deprived of their liberty.

An example of a case concerning Article 6 ICCPR is the case of *Yekaterina Pavlovna Lantsova on behalf of her son Vladimir Albertvich Lantsov* v. *the Russian Federation*.[5] Mr. Lantsvon died of pneumonia after one month in pre-trial detention under deplorable conditions. His mother alleged that her son only received medical care during the last few minutes of his life, and that the prison authorities had refused such care during the preceding days and that this situation caused his dead. The HRCee considered that a properly functioning medical service within the detention centre could and should have known about the dangerous change in the state of health of Mr. Lantsov. It concluded that the Russian Federation failed to take appropriate measures to protect his life during the period he spent in the detention centre, and therefore violated Article 6, paragraph 1 ICCPR.[6]

In other cases on the access to health care for persons in detention, of which most were lodged against the State of Jamaica, the HRCee found violations of Article 7 and Article 10 ICCPR due to measures such as denial or lack of basic medical care,[7] especially after ill-treatment by warders and soldiers,[8] infrequent

[4] Communication No. 458/1991, *Albert Womah Mukong* v. *Cameroon,* para. 9.3; *UN Standard Minimum Rules for the Treatment of Prisoners*, Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its Resolutions 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977; Body *of Principles for the Protection of All Persons under Any Form of Detention of Imprisonment*, Adopted by General Assembly Resolution 43/173 of 9 December 1988.

[5] Communication No. 763/1997, *Yekaterina Pavlovna Lantsova on behalf of her son Vladimir Albertvich Lantsov* v. *the Russian Federation*.

[6] Communication No. 763/1997, *Yekaterina Pavlovna Lantsova on behalf of her son Vladimir Albertvich Lantsov* v. *the Russian Federation,* para. 9.2.

[7] Communication No. 253/1987, *Kelly* v. *Jamaica*; Communication No. 647/1995, *Pennant* v. *Jamaica*; Communication No. 610/1995, *Henry* v. *Jamaica*; Communication No. 527/1993, *Lewis* v. *Jamaica*; Communication No. 663/1995, *Morrison* v. *Jamaica*; Communication No. 668/1995, *Smith and Stewart* v. *Jamaica.*

[8] Communication No. 271/ 1988 and 271/1988, *Barrett and Sutcliffe. S*imilar findings: Communication No. 321/1988, *Thomas* v. *Jamaica,*; Communication No. 592/1994, *Clive Johnson* v. *Jamaica*;

availability of medical and dental care[9], destroying necessary asthma medication,[10] denial of authorisation to receive a doctor in a prisoner's cell,[11] and denial of authorisation for examination in the hospital.[12] In one case, the HRCee also held that deportation of a prisoner to his country of origin where it was unlikely that he would receive the treatment necessary for the psychiatric illness caused by the protracted period of immigration detention in Australia, would amount to a violation of Article 7 ICCPR.[13] Moreover, in some cases in which a violation was found, the HRCee specifically requested immediate medical examination of the prisoner's health and adequate medical treatment if necessary.[14]

In addition to the cases on access to health care for those in detention, the HRCee also dealt with a case concerning access to abortion, which forms part of the entitlements falling under the right to health care.[15] *K.N.L.H.* v. *Peru* concerned the case of a 17-year-old pregnant girl that was carrying an anencephalic foetus.[16] Due to the risk for her life if the pregnancy continued and the fatal condition in which the foetus was, K.N.L.H. decided to terminate the pregnancy. Consequently, authorisation was requested but denied by the administration of the hospital that was part of the Health Ministry on the grounds that the termination would be unlawful under the Criminal Code. According to that statement, the Criminal Code only permitted therapeutic abortion if termination of the pregnancy was the only way of saving the life of the pregnant woman or avoiding serious and permanent damage to her health. Four days after birth, the baby died and the mother fell into a state of deep depression. K.N.L.H. lodged a complaint with the HRCee holding that by refusing to terminate the pregnancy, the medical personnel took a decision which was prejudicial to her and violated Articles 2, 3, 6, 7, 17, 24, as well as Article 26 ICCPR.

In reply to the claim of a violation of Article 6 (right to life) and 7 ICCPR (prohibition of torture or to cruel, inhumane or degrading treatment), the HRCee noted that the refusal of the competent medical authorities to provide the necessary health care service had endangered the life of K.N.L.H. In addition, the HRCee referred to General Comment No. 20 on the prohibition of torture and cruel, inhumane treatment in which is provided that the prohibition enshrined in Article 7 ICCPR relates not only to physical pain but also to mental suffering and that a

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Communication No. 653/1995, *Colin Johnson* v. *Jamaica,*; Communication No. 613/1995, *Leehong* v. *Jamaica.*

[9] Communication No. 845/1998, *Kennedy* v. *Trinidad and Tobago.*

[10] Communication No. 775/1997, *Brown* v. *Jamaica*.

[11] Communication No. 428/1990, *Bozize* v. *Central Africa Republic.*

[12] Communication No. 688/1996, *Arredondo* v. *Peru.*

[13] Communication No. 900/1999, *Mr. C.* v. *Australia,* para. 8.5.

[14] Communication No. 610/1995, *Henry* v. *Jamaica*, para. 9; Communication No. 527/1993, *Lewis* v. *Jamaica*, para.12.

[15] See Chapter 2.

[16] Communication No. 1153/2003, *Karen Noelia Llantoy Huamán* v. *Peru*. Anencephaly is the congenital absence of most of the brain, scalp and skull.

protection against this is particularly important in the case of minors.[17] It noted her mental suffering as she also had to endure the distress of seeing her child's marked deformities while knowing that it would die very soon. On the basis of a doctor's statement and a psychiatric report, the HRCee stated that this prejudicial situation could have been foreseen. Consequently, as the refusal of termination of the pregnancy was the cause of the suffering, it amounted to a violation of Article 7 ICCPR.[18]

In its examination of a claim of violation of the right to private life (Article 17 ICCPR), the HRCee took into account that conditions for a lawful abortion as set out in Peruvian law were present. Consequently, the refusal to act in accordance with the applicant's decision to terminate her pregnancy was considered to constitute a violation of Article 17. Also Article 24 ICCPR was considered to be violated as she did not receive, during or after her pregnancy the medical and psychological support necessary in the specific circumstances of her case, *i.e.* the special vulnerability of the complainant as a minor.[19]

3 THE JUSTICIABILITY OF THE RIGHT TO HEALTH CARE AT REGIONAL HUMAN RIGHTS LEVEL: REVIEW BY THE EUROPEAN COMMITTEE OF SOCIAL RIGHTS AND THE EUROPEAN COURT OF HUMAN RIGHTS

3.1 Introduction

This paragraph will provide an overview of the justiciability of the right to health care at regional human rights level. Firstly, the justiciability of the right to health care with the European Committee of Social Rights is set out. Secondly, the manner in which the ECtHR hitherto articulated and adjudicated on various elements of the right to health care is discussed.

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[17] Communication No. 1153/2003, *Karen Noelia Llantoy Huamán* v. *Peru*, paras. 3.4, 3.5; A/47/40, General Comment No. 20 (1992), 10 March 1992, *Prohibition of torture and cruel inhuman treatment*, paras. 2, 5.

[18] Communication No. 1153/2003, *Karen Noelia Llantoy Huamán* v. *Peru*, paras. 6.3, 6.4; In this case the HRCee did not consider it necessary to include Article 6 ICCPR in its decision. Nevertheless, the dissenting opinion of Hipólito Solari-Yrigoyen on this communication stated that not only taking a person's life, but also placing a person's life in grave danger violates Article 6 ICCPR. He therefore considered that the facts in the present case also reveal a violation of the right to life.

[19] Communication No. 1153/2003, *Karen Noelia Llantoy Huamán* v. *Peru*, para. 6.5: In this sense, reference could also be made to A/37/40, General Comment 6 (1982), 30 April 1982, *Right to life*, para. 5 which states that 'it would be desirable for State parties to take all positive measures to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics'. The complaints under Articles 3 and 26 were declared inadmissible under Article 2 of the Optional Protocol to the ICCPR as these claims were considered to be insufficiently substantiated (para 5.3).

3.2 The Justiciability of the Right to Health Care under the Collective Complaints Procedure at European Committee of Social Rights

The collective complaints mechanism adopted under the AP ESC entitles the European Committee of Social Rights to deal with collective complaints regarding the compliance of the Member States with their obligations under the ESC and RESC. This collective complaints mechanism is set out in Chapter V, paragraph 5.3 together with the reporting system under the ESC and RESC.

Hitherto the European Committee for Social Rights only reviewed the right to health care in three cases. These cases are dealt with in Chapter VIII on the justiciability of the right to equal access to health care under the collective complaints procedure with the European Committee of Social Rights. Nevertheless, in relation to the assessment of the compliance of the Member States with their obligations resulting from the ESC and the RESC two sets of criteria adopted by the European Committee of Social Rights are discussed in this paragraph.

In the cases *Autism Europe* v. *France* on the right to education and *European Roma Rights Centre (ERRC)* v. *Bulgaria* on the right to housing for Roma, the European Committee of Social Rights provided for three criteria States have to take into account in achieving the objectives of both Charters.[20] Although these criteria have not yet been specifically applied to the right to health care, they can be considered to do so. These criteria include that: i) measures must be taken within reasonable time, ii) within measurable progress and iii) with the maximum use of available resources.[21] These criteria are comparable to the criteria set out in Chapter III, paragraph 2.2 on the State obligations on economic, social and cultural rights in general and the right to health care *in concreto*.

In addition to these criteria, the European Committee of Social Rights adopted four criteria set out by the Committee in GC No. 13 on the right to education.[22] It held that all education provided by States must fulfil the criteria of availability, accessibility, acceptability and adaptability.[23] As the European Committee of Social Rights adopted these criteria laid down in a General Comment of the Committee, it is reasonable to assume that regarding the right to health care the criteria of availability, accessibility, acceptability and good quality as laid down by the Committee in GC No. 14 may also be adopted by the European Committee of Social Rights in future cases.

[20] Complaint No. 13/2002, *Autism Europe* v. *France,* para. 53; Complaint No. 31/2005, *European Roma Rights Centre (ERRC)* v. *Bulgaria*, para. 37.
[21] Complaint No. 13/2002, *Autism Europe* v. *France,* para. 53; Complaint No. 31/2005, *European Roma Rights Centre (ERRC)* v. *Bulgaria*, para. 37.
[22] E/C.12/1999/10, General Comment 13 (1999), 8 December 1999, *The right to education*, para. 6.
[23] Complaint No. 41/2007, *Mental Disability Advocacy Center (MDAC)* v. *Bulgaria*, para. 37.

3.3 The Justiciability of Elements of the Right to Health Care at the European Court of Human Rights

In discussions regarding the justiciability of the right to health care, the cases of the EctHR are the ones most often referred to. This can be explained by the fact that the ECtHR is the only judicial body before which such cases can be brought, *i.e.* a court whose rulings are binding. Moreover, in comparison to the complaints procedure at the quasi-judicial European Committee of Social Rights that is characterised by a collective complaints procedure, the complaints procedure at the ECtHR offers an individual complaints mechanism.

Although economic, social and cultural rights are not specifically protected by the ECHR, the ECtHR has ruled on health care issues on numerous occasions and under several provisions of the ECHR.[24] The Articles of the ECHR most often applied are Articles 2, 3, and 8 of the Convention. The right to life in relation to the right to medical care has given rise to complaints under Article 2 ECHR. Article 3 ECHR has been invoked for reasons such as a lack of health care and ill treatment in prisons, and expulsion to countries with inadequate health care facilities and drugs. And Article 8 ECHR has been invoked for reasons of reimbursement of specific health care costs and timely access to health care.[25] These cases will be discussed hereafter.

3.3.1 Article 2 ECHR

In *Powell* v. *the United Kingdom* the ECtHR recognised that acts and omissions of the authorities in the field of health care policy may in certain circumstances fall under their responsibilities under Article 2 ECHR.[26] Consequently, Article 2 ECHR enjoins Member States to refrain from intentional and unlawful taking of life. Moreover, it also imposes on States to take appropriate steps, *i.e.* positive measures to safeguard the lives of those within its jurisdiction. As was stated by the ECtHR in *Calvelli and Ciglio* v. *Italy,* this positive obligation requires States to *e.g.* make regulations compelling hospitals, whether public or private, to adopt appropriate measures for the protection of their patients' lives.[27] In *Nitecki* v. *Poland* the ECtHR ruled that also the right to a life-saving drug might be protected under Article 2 ECHR. In this case, the applicant requested full refund of the costs of his life-saving drugs, while the public health insurance fund reimbursed only 70%. The applicant claimed that since he was unable to afford the remaining 30%, his health would deteriorate to the point where the lack of treatment would inevitably result in his death.[28] The ECtHR ruled that the respondent State could not be said to have

[24] Koch 2009, p. 60.
[25] Koch 2009, p. 60-61
[26] *Powell* v. *the United Kingdom*, Application No. 45305/99, 4 May 2000.
[27] *Calvelli and Ciglio* v. *Italy,* Application No. 32967/96, 17 January 2002, para. 49.
[28] *Nitecki* v. *Poland*, Application No. 65653/01, 21 March 2002, p. 4.

failed to discharge its obligations under Article 2 by not paying the remaining 30% of the drug price.[29]

In the case of *Cyprus* v. *Turkey* the applicant Cyprian Government claimed that the restrictions the enclaved Greek Cypriots and Maronites living in the northern part of Cyprus encountered when seeking medical treatment in the southern part of Cyprus gave rise to a violation of Article 2 ECHR.[30] In reaction to the claim of the Cyprian Government, the ECtHR noted that a case may be brought under Article 2 of the Convention if the authorities of a Contracting State are shown to put an individual's life at risk by denying him health care that is available to the population in general.[31] The ECtHR recognised that during the period under consideration medical visits were indeed hampered on account of restrictions imposed by the Turkish Republic of Northern Cyprus on the movement of the people concerned and that in certain cases delays did occur. However, it also took note of the fact that there was no evidence that the Turkish authorities deliberately withheld medical treatment from the people concerned or that they adopted a practice of delaying the processing of requests of patients to receive medical treatment in the south. Moreover, it also observed that neither the Greek-Cypriot nor Maronite populations were prevented from availing themselves of medical services including hospitals in the north.[32] Therefore, the ECtHR concluded that it had not been established that the lives of any patients were put in danger on account of delay in individual cases.[33]

3.3.2 Article 3 ECHR

The denial of health care and thereby refusing to fulfil positive State obligations can also amount to a violation under Article 3 ECHR, which proscribes torture, and inhuman or degrading treatment. The ECtHR has stated in several cases that the suffering which flows from naturally occurring illness, physical or mental, may be covered by Article 3 ECHR, where it is, or risks being, exacerbated by treatments for which the authorities can be held responsible.[34] The cases dealing with elements of the right to health care under Article 3 ECHR concern either expulsion of aliens to their country of origin or people held under detention.

The first group concerns situations in which individual aliens receive health care for their disease, such as AIDS and mental disorders, in one of the Signatory States. If they are expelled to their country of origin, they will no longer receive any health care or health care at a lower level. The applicants of these cases

[29] *Nitecki* v. *Poland*, Application No. 65653/01, 21 March 2002, p. 5.
[30] *Cyprus* v. *Turkey,* Appication No. 25781/94, 10 May 2001, para. 216.
[31] *Cyprus* v. *Turkey,* Appication No. 25781/94, 10 May 2001, para. 219.
[32] *Cyprus* v. *Turkey,* Appication No. 25781/94, 10 May 2001, para. 219.
[33] *Cyprus* v. *Turkey,* Appication No. 25781/94, 10 May 2001, para. 221.
[34] *N.* v. *UK*, Application No. 26565/05, 27 May 2008, para. 29.

claim that their expulsion under such conditions will amount to a violation of Article 3 ECHR.

In the case *D.* v. *the United Kingdom* the applicant, a national of St Kitts (Saint Christopher and Nevis), had been convicted and sentenced in the United Kingdom and would be deported to St Kitts by the authorities after he had completed his sentence of imprisonment.[35] The applicant was in the advanced stages of AIDS for which he received medical treatment in the United Kingdom. His prognosis was very poor and he appeared to be close to death. Moreover, there was evidence before the ECtHR that the medical facilities in St Kitts were incapable to provide the applicant with the treatment he needed and that he had no family home or close relatives able to look after him there. In view of these exceptional circumstances and bearing in mind the critical physical stage reached in the applicant's fatal illness, the ECtHR ruled that removing him to St Kitts would amount to inhumane treatment and a violation of Article 3 ECHR.[36]

On the basis of this case, various other cases have been lodged with the ECtHR by aliens suffering from AIDS or mental disorders when faced with expulsion to their country of origin.[37] Nevertheless, the facts of the case of *D.* v. *the United Kingdom* were considered exceptional. In none of the subsequent cases the ECtHR found a violation of Article 3 ECHR.

The various cases on the expulsion of aliens suffering from AIDS or mental disorders provide the criteria adopted by the ECtHR in assessing an alleged violation of Article 3 ECHR due to expulsion. These are i) the severity of the health condition and in case of AIDS, the stage reached, ii) whether treatment is available in the host country, although at considerable costs or at a lower level, and iii) whether the applicant has children, family or other relatives to take care of him or her.

The second group of cases under Article 3 ECHR concerns claims regarding a lack of health care for those in detention. The ECtHR has received a considerable number of such cases in which allegations of insufficient or inadequate medical care in institutions of detention are claimed. Article 3 requires States to ensure that prisoners are detained in conditions that do not subject them to distress or hardship.[38] Given the practical demands of imprisonment,[39] the authorities are therefore, *inter alia*, under an obligation to protect the health and well-being of

[35] *D.* v. *the United Kingdom*, Application No. 30240/96, 2 May 1997.
[36] *D.* v. *the United Kingdom*, Application No. 30240/96, 2 May 1997, paras. 52, 53.
[37] *Karara* v. *Finland,* Application No 40900/98, 29 May 1998; *S.C.C.* v. *Sweden*, Application No. 46553/99, 15 February 2000; *N.* v. *UK*, Application No. 26565/05, 27 May 2008; *Bensaid* v. *the United Kingdom,* Application No. 44599/98, 6 February 2001.
[38] *Gelfmann* v. *France* Application No. 25875/03, 14 December 2004, para. 50.
[39] This criterion of 'practical demands of imprisonment' was also used by the Court in *Aleksanyan* v. Russia, Application No. 46468/06, 22 December 2008, para. 148 where the Court stated that the standard of health care 'should be "compatible with the human dignity" of a detainee, but should also take into account "the practical demands of imprisonment".

persons deprived of their liberty.[40] A lack of appropriate medical care may therefore amount to treatment contrary to Article 3 ECHR.[41] Examples of a lack of appropriate health care that amounts to a violation of Article 3 ECHR are the failure to provide suitable psychological care to a mentally disturbed prisoner who subsequently commit suicide,[42] conditions of detention far from suitable for the conditions and physical handicap of a person detained,[43] a failure to admit to a hospital,[44] and other types of untimely and inappropriate medical assistance, for example in respect of HIV and tuberculosis infections.[45] The ECtHR also has held that in very exceptional circumstances, Article 3 may require the conditional liberation of a prisoner who is seriously ill or disabled.[46] However, the ECtHR emphasised that this does not imply that Article 3 ECHR can be interpreted as securing to every detained person medical care of the same level as in the best clinics for civilians.[47] Moreover, according to the case law of the ECtHR, ill-treatment must attain a minimum level of severity for it to fall within the scope of Article 3 ECHR. This must in any event go beyond the unavoidable level of suffering or humiliation inherent to detention.[48]

3.3.3 Article 8 ECHR

According to Article 8 ECHR everyone has the right to have his private life respected. Although the ECtHR has held that the concept of 'private life' is a broad term not susceptible to exhaustive definition, it determines which elements form part of the personal sphere protected by Article 8 ECHR. In the ECtHR's view, private life covers the physical and psychological integrity of a person. It includes elements such as mental health, gender identification, name and sexual orientation and sexual life, and therefore embraces aspects of an individual's physical and social identity.[49] Article 8 ECHR is intended to ensure the development of this

[40] *Gelfmann* v. *France*, Application No. 25875/03, 14 December 2004, para. 50; *Yakovenko* v. *Ukraine* Application No. 15825/06, 25 October 2007, para. 80.
[41] *Yakovenko* v. *Ukraine*, Application No. 15825/06, 25 October 2007, paras. 79, 80.
[42] *Keenan* v. *the Unted Kingdom*, Application No. 27229/95, 3 April 2001, para. 116.
[43] *Price* v. *the United Kingdom*, Application No. 33394/96, 10 July 2001, para. 30.
[44] *McGlinchey a.o.* v. *the United Kingdom,* Application No. 50390/99, 29 April 2003, paras. 57, 58.
[45] *Yakovenko* v. *Ukraine*, Application No. 15825/06, 25 October 2007, para. 101.
[46] *Aleksanyan* v. *Russia*, Application No. 46468/06, 22 December 2008, para. 135: The ECtHR applied this in its consideration of *Gelfmann* v. *France*, Application No. 25875/03, 14 December 2004, para. 57.
[47] *Aleksanyan* v. *Russia*, Application No. 46468/06, 22 December 2008, para. 139.
[48] *Gelfmann* v. *France*, Application No. 25875/03, 14 December 2004, para. 50; *Aleksanyan* v. *Russia*, Application No. 46468/06, 22 December 2008, para. 135.
[49] *Botta* v. *Italy*, Application No. 21439/93, 24 February 1998, para. 32; *Bensaid* v. *the United Kingdom,* Application No. 44599/98, 6 February 2001, para. 47; *Sentges* v. *the Netherlands*, Application No. 27677/02, 8 July 2003, p. 6; *Kück* v. *Germany* Application No. 35968/97, 12 June 2003, para. 69.

identity, personal development, and the right to establish and develop relationships with other human beings and the outside world.[50]

The essential object of Article 8 is to protect the individual against arbitrary interference by the public authorities. However, this does not merely compel the State to abstain from such interference and to respect this right only passively. As with other State obligations under the ECHR, there may be positive obligations that involve the adoption of measures designed to secure respect for private life.[51] However, the ECtHR generally adopts a cautious approach in such cases as such positive obligations could involve the assessment of the priorities in the context of the allocation of limited State resources. This cautious approach is not only based on the lack of authority of the ECtHR in this regard, but also because it considers the national authorities to be in a better position than an international court to assess the demands made on the health care system and the funds available to meet those demands.[52] Moreover, it expressed that it is mindful of the fact that while applying the ECHR to the concrete facts of a case, a decision issued in an individual case will at least to some extent establish a precedent, valid for all Signatory States.[53] Consequently, in cases dealing with positive measures, the margin of appreciation granted to Signatory States of the ECHR tends to be wide.[54]

The ECtHR's cautious approach in the assessment of the priorities in the context of public health care systems can be illustrated by two cases that dealt with a claim on the right to health care services. *Sentges* v. *the Netherlands,* considers the case of a severely disabled person who claims that the authorities should not have rejected his request to be supplied with a medical device, a robotic arm of which the total cost amounts € 36.000, which would have given him immeasurably more autonomy.[55] Without this robotic arm, he was totally dependent on others for every single act and he was therefore not free in his choice with whom to establish and develop relationships. The ECtHR held that there was indeed a link between the situation complained of and the particular needs of the applicant's private life. However, it considered that the applicant had access to the standard health care offered to all persons insured under the Dutch health care system. Therefore, the ECtHR concluded that in refusing to supply the robotic arm, the Dutch authorities had not exceeded their margin of appreciation.[56]

In the admissibility case of *Pentiacova and 48 others* v. *Moldova*, the applicants, who suffered from chronic renal failure, complain about the failure of the State to provide comprehensive haemodialysis treatment.[57] They submit the

[50] *Bensaid* v. *the United Kingdom,* Application No. 44599/98, 6 February 2001, para. 47.
[51] *Botta* v. *Italy*, Application No. 21439/93, 24 February 1998, para. 33.
[52] *Sentges* v. *the Netherlands*, Application No. 27677/02, 8 July 2003, p. 7.
[53] *Sentges* v. *the Netherlands*, Application No. 27677/02, 8 July 2003, p. 7.
[54] *Sentges* v. *the Netherlands*, Application No. 27677/02, 8 July 2003, p. 7.
[55] *Sentges* v. *the Netherlands*, Application No. 27677/02, 8 July 2003, p. 7.
[56] *Sentges* v. *the Netherlands*, Application No. 27677/02, 8 July 2003.
[57] *Pentiacova and 48 others* v. *Moldova*, Application No. 14462/03, 4 January 2005, p. 12.

complaint under Article 8 ECHR claiming that they are obliged to spend most of their families' money on their treatment, which had impaired their private and family life. In this case, the ECtHR noted that it is desirable that everyone should have access to a full range of medical treatment, including life-saving medical procedures and drugs, although Article 8 ECHR does not provide a right to free medical health care. With regard to the facts under consideration, the ECtHR puts forward that the lack of resources means that there are, unfortunately, many individuals in the Signatory States who do not enjoy such medical treatment, especially in cases of permanent and expensive treatment.[58] As the applicants' claim amounts to a call on scarce public resources these would have to be diverted from other worthy needs funded by the taxpayer. Moreover, as in the case of *Sentges* the ECtHR notes that the applicants have access to the standard of health care offered to the general public. It is therefore not of the opinion that the respondent State fails to strike a fair balance between the competing interests of the applicants and the community as a whole or that it fails to discharge its positive obligations under Article 8 ECHR.[59]

The positive obligations of Member States under Article 8 ECHR do not only cover the relation between the individual and the public authorities, but can also apply to relations among private parties.[60] With regard to such relations, Article 8 ECHR may also impose positive obligations on a State in order to protect the rights enshrined in it. However, a prerequisite for this is that there is a direct and immediate link between the measures sought by an applicant and the latter's private life, *i.e.* between the measures the State is urged to take and an individual's private life.[61] This link was found to be present in the case of *Kück* v. *Germany.*[62] This case touches upon the applicant's freedom to define herself as a female person, which the ECtHR considers one of the most basic elements of self-determination.[63] The central issue of the case concerns the application of existing criteria by the German Court to the reimbursement of medical treatment for gender reassignment surgery. The applicant holds that, in the context of the dispute with her private health insurance company, the German Courts failed to give appropriate consideration to her transsexuality.[64]

The ECtHR comes to the conclusion that no fair balance was struck between the interests of the private health insurance company on the one side and the interests of an individual on the other.[65] First of all, the Regional Court referred the applicant to the possibility of psychotherapy as a less radical means of treating

[58] *Pentiacova and 48 others* v. *Moldova*, Application No. 14462/03, 4 January 2005, p. 13.
[59] *Pentiacova and 48 others* v. *Moldova*, Application No. 14462/03, 4 January 2005, p. 14.
[60] *Botta* v. *Italy*, Application No. 21439/93, 24 February 1998, para. 33.
[61] *Botta* v. *Italy*, Application No. 21439/93, 24 February 1998, para. 35.
[62] *Kück* v. *Germany*, Application No. 35968/97, 12 June 2003, para. 84.
[63] *Kück* v. *Germany*, Application No. 35968/97, 12 June 2003, para. 73.
[64] *Kück* v. *Germany*, Application No. 35968/97, 12 June 2003, para. 78.
[65] *Kück* v. *Germany*, Application No. 35968/97, 12 June 2003, para. 84.

her condition, contrary to the statements contained in the expert opinion. Secondly, the Court of Appeal substituted its views which were not based on any medical competence with regard to one of the most intimate feelings and experiences of the applicant. Finally, the burden to prove the medical necessity of treatment, including irreversible surgery, that was placed on Mrs. Kück was considered disproportionate by the ECtHR.[66] Consequently, the ECtHR came to its findings of a violation of Article 8 ECHR on the basis of the fact that the German authorities had overstepped their margin of appreciation.[67]

4 CONCLUSIONS

This Chapter discussed how the human right to health care and elements of this right have hitherto been subject of judicial review. Again, it is demonstrated that there is no watertight division between civil and political rights on the one hand and the right to health care as part of economic, social and cultural rights on the other.

A group of persons may lodge their claim to health care directly with the European Committee of Social Rights. The European Committee of Social Rights provided two sets of useful criteria that are adopted in assessing the compliance of the Member States with their obligations resulting from the ESC and the RESC. The first category of criteria includes that: i) measures must be taken within reasonable time, ii) within measurable progress, and iii) with the maximum use of available resources. The second category of criteria includes the criteria provided by the UN Committee on Economic, Social and Cultural Rights in GC No. 13. Consequently, the criteria of availability, accessibility, acceptability and good quality set out in GC No. 14 on the right to health can be expected to also hold true for future cases concerning the right to health care.

In addition, both the HRCee and the ECtHR addressed, articulated and adjudicated on different elements of the right to health care in their case law under various substantive provisions of the ICCPR and the ECHR respectively. The HRCee has made more than clear that States also have positive obligations in relation to providing health care to persons present in their prisons. In the case of *K.N.L.H.* v. *Peru* too, the general gist of which seems to be a claim on the right to access to health care, the HRCee emphasises the positive obligations of the State. In this case concerning abortion the HRCee makes several clear and highly relevant remarks for the right to health care. It clarifies that making choices in receiving or not receiving health care falls under the right to private life (Article 17 ICCPR) and that the criminalisation of abortion can be found to be incompatible with Articles 3, 6 and 7 ICCPR. Moreover, from this case it emerges that health care may not be denied in case this constitutes a threat to someone's life or in case it leads to cruel, inhumane or degrading treatment. Finally, by ruling that Article 24 ICCPR was

[66] *Kück* v. *Germany*, Application No. 35968/97, 12 June 2003, paras. 79-82.
[67] *Kück* v. *Germany* Application No. 35968/97, 12 June 2003, para. 86.

violated because no necessary medical and psychological care was provided to a person of minor age, the HRCee evidently referred to the right to health care.

The ECtHR recognises that under Article 2 ECHR Member States are also under the obligation to take appropriate steps to safeguard the lives of those within their jurisdiction. This also extends to the health care arena. However, it seems that the threshold set by Article 2 ECHR is particularly high as the immediacy of the risk to life has never gone so far as to have the lack of taking such preventive steps result in a violation of Article 2 ECHR.[68] Moreover, it has been found that under Article 3 ECHR, the Signatory State in which a sick alien is awaiting his or her expulsion to the country of origin is responsible for the provision of health care. However, the Member States do not remain responsible indefinitely. This duty ends once the planned deportation to the country of origin is effectuated. Only in highly exceptional circumstances, which are determined by, *inter alia*, the severity of the health condition and the availability of treatment in the country of origin, an expulsion may amount to a violation of Article 3 ECHR. Under Article 8 ECHR the ECtHR seems less reluctant to intervene with the reimbursement of health care costs with regard to private health care insurance, especially if it touches upon the essential elements of the identity and self-determination of the applicant. However, where it concerns the allocation of limited State resources, the ECtHR does not seem to want to make any statements. This is due to the wide margin of appreciation granted to the Member States, especially in relation to positive measures. Nevertheless, the ECtHR considers it sufficient if the people under the State's jurisdiction have access to a minimum of care, *i.e.* access to basic health care as provided to the general public satisfactory. Consequently, it can be concluded that the ECtHR adopted the view that a minimum level of severity must be attained for a certain situation to fall within the scope of Article 8 ECHR.

The adjudication of economic, social and cultural rights in general and the right to health care *in concreto* via civil and political rights as adopted by the HRCee and the ECtHR follows from the recognition of the indivisibility of human rights and is designated as the so-called *integrated approach*. This integrated approach and the normative explanations thereof shall be discussed in Chapter VII.

[68] Palmer 2009, p. 409.

CHAPTER VII
THE INTEGRATED APPROACH

1 INTRODUCTION

In their task to assess the compliance of Member States with their duties under the ICCPR and ECHR, both the HRCee and the ECtHR have dealt with dimensions of economic, social and cultural rights, including the right to health care *via* civil and political rights. This adjudication of economic, social and cultural rights in general and the right to health care specifically *via* civil and political rights follows from the recognition of the indivisibility of human rights and is designated as the so-called *integrated approach*. This phenomenon will be defined in paragraph 2. Subsequently, paragraph 3 will discuss the normative explanations of the integrated approach in human rights law. Finally, in paragraph 4, these normative explanations on the integrated approach will be reviewed in light of the subject of the present study; the justiciability of the right to equal access to health care.

2 THE INTEGRATED APPROACH: DEFINITION AND EMERGENCE IN HUMAN RIGHTS LAW

In their cases, both the HRCee and the ECtHR have dealt with dimensions of economic, social and cultural rights and the right to health care in specific *via* the rights laid down in the ICCPR and the ECHR respectively. In assessing the compliance of Member States with their duties under the ICCPR, the HRCee took into account elements of economic, social and cultural rights, including the right to health care. It thereby concurred with the statement set out in the Preamble of the ICCPR holding that 'in accordance with the UDHR, the ideal of free human beings enjoying civil and political freedom and freedom from fear and want can only be achieved if conditions are created whereby everyone may enjoy his civil and political rights, as well as his economic, social and cultural rights'.[1] Comparable expressions are used by the General Assembly of the UN which uses the standard expression that 'all human rights and fundamental freedoms are interrelated and indivisible'.[2] In addition, in various Resolutions it stated that 'equal attention and

[1] Preamble ICCPR.
[2] UN General Assembly Resolution 32/130, "Alternative approaches and ways and means within the UN system for improving the effective enjoyment of human rights and fundamental freedoms" (16 December 1977), Preamble.

urgent consideration should be given to the implementation, promotion and protection of both civil and political rights, and economic, social and cultural rights'.[3] Therefore, the promotion and protection of one category of rights should 'never exempt or excuse States from the promotion and protection of the other'.[4]

Also at regional human rights level, the ECtHR does not comply with the strict traditional dichotomy of negative and positive human rights. In the *Airey* case of 1979 the ECtHR delineated 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 […] that the mere fact that an interpretation of the Convention may extend into the sphere of social and economic 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.'[5] Subsequently, in various cases it adjudicated on different dimensions of economic, social and cultural rights, including the right to health care. It thereby indicates that it is artificial to insist on the strict separation of human rights; civil and political, and economic, social and cultural rights are two sides of the same coin.[6]

As such, both the HRCee and the ECtHR 'read' economic, social and cultural rights into civil and political rights. This approach to economic, social and cultural rights *via* civil and political rights is designated as the so-called *integrated approach*. The integrated approach is defined as 'the possibility of the treaty bodies to protect or at least take into account social and economic rights through their task to afford international protection to those rights explicitly covered by the treaties in question'.[7] Consequently, under the integrated approach, civil and political rights are instrumental for the effective protection of economic, social and cultural rights as a violation of these rights may in certain circumstances give rise to a breach of a classical civil and political rights instrument.

Two ways of adopting an integrated approach can be distilled from the cases of the HRCee and the ECtHR.[8] The first is an indirect way in which elements

[3] UN General Assembly Resolution 45/135, "International Covenant on Human Rights" (14 December 1990), Preamble.
[4] UN General Assembly Resolution 44/130, "Indivisibility and interdependence of economic, social, cultural, civil and political rights" (15 December 1989), Preamble.
[5] *Airey* v. *Ireland*, Application No. 6289/73, 9 October 1979, para. 26.
[6] Waldron 1993, Chapter 1. In this Chapter with the title *Two sides of the coin*, Waldron argues for welfare rights on the basis that socio-economic rights are as important as any other interests and that economic security is necessary if other rights (first-generation rights, i.e. civil and political rights) are to be taken seriously. He rejects, however, insisting on the total absolutism of these rights.
[7] Scheinin 2001, p. 32.
[8] Not only the ECtHR and the HRCee, but also the European Committee for Social Rights applies an integrated approach, albeit by protecting civil and political demands *via* economic, social and cultural rights. See for example: Complaint No. 51/2008, *European Roma Rights Centre (ERRC)* v. *France*, para. 99. The integrated approach of the European Committee for Social Rights will not be dealt with in the present study any further. For a comprehensive exposition of this approach under the European Social Charter, see: Koch 2009. Where in the present study is referred to the integrated approach,

of economic, social and cultural rights and the right to health care are taken into account when dealing with the substantive provisions of the ICCPR and the ECHR respectively. The same would hold for the adoption of the non-ancillary prohibition of discrimination enshrined in Article 14 ECHR to substantive provisions under which elements of the right to health care are taken into account. This too can be considered an indirect way.

The second way of adopting the integrated approach can be designated as a direct integrated approach. This is done under Article 26 ICCPR and Article 1 Protocol No. 12 ECHR. Both Articles provide an autonomous prohibition clause and therefore do not require a link to a substantive provision enshrined in the ICCPR or ECHR. Both provisions can be applied directly to rights protected by other human rights instruments.

The major advantage of the integrated approach adopted by the HRCee as well as by the ECtHR is that elements of economic, social and cultural rights can be subject to adjudication by human rights bodies that can provide for a stronger protection of these rights. Especially the adjudication by the ECtHR of elements falling under the economic, social and cultural rights paradigm is of great importance as it is the only judicial human rights body that can provide a binding judgement. Moreover, the integrated approach provides the treaty bodies with the possibility to make complex assessments and to get a step closer to the proper and holistic protection of the entire *palette* of human rights.[9]

3 NORMATIVE EXPLANATION OF THE INTEGRATED APPROACH

In literature, the integrated approach has been described, although a normative explanation has not often been set out. Nevertheless, two concepts have been developed as normative explanations to deal with the phenomenon of the integrated approach and the legal implication of the indivisibility of human rights.[10] These are *the permeability of human rights* of Scott and *the hermeneutic circle* developed by Koch.

The tripartite typology of State obligations has also been developed to overcome the traditional strict perception of the dichotomy of negative and positive rights. It does not, however, provide a normative explanation for the integrated approach. Nevertheless, as the critique of Koch on the tripartite typology of State obligations formed the basis for her work on the hermeneutic circle, it will shortly be dealt with.

As set out in Chapter III, paragraph 3, the best known analytical tool to deal with the traditional perception of the indivisibility of human rights, *i.e.* the

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reference is made to the recognition and protection of economic, social and cultural rights *via* civil and political rights.

[9] Mantouvalou 2005, p. 583, 584.

[10] Koch 2009, p. 29, 30.

dichotomy of negative and positive human rights and corresponding State obligations, is the typology that was developed by Eide.[11] This tripartite typology illustrates that every human right requires both active action from the State and as well as abstention from interfering, and strict divisibility is therefore impossible.

Koch has criticised the application of the tripartite typology. Although she recognises that the typology provides for a more nuanced understanding of the normative character of human rights obligations, she argues that this is not the best way to overcome the traditional indivisibility of human rights. Koch holds that the distinction between the tripartite obligations is not always clear cut.[12] As there is an overlap between these obligations, there is an interdependence of duties, which indicates that human rights cannot be fully realised by performing merely one of the types of obligations they impose. This in its turn leads to a loss in the practical applicability of such a typology.[13] Another point of criticism stated by Koch is the insertion of the obligation to protect between the obligations to respect and to fulfil. This obligation involves a State's responsibility to protect human rights, *inter alia* in horizontal relations by protecting individuals from an infringement of their right by third parties. According to Koch, this is an entirely different issue and should not be included in a typology of State obligations in relation to individuals.[14] If the regulation of non-State actors by the State would be ignored, the State has only two obligations, namely the obligation to respect and the obligation to fulfil. Koch argues that 'what we have achieved [then] is only the substitution of the traditional "positive/negative" dichotomy with another dichotomy'.[15]

Instead of sticking to typologies, Koch proposes as metaphor a continuum, which she later also applies in her *hermeneutic circle of obligations*, which can be imagined as a 'slope' that increases for each 'movement uphill' or as a 'wave of duties'.[16] In her explanation on the usefulness of these metaphors, Koch (2009) sets out that '[t]he recognition of human rights obligations as "waves of duties" is helpful as a starting point when trying to understand the integrated approach and the legal implications of the notion of indivisibility. The wave metaphor sets free socio-economic and civil-political rights from their separated compartments. It is intended to provide a new framework for the understanding of the scope of human rights obligations, and suggests the necessity of a contextual interpretation of human rights conceivably challenging existing text-conformal interpretative traditions'.[17] A contextual interpretation is about applying a legal text to a concrete situation. In case these concrete facts call for an interpretation that reaches into what is

[11] Eide 1987, p. 1.
[12] Koch 2005, p. 91.
[13] Koch 2005, p. 92.
[14] Koch 2009, p. 18.
[15] Koch 2009, p. 19.
[16] Koch 2005, p. 92, 93; Koch 2009, p. 20, 27, 28.She bases her work, *inter alia* on the work of Jeremy Waldron, who also proposes a wave of successive duties, see: Waldron 1993.
[17] Koch 2009, p. 30.

traditionally regarded as falling into the sphere of economic, social and cultural rights, the boundaries between the two categories of rights should be dissolved.[18]

Scott (1999) also advocated the necessity of a contextual interpretation of human rights.[19] He did so after reviewing his earlier work on the *permeability of human rights*. By permeability he means 'the openness of a treaty dealing with one category of human rights to having its norms used as vehicles for the direct or indirect protection of norms of another treaty dealing with a different category of human rights'.[20]

The idea of permeability was put forward by Scott as a means to give practical legal effect to the abstract doctrine of indivisibility and interdependence, as applied by the human rights treaty bodies with their integrated approach.[21] According to Scott, interdependence must be understood as having two senses: *organic interdependence* and *related interdependence*. By organic interdependence, Scott understands that 'one right forms a part of another right and may therefore be incorporated into that latter right. From the organic rights perspective, interdependent rights are inseparable or indissoluble in the sense that one right (the core right) justifies the other (derivative right). To protect right *x* will mean directly protecting right *y*.'

Chapter VI on the justiciability of the right to health care, provided a broad array of examples of case law that illustrate the organic interdependence of human rights. *E.g.* there is an organic interdependence between the right to access to health care and the right to life (Article 2 ECHR,[22] Article 6 ICCPR[23]), the prohibition of torture, inhumane or degrading treatment (Article 3 ECHR,[24] Article 7 ICCPR[25]), and the right to respect for private and family life (Article 8 ECHR[26]).

The other sense of interdependence, the related interdependence, entails that 'the rights in question are mutually reinforcing or mutually dependent, but distinct'.[27] However, although that they are viewed as separate, the rights in question are treated as equally important and complementary.[28] The related

[18] Koch 2009, p. 55.
[19] Scott 1999, p. 641.
[20] Scott 1989, p. 771. This definition of the permeability of human rights is very similar to the definition of the integrated approach as set out by Martin Scheinin: Scheinin 2001, p. 32.
[21] Scott 1989, p. 771. Scott groups the three notions of indivisibility, interdependence and interrelatedness under one designation: interdependence, see: Scott 1989, p. 779.
[22] *E.g. Calvelli and Ciglio* v. *Italy,* Application No. 32967/96, 17 January 2002.
[23] *E.g.* Communication no. 763/1997, *Yekaterina Pavlovna Lantsova on behalf of her son Vladimir Albertvich Lantsov* v. *the Russian Federation*.
[24] *E.g. D.* v. *the United Kingdom*, Application No. 30240/96, 2 May 1997.
[25] *E.g.* Communication No. 763/1997, *Yekaterina Pavlovna Lantsova on behalf of her son Vladimir Albertvich Lantsov* v. *the Russian Federation*.
[26] *E.g. Sentges* v. *the Netherlands*, Application No. 27677/02, 8 July 2003; *Kück* v. *Germany*, Application No. 35968/97, 12 June 2003.
[27] Scott 1989, p. 782, 783.
[28] Scott 1989, p. 803; Mantouvalou 2005, p. 573. This implies that both rights are intrinsically valuable as the enjoyment of one type of rights is rendered meaningless if the other type of rights is neglected.

interdependence, as Scott sets out in his explanation on the both senses of interdependence, 'may be viewed as distinct from organic permeability because it involves the question of whether a right in the ICCPR *applies to* a right in the ICESCR, and not whether this latter right is *part of* the former right'.[29] In this sense, the ICCPR is the instrumental means for the protection of rights enshrined in the ICESCR.

The prohibition of discrimination as provided by the autonomous provisions of Article 26 ICCPR and Article 1 Protocol No. 12 ECHR could serve as an example of the related interdependence as these apply to 'any right set forth by law', and therefore also to economic, social and cultural rights.[30] Another example is the right to a fair trial provided by Article 14 ICCPR and Article 6 ECHR. In relation to Article 6 ECHR, the ECtHR has dissociated itself from the understanding that this right only applies to private law issues and has subsequently applied it to certain social security rights.[31]

In his later work, Scott is critical about the use of categories to explain the integrated approach. He stated that legal categories could result in certain formalism and could consequently, lessen the human rights protection as they can result in 'ceiling effects'.[32] A ceiling effect is created if a treaty body refers to human rights enshrined in a legal instrument other than its own and uses this as a means not to expand a given right, but to limit the meaning, and thus the scope, of the protection. This could be done if: i) the treaty body does not include a right in its judgement that is already protected by another treaty, or ii) the treaty body includes a right protected under another treaty, but the protection of that right can be no more generous than the protection under that other treaty.[33]

Scott argues that human rights cannot be confined to two neat categories of interdependence. Even if 'it seems analytically correct to emphasise the partial dependence of one right upon protection of another […], this does not mean that the two rights do not relate in a more mutually dependent way when viewed more systemically and/or across a range of contexts'.[34] Therefore, 'effective human rights

[29] Scott 1989, p. 783.
[30] Protocol No. 12 ECHR. The same holds true for Article 26 ICCPR.
[31] Koch 2009, p. 34.
[32] Scott 1999, p. 636, 638. Koch notices that it is questionable whether categorisation has such an influence on the treaty bodies as it can be considered a mere academic exercise of limited practical use. Moreover, she argues that categories such as related and organic interdependece could also, under favourable conditions, lead to positive textual inferentialism, see: Koch 2009, p. 36. For illustrative case law: Koch 2009, Chapter 9, section 8.
[33] Scott 1999, p. 638. An example of rights set out by Scott is the right to freedom of association with others, laid down in Article 22 ICCPR in relation to the right to strike as enshrined in Article 8 ICESCR, Scott 1999, p. 638. Scott also refers to the phenomenon of ceiling effect as a 'juridical disease' that can be called 'negative textual inferentialism', Scott 1999, p. 639.
[34] Scott 1999.

protection can, and should, be a result of a contextual interpretative analysis of what is needed to make a right truly a right of "everyone"'.[35]

Koch expressed similar comments on the categorisation of interdependence under the notion of permeability as Scott did.[36] Moreover, she deems that by speaking of one category of human rights permeating another category of human rights, it is suggested that what is permeating does not really belong there. This, in its turn, could create the impression that treaty bodies 'are working near the limits of their mandate or even overstepping their mandate by borrowing norms from another treaty' by applying an integrated approach.[37]

After considering the notion of permeability, the perception of human rights as waves of duties, and the contextual interpretative analysis, Koch holds the opinion that there is a way to come even closer to a theory for the explanation and development of the integrated approach.[38] She introduces the hermeneutic perspective on human rights and argues that the various elements of the hermeneutic circle – as elements of a greater whole – contribute each in their way to the understanding of the integrated approach of the treaty bodies to the indivisibility of human rights.[39] As with the waves of duties, with which Koch proposes to replace the tripartite typology of State obligations, she perceives the process of interpretation as an ongoing process and consequently designates this as the hermeneutic circle. As this is an infinite process, the hermeneutic circle can also be perceived as a hermeneutic spiral.[40]

The central theme in hermeneutics is that the whole must be understood in terms of the detail and the detail must be understood in terms of the whole.[41] The coherence between the detail and the whole is important for the understanding of the relations between the individual norm, the smaller entities of that norm, and the entire system of human rights norms. This does not only allow for, but actually requires the application of a broader range of legal sources, including *inter alia* the sources which are traditionally considered to be part of the framework of instruments protecting economic, social and cultural rights.[42] The right interpretation leads to harmony between this individual norm and the entire system of norms. As this is an infinite process this represents the hermeneutic circle.[43]

Within the hermeneutic circle, two elements are present: the horizontal structure of the hermeneutic circle and the vertical structure of the hermeneutic

[35] Scott 1999, p. 641.
[36] Koch 2009.
[37] Koch 2006, p. 405-430, p. 424.
[38] Koch 2009, p. 37.
[39] Koch 2006, p. 424.
[40] Koch 2009, p. 45.
[41] The designation of 'hermeneutics' is derived from the Greek verb *hermeneuein*, which means understanding, or to interpret – in this case a text – that has been written many years ago, Koch 2009, p. 41.
[42] Koch 2006, p. 424.
[43] Koch 2009, p. 42, 43.

circle.[44] The horizontal structure of the hermeneutic circle is based on the idea that present understanding is determined by previous understanding, and present understanding will have an impact on future interpretation.[45] Case law is illustrative for this notion as legal instruments like the ECHR are continuously subject to new interpretation, but builds on previous case law of the ECtHR.

In hermeneutic thinking, the interpretative process is not only about the past, present and future, but also about the encounter between text and context. This is what is defined as the vertical structure of the hermeneutic circle.[46] This is what it is about in legal interpretation: interpretation is about applying a legal text to a concrete contextual situation. It is impossible to properly interpret without finding a solution for a concrete legal problem. The interpreter has to facilitate that encounter between the legal provision and the concrete facts of a case.[47] In case these concrete facts call for an interpretation that reaches into what is traditionally regarded as falling into the sphere of economic, social and cultural rights, the boundaries between the two categories of rights should be dissolved.[48]

4 NORMATIVE EXPLANATIONS OF THE INTEGRATED APPROACH AND THE JUSTICIABILITY OF THE RIGHT TO EQUAL ACCESS TO HEALTH CARE

Both the work of Scott and Koch provides for a normative explanation of the indivisibility of human rights and the integrated approach.

The notion of the permeability of human rights, as provided by Scott in his normative explanation of the integrated approach, appears useful for the understanding of the integrated approach adopted by the HRCee and the ECtHR. It is valuable for a comprehensive protection of civil and political rights and therefore for the protection of the entire array of human rights as indivisible rights. Moreover, this is of relevance for the justiciability of economic, social and cultural rights, including the right to equal access to health care. First of all, the interdependence of what Scott describes as related organic interdependence is what provides a useful framework for the present study. In relation to the justiciability of the right to equal access to health care, the related interdependence describes how one right applies to

[44] Koch 2009, p. 41.
[45] Koch 2009, p. 41.
[46] Very interesting in this regard is what the ECtHR set out in *Christine Goodwin* v. *the United Kingdom*, Application No. 28957/95, 11 July 2002, paras. 74, 75 on its proposal to interpret the application of the ECHR in the light of present-day conditions. Its considerations could be designated as the vertical structure of the hermeneutic circle.
[47] Koch 2009, p. 41, 53, 53.
[48] Koch 2009, p. 55. In this way, 'context' also refers to the legal context. An example of a case that illustrates the vertical structure of the hermeneutic circle where the text has been applied to a particular context is the case of *D.* v. *the United Kingdom*, Application No. 30240/96, 2 May 1997. It is a common perception that the expulsion of sick aliens does not fall under the provision of Article 3 ECHR. However, the factual circumstances of this case were so exceptional that the provision applied after all.

another right – in this sense the autonomous civil and political right to equal treatment and the prohibition of non-discrimination to the right to health care – and can serve as a vehicle for its protection. Organic interdependence can be perceived by the adoption of a non-ancillary prohibition of discrimination to substantive human rights provisions that take into account elements of economic, social and cultural rights including the right to health care.

In comparison to the concept of the permeability of human rights, Koch provides for a more complete understanding of the integrated approach with her work on the application of the hermeneutic perspective on the indivisibility of human rights. She presents a multidimensional model that provides various elements that contribute to this understanding. Besides the concept of the whole and the detail together with its various implications, the vertical structure of the hermeneutic circle is what is of great importance for the present study. It provides for a contextual interpretative analysis, something that was also proposed by Scott in his later work. The vertical structure of the hermeneutic circle demonstrates what is crucial for the integrated approach: the text encounters the context. This is exactly what has been done in the cases described in Chapter VI on the justiciability of the right to health care in which both the HRCee and the ECtHR applied an integrated approach. In seeking a proper protection of human rights, the ECtHR as well as the HRCee have taken into account the concrete facts of the case, *i.e.* the context. And as these concrete facts called for an interpretation that included economic, social and cultural rights' requirements, the strict boundaries between the two traditional categories of rights were abolished.

However, in her advocacy of the indivisibility of human rights, Koch aims at more than just *recognition* of the indivisibility of human rights by the various human rights bodies, *inter alia* by their application of the integrated approach.[49] Koch also aims at further evolutionary integrative steps at institutional level. For example, she deems necessary for the evolution towards indivisibility of human rights to abolish the reporting system and collective complaints procedure under the ESC and RESC and to entrust the ECtHR with adjudicating individual complaints concerning economic, social and cultural rights.[50]

It can reasonably be agreed with Koch that it is artificial to insist on the indivisibility and non-justiciability of economic, social and cultural rights. The extensive set of examples provided for in the present study demonstrates that the lack of an economic, social and cultural rights' requirements can lead to a violation of civil and political rights. In addition, a strict separation of the traditional categories of rights would not only result in a lack of protection of the 'category' of economic, social and cultural rights, but also in a too narrow protection of civil and political rights. In the case of such a strict separation, elements that touch upon or have a supposition of falling under economic, social and cultural rights, would not

[49] See: Koch 2003 p. 3-39; Koch 2006, p. 405-430; Koch 2009, p. 310.
[50] Koch 2009.

be considered as part of the protection of civil and political rights and will therefore not be taken into account. However, the prospects for far-reaching integrative steps at institutional level do not seem bright. For example, just consider the political reluctance of the State parties of the ICESCR in relation to the ratification of the OP ICESCR for an individual complaints procedure. The political will for such steps can be considered as non-existing for the time being.

For this research present-time reality has to be taken into account. As put forth by Koch (2006): 'The fact that (social) fulfillment elements of civil rights can be considered justiciable by applying a hermeneutic – and thereby integrated – approach does not necessarily entail the justiciability of social fulfillment rights. He who cannot link his need to a civil right – because he is only hungry, homeless or sick – cannot invoke the integrated approach, and even if a link to a civil right can be established, a certain nearness or proximity must be required for the integration to be legally acceptable.'[51]

For the time being, the justiciability of the right to equal access to health care can be challenged under the collective complaints procedure with the European Committee for Social Rights. In addition, fortunately the potential of the integrated approach seems far from exhausted. After reviewing the case law of the ECtHR and the HRCee within the horizontal structure of the hermeneutic circle, it can be concluded that this previous understanding of the case law determines the present understanding as well as the future understanding of the justiciability of the right to health care. Within this previous understanding, these two treaty bodies protected or at least took into account the right to access to health care *via* their task of protecting those rights explicitly covered by the ECHR and the ICCPR. Moreover, various elements of health care that are not yet covered, are not entirely ruled out for protection *via* the integrated approach. The issue for the following Chapters is therefore not whether these bodies have a say in disputes that concern the accessibility to health care, but how they will apply the integrated approach.

5 CONCLUSIONS

The phenomenon of integrated approach is defined as the possibility of treaty based bodies, such as the HRCee and the ECtHR, to protect or at least take into account social and economic rights when providing international protection for those rights explicitly covered by the treaties in question. Two ways of adopting an integrated approach are distilled from the cases of the HRCee and the ECtHR: an indirect way and a direct way. By the indirect integrated approach, elements of economic, social and cultural rights and the right to health care are taken into account when dealing with the substantive provisions of the ICCPR and the ECHR respectively. Under the direct adoption of the integrated approach autonomous provisions of the ICCPR and the ECHR are directly applied to rights protected by other human rights

[51] Koch 2006, p. 425.

instruments. Examples of such provisions are Article 26 ICCPR and Article 1 Protocol No. 1 ECHR.

Scott and Koch provide normative explanations of the integrated approach in human rights law. In his early work on the *permeability of human rights* Scott defined permeability as the openness of a treaty dealing with one category of human rights to having its norms used as a vehicle for the direct or indirect protection of norms of another treaty dealing with a different category of human rights. Scott made a distinction between two categories of permeability, which are comparable to the notions of the indirect and direct integrated approach as set out by the present author. The organic interdependence, which implies that one right forms part of another right by which it may be protected, is comparable to the notion of indirect integrated approach. The related interdependence corresponds to what is understood by direct integrated approach, namely that one right, for example Article 26 ICCPR, applies to another right, *e.g.* Article 12 ICESCR.

Later, Scott adapted his work on the permeability of human rights and just like Koch, he advocated the necessity of a contextual interpretation of human rights. This contextual interpretation of human rights is considered necessary to challenge the existing text-conformal interpretative traditions. In her *hermeneutic circle of obligations* Koch perceives the process of contextual interpretation of human rights as a continuing process.

Both the work of Scott and Koch are useful for the understanding of the integrated approach adopted by the HRCee and the ECtHR, especially in the light of the subject of the present study: the justiciability of the right to equal access to health care by which the prohibition of discrimination applies to the right to health care under the integrated approach. If this is done *via* a non-ancillary non-discrimination provision, this can be considered to fall under the category of organic interdependence. If an autonomous prohibition of discrimination is applied to the right to health care, this can be considered to constitute related interdependence.

Moreover, contextual interpretative analysis within the vertical structure of Koch's hermeneutic circle demonstrates what is crucial for the integrated approach: text encounters context. In seeking proper protection of human rights, the ECtHR as well as the HRCee has taken into account the concrete facts of the case, *i.e.* the context. And as these concrete facts called for an interpretation that included economic, social and cultural right demands, the strict boundaries between the two traditional categories of rights were abolished. Whether this could be done under Article 14 ECHR in a case concerning unequal access to health care by the ECtHR will be examined in the first part of Chapter IX. This could also comprise what Scott defined as organic interdependence. Related interdependence would signify that Article 26 ICCPR and Article 1 Protocol No. 12 ECHR have to apply to the right to health care for the right to equal access to be justiciable. This possibility shall be investigated in the second part of Chapter IX and in Chapter X. However, before that, the justiciability of the right to equal access to health care at the

European Committee of Social Rights, which is entitled to adjudicate complaints concerning access to health care, will be examined in Chapter VIII.

PART C

THE JUSTICIABILITY OF THE RIGHT TO EQUAL ACCESS TO HEALTH CARE

CHAPTER VIII
THE JUSTICIABILITY OF THE RIGHT TO EQUAL ACCESS TO HEALTH CARE AT THE EUROPEAN COMMITTEE OF SOCIAL RIGHTS

1 INTRODUCTION

In this Chapter the justiciability of the right to equal access to health care at the European Committee of Social Rights will be discussed. The ESC and RESC provide for economic, social and cultural rights. Therefore, in comparison to the complaints mechanisms under the ECHR and the ICCPR, it is not necessary to adopt an integrated approach when adjudicating cases on the right to equal access to health care.

In its cases on the accessibility of the rights provided by the ESC and RESC, the European Committee of Social Rights clarifies that it considers this term to imply accessibility to everyone, without discrimination.[1] Consequently, in the cases that deal with a complaint stating that a specific group of persons did not benefit from the rights enshrined in the ESC and RESC in comparison to others, the European Committee of Social Rights adopts the principle of equal treatment and non-discrimination. Paragraph 2 will show how the European Committee of Social Rights adopts these principles in its case law on the accessibility of the entitlements provided by the ESC and the RESC and what criteria apply.

Under the collective complaints procedure, the European Committee of Social Rights hitherto dealt with three cases on unequal access to health care that affected certain groups of persons. These cases shall be discussed in paragraph 3. Finally, paragraph 4 provides an analysis of the lessons that can be drawn as regards the justiciability of the right to health care at the European Committee of Social Rights.

2 THE ASSESSMENT OF COMPLAINTS ABOUT UNEQUAL TREATMENT AND DISCRIMINATION BY THE EUROPEAN COMMITTEE OF SOCIAL RIGHTS

The right to equal treatment and non-discrimination is enshrined in various provisions of both the ESC and the RESC. The preamble of the ESC of 1961 provides that 'the enjoyment of social rights should be secured without discrimination on grounds of race, colour, sex, religion, political opinion, national extraction or social origin'. In the RESC of 1996, this prohibition was laid down in a separate Article, Article E which reads: 'The enjoyment of the rights set forth in this Charter

[1] Complaint No. 41/2007, *Mental Disability Advocacy Center (MDAC)* v. *Bulgaria*, para. 37.

shall be secured without discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national extraction or social origin, health, association with a national minority, birth or other status.' Moreover, in both the ESC and the RESC the right to equal treatment and prohibition of discrimination are also enshrined in their substantive provisions. Article 4, paragraph 3 ESC and RESC enshrines that with a view to ensure the effective exercise of the right to a fair remuneration, the contracting States have to recognise the right of men and women workers to equal pay for work of equal value. With respect to the right to social security and the right to social and medical assistance laid down in Articles 12 and 13 ESC and RESC respectively, it is prescribed that these provisions have to be provided on an equal footing to the nationals of the Signatory States as to nationals of other contracting parties lawfully within their territories. And the right to equal treatment in matters of employment and occupation without discrimination on the grounds of sex or family responsibilities is laid down by Article 20 and Article 27 of the RESC.

According to the European Committee for Social Rights, the importance of the prohibition of discrimination with respect to the achievement of substantive rights contained in the RESC, was highlighted by the insertion of this prohibition as a separate provision in Article E. It considers this provision of great importance to help secure the equal effective enjoyment of all the rights concerned. Moreover, in a case concerning the right to education the European Committee of Social Rights clarified that all education provided by States must fulfil the criteria of availability, accessibility, acceptability and adaptability.[2] With regard to these criteria, it referred to GC No. 13 of the Committee.[3] It elucidated that the term accessibility implies that such provisions have to be accessible to everyone, without discrimination and have to be designated to respond to people with special needs. These findings can reasonably be considered to apply to all economic, social and cultural rights provided for by and protected under the ESC and the RESC.

Article E RESC constitutes an ancillary norm. It has to be read and applied in combination with a substantive provision of the RESC and there can be no room for its application unless the facts at issue fall within the ambit of one or more of these provisions. However, as clarified by the European Committee of Social Rights, Article E does not necessarily presuppose a breach of these clauses and to this extent it can be considered to have an autonomous meaning.[4] Therefore, a measure that in itself is in conformity with the substantive provision concerned, may infringe this provision if read in conjunction with Article E for the reason that it is of a discriminatory nature.[5]

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[2] Complaint No. 41/2007, *Mental Disability Advocacy Center (MDAC)* v. *Bulgaria*, para. 37.
[3] E/C.12/1999/10, General Comment 13 (1999), 8 December 1999, *The right to education*, para. 6.
[4] Complaint No. 50/2008, *Confédération Française Démocratique du Travail (CFDT)* v. *France*, para. 37; Complaint No. 51/2008, *European Roma Rights Centre (ERRC)* v. *France*, para. 79.
[5] Complaint No. 26/2004, *Syndicat de Agrégés de l'Enseignement Supérieur (SAGES)* v. *France*, para. 34.

In its case law on Article E, the European Committee of Social Rights regularly made reference to the jurisprudence of the ECtHR. It elucidated that the ESC and the RESC are envisaged as human rights instruments to complement the rights enshrined in the ECHR, which highlights the indivisibility and interdependence of all human rights.[6] Consequently, it surveys that its interpretation of the provisions laid down in the RESC is fully in line with the ECtHR's interpretation of the relevant provisions of the ECHR.[7] As such, it considers the role and wording of Article E comparable to those of Article 14 ECHR, which does not amount to an autonomous prohibition of discrimination either.[8]

The European Committee of Social Rights deals with cases on indirect as well as direct discrimination. In dealing with cases on direct discrimination, the European Committee of Social Rights adopts a similar model of assessment as does the ECtHR.[9] It set out that 'a difference in treatment between people in comparable situations constitutes discrimination [..] if it does not pursue a legitimate aim and is not based on objective and reasonable grounds'.[10] A difference in treatment can moreover be considered not to be discriminatory if there is no reasonable relationship of proportionality between the means employed and the aim pursued.[11]

According to the European Committee of Social Rights the first thing to establish is established whether the group of persons represented by a complainant organisation is in a situation comparable to the group it refers to. For example, in the case *Confédération Française Démocratique du Travail (CFDT)* v. *France* the European Committee of Social Rights ruled that the group of civilian officials of the French forces in Germany and the civilian officials of the French forces in France were not in a comparable situation. Consequently, the difference in treatment with respect to the conditions of integration into civil service was not considered to amount to discriminatory treatment.[12]

If the group represented by a complainant organisation is found to be in a comparable situation to the group it refers to, it has to be considered whether a difference in treatment can be justified. For this, the aim of the distinction is examined. In a case against France, the *Syndicat national des Professions du*

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[6] Complaint No. 14/2003, *International Federation of Human Rights Leagues (FIDH)* v. *France*, paras. 27, 28.
[7] Complaint No. 39/2006, *European Federation of National Organisations working with the Homeless (FEANTSA)* v. *France*, para. 65.
[8] Complaint No. 26/2004, *Syndicat de Agrégés de l'Enseignement Supérieur (SAGES)* v. *France*, para. 34. This approach can be expected to apply to the case law of the ECtHR under Article 1 Protocol No. 12 ECHR as well, as the ECtHR which has indicated that notions of discrimination prohibited by Article 14 ECHR and by Article 1 Protocol No. 12 ECHR are to be interpreted in the same manner.
[9] See Chapter 9.
[10] Complaint No. 6/1999, *Syndicat national des Professions du tourisme* v. *France*, para. 25.
[11] Complaint No. 50/2008, *Confédération Française Démocratique du Travail (CFDT)* v. *France*, para. 38.
[12] Complaint No. 50/2008, *Confédération Française Démocratique du Travail (CFDT)* v. *France*, para. 47.

tourisme claimed that all bodies offering guided tours within the remit of the Ministry of Culture and Communication discriminated between lecturer guides approved by these bodies and interpreter guides and national lecturers with a State diploma, which resulted in a denial of the right to work for those with a State diploma.[13] In reply, the French State explained that these restrictions were applied for reasons of security of persons and property. However, the European Committee of Social Rights did not consider this to constitute a legitimate aim.[14] Subsequently, the European Committee of Social Rights also dealt with the criterion of reasonableness and objectivity of the difference made between these groups of guides. It ruled that it did not consider the reasons of security of persons and property to meet these criteria sufficiently, at least not if these approved lecture guides conducted visits not accompanied by security staff. Moreover, the selection criteria for these lecturers were not in any way linked to competencies in security matters.[15]

In another case, the case of *International Federation of Human Rights Leagues (IFHR)* v. *Ireland*, the European Committee of Social Rights found that a difference in treatment of Irish nationals on the basis of their place of residence was based on objective and reasonable grounds.[16] Irish nationals who were in receipt of an Irish old age pension but were not residing permanently in Ireland were refused access to a free travel scheme. The European Committee of Social Rights considered that States may legitimately restrict the scope of application of measures adopted to give effect to the rights of elderly as enshrined in Article 23 if such restrictions are reasonable and objective and do not constitute a denial of the core entitlements of elderly persons to essential social protection. Considering the nature of the benefits at issue, the European Committee of Social Rights found that the difference in treatment between Irish nationals did not constitute an unreasonable restriction.

In the assessment of unequal treatment, the European Committee of Social Rights also takes into account the margin of appreciation the Signatory States of the ESC and RESC enjoy. With reference to the case law of the ECtHR, the European Committee of Social Rights set out that State parties 'enjoy a certain "margin of appreciation" in assessing whether and to what extent differences in otherwise similar situations justify a different treatment in law'. Nevertheless, it is ultimately for the European Committee of Social Rights 'to decide whether the difference lies within this margin'.[17]

[13] Complaint No. 6/1999, *Syndicat national des Professions du tourisme* v. *France*.
[14] Complaint No. 6/1999, *Syndicat national des Professions du tourisme* v. *France*, para. 39.
[15] Complaint No. 6/1999, *Syndicat national des Professions du tourisme* v. *France*, para. 41.
[16] Complaint No. 42/2007, *International Federation of Human Rights Leagues (IFHR)* v. *Ireland*, paras.19, 20.
[17] Complaint No. 50/2008, *Confédération Française Démocratique du Travail (CFDT)* v. *France*, para. 39; Complaint No. 51/2008, *European Roma Rights Centre (ERRC)* v. *France*, para. 82.

The European Committee of Social Rights has not dealt with the margin of appreciation in many cases in relation to unequal treatment and non-discrimination. One example is the case of *Autism Europe* v. *France* on the right to education for adults and children with autism.[18] In this case it stated that the fact that the establishments specialised in the education of those with autism were not in general financed from the same budget as normal schools, did not in itself amount to discrimination 'since it is primarily for States themselves to decide on the modalities of funding'.[19] However, in relation to the compliance of Member States with their obligations under the substantive provisions of the RESC, the European Committee of Social Rights did adopt some criteria in determining the scope of the margin of appreciation. Again in reference to the case law of the ECtHR, it elucidated that 'if discretion must be left to the competent national authorities, the margin will tend to be narrower where the right at stake is crucial to the individual's effective enjoyment of intimate or key rights. Where a particularly important facet of an individual's existence or identity is at stake, the discretion allowed to the State will be restricted.'[20]

So far, the European Committee of Social Rights has not clarified whether it considers the ground of distinction to have an influence on the intensity of the margin of appreciation. Nevertheless, considering the fact that it regularly refers to the case law of the ECtHR which generally grants a restricted margin of appreciation to the respondent State in case the distinction is considered to be based on a suspect ground and is concerned to adjudicate in line with it, the ground of distinction can be expected to play a role in its considerations.

With respect to the ground of distinction, the European Committee of Social Rights recognised several other grounds of distinction to fall under the open-ended non-discrimination provision of Article E. In the *Autism Europe* v. *France* case the European Committee of Social Rights considered disability to be covered by the reference 'other status'.[21] And in *CFDT* v. *France* the European Committee of Social Rights considered the ground of distinction, namely duties carried out in the service of the French forces stationed in Germany under German law or in France under French Law, to fall under the denomination of 'other status' listed in Article E.[22]

Although the European Committee of Social Rights clearly set out the model it applies in relation to direct discrimination, it is not always adopted in a consequent manner. In some cases not all phases of the model are dealt with explicitly. However, the European Committee of Social Rights has hitherto dealt

[18] Complaint No. 13/2002, *Autism Europe* v. *France*, para. 54.
[19] Complaint No. 13/2002, *Autism Europe* v. *France*, para. 54.
[20] Complaint No. 58/2009, *Centre on Housing Rights and Evictions (COHRE)* v. *Italy*, para. 120.
[21] Complaint No. 13/2002, *Autism Europe* v. *France*, para. 51. Also dealt with as such in Complaint No. 41/2007, *Mental Disability Advocacy Center (MDAC)* v. *Bulgaria*.
[22] Complaint No. 50/2008, *Confédération Française Démocratique du Travail (CFDT)* v. *France*, para. 44.

with only a few cases on direct discrimination. It is therefore still difficult to draw concrete conclusions regarding the adoption of this model by the European Committee of Social Rights.

The case law of the European Committee of Social Rights is mainly known for its cases on *indirect* discrimination. In one of its early cases, *Autism Europe* v. *France*, the European Committee of Social Rights set out that it considered Article E to not only prohibit direct discrimination but also all forms of indirect discrimination.[23] Also here it referred to the ECtHR and cited the ECtHR's approach in the case of *Thlimmenos* v. *Greece*: 'The right not to be discriminated against in the enjoyment of the rights guaranteed under the Convention is also violated if States without an objective and reasonable justification fail to treat differently persons whose situations are significantly different.'[24] Thus, 'by failing to take due and positive account of all relevant differences or by failing to take adequate steps to ensure that the rights and collective advantages that are open to all are genuinely accessible by and to all', indirect discrimination may arise.[25] Consequently, merely guaranteeing identical treatment as a means of protection against discrimination is not sufficient.[26]

In many of its cases on equal treatment and non-discrimination, the European Committee of Social Rights dealt with the circumstances of vulnerable and marginalised groups. Most of these cases concerned the systematically disadvantaged Roma communities. The substantive equality that is emphasised and aimed at by the recognition and application of the prohibition of indirect discrimination serves as an important protection for this vulnerable group. The corresponding positive obligations of the Member States are important for an effective enjoyment of their economic, social and cultural rights guaranteed by the ESC and RESC.[27]

In many of these cases on the affected Roma communities, the European Committee of Social Rights found that their specific differences and needs were not or not sufficiently taken into account, which resulted in indirect discrimination. For example, in *European Roma Rights Centre (ERRC)* v. *Bulgaria* the complainant organisation alleged that Bulgaria discriminated against Roma as regards housing, with the result that Roma families were segregated in housing matters, were living in substandard housing conditions with inadequate infrastructure, lacked legal security of tenure, and were subject to forced evictions.[28] In this case, the European

[23] Complaint No. 13/2002, *Autism Europe* v. *France*.
[24] *Thlimmenos* v. *Greece,* Application No. 34369/97, 6 April 2000, para. 44.
[25] Complaint No. 13/2002, *Autism Europe* v. *France*, para. 52; Complaint No. 41/2007, *Mental Disability Advocacy Center (MDAC)* v. *Bulgaria*, paras. 51, 52.
[26] Complaint No. 49/2008, *International Centre for the Legal Protection of Human Rights (INTERIGHTS)* v. *Greece*, para. 40; Complaint No. 51/2008, *European Roma Rights Centre (ERRC)* v. *France*, para. 84.
[27] *European Roma Rights Centre (ERRC)* v. *Bulgaria*, ECSR 3 December 2008, EHRC 2009/92 with annotation of Henrard, p. 964.
[28] Complaint No. 31/2005, *European Roma Rights Centre* v. *Bulgaria*, para. 7.

Committee of Social Rights found that the simple guarantee of equal treatment as the means of protection against any discrimination did not suffice. It was reiterated that Article E RESC imposes an obligation of taking into account the relevant differences and to act accordingly. Therefore, positive measures were considered to be needed to secure the integration of an ethnic minority such as the Roma into mainstream society.[29] Similar complaints as in the case of *ERRC* v. *Bulgaria* were lodged by the ECCR against Italy, Greece, France, Bulgaria and Portugal regarding the right to housing for Roma.[30]

In the various cases on indirect discrimination, the European Committee of Social Rights seems to adopt a casuistic approach. No clear criteria are adopted and little insight is provided into the considerations of the European Committee of Social Rights.[31] Nevertheless, it clarified that statistics play an important role in its findings. In various cases it based its finding that differences or needs of vulnerable groups were not sufficiently taken into account on statistical data. For example, in *MDAC* v. *Bulgaria* only 2,8% of the children with autism were attending mainstream primary education at the time of the complaint and 3,4% of them enjoyed education speciacally set up for them.[32] Consequently, the European Committee of Social Rights found Article 17, paragraph 2 *juncto* Article E RESC to be violated.[33] Moreover, the European Committee of Social Rights also consulted other sources for its findings in cases on indirect discrimination, such as documents of the UN Special Rapporteur on the Right to Adequate Housing and GC No. 13 of the Committee on Economic, Social and Cultural Rights and reports of the European Commission against Racism.[34]

In its cases on equal treatment and non-discrimination, the ESCR clearly set out that the Member States of the ESC and the RESC have to be mindful of the impact their choices, legislation and the effect of that legislation have, especially as regards groups with increased vulnerabilities. Moreover, it has emphasised that

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[29] Complaint No. 31/2005, *European Roma Rights Centre* v. *Bulgaria*, paras. 42, 55, 57.
[30] Complaint No. 27/2004, *European Roma Rights Centre* v. *Italy*; Complaint No. 15/2003, *European Roma Rights Center* v. *Greece*; Complaint No. 31/2005, *European Roma Rights Centre* v. *Bulgaria*; Complaint No. 51/2008, *European Roma Rights Centre (ERRC)* v. *France*; Complaint No. 61/2010, *European Roma Rights Centre (ERRC)* v. *Portugal*. Other examples of cases on unequal treatment, indirect discrimination and the right to housing for Travelers in general and Roma in specific: Complaint No. 33/2006, *International Movement ATD Fourth World* v. *France*; Complaint No. 49/2008, *International Centre for the Legal Protection of Human Rights (INTERIGHTS)* v. *Greece*; Complaint No. 58/2009, *Centre on Housing Rights and Evictions (COHRE)* v. *Italy*.
[31] *European Roma Rights Centre (ERRC)* v. *Bulgaria*, ECSR 3 December 2008, NJCM-Bulletin 34 (2009) 6 with annotation of Hendriks, p. 667.
[32] Complaint No. 41/2007, *Mental Disability Advocacy Center (MDAC)* v. *Bulgaria*.
[33] Complaint No. 41/2007, *Mental Disability Advocacy Center (MDAC)* v. *Bulgaria*, paras. 53, 43, 45. See also: Complaint No. 13/2002, *Autism Europe* v. *France*; Complaint No. 15/2003, *European Roma Rights Center* v. *Greece*; Complaint No. 27/2004, *European Roma Rights Centre* v. *Italy*.
[34] Complaint No. 33/2006, *International Movement ATD Fourth World* v. *France*, para. 152; Complaint No. 41/2007, *Mental Disability Advocacy Center (MDAC)* v. *Bulgaria*, para 37; Complaint No. 46/2007, *European Roma Rights Centre (ERRC)* v. *Bulgaria*, para. 46.

adequate steps have to be taken in order to ensure that the rights enshrined in the ESC and RESC are actually accessible to all. By this, the European Committee of Social Rights clearly showed that equal treatment and non-discrimination is not only a fundamental right but also a prerequisite for the effective access to economic, social and cultural rights.

3 CASE LAW OF THE EUROPEAN COMMITTEE OF SOCIAL RIGHTS ON THE RIGHT TO EQUAL ACCESS TO HEALTH CARE UNDER THE COLLECTIVE COMPLAINTS MECHANISM

On the basis of the cases set out in the previous paragraph, it can be concluded that equal treatment and non-discrimination are deemed important requirements by the European Committee of Social Rights for the accessibility of the economic, social and cultural rights enshrined in the ESC and RESC. The same holds for the right to health care. Health care should be accessible to everyone on a non-discriminatory basis. This is provided for and protected by Articles 11, 12 and 13 *juncto* E RESC. Moreover, this right can be directly adjudicated by the European Committee of Social Rights under the collective complaints procedure.

The European Committee of Social Rights has hitherto dealt with three cases on the accessibility of health care. In these cases Articles 11, 13, 17 and E RESC were addressed. The first case was the case of *International Federation of Human Rights Leagues (FIDH)* v. *France*.[35] The ruling in this case is important as the European Committee of Social Rights provided clarification of its approach in relation to the accessibility to health care for persons and their children unlawfully residing in a Member State. In this complaint, FIDH submitted that the provisions of a newly implemented French law on entitlements to state medical care constituted a violation of the right to medical assistance provided for by Article 13 of the RESC.[36] The French law ended the exemption of illegal immigrants with very low incomes from all charges of health care treatment. Due to this law, the beneficiaries had to pay a flat-rate charge for medical treatment outside the hospital and a daily charge for in-patient hospital treatment. According to the FIDH this constituted a violation of Article 13 RESC.

The scope of the ESC as well as the RESC in terms of persons protected is restricted by the Appendix included in both Charters. It provides that the persons covered under the RESC include foreigners only in so far as they are nationals of other Member States lawfully resident, or working regularly within the territory of the party concerned.[37] Similar provisions are enshrined in various Articles of the

[35] Complaint No. 14/2003, *International Federation of Human Rights Leagues (FIDH)* v. *France*.
[36] Complaint No. 14/2003, *International Federation of Human Rights Leagues (FIDH)* v. *France*, para. 16.
[37] Paragraph 1 of the Appendix of both the ESC and the RESC reads: 'Without prejudice to Article 12, paragraph 4, and Article 13, paragraph 4, the persons covered by Articles 1 to 17 and 20 to 31 include foreigners only in so far as they are nationals of other Parties lawfully resident or working regularly

RESC such as Article 13, paragraph 4. Article 13, paragraph 4 RESC prescribes that the Signatory States of the ESC undertake to apply paragraphs 1, 2 and 3 'on an equal footing with their nationals to nationals of other Parties lawfully within their territories, in accordance with their obligations under the European Convention on Social and Medical Assistance, signed at Paris on 11 December 1953'. Under the European Convention on Social and Medical Assistance, the Contracting Parties have a duty to ensure that nationals of the other Contracting Parties who are lawfully present in one of the Signatory States, and who are without sufficient resources, shall be entitled on an equal basis as its own nationals and on the same conditions to social and medical assistance.[38]

The FIDH declared to be aware of this provision. However, it held that by no way it could be justified denying them all medical assistance. The European Committee of Social Rights agreed with this claim and stated that 'human dignity is the fundamental value and indeed the core of positive European human rights law – whether under the European Social Charter or under the European Convention of Human Rights – and health care is a prerequisite for the preservation of human dignity'. Consequently, the majority of the Committee members found that 'legislation or practice which denies entitlements to medical assistance to foreign nationals, within the territory of a State Party, even if they are there illegally, is contrary to the Charter'.[39] However, Article 13 RESC was found not to be violated. The European Committee of Social Rights stated that the legislation in question did not deprive illegal immigrants of all entitlement to medical assistance. They were provided with State assistance to meet certain costs of health care for an uninterrupted period of more than three months, and treatment for emergencies and life threatening conditions.[40] Apparently, the European Committee for Social Rights deems these entitlements for illegal immigrants to be sufficient to meet the criteria of Article 13 RESC.[41] This was, however, found to be different in relation to access to health care for children illegally present in France. Although the minimum level of health care provided to illegal immigrants in France was considered sufficient to

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within the territory of the Party concerned, subject to the understanding that these articles are to be interpreted in the light of the provisions of Articles 18 and 19.'

[38] Article 1, European Convention on Social and Medical assistance and protocol thereto, 11 December 1953, E.T.S. 14.

[39] Complaint No. 14/2003, *International Federation of Human Rights Leagues (FIDH)* v. France, paras. 31, 32. The Committee members Mr S. Evju, Mrs P. Koncar, and Mr L. Francois had another view and pointed to paragraph 1 of the Appendix to the RESC in their dissenting opinion. They argued that Article 13, paragraph 4 RESC does not lend itself to such expansive construction as to include persons not lawfully present or resident within the territory of a Contracting Party.

[40] Complaint No. 14/2003, *International Federation of Human Rights Leagues (FIDH*) v. *France*, paras. 33, 34.

[41] In his dissenting opinion, Mr. T. Akillioğlu, set out that he cannot subscribe to the reasoning of the majority, according to which the minimum medical assistance offered to illegal immigrants is sufficient to meet the requirements of Article 13 ESC. Moreover, he stated that not only Article 17, but also article 13 ESC is violated due to discrimination between nationals and foreigners and nationals and illegal immigrants.

meet the criteria of Article 13 RESC, the European Committee for Social Rights applied a different approach to *children* unlawfully present in a Member State of the RESC. In France, children of illegal immigrants were only admitted to the medical assistance scheme after a certain period of time and medical assistance to these children was limited to situations that involved an immediate threat to life. The European Commission for Social Rights ruled that this situation was not in conformity with Article 17 ESC. It based its findings on the provisions enshrined in the UN Convention of the Rights of the Child, which were found to directly inspire the interpretation of Article 17 RESC.[42]

In this case, the European Committee of Social Rights extended the application to Articles 13 and 17 to illegal immigrants. However, it did not clarify what level of health care provided to children unlawfully present in the territory of a Member State can be considered to be in conformity with Article 17 RESC nor did it elucidate whether the level of health care provided to these children has to be equal to that provided to children with French nationality and other children lawfully residing in France. The case *Defence for Children International (DCI)* v. *the Netherlands* provided for more clarification in this regard.[43] This case dealt with a complaint of DCI on Dutch legislation and practice in the Netherlands that denied children unlawfully present in its territory access to housing. DCI considered that the Netherlands had to treat all children equal, regardless of their legal status.[44]

In reply to this claim, the European Committee of Social Rights first of all held that the ESC guarantees each child a significant number of fundamental rights, such as the right to health as laid down by Article 11 RESC.[45] Moreover, it found that the restriction laid down by the Appendix to the RESC should not end up having unreasonably detrimental effects where the protection of vulnerable groups is at stake.[46] Consequently, in this case too the European Committee of Social Rights seems to expand the protection of the ESC and RESC to persons not legally present or residing within the territory of a Signatory State. Nevertheless, in reference to the case law of the ECtHR, it also held that States have the right under international law to control the entry, residence and expulsion of aliens from their territories. Therefore, the Netherlands was considered to legitimately treat children lawfully residing and children unlawfully present in its territory differently.[47] Moreover, the European Committee of Social Rights elucidated that for that reason, Article E RESC does not serve the purpose to claim entitlements to rights under the RESC for such groups of persons.[48]

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[42] Complaint No. 14/2003, *International Federation of Human Rights Leagues (FIDH)* v. *France*, para. 36, 37.
[43] Complaint No. 47/2008, *Defence for Children International (DCI)* v. *the Netherlands*.
[44] Complaint No. 47/2008, *Defence for Children International (DCI)* v. *the Netherlands*, para. 6.
[45] Complaint No. 47/2008, *Defence for Children International (DCI)* v. *the Netherlands*, para. 25.
[46] Complaint No. 47/2008, *Defence for Children International (DCI)* v. *the Netherlands*, para. 37.
[47] Complaint No. 47/2008, *Defence for Children International (DCI)* v. *the Netherlands*, para. 41.
[48] Complaint No. 47/2008, *Defence for Children International (DCI)* v. *the Netherlands*, para. 74.

In the second case about the right to equal access to health care, Article E RESC was taken into account. *European Roma Rights Centre (ERRC)* v. *Bulgaria* constituted a case relating to the right to access to health care for the Roma community in Bulgaria under Articles 11 and 13 *juncto* Article E RESC.[49] The ERRC claimed that the State did not ensure universal access to health insurance coverage and that the existing Bulgarian health insurance legislation discriminated against the most vulnerable individuals, amongst which the Roma community. It set out that although Bulgarian legislation provided State-subsidised health insurance for socially vulnerable individuals, this was made conditional on being eligible for the right to social assistance or being registered as unemployed. As the majority of the large number of Roma did not receive social assistance nor were registered as unemployed, they could not benefit from this type of public health insurance coverage. Moreover, it was also held that government policies did not adequately address the specific health risks and living conditions of the Roma communities.[50]

The complaints about discrimination by the Bulgarian health insurance legislation and the linkage between being eligible for social assistance and for health care under the State-subsidised health insurance system were dealt with under Article 13, paragraph 1 RESC. Not only the law, but also its effects were taken into account. The European Committee of Social Rights found that the Law on Health Insurance did not make any difference between Bulgarian citizens. The conditions it imposed to benefit from medical treatment, as well as those for being exempt from paying health insurance contributions were considered to be neutral. Consequently, these provisions were considered not to discriminate against Roma.[51] Moreover, the European Committee of Social Rights observed that there was a subsidiary non-contributory system, open to persons receiving social assistance who did not benefit from the contributory system. This system was considered to ensure that some of the most disadvantaged sections of the community had access to health care. However, the European Committee of Social Rights established that the linkage between social security and health care coverage had the effect that persons who did not qualify for social assistance or who temporarily lost the right to social assistance were left without health care coverage. These persons only had access to emergency medical care and obstetrical care for women. In addition, there was a mechanism in place that covered the costs of hospital treatment for a period of one year. According to the European Committee of Social Rights this mechanism did not provide for a long-term solution. These measures were considered insufficient to ensure health care for poor or socially vulnerable persons. As there were no measures established that provided for primary or specialised outpatient medical

[49] Complaint No. 46/2007, *European Roma Rights Centre (ERRC)* v. *Bulgaria*.
[50] Complaint No. 46/2007, *European Roma Rights Centre (ERRC)* v. *Bulgaria*, paras. 5, 20, 22.
[51] Complaint No. 46/2007, *European Roma Rights Centre (ERRC)* v. *Bulgaria*, para. 40.

care for these groups and the provision of free health care was restricted to situations of emergency, Article 13, paragraph 1 RESC was found to be violated.[52]

Subsequently, the European Committee of Social Rights dealt with the allegation of unequal access for Roma to health care services which resulted in their specific health risks not being adequately addressed, thus amounting to indirect discrimination. In reference to its own Conclusions, the European Committee of Social Rights reiterated that Article 11 RESC 'imposes a range of positive obligations to ensure an effective exercise of the right to health'. In addition, it set out that it 'assesses compliance with this provision paying particular attention to the situation of disadvantaged and vulnerable groups'.[53] Thereby it indicated to focus on substantive equality and indirect discriminatorion in case of a lack of compliance with the positive obligations a Member State has. Moreover, the European Committee of Social Rights considered that there was sufficient evidence that showed that Roma communities did not live in healthy environments and that their health status was inferior to that of the general population. It based its findings on various studies referred to by the ERRC and other sources such as a report on Bulgaria of the European Commission against Racism. This situation was in part attributed to the failure of prevention policies by the Bulgarian State. The European Committee of Social Rights stated that Bulgaria failed to meet its positive obligations to ensure that Roma enjoyed an adequate access to health care, especially as it did not take reasonable steps to address the specific problems faced by Roma communities. Consequently, as they did not benefit from appropriate responses to their health care needs, Article 11 *juncto* E RESC was found to be violated.[54]

The third case that dealt with equal treatment and non-discrimination in relation to the right to health care was also lodged by the ERRC against Bulgaria.[55] In this case, the ERRC contested the same Social Assistance Act as in the previous case. Various amendments to this act limited the time during which social assistance could be received. One of the complaints of the ERRC concerned the linkage between being entitled to receive social assistance and *inter alia* the right to health care insurance. The ERRC claimed that the amendments to the social assistance act had a disparate and unjustified impact on Roma. Therefore, they were also disproportionately affected in relation to their right to health care, which amounted to indirect discrimination.[56]

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[52] Complaint No. 46/2007, *European Roma Rights Centre (ERRC)* v. *Bulgaria*, paras. 41, 42, 43, 44. However, the European Committee of Social Rights did not clarify what has to be understood under the terms primary or specialised outpatient medical care and emergency care. See for comments on this: *European Roma Rights Centre (ERRC)* v. *Bulgaria* ECSR 3 December 2008, NJCM-Bulletin 34 (2009) 6 with annotation of Hendriks, p. 666.
[53] Complaint No. 46/2007, *European Roma Rights Centre (ERRC*) v. *Bulgaria*, para. 45.
[54] Complaint No. 46/2007, *European Roma Rights Centre (ERRC)* v. *Bulgaria*, paras. 46, 47,49, 50, 51.
[55] Complaint No. 48/2008, *European Roma Rights Centre (ERRC)* v. *Bulgaria*.
[56] Complaint No. 48/2008, *European Roma Rights Centre (ERRC)* v. *Bulgaria*, paras. 20, 21, 22, 44.

The European Committee of Social Rights recognised that the amendments to the social assistance act were likely to have a considerable impact upon Roma. However, it already found that Article 13, paragraph 1 RESC was violated. Therefore, the European Committee of Social Rights held that it was not necessary to examine the allegation of a breach of Article E read in conjunction with Article 13, paragraph 1 RESC, Nevertheless, it did clarify that this allegation was taken into account in the considerations on the alleged violation of Article 13, paragraph 1 RESC.[57]

4 THE CASE LAW OF THE EUROPEAN COMMITTEE OF SOCIAL RIGHTS AND THE JUSTICIABILITY OF THE RIGHT TO EQUAL ACCESS TO HEALTH CARE

The previous cases confirm what was held about the justiciability of the right to equal access to health care: it is justiciable by the European Committee of Social Rights. The European Committee of Social Rights stated that it considered the term accessibility of the economic, social and cultural rights enshrined in the ESC and RESC, to signify accessibility to everyone on a non-discriminatory basis.[58] In the three cases hitherto dealt with by the European Committee of Social Rights, this interpretation was adopted.

From the first case concerning the right to equal access to health care, it emerges that the provisions on the scope of protection by the ESC and RESC provided for by the Appendix of both Charters nuances this designation of equal access to health care.[59] This provision implies that people unlawfully present in a Member State are not protected by the provisions enshrined in the ESC and RESC. Nevertheless, the European Committee of Social Rights set out that these people should not be denied all medical assistance. It furthermore clarified that being entitled to State assistance to meet certain costs of health care for a period of more than three months and to treatment for emergencies and life threatening conditions was sufficient to meet the criteria of Article 13, paragraph 1 RESC. Consequently, this basic health care should be provided to everyone. By this finding, the European Committee of Social Rights restricts the margin of appreciation of the Member States. However, it is difficult to draw concrete conclusions on what health care should be provided to this group of illegal residents as the European Committee of Social Rights did not specify what it considered to fall under the denomination of emergency care.

For children unlawfully present within the territory of a Member State, the European Committee of Social Rights applies a different standard. There it found that the above minimum is not sufficient. Hence, it seems to acknowledge that children, by reason of their physical and mental immaturities, need special

[57] Complaint No. 48/2008, *European Roma Rights Centre (ERRC)* v. *Bulgaria*, paras. 45, 46.
[58] Complaint No. 41/2007, *Mental Disability Advocacy Center (MDAC)* v. *Bulgaria*, para. 37.
[59] Complaint No. 14/2003, *International Federation of Human Rights Leagues (FIDH)* v. *France*.

safeguards and care, including appropriate legal protection.[60] As held in the case of *Defence for Children International (DCI)* v. *the Netherlands* these children have the right to a significant number of fundamental rights enshrined in the ESC and the RESC, such as the rights laid down in Article 11 ESC. Nevertheless, Member States are allowed to treat these children differently in comparison to children lawfully present in their territory. As such, Article E RESC does not serve the purpose to claim entitlements of the right to health care for both children and other persons unlawfully present in the territory of a Member State.

In all other circumstances, Article E RESC seems to apply to claims on the right to equal access to health care. In dealing with this, the European Committee of Social Rights clarified that both direct discrimination and indirect discrimination are prohibited. For example, health insurance legislation can be considered not to be discriminatory if it is neutral and does not make any difference between citizens. However, the European Committee of Social Rights paid much attention to the factual consequences of a treatment, law or practice and the positive obligations of Member States in order to achieve substantive equality. The cases that dealt with indirect discrimination appeared to be mainly directed at vulnerable and marginalised groups, and of these cases most concerned the protection of the rights of Roma communities. The European Committee of Social Rights emphasised that Member States have positive obligations to ensure an effective exercise of the right to equal access to health care, whether in fact or in effect.[61] Nevertheless, the European Committee of Social Rights did not provide the considerations on its findings nor the criteria a State is supposed to meet in order to have accomplished its positive obligations.

Thus far only three cases in which unequal access to health care was alleged were dealt with on their merits and in only two of them the European Committee of Social Rights actually assessed the claim to this right substantively. In order to draw further conclusions on the justiciability of the right to equal access to health care under the ESC and RESC it is interesting to have a look at the conclusions that can be drawn from the other cases in which the European Committee dealt with equal treatment and non-discrimination.

In a case about unequal access to health care in which direct discrimination under Article E RESC is alleged, the European Committee of Social Rights adopts the model of assessment provided by the case law of the ECtHR. In this model it first determines whether the group of persons is comparable to the group of people it refers to. Secondly, it establishes whether these groups are treated differently. If this is found to be the case, it has to be examined whether this difference in treatment can be justified. The assessment of the justification of the difference in treatment constitutes of two phases, namely the assessment of whether the

[60] Preamble CRC and also referred to by the European Committee of Social Rights in Complaint No. 14/2003, *International Federation of Human Rights Leagues (FIDH)* v. France, para. 36.
[61] Vasey 2009, p. 61.

distinction pursues a legitimate aim and whether it is reasonable and objective. The proportionality test is also included by the European Committee of Social Rights in this phase. In case the difference in treatment is found to be justified, the difference in treatment will not be considered to constitute discrimination. If not, discrimination is established and consequently, the ESC or RESC are considered to be violated.

However, the European Committee of Social Rights has thus far not dealt with many cases under this model of assessment. Nevertheless, some conclusions can be drawn that may be relevant for a possible future case concerning unequal access to health care in which direct discrimination is alleged. The first conclusion is about the margin of appreciation attributed to the Member States. The European Committee of Social Rights has stated that the decision how to finance specialised education of those with autism falls within this margin of appreciation.[62] Therefore, it can also be considered to be primarily for the Member States to decide how health care and health care insurance systems are funded.

Moreover, the European Committee of Social Rights clarifies that in specific circumstances, the scope of application of measures adopted to give effect to the rights enshrined in the ESC and RESC can be considered to be based on reasonable and objective grounds as long as it does not constitute a denial of the core entitlements.[63] In the second case concerning the accessibility of health care, the European Committee of Social Rights states that vulnerable people without resources in need of health care at least have to be entitled to free emergency care, hospital treatment, primary care, and specialised outpatient care or to covering expenses for these types of care. These types of care were considered to fall under the responsibilities of the Member States following from Article 13, paragraph 1 RESC.[64] Although the European Committee of Social Rights has not said so explicitly, nor published its considerations, , it seems to have indicated that these types of health care have to be considered to constitute the core health care entitlements falling under Article 13, paragraph 1 RESC. Nevertheless, the types of care supposedly falling under this core content are very broadly defined.[65]

This requirement of protecting the core content of a right in assessing the justification of a difference in treatment is not addressed in the cases on indirect discrimination. In these cases, the European Committee of Social Rights mainly dealt with the positive obligations Member States have under the ESC and RESC with respect to vulnerable and marginalised groups. In many cases it dealt with the specific problems faced by Roma communities. Therefore, it seems to be particularly concerned with the needs of these groups. This is an important criterion

[62] Complaint No. 13/2002, *Autism Europe* v. *France*, para. 54.
[63] Complaint No. 42/2007, *International Federation of Human Rights Leagues (IFHR)* v. *Ireland*, paras. 9, 20.
[64] Complaint No. 46/2007, *Europeaan Roma Rights Centre (ERRC)* v. *Bulgaria*, paras. 43, 44.
[65] *European Roma Rights Centre (ERRC)* v. *Bulgaria*, ECSR 3 December 2008, NJCM-Bulletin 34 (2009) 6 with annotation of Hendriks, p. 665.

and indicates that this requirement should also be taken into account by the Member States when adapting their health care policies and measures to such groups.

Unfortunately, as set out before, it has to be concluded that in the cases on indirect discrimination the European Committee of Social Rights provides for very little clarification on its findings in these cases. Actually, only one case allows the conclusion that the measure concerned met the requirement of a positive obligation. This was a non-contributory health care system, which provided for more than only emergency health care and was open to persons without resources who did not benefit from the contributory system.[66] Moreover, the European Committee of Social Rights only clarifies that to establish whether there is indirect discrimination or not it makes use of statistics and documents of authoritative institutions and organisations. Unfortunately, with regard to the use of statistics, it does not specify what differences are acceptable and what not.

This lack of clear criteria and insight into the considerations made in cases on indirect discrimination and positive obligations of the Member States is unsatisfactory. The interpretations concerning indirect discrimination of the European Committee of Social Rights are thus difficult to transfer to other cases, such as a future case about unequal access to health care. Moreover, this can create the image of an unpredictable body of collective case law emerging, which might damage the authority of the European Committee of Social Rights.[67] Nevertheless, despite this weakness, the case law of the European Committee of Social Rights thus far has provided some useful criteria that may apply to other cases on unequal access to health care, but further cases will have to prove this point.

5 CONCLUSIONS

In its case law, the European Committee of Social Rights clearly shows that equal treatment and non-discrimination is not only a fundamental right but also a prerequisite for the effective enjoyment of economic, social and cultural rights. This does not only include equal treatment in a formal sense, but also substantive equality. Consequently, the European Committee of Social Rights deals with both direct and indirect discrimination. However, until now not many cases dealt with direct discrimination. The case law of the European Committee of Social Rights is therefore mainly known for its cases on indirect discrimination. In many of these cases, the European Committee of Social Rights deals with the situation of vulnerable and marginalised groups including the systematically disadvantaged Roma communities. In these cases, it is clearly set out that the Member States of the ESC and the RESC have to be mindful of the impact of their choices, legislation and the effect that legislation has, especially in relation to groups with heightened

[66] Complaint No. 46/2007, *Europeaan Roma Rights Centre (ERRC)* v. *Bulgaria*, para. 41.
[67] *European Roma Rights Centre (ERRC)* v. *Bulgaria*, ECSR 3 December 2008, NJCM-Bulletin 34 (2009) 6 with annotation of Hendriks, p. 667.

vulnerabilities. Moreover, the European Committee of Social Rights has emphasised that adequate steps have to be taken in order to ensure that the rights enshrined in the ESC and RESC are actually accessible to all. These conclusions can prove to be of relevance for a case concerning unequal access to health care.

The European Committee of Social Rights has hitherto only dealt with three cases on unequal access to health care. These cases constituted cases on access to health care for people unlawfully present within the territory of a Member State and in relation to the provision of free health care. Although more cases have to be awaited in order to be able to draw concrete conclusions about the approach of the European Committee of Social Rights to the right to equal access to health care, some provisional conclusions can be drawn.

Legislation or practices which deny entitlements to medical assistance to foreign nationals, even if they are unlawfully present within the territory of a State party, is contrary to the ESC and the RESC. The provision of State assistance to meet certain costs of health care for an uninterrupted period of more than three months and treatment for emergencies and life threatening conditions, can, however, be considered sufficient to meet the criteria of the RESC. Other standards apply to the children of illegal immigrants. Being admitted to a medical assistance scheme after a certain period of time and the provisions of health care in situations that involve an immediate threat to life are not considered sufficient for this group. Nevertheless, the Signatory States do not have to treat children unlawfully present in their territories equal in comparison to children lawfully residing there. It is justified to make a distinction between these groups of persons. It is clarified that Article E RESC does not serve the purpose to claim entitlements to rights under the RESC for groups of persons unlawfully present in a Member State. This nuances the definition of the right to equal access to health care and other rights provided for by the ESC and RESC.

In all other circumstances, Article E RESC seems to apply to claims on the right to equal access to health care. Moreover, the European Committee of Social Rights clarifies that vulnerable people without resources and in need of health care at least have to be entitled to free emergency care, hospital treatment, primary care, and specialised outpatient care or to covering expenses for these types of care. Although this was not made explicit the Committee seems to have indicated that these types of health care have to be considered to constitute the core health care entitlements falling under Article 13, paragraph 1 RESC.

CHAPTER IX
THE JUSTICIABILITY OF THE RIGHT TO EQUAL ACCESS TO HEALTH CARE AT THE EUROPEAN COURT OF HUMAN RIGHTS

1 INTRODUCTION

The ECtHR takes elements of the right to health care into account in its task of affording protection of those rights explicitly covered by the ECHR. Consequently, under specific circumstances in which health care was not available or accessible, this constituted breach of a classical civil and political rights provision. This integrated approach is also adopted in cases concerning Article 14 ECHR. The ECtHR has ruled that although there rests no obligation on a State to provide certain socio-economic entitlements or to create a system of entitlements, if such a system has been set up by a State, it must create this in a manner which is compatible with the prohibition of discrimination covered by Article 14 ECHR.[1] Consequently, the provision of Article 14 ECHR also extends beyond the enjoyment of the rights and freedoms which the ECHR requires its Signatory States to guarantee.[2]

This potential of the justiciability of elements of economic, social and cultural rights *via* Article 14 ECHR is of great interest as regards the subject of the present study. In paragraph 2 the assessment model under Article 14 ECHR adopted by the ECtHR will be discussed. This assessment model is extensively dealt with by Gerards in her authoritative book 'Judicial Review in Equal Treatment Cases'.[3] Her work shall be used as a basis in setting out how the ECtHR applies this assessment model to general cases. In addition, paragraph 2 will also include an examination of how the assessment model under Article 14 ECHR is adopted to cases that deal with elements of economic, social and cultural rights under the substantive provisions of the ECHR.

Not many general criteria can be discerned in the adoption of the assessment model, except from the determination of the intensity of the assessment.

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[1] *Runkee and White* v. *the United Kingdom,* Application Nos. 42949/98, 53134/99, 10 May 2007, para. 33; *Tarkoev and others* v. *Estonia*, Application Nos. 14480/08, 47916/08, 4 November 2010, para. 40; *Case "relating to certain aspects of the laws on the use of languages in education in Belgium"* v. *Belgium,* Application Nos. 1474/62, 1677/62, 1691/62, 1769/63, 2126/64, 23 July 1968, p. 30, para. 9; *Stec and others* v. *the United Kingdom,* Application Nos. 65731/01, 65900/01, 12 April 2006, para. 53; *Sidabras and Džiautas* v. *Lighuania,* Application Nos. 55480/00, 59330/00, 27 July 2004, para. 52.

[2] *P.B. and J.S.* v. *Austria,* Application No. 18984/02, 22 July 2010, para. 32. Another example is *Niedzwiecki* v. *Germany,* Application No. 58453/00, 25 October 2005, para. 31 in which the ECtHR held: 'By granting child benefits, States are able to demonstrate their respect for family life within the meaning of Article 8 of the Convention; the benefits therefore falls within the scope of that provision'.

[3] Gerards 2005.

Paragraph 3 will set out what elements are taken into account to determine the intensity of the assessment under Article 14 ECHR. Also in this paragraph, the cases dealing with elements of economic, social and cultural rights will be discussed separately. In paragraph 5 the findings of the previous paragraph shall be analysed in the light of the justiciability of the right to equal access to health care at the ECtHR.

The Member States of the CoE have expressed their resolve to secure in addition to Article 14 ECHR a more extensive protection against discrimination by opening for ratification Protocol No. 12 ECHR.[4] Protocol No. 12 ECHR provides for an autonomous non-discrimination clause with respect to all human rights defined by law, including those protected by other treaties than the ECHR. In paragraph 5 Protocol No. 12 ECHR will be set out together with observations on its potential for the justiciability of the right to equal access to health care.

2 THE ASSESSMENT MODEL UNDER ARTICLE 14 ECHR OF THE EUROPEAN COURT OF HUMAN RIGHTS

2.1 Introduction

The *Belgian Linguistics* case was the first case in which the ECtHR gave an opinion on the application of Article 14 ECHR. In earlier cases, it practiced a rather strict approach: a claim on Article 14 ECHR was considered to be admissible only where the substantive Article with which it was read in conjunction, was violated. This approach had the result that an alleged claim of Article 14 ECHR had hardly any chance of success.[5] In its decision on the *Belgian Linguistics* case, the ECtHR adapted its approach: 'While it is true that this guarantee has no independent existence in the sense that under the terms of Article 14 it relates solely to "rights and freedoms set forth in the Convention", a measure that in itself is in conformity with the requirements of the Article enshrining the right or freedom in question may however infringe this Article when read in conjunction with Article 14 for the reason that it is of a discriminatory nature.'[6] Thus, although Article 14 does not constitute a subordinate non-discrimination clause, it does not presuppose a violation of these provisions for its application and to that extent it is autonomous.[7]

In the *Belgian Linguistics* case, the ECtHR set out a number of criteria for the assessment of a complaint under Article 14 ECHR. It stated that 'the principle of equality of treatment is violated if the distinction has no objective and reasonable justification. The existence of such a justification must be assessed in relation to the

[4] *Nachova* v. *Bulgaria,* Application Nos. 43577/98, 43579/98, 26 February 2004, para. 168.
[5] Gerards 2005, p. 104.
[6] *Case "relating to certain aspects of the laws on the use of languages in education in Belgium"* v. *Belgium,* Application Nos. 1474/62, 1677/62, 1691/62, 1769/63, 2126/64, 23 July 1968, p. 30, para. 9.
[7] Ruled as such in different cases, *e.g. Sahin* v. *Germany,* Application No. 30943/96, 8 July 2003, para. 85.

aim and effects of the measure under consideration, regard being had to the principles which normally prevail in democratic societies. A difference of treatment in the exercise of a right laid down in the Convention must not only pursue a legitimate aim: Article 14 is likewise violated if it is clearly established that there is no reasonable relationship of proportionality between the means employed and the aim sought to be realised.' These criteria formed the basis of the assessment model, which was later completed with another assessment criterion. In the case of *Marckx* the ECtHR included, as a first phase, the assessment of whether individuals are placed in similar situations.[8]

The use of these criteria in the assessment of alleged violations of Article 14 ECHR is now well-established case law.[9] Its assessment model can be formulated as follows:

- Phase 1: Are the individuals concerned placed in similar situations?
- Phase 2: Does the distinction have an objective and reasonable justification by assessing whether:
    - 2a: the difference in treatment pursues a legitimate aim;
    - 2b: there is a clearly established reasonable relationship of proportionality between the means employed and the aim sought to be realised.[10]

In the subsequent paragraphs the adoption of this assessment model by the ECtHR will be discussed. In every sub-paragraph a distinction shall be made between the adoption of every phase in general cases under Article 14 ECHR and in cases that deal with elements of economic, social and cultural rights.

2.2 The First Phase of the Assessment Model of Article 14 ECHR: General Cases

The first phase of the assessment model issued by the ECtHR prescribes a comparability test. In this phase, the ECtHR examines whether in the case submitted the applicant is in a similar position as the person or group he refers to.[11]

From its established case law, it seems that the ECtHR only finds it necessary to examine whether there is an objective and reasonable justification for the unequal treatment if it is demonstrated that there is a difference in the treatment of persons in analogous situations. As such, if they are not in a relevantly similar

[8] *Marckx* v. *Belgium*, Application No. 6833/74, 13 June 1979, para. 32. The ECtHR ruled: 'Article 14 safeguards individuals, placed in similar situations, from any discrimination in the enjoyment of the rights and freedoms set forth in those other provisions.'
[9] Gerards 2005, p. 123.
[10] See model Gerards 2005, p. 123. Later, indirect discrimination and substantive discrimination were recognised as well. This is dealt with in the paragraph on the first phase of the assessment model.
[11] Gerards 2005, p. 123.

situation, the ECtHR will in principle not go further into the question whether the alleged distinction amounts to a violation of Article 14 ECHR.[12]

In examining whether the cases submitted are comparable it is not necessary that the applicant is in an identical situation as the person or group he refers to. As the European Commission of Human Rights stated in the *Rasmussen* v. *Denmark* case of 1983: '[T]he fact that there are some differences between two individuals does not render Art. 14 inapplicable. The situation of the individuals need not be identical but only similar.'[13] Therefore, the applicant should be in a sufficiently comparable position and interest as the person or group he refers to in order to say that they are in a similar situation.[14]

The first phase of the assessment model applied under Article 14 ECHR includes, however, more than a test of comparability. In addition to direct unequal treatment, the ECtHR also takes into account other types of unequal treatment, such as substantive inequalities and indirect unequal treatment. Since the *Thlimmenos* v. *Greece* case of 2000, the ECtHR expressly recognised that substantive inequalities also fall within the scope of Article 14 ECHR: 'The Court has so far considered that the right under Article 14 not to be discriminated against in the enjoyment of the rights guaranteed under the Convention is violated if States treat differently persons in analogous situations without providing an objective and reasonable justification. However, the Court considers that this is not the only facet of the prohibition of discrimination in Article 14. The right not to be discriminated against in the enjoyment of the rights guaranteed under the Convention is also violated if States without an objective and reasonable justification fail to treat differently persons whose situations are significantly different.'[15] Moreover, as set out in *Kelly and others* v. *the United Kingdom* judgement: 'Where a general policy or measure has disproportionately prejudicial effects on a particular group, it is not excluded that this may be considered as discriminatory notwithstanding that it is not specifically aimed or directed at that group.'[16] Consequently, a claim of indirect discrimination can also be brought under Article 14 ECHR.

The requirements as regards proof of indirect unequal treatment are generally high. The applicant in a case has to show the existence of a prima facie indication that a specific rule or measure, although formulated in a neutral manner, in fact has a discriminatory effect. In principle, the ECtHR requires this to be shown

[12] *Odièvre* v. *France*, Application No. 42326/98, 13 February 2003, para. 56 in which the ECtHR ruled: 'In any event, the ECtHR considers that the applicant has suffered no discrimination with regard to her filiation, as, […] and, secondly, she cannot claim that her situation with regard to her natural mother is comparable to that of children who enjoy established parental ties with their natural mother: *Burden* v. *the United Kingdom*, Application No. 13378/05, 29 April 2008, para. 66.

[13] *Rasmussen* v. *Denmark,* Application No. 8777/79, 5 July 1983, para. 75.

[14] *Rasmussen* v. *Denmark,* Application No. 8777/79, 5 July 1983, para. 75. See also *Paulík* v. *Slovakia*, Application No. 10699/05, 10 October 2007, para. 54; *Clift* v. *the United Kingdom,* Application No. 7205/07, 13 July 2010, para. 66.

[15] *Thlimmenos* v. *Greece,* Application. No. 34369/97, 6 April 2000, para. 44.

[16] *Kelly and others* v. *the United Kingdom*, Application No. 30054/96, 4 May 2001, para. 148.

by undisputed official statistics. However, the ECtHR has indicated that indirect discrimination can also be proven by other means. No specific criteria are provided for proof other than by statistics. Nevertheless, the ECtHR has ruled in *Oršuš* that if a specific measure clearly represents a difference in treatment, this can be regarded as sufficient proof of indirect discrimination.[17]

If the applicant is able to produce evidence that a rule or practice is discriminatory in effect, the burden of proof shifts to the respondent State, to whom it falls to show that the difference in treatment is not discriminatory. By this the ECtHR recognises that if the onus of demonstrating that a difference is not in practice discriminatory, does not shift to the respondent State, it is extremely difficult for an applicant to prove indirect discrimination.[18]

Another important factor that has to be fulfilled in order for a case to be dealt with under Article 14 ECHR is the ground of distinction. Article 14 ECHR only applies to cases of unequal treatment that are brought on one or more grounds that fall under Article 14 ECHR. The grounds listed in Article 14 ECHR include sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, and birth. In addition, as indicated by the words 'other status' as provided by Article 14 ECHR, a treatment based on other grounds of distinction can also be subject to assessment by the ECtHR.

In *Kjeldsen, Busk Madsen and Pedersen* v. *Denmark* the ECtHR elucidated that 'a personal characteristic by which persons or groups of persons are distinguishable from each other' is determinant in order to fall under Article 14 ECHR.[19] However, as indicated in a more recent case, the case of *Clift* v. *the United Kingdom*, the words 'other status' have been given wide meaning throughout the jurisprudence of the ECtHR.[20] The ECtHR does not only accept grounds that relate to characteristics which can be said to be 'personal' in the sense that they are innate characteristics or inherently linked to the identity or the personality of the individual. It also accepts statuses that cannot be characterised as such, like property, a distinction based on military rank, holders of a planning permission, being a convicted prisoner or the status of a former KGB officer as possibly opposing Article 14 ECHR.[21] Nevertheless, the ECtHR is not consistent and transparent in applying its own line of reasoning. For example, it is unclear why in

[17] *Oršuš and others* v. *Croatia*, Application No. 15766/03, 16 March 2010, para. 153.
[18] *D.H. and others* v. *Czech Republic,* Application No. 57325/00, 13 November 2007, para. 180.
[19] *Kjeldsen, Busk Madsen and Pedersen* v. *Denmark,* Application Nos. 5095/71, 5920/72, 5926/72, A.23, 7 December 1976, para. 56. See also: *Gerger* v. *Turkey,* Application No. 24919/94, 8 July 1999, para. 69.
[20] *Clift* v. *the United Kingdom,* Application No. 7205/07, 13 July 2010, para. 55; *Carson and others* v. *the United Kingdom,* Application No. 42184/05, 16 March 2010, para. 70.
[21] *Clift* v. *the United Kingdom,* Application No. 7205/07, 13 July 2010, para. 56-59. This approach is explained by the ECtHR in light of the aim of the Convention, *i.e.* 'to guarantee not theoretical or illusory rights but rights that are practical and effective', *Clift* v. *the United Kingdom,* Application No. 7205/07, 13 July 2010, para. 60.

Clift v. *the United Kingdom* the duration of imprisonment is considered as a personal characteristic whereas in the case of *Peterka* v. *Czech Republic* the length of contract of employment was not considered to fall within this term.[22]

In practice, the ECtHR is also reluctant to elaborate on the standards it uses for the application of its test under the first phase of the assessment under Article 14 ECHR. It adopts a casuistic approach and hardly provides any criteria for the determination of this phase.[23] It seems that it is up to the applicant to demonstrate that Article 14 ECHR is applicable to his situation, *i.e.* whether he is in a relevantly similar situation in comparison to others treated differently, whether he is in a different situation but treated as equal, or whether he is treated unequally in an indirect manner.[24] Moreover, the ECtHR adopts this first phase of the assessment model in an inconsistent manner.[25] In a relatively large number of cases the ECtHR pays no attention whatsoever to this phase and in other cases it occurs that the ECtHR explicitly mentions this phase and subsequently fails to apply it to the case under consideration. And in other cases, *i.e.* in cases in which the ECtHR deals with direct unequal treatment, it frequently occurs that the ECtHR states that there is a situation of comparable cases without further explanation.[26] In the cases in which an indirect unequal treatment is alleged, the approach of the ECtHR seems to be more consistent: in these cases the first phase of the assessment model is set out elaborately by acknowledging indirect discrimination and by considering whether there is such an effect in the case under consideration.

2.3 The First Phase of the Assessment Model of Article 14 ECHR: Cases Dealing with Elements of Economic, Social and Cultural Rights

After analysing a large number of cases that dealt with elements of economic, social and cultural rights under Article 14 ECHR, a similar picture emerges on the application of the first phase of the assessment under Article 14 ECHR to cases of direct discrimination. Here too, the ECtHR seems to apply this phase in an inconsistent manner. In some cases the ECtHR merely concludes that there is a comparable situation, without providing further explanation and without reference

[22] *Clift* v. *the United Kingdom,* Application No. 7205/07, 13 July 2010, para. 63; *Clift* ECtHR 13 July 2010, *EHRC* 2010/ 94 with annotation Gerards, p. 1186. Gerards considers the jurisprudence of the ECtHR as unclear and inconsistent, p. 1186; *Peterka* v. *Czech Republic*, Application No. 21990/08, 5 May 2008, p. 6.
[23] Gerards 2005, p. 127.
[24] *E.g. Clift* v. *the United Kingdom,* Application No. 7205/07, 13 July 2010, para. 66.
[25] Gerards 2005, p. 129, 130.
[26] Gerards 2005, p. 130. Examples of cases in which the ECtHR did not adopt the first phase of its assessment model in a consistent manner are *Case of Fretté* v. *France*, Application No. 36515/97, judgement 26 February 2002; *L. and V.* v. *Austria*, Application Nos. 39392/98, 39829/98, 9 January 2003.

to the first phase of the assessment model.[27] It also occurs frequently that Article 14 ECHR is applied without reference to the first phase at all.[28] Moreover, it frequently happens that the ECtHR indicates to apply the first phase but hardly provides any clarification for its findings.[29] In contrast, in other cases the ECtHR provides for an elaborate explanation on what elements it takes into account when applying the first phase of its assessment model. Although no general criteria are provided, in these cases the ECtHR does provide for an insight into its considerations.[30]

The concept of indirect discrimination and its recognition under Article 14 ECHR has also been developed in several important cases that deal with elements of economic, social and cultural rights. The general approach in these cases is more careful and consistent although the adoption of its requirement of substantial evidence to prove whether a certain treatment is discriminatory in effect seems to be less consistent. For example, in the admissibility case of *Hoogendijk* the ECtHR found that a disproportionate impact on a minority group was established merely based on statistical evidence, whereas in the case of *D.H. and others* v. *Czech Republic* the ECtHR required additional evidence.[31] Later, in the Grand Chamber case of *D.H. and others* v. *Czech Republic*, the ECtHR adapted its approach and put forward that it accepts only statistics as evidence. However, in that case too it appears not to be entirely consistent in the application of its requirements.[32] In the same case, in which the ECtHR first states that statistics at least have to appear on critical examination to be reliable and significant, it later accepts statistics that are not 'entirely reliable' as sufficient proof.[33] In addition, in the Grand Chamber case *D.H. and others*, the ECtHR also makes clear that indirect discrimination can be proven without statistical evidence.[34]

The ECtHR adopts the same approach in one of its latest cases on indirect discrimination, *i.e.* the case of *Oršuš and others* v. *Croatia.*[35] This case concerns

[27] *Zubczewski* v. *Sweden*, Application No. 16149/08, 12 January 2010; *Zubczewski* ECtHR 12 January 2010, *EHRC* 2010/52 with annotation Brems, p. 630.
[28] *Karner* v. *Austria,* Application No. 40016/98, 24 July 2003, para. 33; *Niedzwiecki* v. G*ermany,* Application No. 58453/00, 25 October 2005, para. 33; *Stec and others* v. *the United Kingdom,* Application Nos. 65731/01, 65900/01, 12 April 2006, para. 54-60.
[29] *Fogarty* v. *the United Kingdom*, Application No. 37112/97, 21 November 2001, para. 42; *Fogarty* ECtHR 21 November 2001, *EHRC* 2002/4 with annotation Heringa and Gerards, p. 47; *Wessels-Bergervoet* v. *the Netherlands*, Application No. 34462/97, 4 June 2002, para. 47, 48; *Sidabras and Džiautas* v. *Lighuania,* Application Nos. 55480/00, 59330/00, 27 July 2004, para. 41.
[30] *Carson and others* v. *the United Kingdom,* Application No. 42184/05, 16 March 2010, paras. 83-90; *Burden* v. *the United Kingdom*, Application No. 13378/05, 29 April 2008, paras. 62-66. Nevertheless, in dealing with the first phase, it seems that other phases such as the legitimacy of the aim of the distinction were also included in the considerations.
[31] *D.H. and others* v. *Czech Republic,* Application No. 57325/00, 13 November 2007, para. 52.
[32] *D.H. and others* v. *Czech Republic,* Application No. 57325/00, 13 November 2007, para. 187.
[33] *D.H. and others* v. *Czech Republic,* Application No. 57325/00, 13 November 2007, para. 191. The ECtHR adopted this approach as there was no official information available which could provide evidence.
[34] *D.H. and others* v. *Czech Republic,* Application No. 57325/00, 13 November 2007, para. 188.
[35] *Oršuš and others* v. *Croatia*, Application No. 15766/03, 16 March 2010.

alleged indirect discrimination in respect of the applicants' right to education. They were assigned to separate classes which according to them resulted in unequal treatment on the basis of ethnic criteria, namely them being Roma children. In this case the ECtHR finds that the statistics submitted do not convincingly establish evidence that the effect of assigning the children to separate classes was discriminatory. However, here too, it recognises that indirect discrimination may be proven without statistical evidence.[36] Subsequently it ruled: 'In this connection the ECtHR notes that the measure of placing children in separate classes on the basis of their insufficient command of the Croatian language was applied only in respect of Roma children in several schools […t]hus, the measure in question clearly represents a difference in treatment.'[37] Consequently, if a measure does not have a disproportionate effect on the whole, but results in a segregation of a part of that group this provides for sufficient rationale to identify it as having an indirect discriminatory effect.[38]

It is difficult to find a clarification for the inconsistent application of the first phase of the assessment under Article 14 ECHR. Moreover, no clear line of reasoning can be detected, especially from the cases on direct discrimination. Nevertheless, after taking a closer look at the cases that have been examined, it emerges that the ground of distinction seems to have an influence on how extensive the first phase is dealt with by the ECtHR: in cases in which the distinction is based on a suspect ground of distinction, the ECtHR seems to conclude more easily that the applicant's situation was comparable to that of the group referred to.[39] In cases in which this is not the case, and certainly in those where it still has to be determined whether the basis of distinction can be classified as 'other status', the ECtHR seems to apply the first phase more extensively.[40]

2.4 The Second Phase of the Assessment Model of Article 14 ECHR: General Cases

Once it is determined that a treatment is unequal or unequal in effect, the ECtHR examines whether the distinction has an objective and reasonable justification. In this phase of the assessment, the ECtHR first determines whether a legitimate aim is pursued by the distinction made. Subsequently, the ECtHR assesses whether there is a reasonable relationship of proportionality between the goal sought and the interest affected by the distinction. The assessment of the legitimate aim and the

[36] *Oršuš and others* v. *Croatia*, Application No. 15766/03, 16 March 2010, para. 152.
[37] *Oršuš and others* v. *Croatia*, Application No. 15766/03, 16 March 2010, para. 153.
[38] *Oršuš and others,* ECtHR16 March 2010, *ECHR* 2010/59 with annotation Gerards, p. 723.
[39] *Wessels-Bergervoet* v. *the Netherlands*, Application No. 34462/97, 4 June 2002; *Schalk and Kopf* v. *Austria*, Application No. 30141/04, 24 June 2010; *Karner* v. *Austria,* Application No. 40016/98, 24 July 2003.
[40] *Burden* v. *the United Kingdom*, Application No. 13378/05, 29 April 2008; *Carson and others* v. *the United Kingdom,* Application No. 42184/05, 16 March 2010.

proportionality test as applied in general cases under Article 14 ECHR will be set out in the following two paragraphs.

2.4.1 Phase 2a: Legitimate Aim

As reiterated in its established case law, in the assessment of whether there is an objective and reasonable justification for a distinction made, the ECtHR first determines if the distinction pursues a legitimate aim. For this, the aim of the distinction has to be identified. In general, the ECtHR accepts the aims brought forward by the State and it does not verify whether the distinction serves another purpose than the one stated. Moreover, the aims accepted by the ECtHR as legitimate are generally very broad. Examples of legitimate aims are 'protecting the rights of others' and 'the protection of interests of children'.[41] Unless the applicant makes it likely that there is a discrepancy between the aim brought forward and the 'real' goal of the distinction, the ECtHR does not question whether there is another aim than the one brought forward.[42] According to Gerards (2005), this can be explained by the limited means the ECtHR has and the scope of its judicial function.[43]

After the determination of the aim pursued, the ECtHR determines whether the aim legitimizes the distinction made. As in the first phase of the assessment of an alleged unequal treatment, this is done in a casuistic way. At this stage too, the ECtHR does not clarify when an aim can be considered as justified. Moreover, the ECtHR does not seem to assess the cases at issue in a consistent way. In some cases, the ECtHR sets out its reasoning and findings in relation to the legitimate aim and in other cases the ECtHR simply states that there is a legitimate aim without providing further explanation. One example of a case in which the adopted criteria for the assessment establishing a justification are not provided by the ECtHR, is the case of *Palau-Martinez* v. *France*.[44] In this case the ECtHR first describes the second phase of its assessment by stating that: 'Such a difference in treatment is discriminatory in the absence of an "objective and reasonable justification", that is, if it is not justified by a "legitimate aim" and if there is no "reasonable relationship of proportionality between the means employed and the aim sought to be realised"'.[45] After this, it immediately continued by ruling: 'The Court is of the opinion that the aim pursued in the instant case, namely protection of the children's interest, is legitimate.'[46]

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[41] *Palau-Martinez* v. *France*, Application No. 64927/01, 16 December 2003, para. 40; *Fretté* v. *France*, Application No. 36515/97, 26 February 2002, para. 38; *L. and V.* v. *Austria*, Application Nos. 39392/98, 39829/98, 9 January 2003, para. 46.
[42] Gerards 2005, p. 139.
[43] Gerards 2005, p. 140.
[44] *Palau-Martinez* v. *France*, Application No. 64927/01, 16 December 2003.
[45] *Palau-Martinez* v. *France*, Application No. 64927/01, 16 December 2003, para. 39.
[46] *Palau-Martinez* v. *France*, Application No. 64927/01, 16 December 2003, para. 40.

However, where a distinction is based on a suspect ground, the ECtHR imposes noticeably stricter requirements.[47] In such the ECtHR generally states that very weighty reasons have to be put forward before a difference in treatment on a suspect ground can be regarded as compatible with the Convention.[48] This is designated as the 'very weighty reasons test' and implies that a more strict assessment applies. In cases in which the goal is considered 'particularly convincing and weighty' the difference in treatment is found to be legitimate.[49] However, if a distinction is based exclusively on a suspect ground, it seems very difficult to escape from a finding of a violation of Article 14 ECHR. And in the case of *Salgueiro da Silva Mouta* v. *Portugal* the ECtHR even found that although the goal was in itself legitimate, it could not justify a differential treatment which was based solely on a suspect ground, *i.e.* religion.[50]

The intensity of the assessment adopted by the ECtHR and the suspectness of a ground of distinction shall be further discussed in paragraph 3. However, what is important about the requirement of 'particularly convincing and weighty' reasons for justification is that it suggests that the ECtHR carries out a sort of proportionality test within the framework of the assessment of the aim pursued.[51] This approach shows that the ECtHR does not only apply the legitimate aim criterion inconsistently, but also that the different phases are not always dealt with separately.[52]

2.4.2 Phase 2b: The Proportionality Test

According to the ECtHR's assessment model, it does not suffice if a difference in treatment in the exercise of a right laid down in the Convention has a legitimate aim. Article 14 ECHR is likewise violated if there is no relationship of proportionality between the means employed and the aim sought to be realised. Determining the relationship between goals and means is part of the second phase of the ECtHR's assessment model under Article 14 ECHR. It is directed at

[47] Gerards 2005, p. 142.
[48] Just a few examples are: *Sahin* v. *Germany,* Application No. 30943/96, 8 July 2003, para. 94; *L. and V.* v. *Austria*, Application Nos. 39392/98, 39829/98, 9 January 2003, para. 45.
[49] This was also found as such in the cases *Fretté* v. *France*, Application No. 36515/97, 26 February 2002, paras. 37, 38 and *Palau-Martinez* v. *France*, Application No. 64927/01, 16 December 2003, paras.
37, 40. See also: *Palau-Martinez,* ECtHR 16 December 2003, *EHRC* 2004/ 9, with annotation Gerards.
[50] *Salgueiro da Silva Mouta* v. *Portugal*, Application No. 33290/96, 21 December 1999, paras. 30, 35, 36. See also: *Schalk and Kopf* v. *Austria*, Application No. 30141/04, 24 June 2010, para. 93.
[51] Gerards 2005, p. 143.
[52] For another example, see *L. and V.* v. *Austria*, Application Nos. 39392/98, 39829/98, 9 January 2003, paras. 4 9, 52, 53.

examining whether a relationship of proportionality is 'reasonable' and 'clearly established'.[53]

As it is in principle left to the national authorities to strike a balance of interest, the assessment of the relationship of proportionality is in most cases marginal.[54] Although there are cases in which the ECtHR applies a strict assessment, in general the ECtHR adopts a restraint position. Moreover, in this phase of the assessment too, the ECtHR seems reluctant to clarify the requirements of 'a reasonable relationship of proportionality'.[55] An example of this approach was found in the case of *Palau-Martinez* v. *France*.[56] In this case the ECtHR extensively set out its considerations without providing the criteria it applied for its finding that there was no proportionate relationship. This case concerned the custody of two children that had been withdrawn from their mother. The ECtHR found that there was a differential treatment between the parents on the basis of the mother's religion. And although it found that the aim pursued, *i.e.* the protection of the children's interest, was legitimate, it could not conclude that there was a reasonably proportionate relationship between the means employed and the aim pursued.

In addition to this example of a very general test of proportionality in which the adopted criteria for assessment are not clarified, it also happens that the proportionality test is completely missing. This can be partly explained by the accessory nature of Article 14 ECHR. In a number of cases the ECtHR already examined in depth the proportionality when examining the case under the alleged violation of a substantive convention article. This would mean that dealing with the same facts under Article 14 ECHR would in many cases lead to repetition of arguments and conclusions.[57]

Gerards (2005) is critical about the manner in which the ECtHR applies the proportionality test: 'One might be able to conclude from the omission of the goal-means test and the lack of reasoning presented that the ECtHR does not take the assessment of reasonableness very seriously. This is problematic, since it has been shown that the accent of the assessment is placed entirely on the goal-means test through a frequently restrained and superficial assessment of the aims pursued. As a proportionality test is in practice often omitted, there is a lack of good protection against unequal treatment.'[58] Thus, besides the fact that it seems that the assessment of the legitimate aim and the proportionality test are sometimes dealt with at the same time, the critique of the inconsistent and non-transparent manner of assessment also touches upon the application of the proportionality test itself.

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[53] *Case "relating to certain aspects of the laws on the use of languages in education in Belgium"* v. *Belgium,* Application Nos. 1474/62, 1677/62, 1691/62, 1769/63, 2126/64, 23 July 1968.
[54] Gerards 2005, p. 145, 146.
[55] Gerards 2005, p. 145.
[56] *Palau-Martinez* v. *France*, Application No. 64927/01, 16 December 2003.
[57] *Sahin* v. *Germany*, ECtHR 8 July 2003, *EHRC* 2001/81, with annotation Gerards, p. 754.
[58] Gerards 2005, p. 148.

2.5 The Second Phase of the Assessment Model of Article 14 ECHR: Cases Dealing with Elements of Economic, Social and Cultural Rights

2.5.1 The Second Phase 2a: The Legitimate Aim

The ECtHR also applies the legitimacy of aim test inconsistently when dealing with cases covering elements of economic, social and cultural rights under Article 14 ECHR. In some cases this phase was completely omitted.[59] And in other cases this phase was dealt with under the phase of assessing the proportionality of the measures taken.[60] However, in most of its cases, the ECtHR states that there is a legitimate aim without further explanation.[61] Moreover, the ECtHR generally accepted the aims brought forward by the State and the aims accepted as legitimate are generally also very broad. These range from 'protecting the rights of others through preservation of the environment', and 'protection of the traditional family unit' to 'protection of national security, public safety, the economic well-being of the country and the rights and freedoms of others'.[62] However, in some cases more specific aims are considered legitimate: 'to protect, against criminal behavior, the life of its citizens particularly those who belong to especially vulnerable categories by reason of their age or infirmity' and 'to adapt the education system to the capacity of children with special needs to find a solution for children with special educational needs'.[63]

In contrast to the approach detected in most of the cases dealing with elements of economic, social and cultural rights under Article 14 ECHR, there are a few examples in which a different approach is adopted. The case of *S.H. and others* v. *Austria* provides for a good illustration of this other approach.[64] This judgement shows a case about a very sensitive issue in which the Member States of the CoE

[59] Ommitted in: *Schalk and Kopf* v. *Austria*, Application No. 30141/04, 24 June 2010; *Muñoz Díaz* v. *Spain*, Application No. 49151/07, 8 December 2009; *Willis* v. *the United Kingdom*, Application No. 36042/97, 11 June 2002. In other cases no reasons where put forward by the States for an unequal treatment. This led to the conclusion that there was no legitimate aim: *Niedzwiecki* v. *Germany,* Application No. 58453/00, 25 October 2005, para. 33; *Zarb Adami* v. *Malta,* Application No. 17209/02, 20 June 2006, para. 83; *P.B. and J.S.* v. *Austria,* Application No. 18984/02, 22 July 2010, paras. 42, 43. In these cases, is was not necessarily the case that this phase was applied in an inconsistent way.

[60] *Wessels-Bergervoet* v. *the Netherlands*, Application No. 34462/97, 4 June 2002, paras. 51-54.

[61] *Karner* v. *Austria,* Application No. 40016/98, 24 July 2003, para. 40; *Oršuš and others* v. *Croatia*, Application No. 15766/03, 16 March 2010, para. 157. Another example is: *Jane Smith* v. *the United Kingdom,* Application No 25154/94, 18 January 2001, paras. 89, 138.

[62] *Jane Smith* v. *the United Kingdom,* Application No 25154/94, 18 January 2001, para. 138; *Karner* v. *Austria,* Application No. 40016/98, 24 July 2003, para. 39; *Sidabras and Džiautas* v. *Lighuania,* Application Nos. 55480/00, 59330/00, 27 July 2004, para. 55.

[63] *Pretty* v. *the United Kingdom,* Application No. 2346/02, 29 April 2002, para. 89 in which it refers to paragraph 14, sub 24; *D.H. and others* v. *Czech Republic,* Application No. 57325/00, 13 November 2007, para. 198; *idem Oršuš and others* v. *Croatia*, Application No. 15766/03, 16 March 2010, para. 157.

[64] *S.H. and others* v. *Austria,* Application No. 57813/00, 1 April 2010.

are expected to have a wide discretion in setting their policies. Nevertheless, the ECtHR elaborately assessed the facts of the case and brushed aside all aims brought forward by the Austrian Government.

S.H. and others v. *Austria* was about two couples claiming that they were discriminated against by the Austrian Artificial Procreation Act. The first applicant (S.H.) could not conceive a child by natural means due to fallopian-tube-related infertility and her husband (D.H.) was infertile. S.H. wished for *in vitro* fertilisation using sperm from the third applicant, M.G. The wife of the third applicant, H.E.G. suffered from agonadism which means that she does not produce ova at all. The only way open to her and her husband of conceiving a child would be to implant in her uterus an embryo conceived with ova from S.H. as a donor and sperm from her husband. Both methods were ruled out by the Artificial Procreation Act. The legislation in force only allowed for artificial insemination by homologous methods such as using ova and sperm from the spouses or the cohabiting couple or with donor sperm, while categorically prohibiting ova donation and heterologous methods.

The ECtHR deals extensively with the aims put forward by the Austrian Government for this treatment and provides the considerations it makes to come to the conclusion that there is no legitimate aim.[65] It also deals extensively with the prohibition of discrimination in relation to elements of economic, social and cultural rights: 'The Court considers that concerns based on moral considerations or on social acceptability are not in themselves sufficient reasons for a complete ban on a specific artificial procreation technique such as ova donation. Such reasons may be particularly weighty at the stage of deciding whether or not to allow artificial procreation in general, and the Court would emphasise that there is no obligation on a State to enact legislation of that kind and to allow artificial procreation. However, once the decision has been taken to allow artificial procreation and notwithstanding the wide margin of appreciation afforded to the Contracting States, the legal framework devised for this purpose must be shaped in a coherent manner which allows the various legitimate interests involved to be taken into account adequately and in accordance with the obligations deriving from the Convention.'[66]

2.5.2 The Second Phase 2b: The Proportionality Test

The proportionality test too is often not addressed in cases where elements of economic, social or cultural rights are dealt with under Article 14 ECHR, because it has already been dealt with under the substantive Convention provision in

[65] *S.H. and others* v. *Austria,* Application No. 57813/00, 1 April 2010, paras. 73-85.
[66] *S.H. and others* v. *Austria,* Application No. 57813/00, 1 April 2010, para. 74.

conjunction with which Article 14 ECHR is claimed to be violated.[67] However, in other cases the proportionality test is omitted without reasoning or it is dealt with implicitly and not designated as such.[68] However, here too *S.H. and others* v. *Austria* provides the exception to the rule in that the ECtHR describes extensively its application of the proportionality test.[69]

With regard to the treatment of the couple S.H. and D.H. the ECtHR provides that the argument of efficiency for not allowing *in vitro* fertilisation in order to conceive a child does not outweigh the wish for a child. It considers this wish for a child as a particularly important facet of an individual's existence or identity that is to be protected by Article 8 ECHR.[70]

In relation to the second couple, H.E.G. and M.G., which wished for *in vitro* fertilisation by ova donation, the Austrian government argues that this method poses various risks. It holds, firstly, that it could create the risk of being employed for other than therapeutic purposes, *i.e.* 'selection' of children and secondly, that it may lead to the exploitation and humiliation of women. In reply to this argumentation, the ECtHR considers that the risks associated with such techniques in a sensitive field like medically assisted procreation must be taken seriously. However, it considers the measures taken to be subsidiary; it deems a complete ban on this medical technique not to be the only means or the least intrusive means of effectively preventing these risks. As a result, it considers this unequal treatment not to be proportionate[71]

In this case the ECtHR emphasises the broad margin of appreciation granted to the Signatory States. It states that: 'Since the use of IVF treatment gives rise to sensitive moral and ethical issues against a background of fast-moving medical and scientific developments, and since the questions raised by the case touch on areas where there is no clear common ground amongst the Member States, the Court considers that the margin of appreciation to be afforded to the respondent State must be a wide one'. Nevertheless, this wide margin of appreciation does not deter the ECtHR from adopting a restraint position in applying the proportionality test.

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[67] *Schlumpf* v. *Switzerland*, Application No. 29002/06, 8 January 2009; *Jane Smith* v. *the United Kingdom,* Application No 25154/94, 18 January 2001, para. 138.

[68] *Wessels-Bergervoet* v. *the Netherlands*, Application No. 34462/97, 4 June 2002, para. 52; *Pretty* v. *the United Kingdom,* Application No. 2346/02, 29 April 2002, para. 89; *Koua Poirrez* v. *France*, Application No. 40892/98, 30 September 2003, paras. 48, 49; *Willis* v. *the United Kingdom*, Application No. 36042/97, 11 June 2002, paras. 41-43; *Case of Willis* v. *the United Kingdom*, ECtHR 11 June 2002, *ECHR* 2002/62 with annotation Gerards, p. 577.

[69] *S.H. and others* v. *Austria,* Application No. 57813/00, 1 April 2010.
Other examples: *Muñoz Díaz* v. *Spain*, Application No. 49151/07, 8 December 2009, paras. 7-14; *Sidabras and Džiautas* v. *Lighuania,* Application Nos. 55480/00, 59330/00, 27 July 2004, paras. 56-61; *D.H. and others* v. *Czech Republic,* Application No. 57325/00, 13 November 2007, paras. 200-209; *Oršuš and others* v. *Croatia*, Application No. 15766/03, 16 March 2010, paras. 180-184.

[70] *S.H. and others* v. *Austria,* Application No. 57813/00, 1 April 2010, para. 93.

[71] *S.H. and others* v. *Austria,* Application No. 57813/00, 1 April 2010, para. 76.

3 THE DEGREE OF ASSESSMENT UNDER ARTICLE 14 ECHR

3.1 Introduction

As indicated in the previous paragraph, the ECtHR adopts various degrees of assessment in cases concerning Article 14 ECHR. There are cases in which the ECtHR proceeds to a more thorough assessment and there are circumstances where it adopts a less strict assessment. The various factors influencing the degree of assessment under Article 14 ECHR will first be discussed in this paragraph. Second, the degree adopted by the ECtHR in cases that deal with elements of economic, social and cultural rights under Article 14 ECHR will discussed in paragraph 3.3.

3.2 The Degree of Assessment Adopted under Article 14 ECHR and the Various Factors Influencing it

The degree of assessment adopted by the ECtHR under Article 14 ECHR is determined by the scope of the doctrine of the margin of appreciation.[72] This doctrine implies that discretion is granted to the Signatory States to answer the question of which measures are necessary in concrete circumstances.[73] States are in principle considered to be in a better position than an international court to evaluate the local needs and conditions.[74] This is determined as the 'better placed argument'. Securing rights and freedoms enshrined in the ECHR is therefore primarily the responsibility of the Member States.[75] However, this margin of appreciation does not grant the Member States arbitrary power. The role of the ECtHR is subsidiary to the national systems safeguarding human rights.[76] As such, decisions of national

[72] Gerards 2005, p. 165. This is established case law and reiterated as: 'the Contracting States enjoy a certain margin of appreciation in assessing whether and to what extent differences in otherwise similar situations justify a different treatment'. The first case in which the ECtHR referred to this doctrine, although not yet using this formulation, is the Belgian Linguistics case: *Case "relating to certain aspects of the laws on the use of languages in education in Belgium"* v. *Belgium,* Application Nos. 1474/62, 1677/62, 1691/62, 1769/63, 2126/64, 23 July 1968, p. 31, para. 10. A few examples are: *Rasmussen* v. *Denmark*, Application No. 8777/79, 5 July 1983, para. 40; *Petrovic* v. *Austria*, Application No. 20458/92, 27 March 1998, para. 38; *Fretté* v. *France*, Application No. 36515/97, 26 February 2002, paras. 39, 40; *Sahin* v. *Germany,* Application No. 30943/96, 8 July 2003, para. 93. It should be noted that the margin of appreciation does not only play a role when assessing in view of Article 14 EHCR. However, this part of the research is focused on the margin of appreciation under Article 14 ECHR.

[73] Gerards 2005, p. 180.

[74] *E.g. Fretté* v. *France*, Application No. 36515/97, 26 February 2002, para. 41.

[75] Henrard 2008a, p. 111.

[76] Explanatory Report to the Protocol No. 14 to the ECHR, Amending the control system of the Convention, C.E.T.S. No. 194, 12 May 2009; *Handyside* v. *the United Kingdom*, Application No. 5493/72, 7 December 1976, para. 48.

authorities remain subject to review by the ECtHR for conformity with the requirements of Article 14 ECHR and other provisions of the Convention.[77]

The scope of the margin of appreciation granted by the ECtHR is variable and thus also the degree of assessment under Article 14 ECHR. The assessment is more strict in case of a strict margin of appreciation and *vice versa.* As such, the degree of assessment is proportionate to the scope of the margin of appreciation.[78]

Despite the casuistic approach of the ECtHR, various factors can be identified in its case law that influence the degree of assessment. The most important factors are the ground for distinction, the presence of a European consensus and the 'better placed'- argument ,hereinafter discussed in this order.[79]

The ground for distinction proves an important factor in determining the degree of assessment of an alleged violation of the prohibition of discrimination. Where a distinction is based on a suspect ground, the ECtHR adopts a 'very weighty reasons' test. Under this test very weighty reasons need to be brought forward before a difference in treatment on a suspect ground can be considered compatible with the ECHR. And where the distinction is exclusively based on a suspect ground, the degree of assessment seems even higher.

The ECtHR has qualified certain grounds of distinction as suspect in its case law. These are gender, birth out of wedlock, religion, sexual orientation, property, nationality, marital status, nationality, and race.[80] The ECtHR has not explained what considerations have led to these grounds to be identified as suspect.[81] Nevertheless, Judge Zupančič has set out a certain hierarchy among these suspect grounds. He stated in his dissenting opinion in the case of *Burden* that some categories 'for example, race or national origin, call for the strictest scrutiny test. Under this test, the decision or the law underlying it would be upheld only if it was suitably tailored to serve a compelling State interest. When it comes to gender, or illegitimacy of birth, the decision would be presumed invalid under the intermediate test unless substantially related to a sufficiently important interest.'[82] So if a distinction is based on these grounds, stricter requirements will apply to the aim pursued.

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[77] This is established case law, see *e.g. Fretté* v. *France*, Application No. 36515/97, 26 February 2002, para. 41.
[78] Henrard 2008a, p. 200.
[79] *Fretté* ECtHR 26 February 2002, *EHRC* 2002/30 with annotation Gerards, p. 278.
[80] Gender and marital status: *Wessels-Bergervoet* v. *the Netherlands*, Application No. 34462/97, 4 June 2002, para. 47; birth out of wedlock: *Sahin* v. *Germany,* Application No. 30943/96, 8 July 2003, para. 94; religion: *Salgueiro da Silva Mouta* v. *Portugal*, Application No. 33290/96, 21 December 1999, para. 31; sexual orientation: *E.B.* v. *France,* Application No. 43546/02, 22 January 2008, para. 91; property: *Clift* v. *the United Kingdom,* Application No. 7205/07, 13 July 2010, para. 56; nationality: *Gaygusuz* v. *Austria,* Application No. 17371/90, 19 September 1996, para. 42; race: *Angelova and Iliev* v. *Bulgaria*, Application No. 55523/00, 26 July 2007.
[81] Gerards 2005, p. 201, 220.
[82] *Burden* v. *the United Kingdom*, Application No. 13378/05, 29 April 2008, dissenting opinion Judge Zupančič.

Another important factor that played a role when determining the extent of the margin of appreciation is the common ground factor.[83] Whether there is a common ground depends on the presence or absence of a consensus between the various Member States of the CoE on the subject at issue.[84] Three types of common ground and corresponding degrees of assessment of an alleged violation can be discerned. Firstly, in case there is no consensus on the difference in treatment, the assessment is in general marginal. Secondly, the assessment is also marginal if there is a consensus that recognises or approves the distinction made. Thirdly, if there is consensus that disapproves certain practices the degree of assessment is normally strict. This third type of common ground does not only emerge from a situation on which the Member States of the CoE have agreed. As found in the *Kiyutin* v. *Russia* case a common ground can also be considered to be present if it appears that a specific unequal treatment has little support among the CoE Member States, *i.e.* if only a minority of States applies such a measure.[85]

The reason for taking into account the absence or presence of a common ground is that national authorities are ultimately responsible for the implementation of the ECHR. Moreover, the willingness of the Member States to follow the decisions of the ECtHR would greatly diminish if it did not take into account existing national legislation.[86]

A common ground can exist at national level, *i.e.* if a consensus can be found in the correspondence between the adopted national policies and legislation of the various Member States. The ECtHR is not entirely clear on when a European consensus is considered to exist at the national level. For example, it does not clarify how many of the Signatory States need to support a particular viewpoint. The ECtHR seems to determine on a case by case basis whether there is a consensus.

Some indicators can be discerned for the establishment of a common ground at national level. For example, in the case of *Schalk and Kopf* v. *Austria* in which a distinction based on sexual orientation was at issue, the ECtHR held that: 'The Court cannot but note that there is an emerging European consensus towards legal recognition of same-sex couples. Moreover, this tendency has developed rapidly over the past decade. Nevertheless, there is not yet *a majority* of States providing for legal recognition of same-sex couples. The area in question must therefore still be regarded as one of evolving rights with no established consensus, where States must also enjoy a margin of appreciation in the timing of the introduction of legislative changes.' [87] In the case of *Petrovic* v. *Austria* too the

[83] *Petrovic* v. *Austria*, Application No. 20458/92, 27 March 1998, para. 38; *Rasmussen* v. *Denmark*, Application No. 8777/79, 5 July 1983, para 40.
[84] Gerards 2005, p. 171.
[85] *Kiyutin* v. *Russia,* Application No. 2700/10, 10 March 2011, para. 65.
[86] Gerards 2005, p. 171.
[87] *Schalk and Kopf* v. *Austria*, Application No. 30141/04, 24 June 2010, para. 105. Emphasis added, MSG.

criterion of a majority was decisive for determining the margin of appreciation: 'It is clear that at the material time, that is at the end of the 1980s, there was no common standard in this field, as the majority of the Contracting States did not provide for parental leave allowances to be paid to fathers. […] The Austrian authorities' refusal to grant the applicant a parental leave allowance has not, therefore, exceeded the margin of appreciation allowed to them. Consequently, the difference in treatment complained of was not discriminatory within the meaning of Article 14.'[88] Hence, for a consensus to be considered to be present the factors of a majority and the inclusion in national law are important factors. That there is a tendency towards legal recognition was as such not considered sufficient for this purpose.[89]

For a consensus to exist at international level, this majority requirement did not seem to count. When searching for a common ground, the ECtHR also takes into account international law.[90] It does so, for example in the case of *Marckx* v. *Belgium.*[91] This case clarifies that the mere existence of a treaty denotes that there is a clear common ground. In establishing whether a common ground was present at international level, the ECtHR referred to two conventions. The first one was signed by only eight of the ten negotiating States and only ratified by four members of the CoE at the time of the judgement. The second convention was signed by only ten and ratified by only four members.[92] According to the ECtHR this small number of contracting States does not detract it from finding that there was a common ground.

In the recent and revolutionary case of *Demir and Baykara* the ECtHR provides further explanation on this matter. [93] In this case, the ECtHR elaborately explains how it interprets the provisions of the ECHR in the light of other international texts and instruments. It clarifies that it does not consider the provisions of the ECHR as the sole framework of reference. On the contrary, it states that it must also take into account relevant rules and principles of international law applicable in relations between the Signatory States. This approach is explained by the fact that the common international or regional legal standards of the Member States of the CoE reflect a consensus that the ECtHR

[88] *Petrovic* v. *Austria*, Application No. 20458/92, 27 March 1998, paras. 39, 11.
[89] See also *Schalk and Kopf* v. *Austria*, Application No. 30141/04, 24 June 2010, para. 92.
[90] Gerards 2005, p. 177. However, the ECtHR does not provide any clarification on whether it attaches more importance to a common ground due to consensus between the national policies or legislation or to a consensus due to the existence of international instruments.
[91] *Marckx* v. *Belgium*, Application No. 6833/74, 13 June 1979, para. 41.
[92] The Brussels Convention on the Establishment of Maternal Affiliation of Natural Children and the European Convention on the Legal Status of Children born in or out of Wedlock, 15 October 1975, E.T.S. 085.
[93] *Demir and Baykara* v. *Turkey,* Application No. 34503/97, 12 November 2008. And followed by a series of cases which also apply this approach: *Weller* v. *Hungary*, Application No. 44399/05, 31 March 2009; *Tănase* v. *Moldova*, Application No. 7/08, 27 April 2010; *Soltysyak* v. *Russia,* Application No. 4663/05, 10 February 2011; *Lalmahomed* v. *the Netherlands*, Application No. 26036/08, 22 February 2011; *Kiyutin* v. *Russia,* Application No. 2700/10, 10 March 2011.

considers it necessary to be taken into account when clarifying the scope of a provision of the ECHR.[94] When searching for a common ground, the ECtHR may refer to these sources of law, including specialised human rights instruments if relevant to the case.

The ECtHR indicates that it can also take into account non-binding instruments of the CoE organs, in particular recommendations and Resolutions of the Committee of Ministers and the Parliamentary Assembly and norms emanating from other organs of the CoE.[95] Moreover, and this is perhaps the most interesting part of this judgement, the ECtHR observed that in searching for a common ground it makes no distinction between sources of law according to whether or not they have been signed or ratified by the respondent State.[96] Thus indicating that the mere presence of a specific standard suffices to declare a common ground present between the Member States of the CoE, regardless of whether the respondent State has signed or ratified the treaty concerned.

By way of example, in the *Demir and Baykara* case the ECtHR refers to various sources of international law from which a consensus emerges. These include the CRC, the ILO Conventions, the ICCPR, the American Convention on Human Rights, the CAT, UDHR, work of the European Commission for Democracy through Law, the ESC, the European Union's Charter of Fundamental Rights, the Convention on Human Rights and Biomedicine, the Convention on Civil Liability for Damage resulting from Activities Dangerous to the Environment, the Convention on the Protection of the Environment through Criminal Law, work from the Steering Committee for Human Rights, and the ICESCR.[97]

The last factor influencing the degree of assessment that is taken into account in this part of the present study is the 'better placed' argument. As mentioned at the beginning of this paragraph, Member States are considered to be in a better position than international courts to answer the question of what measures are necessary in concrete national circumstances. As such, they are granted a wide margin of appreciation in evaluating local needs and conditions. For example, in case of a complaint about punishment imposed by a national court or the protection of the rights of children, the ECtHR considers itself to be less well placed to take a substantive decision.[98]

Furthermore, the 'better placed' argument plays an important role when it comes to general measures of economic or social strategy. As reiterated in the case

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[94] *Demir and Baykara* v. *Turkey,* Application No. 34503/97, 12 November 2008, paras. 67, 76, 85.
[95] *Demir and Baykara* v. *Turkey,* Application No. 34503/97, 12 November 2008, paras. 74, 75, 85.
[96] *Demir and Baykara* v. *Turkey,* Application No. 34503/97, 12 November 2008, paras. 78, 86. See *inter alia*, *Lalmahomed* v. *the Netherlands*, Application No. 26036/08, 22 February 2011, Concurring Opinion of Judge Ziemele, p. 13, 14 in which he defines the approach of the ECtHR in the *Demir and Baykara* case and subsequent cases in relation to the role of non-ratified treaties as 'unfortunate drafting'.
[97] *Demir and Baykara* v. *Turkey,* Application No. 34503/97, 12 November 2008, paras. 69-84, 99.
[98] Gerards 2005, p. 180, 181.

law of the ECtHR, 'because of their direct knowledge of their society and its needs, the national authorities are in principle better placed than the international judge to appreciate what is in the public interest on social or economic grounds'.[99] Consequently, in general the ECtHR respects the legislature's policy choice. However, the ECtHR does assess whether the national authorities acted arbitrarily or not and examines carefully whether the procedure followed has been careful.[100] Moreover, it assesses whether the national authorities acted in a non-discriminatory manner.

The three factors set out above influence the degree of assessment by the ECtHR under Article 14 ECHR and thereby determine the margin of appreciation granted to the respondent state. Normally, if a distinction is based on a suspect ground, a very weighty reasons test is applied. The common ground factor is decisive for this as well. Accordingly, if a distinction is based on a suspect ground and there is a European consensus that argues that the measure is not acceptable, generally Article 14 ECHR *juncto* a substantive provision is found to be violated.[101] In addition, in case no distinction is made on a suspect ground and there is no common ground, the respondent State is considered to be in better position to appreciate the situation in hand and consequently it is not considered to transgress the principle of proportionality. However, in cases where the various factors contradict each other, the ECtHR seems to be less clear. Generally, it does state which factors play a role in determining the intensity, but the ECtHR does not provide a clarification of how it balances these factors and why this leads to the conclusion that a particular degree should apply.[102]

3.3 The Degree adopted by the ECtHR in Cases that Deal with Elements of Economic, Social and Cultural Rights under Article 14 ECHR

When assessing cases under Article 14 ECHR concerning elements of economic, social and cultural rights, the ECtHR principally adopts a restraint position. The reason for granting States a wide margin of discretion in this field can be found in the subsidiary role of the ECtHR. National authorities are in principle considered to be in a better position than the ECtHR to appreciate what is in the public interest with regard to measures of economic and social strategy. Moreover, it is considered that within a democratic society the opinions in the field of political, economic and social issues differ widely.[103] Due to this lack of common ground, the ECtHR holds that the margin of appreciation granted to the legislature in implementing measures

[99] *E.g. Clift* v. *the United Kingdom,* Application No. 7205/07, 13 July 2010, para. 73.
[100] Gerards 2005, p. 180.; *Palau-Martinez* v. *France*, Application No. 64927/01, 16 December 2003, para. 38; *Clift* v. *the United Kingdom,* Application No. 7205/07, 13 July 2010, para. 73; *S.H. and others* v. *Austria,* Application No. 57813/00, 1 April 2010, para. 69.
[101] *E.g. L. and V.* v. *Austria*, Application Nos. 39392/98, 39829/98, 9 January 2003, paras. 45-47.
[102] Gerards 2005, p. 195.
[103] *James and others* v. *the United Kingdom,* Application. No. 8793/79, 21 February 1986.

relating to these issues should be a wide one, unless the legislature's judgement is manifestly without reasonable foundation.[104] However, the factors that play a role in the establishment of the margin of appreciation granted to the Signatory States in general cases, also determine the degree of assessment in these cases.

From the cases dealing with elements of economic, social and cultural rights under Article 14 ECHR a line of reasoning is discerned that applies in determining the degree of assessment. This approach can be divided into several categories which provide clarification of the general approach of the ECtHR in such cases. Nevertheless, it should be kept in mind that the degree adopted in cases under Article 14 ECHR ultimately remains case specific.

In cases falling under the first category, a wide margin of appreciation was granted to the Signatory States of the CoE when adopting measures that are related to economic, social and cultural rights.[105] This is defined as the basic approach. Based on the 'better placed' argument, the ECtHR tends to respect the policy choice of the national State, unless the difference in treatment is manifestly without reasonable foundation.[106]

The second category includes cases in which there is a difference in treatment in the field of economic, social and cultural rights that is based on a suspect ground.[107] Particularly serious reasons are required to justify a distinction based on such a suspect ground.[108] Consequently, a less discretionary margin was granted to the specific Member State. Moreover, in general in cases in which a distinction was based on a suspect ground, Article 14 ECHR was found to be violated. Exemptions to this line of approach are cases in which it is shown that the State concerned already is taking measures to correct factual inequalities in relation to the issues concerned.[109]

The third category comprises cases where the distinction is not only based on a suspect ground, but is exclusively based on this suspect ground. In these cases, the margin of discretion is restricted and it seems difficult to avoid a finding of Article 14 ECHR being violated. The *Wessels-Bergervoets* case falls under this third category.[110] This case deals with a complaint on a difference in treatment

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[104] *James and others* v. *the United Kingdom,* Application. No. 8793/79, 21 February 1986, para. 46.
[105] *Burden* v. *the United Kingdom,* Application No. 13378/05, 29 April 2008; *Carson and others* v. *the United Kingdom,* Application No. 42184/05, 16 March 2010; *Tarkoev and others* v. *Estonia*, Application Nos. 14480/08, 47916/08, 4 November 2010.
[106] *E.g. Walker* v. *the United Kingdom,* Application No. 37212/02, August 2006, para. 33; *Muñoz Díaz* v. *Spain*, Application No. 49151/07, 8 December 2009, para. 49.
[107] *E.g. Niedzwiecki* v. G*ermany,* Application No. 58453/00, 25 October 2005, para. 31-33; *Andrejeva* v. *Latvia,* Application No. 55707/00, 18 February 2009; *Muñoz Díaz* v. *Spain*, Application No. 49151/07, 8 December 2009; *Zeman* v. *Austria,* Application No. 23960/02, 29 June 2006.
[108] *E.g. J.M.* v. *the United Kingdom,* Application No. 37060/06, 28 September 2010, para. 54.
[109] *Runkee and White* v. *the United Kingdom,* Application Nos. 42949/98, 53134/99, 10 May 2007, paras. 40, 41; *Andrle* v. *Czech Republic*, Application No. 6268/08, 17 February 2011, paras. 56-58.
[110] *Wessels-Bergervoet* v. *the Netherlands*, Application No. 34462/97, 4 June 2002, paras. 49-55. Another examples is: *Willis* v. *the United Kingdom*, Application No. 36042/97, 11 June 2002, paras. 46-50.

exclusively based on the grounds of sex and marital status. Under the Dutch General Old Age Act a specific group of married women received 38% less old-age pension what married men in the same situation received. The ECtHR considered that very strong reasons had to be put forward before it could justify a difference in treatment exclusively based on such a suspect ground. As a result, it adopted the very weighty reasons test and a high degree assessment under Article 14 ECHR. Subsequently, it found that the difference in treatment was not based on any objective or reasonable justification as it failed to pass the proportionality test.

The fourth category is characterised by cases in which the distinction is based on a suspect ground and in which a common ground is considered to be present: a specific treatment is considered inappropriate or a certain form of unequal treatment finds little support among the Member States of the CoE. Cases falling under the fourth category are marked by a very restricted margin of appreciation and consequently, by high degree assessment under Article 14 ECHR.

An example of a case falling under this category is the case of *Karner* on a difference in treatment based on sexual orientation.[111] Karner, the legal heir of his partner with whom he had a homosexual relationship, wanted to continue living in the flat where they had been living together. The rental agreement provided family members and other life companions of the deceased a right to succeed to the tenancy. However, following the death of Karner's partner the owner of the apartment started proceedings to terminate the lease. Karner challenged the appeal and ultimately the Austrian Supreme Court stated the lease could be terminated.

The ECtHR subsequently holds that very weighty reasons have to be put forward before a difference in treatment based exclusively on sexual orientation can be justified. Moreover, reference is made to the common ground existing at national level of the Member States stipulating equal treatment of unmarried different-sex partners and unmarried same-sex partners. This is supported by recommendations and legislation of European institutions as well.[112] Consequently, the ECtHR applies a high degree assessment. It states that 'the principle of proportionality does not merely require that the measure chosen is in principle suited for realising the aim sought. It must also be shown that it was necessary in order to achieve that aim to exclude certain categories of people – in this instance persons living in a homosexual relationship – from the scope of application of section 14 of the Rent

[111] *Karner* v. *Austria,* Application No. 40016/98, 24 July 2003. Other examples in this category are: *Oršuš and others* v. *Croatia*, Application No. 15766/03, 16 March 2010, paras. 148, 149, 182, 184; *D.H. and others* v. *Czech Republic,* Application No. 57325/00, 13 November 2007, paras. 176, 182, 205, 207, 208; *Glor* v. *Switzerland,* Application No. 13444/04, 30 april 2009, paras. 80, 83, 84, 93, 94. *Luczak* v. *Poland,* Application No. 77782/01, 27 November 2007, para. 52.

[112] Such as Protocol No. 12 ECHR, recommendations by the Parliamentary Assembly of the Council of Europe (Recommendations 1470 (2000) and 1474 (2000)), the European Parliament (Resolution on equal rights for homosexuals and lesbians in the EC, OJ C 61, 28 February 1994, p. 40; Resolution on respect for human rights in the European Union 1998-1999, A5-0050/00, § 57, 16 March 2000) and the Council of the European Union (Directive 2000/78/EC, OJ L 303/16, 27 November 2000; *Karner* v. *Austria,* Application No. 40016/98, 24 July 2003, para. 36.

Act.' Subsequently, it ruled that the Austrian government did not advance arguments that would allow for such a conclusion.[113]

Karner is a case that can be regarded as salient. Karner died before this case was decided on by the ECtHR. Generally, the ECtHR does accept a successor in title to continue proceedings if the applicant has died. However, in this case there were no heirs.[114] Yet, the ECtHR seems to consider the issue of discrimination based on sexual orientation as fundamental. This emerges from, *inter alia*, its deviation from the casuistic approach it normally adopts. It declares to be willing to not only protect the rights of individuals, but more generally, 'to elucidate, safeguard and develop the rules instituted by the Convention, thereby contributing to the observance by the States of the engagements undertaken by them as Contracting Parties'. This because 'its mission is also to determine issues on public-policy grounds in the common interest, thereby raising the general standards of protection of human rights and extending human rights jurisprudence throughout the community of Convention States'.[115]

From the cases that fall under the fourth category it emerges that the presence of a common ground holding that a difference in treatment is impermissible is decisive in finding that Article 14 ECHR is violated. In contrast, in cases concerning a distinction based on a suspect ground for which no common ground is considered to exist, the degree of assessment adopted is marginal and the discretion granted to the respondent States considerable.[116]

4 ARTICLE 14 ECHR AND THE RIGHT TO EQUAL ACCESS TO HEALTH CARE

4.1 Introduction

In the previous paragraphs, the findings concerning the adoption of Article 14 ECHR by the ECtHR in general and in cases that deal with elements of economic, social and cultural rights specifically, were discussed. In this paragraph these findings are analysed in the light of the factors that can be expected to play a role in the assessment of cases pertaining to Article 14 ECHR at the ECtHR.

Lodging a complaint against a CoE Member State before the ECtHR on unequal access to health care is in principle not easy. The ECHR does not grant a right to economic, social and cultural rights and therefore neither to the right to health care nor to the right to equal access to health care. However, it is not impossible to be successful with a case relating to unequal access to health care. In

[113] *Karner* v. *Austria,* Application No. 40016/98, 24 July 2003, para. 41.
[114] *Karner* v. *Austria,* Application No. 40016/98, 24 July 2003, dissenting opinion judge Grabenwarter, para. 1.
[115] *Karner* v. *Austria,* Application No. 40016/98, 24 July 2003, para. 26.
[116] *Schalk and Kopf* v. *Austria*, Application No. 30141/04, 24 June 2010, paras. 105-106; *Stec and others* v. *the United Kingdom,* Application Nos. 65731/01, 65900/01, 12 April 2006, para. 64; *Petrovic* v. *Austria*, Application No. 20458/92, 27 March 1998, paras. 37, 39, 42, 43.

various cases the ECtHR adopted a contextual interpretation by which elements of economic, social and cultural rights, including the right to health care were adjudicated under the substantive provisions of the ECHR.[117] This was mainly done under Articles 2, 3, and 8 ECHR. Moreover, this integrated approach is also adopted under Article 14 ECHR. It is established case law that once a State has decided to set up establishments or to provide certain entitlements it must do so in a non-discriminatory way which is compatible with Article 14 ECHR. Consequently, Article 14 ECHR serves as a tool against discrimination in the accessibility of socio-economic entitlements for which the ECtHR can be seen as an arbiter.[118] The advantage of this possibility is that a right to equal access to health care could be protected under an individual complaints mechanism by the only judicial human rights body. However, the disadvantage of this possibility lies in the fact that an appeal to elements of economic, social and cultural rights can only be made under Article 14 ECHR once a State provides certain entitlements or has set up a specific benefit system. Nevertheless, this is an obligation emerging from other human rights treaties such as the ESC and RESC, and the ICESCR and therefore it can be expected that at least certain measures in this regard have been taken in the majority of CoE Member States.

4.2 The Right to Equal Access to Health Care and its Justiciability under Article 14 ECHR

The application of the different phases of the assessment model under Article 14 ECHR shows many defects. The phases are frequently abolished, the findings are often not clarified and the adopted criteria are generally not provided for. There is no reason why these findings should not apply to a case in which equal access to health care is adjudicated. Unfortunately, this approach hinders the predictability of the assessment and adoption of these phases in relation to the justiciability of an unequal treatment in accessing health care.

Nevertheless, three conclusions can be drawn that can be relevant for a possible future case concerning unequal access to health care. Firstly, the aims brought forward by the State to justify the distinction made tend to be very broad and are generally accepted by the ECtHR to be legitimate. Therefore, the ECtHR can be expected to accept the aims put forward by a State to justify an unequal treatment in accessing health care. Examples are maintaining the financial stability, the protection of rights of others, the protection of public health, and the protection of the traditional family unit.

Secondly, Article 14 ECHR only applies to discriminatory measures that are taken on one or more grounds that fall under Article 14 ECHR. Consequently, cases on unequal access to health care in which a distinction is based on or results

[117] This contextual interpretation is part of the hermeneutic circle of Koch discussed in Chapter 7.
[118] Palmer 2009, p. 424; De Schutter 2002, p. 221, 222.

in a distinction on these grounds can be assessed under Article 14 ECHR. Moreover, as the grounds enlisted in Article 14 ECHR are illustrative and not exhaustive, a difference in treatment that is based on another ground can be subject to an assessment by the ECtHR as well. As the ECtHR is not always very consistent and transparent in its case law on why it defines a ground of distinction as falling under other status, it is difficult to provide concrete criteria. Nevertheless, the words 'other status' have generally been given a broad meaning. The ECtHR also accepted other grounds than grounds that are innate characteristics or inherently linked to the identity or the personality of the individual, to fall under Article 14 ECHR. [119]

The grounds that could play a role in a case concerning the right to equal access to health care can be found in the case law of the ECtHR. In *P.B. and J.S.*[120] sexual orientation forms the ground of distinction for not providing an extension of the accident and sickness insurance coverage to a same-sex partner. Another important ground of distinction is disability. In *Glor* the ECtHR rules that there is no doubt that a discrimination based on this ground falls under the scope of Article 14 ECHR.[121] And in *Kiyutin* v. *Russia*, the ECtHR recognises health status, *i.e.* being infected with AIDS and being diagnosed with the progressive phase of HIV, Hepatitis B and C, to be covered by the term 'other status'.[122] In addition, the need of medical assistance in order to conceive a child is considered as another ground of distinction falling under the denomination of 'other status'.[123] In *S.H. and others* v. *Austria* the ECtHR considers both couples to be in a comparable situation to other couples who wishes to avail themselves of medically assisted procreation techniques but who, owing to their medical condition do not need ova donation or sperm donation for *in vitro* fertilisation.[124] In line with the statement of the ECtHR that individuals not need be in an identical but only a sufficiently comparable position and a comparable interest as the person or group they refer to in order to fall under Article 14 ECHR, it seems that the fact that the two couples need different methods of fertilisation is not decisive.[125] What is decisive is their medical need. Although this is a thin line of reasoning, this finding is important for the right to equal access to health care as well. Hence, if a certain treatment is based on or results in a difference in treatment between people with a comparable medical need this could be challenged before the ECtHR.[126]

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[119] *Clift* v. *the United Kingdom,* Application No. 7205/07, 13 July 2010, para. 56.
[120] *P.B. and J.S.* v. *Austria,* Application No. 18984/02, 22 July 2010, para. 32.
[121] *Glor* v. *Switzerland,* Application No. 13444/04, 30 april 2009, para. 80.
[122] *Kiyutin* v. *Russia,* Application No. 2700/10, 10 March 2011, paras. 9, 57.
[123] *S.H. and others* v. *Austria,* Application No. 57813/00, 1 April 2010, separate opinion of Judge Jebens, p. 26.
[124] *S.H. and others* v. *Austria,* Application No. 57813/00, 1 April 2010, para. 63.
[125] *Rasmussen* v. *Denmark*, Application No. 8777/79, 5 July 1983, para.75.
[126] The aforesaid, however, does not mean that states may not take into account the needs of those at whomch entitlements or other measures are directed. Nevertheless, if this implies that the measures taken results in a difference in treatment,, regardless of whether this is direct or indirect they still have to satisfy the requirement of being reasonable and objectively justified, see *Kjartan Ásmundsson* v.

The third conclusion of possible importance for a future case about unequal access to health care relates to the recognition of indirect discrimination by the ECtHR. The recognition of indirect discrimination comprises an expansion of the scope of protection that is offered by Article 14 ECHR. An applicant of a case relating to unequal access to health care may attempt to show that an apparently neutral treatment in accessing health care leads to indirect discrimination on the basis of a suspect ground.[127] As a justification of a distinction based on a suspect ground requires for 'very weighty reasons' to be brought forward by the State this leads to a restricted margin of appreciation for the respondent State and high degree assessment under Article 14 ECHR. This increases the chance of Article 14 ECHR being found to be violated. However, it should be noted that the requirements placed on the proof of an indirect unequal treatment is generally particularly high.

In contrast to the adoption of the phases of the assessment model of Article 14 ECHR, the factors determining the degree of assessment, and thereby the margin of appreciation granted to a respondent State, are applied more consistently. From the cases that deal with elements of economic, social and cultural rights various approaches can be discerned that were divided into four categories. These categories provide an insight in the approach of the ECtHR. Moreover, although the degree adopted eventually remains case specific, it seems that these categories make the outcome of a case more predictable.

The categories, set out in paragraph 3.3, can also apply to future cases on unequal access to health care. Therefore, it is important to consider how the factors influencing the degree of assessment under Article 14 ECHR, could appear in such a case.

In a possible future case about unequal access to health care, the respondent State will in principle be granted a wide margin of discretion. In such a case, the ECtHR can be expected to act with restraint. The respondent State would in principle be considered to be in a better position than the ECtHR considers itself to be to determine what is in the public interest with respect to this issue. Due to this 'better placed'-argument, the degree of assessment will be marginal. However, the scope of the margin of appreciation and thereby the degree of assessment under Article 14 ECHR is also subject to the assessment of the ground of distinction and the existence or absence of a consensus between the Member States of the CoE.

If a distinction is based on a suspect ground, less discretion is granted to the respondent State and the chances of success of an appeal on Article 14 ECHR for the applicant that has been subject to discriminatory measures in accessing health care are higher.

Iceland, Application No. 60669/00, 12 October 2004, para. 43; *Karlheinz Schmidt* v. *Germany,* Application No. 13580/88, 18 July 1994, paras. 25-28.

[127] *Hoogendijk* v. *the Netherlands,* ECtHR 6 January 2005, *EHRC* 2005/24, with annotation Gerards, p. 248, 249.

The ECtHR has identified several grounds of distinction as suspect: gender, birth out of wedlock, religion, sexual orientation, property, nationality, marital status, and race.[128] These can all prove to be of importance in a case relating to equal access to health care. Because the ECtHR does not provide general criteria whereby it could be determined which grounds of distinction can be considered as suspect and why, it is difficult to draw any concrete conclusions on what other grounds of distinction can be designated as being suspect. However, in addition to the suspect grounds listed above, disability was considered to constitute a suspect ground as well. For example, in the case *Glor* the ECtHR held that the discretion of a State party in establishing a different legal treatment for persons with disabilities is greatly reduced.[129] And also in the case *Kiyutin* v. *Russia* in which a distinction was based on the health status of the applicant, *i.e.* being HIV infected, the ECtHR adopted a very weighty reasons test.

The degree of assessment adopted under Article 14 ECHR is also determined by the common ground factor. According to the fourth category distilled from the cases in which the ECtHR deals with elements of economic, social and cultural rights, the common ground factor is even found to be decisive for a difference in treatment to be considered to amount to discrimination.

In a case concerning unequal access to health care the establishment of whether a common ground exists between the Signatory States of the CoE can be based on several elements. These include, *inter alia,* the existence of health care systems in the Member States. The fact that the majority of the CoE Member States has established a health care system which at least provides its citizens for basic health care, is very important.[130] Although these systems differ widely, this indicates that there is consensus on the importance of access to health care for individuals. Moreover, as ruled by the ECtHR in *Luczak* v. *Poland*, to leave a person bereft of any social insurance in the event of sickness, occupational injury or invalidity due to unequal treatment by the national legislation is incompatible with current trends in social security legislation in Europe.[131]

Since the revolutionary case of *Demir and Baykara* it is also clear that the framework provided in Chapter II on the right to health and the right to health care can serve to establish whether a common ground is present with regard to a case concerning unequal access to health care.[132] Moreover, the ECtHR elucidated that

[128] Gender and marital status: *Wessels-Bergervoet* v. *the Netherlands*, Application No. 34462/97, 4 June 2002, para. 47; birth out of wedlock: *Sahin* v. *Germany,* Application No. 30943/96, 8 July 2003, para. 94; religion: *Salgueiro da Silva Mouta* v. *Portugal*, Application No. 33290/96, 21 December 1999, para. 31; sexual orientation: *E.B.* v. *France,* Application No. 43546/02, 22 January 2008, para. 91; property: *Clift* v. *the United Kingdom,* Application No. 7205/07, 13 July 2010, para. 56; nationality: *Gaygusuz* v. *Austria,* Application No. 17371/90, 19 September 1996, para. 42; race: *Angelova and Iliev* v. *Bulgaria*, Application No. 55523/00, 26 July 2007.
[129] *Glor* v. *Switzerland,* Application No. 13444/04, 30 april 2009, para. 84.
[130] Backman et al. 2008, p. 2047-2085.
[131] *Luczak* v. *Poland,* Application No. 77782/01, 27 November 2007, paras. 16, 52.
[132] *Demir and Baykara* v. *Turkey,* Application No. 34503/97, 12 November 2008.

in searching for a common ground it makes no distinction between sources of law according to whether or not they have been signed or ratified by the respondent State.[133] Hereinafter a distinction is made between the sources of regional and international human rights law that hitherto have been taken into account in the case law of the ECHR for the purpose of establishing whether a common ground was present and which are relevant to a case about unequal access to health care.

The ECtHR has elucidated that it particularly takes into account the instruments of other CoE organs in order to interpret the guarantees of the ECHR and to establish whether there is a common European standard in the field under consideration.[134] Therefore, the instruments that could also come into play in establishing whether a common ground on the accessibility of health care exists include, *inter alia*, include the ESC, the RESC, and the Convention on Human Rights and Biomedicine.

In various cases the Convention on Human Rights and Biomedicine was recognised as a relevant framework of international human rights law.[135] Moreover, in *Vo.* v. *France* the ECtHR consults this convention in order to establish whether there exists a common ground regarding the subject of the case.[136] The same occurred in *Glass* v. *the United Kingdom* although the ECtHR went a step further in this case by reviewing British legislation under the Convention on Human Rights and Biomedicine.[137] The ECtHR ruled: 'It would add that it does not consider that the regulatory framework in place in the United Kingdom is in any way inconsistent with the standards laid down in the Council of Europe's Convention on Human Rights and Biomedicine.'[138] However, this Convention has never been ratified by the United Kingdom. As Lawson (2010) puts it; 'the Oviedo Convention is imposed on Britain through the backdoor'.[139]

The ESC and RESC are invoked on a more frequent basis. In various cases, the ECtHR refers to the ESC and RESC as being part of the international relevant framework in which the issue under consideration needs to be considered and on the basis of which a common ground is found to be present.[140] The relevance of the

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[133] *Demir and Baykara* v. *Turkey,* Application No. 34503/97, 12 November 2008, paras. 78, 86.
[134] *Tănase* v. *Moldova*, Application No. 7/08, 27 April 2010, para. 176; *Soltysyak* v. *Russia,* Application No. 4663/05, 10 February 2011, para. 51.
[135] *S.H. and others* v. *Austria,* Application No. 57813/00, 1 April 2010; *Evans* v. *the United Kingdom,* Application No. 6339/05, 10 April 2007; *Cyprus* v. *Turkey,* Application No. 25781/94, 10 May 2001; *Glass* v. *the United Kingdom* Application No. 61827/00, 9 March 2004.
[136] *Vo.* v. *France*, Application No. 53924/00, 8 July 2004, para. 84. See also *S.H. and others* v. *Austria,* Application No. 57813/00, 1 April 2010, Dissenting Opinion of Judge Steiner.
[137] *Glass* v. *the United Kingdom* Application No. 61827/00, 9 March 2004; Lawson, 2010, p. 33.
[138] *Glass* v. *the United Kingdom* Application No. 61827/00, 9 March 2004, para 75.
[139] Lawson 2010, p. 34. The role of non-ratified treaties will be discussed in Chapter 10 in relation to the common ground factor that determines the intensity of the assessment of cases under Article 14 ECHR.
[140] *Demir and Baykara* v. *Turkey,* Application No. 34503/97, 12 November 2008, paras. 45, 99; *Botta* v. *Italy* Application No. 21439/93, 24 February 1998, paras. 22, 28; *Nart* v. *Turkey,* Application No. 20817/04, 6 May 2008, para. 20; *Zehnalova and Zehnal* v. *Czech Republic*, Application No. 38621/97,

ESC was also upheld by the Concurring Opinion of Judge Tulkens in the case *Weller* v. *Hungary*. He stated: '[..] if the children's mother had herself lodged an application with the ECtHR, the refusal to award her maternity benefit on the basis of nationality could certainly have been challenged, on the basis of our case-law, as being contrary to Article 14 of the Convention taken together with Article 8, construed, *inter alia*, in the light of Article 12 § 4 of the European Social Charter, which provides that domestic law cannot reserve social-security rights to their own nationals'.[141]

The ECtHR has also attached importance to recommendations issued by the Committee of Ministers and the Parliamentary Assembly in establishing a common ground.[142] In the case *Koua Poirrez* v. *France* the ECtHR refers to Recommendation No. R (92) 6 on 'A coherent policy for people with disabilities' in order to establish whether the measure that is assessed under Article 14 ECHR is in conformity with this instrument.[143] This recommendation also urges the members of the CoE to implement an operational health program that includes *inter alia* medical care, medical and functional rehabilitation and pharmaceutical assistance. Based on this finding, the recommendations discussed in Chapter III, paragraph 5.3, which are part of the framework on the right to equal access to health care, can serve to establish whether a common ground is present in relation to a right to equal access to health care. For example, the Recommendation No. 1626(2003) on 'The reform of health care systems in Europe' calls on the Member States of the CoE 'to take as their main criterion for judging the success of health system reforms the effective access to health care for all, without discrimination, as a basic human right'.[144] Another example is Recommendation No. 1503(2001) on 'Health conditions of migrants and refugees in Europe' which prescribes that migrants should be entitled to rights such as the right to equal treatment in connection with health conditions. Moreover, in this recommendation the Parliamentary Assembly set out that it considers the right to access to health care one of the basic universal human rights, which should be equally applicable to all people, including migrants, refugees and displaced persons.[145] Of course, these instructions are addressed to

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14 May 2002, p. 12; *Sidabras and Džiautas* v. *Lighuania,* Application Nos. 55480/00, 59330/00, 27 July 2004, para. 47; *Demir and Baykara* v. *Turkey,* Application No. 34503/97, 12 November 2008, paras. 77, 103.

[141] *Weller* v. *Hungary*, Application No. 44399/05, 31 March 2009, Concurring Opinion of Judge Tulkens.

[142] *Demir and Baykara* v. *Turkey,* Application No. 34503/97, 12 November 2008, para. 74.

[143] *Koua Poirrez* v. *France*, Application No. 40892/98, 30 September 2003, para. 39; Recommendation No. R (92) 6 on a coherent policy for people with disabilities, adopted by the Committee of Ministers of the Council of Europe on 9 April 1992.

[144] Recommendation 1626 (2003) on 'the reform of health care systems in Europe: reconciling equity, quality and efficiency', adopted by the Parliamentary Assembly of the Council of Europe on 1 October 2003.

[145] Recommendation 1503(2001) on 'Health conditions of migrants and refugeest in Europe', adopted by the Parliamentary Assembly on 14 March 2001.

measures in a field that is characterised as a sensitive topic due to scarce financial resources. Nevertheless, it is clear that these recommendations can serve as a relevant instrument in establishing whether a common ground is present.

As clarified in the case of *Demir and Baykara*, the obligations the substantive provisions of the ECHR impose on its Signatory States may also be interpreted in the light of relevant international human rights instruments.[146] In this case international instruments were provided as examples and various elements of this framework have likewise been referred to in some cases of the ECtHR in order to establish whether a common ground was present.[147] For example, the ICESCR and its corresponding GC No. 20 on non-discrimination were designated as relevant legal framework and consulted in defining the meaning of the ECHR.[148] This implies that Article 12 ICESCR and GC No. 14 on the right to the highest attainable standard to health could also serve as foundations to establish that a common ground exists regarding access to health care on a non-discriminatory basis.

The fact that the ECtHR in the *Demir and Baykara* case provide such an extensive explanation and clarification of the instruments that can serve to establish a common ground, forms an important foundation for the analysis of the possible application to a case concerning unequal access to health care. The absence or existence of a common ground factor is demonstrated to be decisive for the margin of appreciation granted to a respondent State and therefore for the degree of assessment. As the legal framework of instruments set out above includes provisions on the right to equal access to health care, these can serve as a basis for the establishment of the presence of a common ground and, therefore, for a higher degree assessment under Article 14 ECHR.

5 ARTICLE 1 PROTOCOL NO. 12 TO THE ECHR

5.1 Introduction

In addition to what is written about the application of Article 14 ECHR by the ECtHR, notice should also be taken of Protocol No. 12 ECHR. Protocol No. 12 ECHR contains an autonomous prohibition clause and therefore, unlike Article 14 ECHR, it does not require a link to a substantive provision enshrined in the ECtHR for a case to be admissible.

[146] *Demir and Baykara* v. *Turkey,* Application No. 34503/97, 12 November 2008.
[147] *Demir and Baykara* v. *Turkey,* Application No. 34503/97, 12 November 2008, paras. 74, 75, 85.
[148] E/C.12/GC/20, General Comment 20 (2009), 2 July 2009, *Non-discrimination in economic, social and cultural rights (Art. 2, para. 2 ICESCR)*; *Demir and Baykara* v. *Turkey,* Application No. 34503/97, 12 November 2008, paras. 41, 99; *Kiyutin* v. *Russia,* Application No. 2700/10, 10 March 2011, para. 30.

5.2 Article 1 Protocol No. 12 ECHR and its Application

Article 1 Protocol No. 12 reads as follows:

> 1. The enjoyment of any right set forth by law shall be secured without discrimination on any ground such as sex, race, colour, language, religion, political or other opinion, national or social origin, association with a national minority, property, birth or other status.
> 2. No one shall be discriminated against by any public authority on any ground such as those mentioned in paragraph 1.

Before the adoption of Protocol No. 12 ECHR, there was a limit to European non-discrimination case law inherent to the fact that Article 14 ECHR was construed in a non-autonomous manner.[149] In line with the premise that human rights are meaningless unless they are enjoyed by everybody, the adoption of Protocol No. 12 ECHR constitutes a big step forward to overcome this limitation. This protocol unchained the right to non-discrimination from other rights and provides a general prohibition of discrimination with respect to all human rights defined by law.[150]

The entry into force of Protocol No. 12 ECHR has a long history. The possibility of providing further guarantees in the field of equality and non-discrimination through a protocol to the ECHR has been proposed and studied from the 1960s onwards.[151] Finally in 2000, the Member States of the CoE have expressed their resolve to secure in addition to Article 14 ECHR a more extensive protection against discrimination by the adoption of Protocol No. 12 ECHR, which entered into force in 2005.[152]

In substantive terms, Protocol No. 12 ECHR adds nothing new to the framework of international and regional human rights law. The principle of equality is already enshrined in various instruments at international and regional level. What is new is the expansion of the case law of the ECtHR.[153] This expansion encountered resistance of many Member States of the CoE to adopt a Protocol including a autonomous prohibition of discrimination. Different arguments were brought forward for keeping Article 14 ECHR as it stood. The legislation of the majority of the Member States was considered to already offer effective protection

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[149] Council of Europe, Non-discrimination: A human right - seminar marking the entry into force of protocol no. 12. Strasbourg: Council of Europe Publishing 2006, p. 107.
[150] Petrova 2006, p. 30.
[151] Explanatory Report to Protocol No. 12 to the Convention for the Protection of Human Rights and Fundamental Freedoms, 4 June 2000, E.T.S. No. 177, para. 2.
[152] *Nachova* v. *Bulgaria,* Application Nos. 43577/98, 43579/98, 26 February 2004, para. 168; Explanatory Report to Protocol No. 12 to the Convention for the Protection of Human Rights and Fundamental Freedoms, 4 June 2000, ETS No. 177, paragraph 2, 13; Chart of signatures and ratifications, see:
http://conventions.coe.int/Treaty/Commun/QueVoulezVous.asp?NT=177&CM=8&DF=20/05/2011&CL=ENG
[153] Council of Europe 2006, p. 105.

against discrimination and the national legislatures were considered to be better placed than the ECtHR to handle discrimination matters.[154] In addition, there was a fear that the non-discrimination provision of Protocol No. 12 ECHR would extend to private relations and therefore would have a horizontal effect.[155] Moreover, it was unclear how Protocol No. 12 ECHR was going to be applied by the ECtHR, especially as it constitutes an autonomous discrimination provision that is applicable to any kind of State activity.[156]

The explanatory report to Protocol No. 12 ECHR responds to the fears of various Member States of the CoE of adopting an autonomous non-discrimination clause. The explanatory report clarifies the approach to the extension of the non-discrimination provision of Protocol No. 12 ECHR to private relations and its horizontal effect. It sets out that positive obligations cannot be excluded altogether. After all, a failure to provide protection from discrimination in relations between private persons might be so clear-cut and grave that the responsibility of the State under Article 1 of the Protocol could come into play. For example, this question could arise if there is a clear lacuna in domestic law protection from discrimination. Nonetheless, the explanatory report elucidated that the extent of any positive obligations flowing from Article 1 is likely to be limited. Article 1 Protocol No. 12 ECHR protects against discrimination by public authorities. Therefore, any positive obligation in the area of relations between private persons would concern, at the most, relations in the public sphere normally regulated by law, for which the State has a certain responsibility. Examples of such areas provided in the explanatory report include arbitrary denial of access to work, access to restaurants, or to services which private persons may make available to the public such as medical care or utilities such as water and electricity. As such, purely private matters are not affected by Protocol No. 12 ECHR.[157]

Moreover, the explanatory report provides for an explanation of why the list of non-discrimination grounds enshrined in Article 1 Protocol No. 12 ECHR is identical to that in Article 14 ECHR. According to the explanatory report to Protocol No. 12 ECHR, it was considered unnecessary to include other grounds for distinction since the list of non-discrimination grounds is not exhaustive. This is not because of a lack of awareness that other grounds have become important in relation to discrimination and unequal treatment in today's society. After all, as set out in the previous paragraphs, the ECtHR has recognised various other grounds of distinction to fall under the discrimination clause of Article 14 ECHR. The list from Article 14 ECHR was copied as such because the inclusion of any additional ground might give rise to the unwanted interpretation that discrimination based on other

[154] Council of Europe 2006, p. 74.
[155] Council of Europe 2006, p. 47.
[156] Council of Europe 2006, p. 47, 74.
[157] Explanatory Report to Protocol No. 12 to the Convention for the Protection of Human Rights and Fundamental Freedoms, 4 June 2000, E.T.S. No. 177, paras. 24-28.

grounds is *a priori* not protected by Protocol No. 12 ECHR.[158] In addition, the explanatory report also defines the scope of the words 'any right set forth by law' as laid down by Article 1, paragraph 1 of the Protocol. First of all, this expression limits its possible horizontal effect. Moreover, it also clarifies that Article 1 Protocol No. 12 ECHR may also cover international law although this does not entail a duty for the ECtHR to examine States' compliance with rules of law imposed by other international instruments.[159]

The great importance of Protocol No. 12 ECHR lies in the fact that the ECtHR can now attend to matters in which no direct link can be established with the substantive provisions of the ECHR.[160] Protocol No. 12 ECHR provides access to protection against discrimination in relation to all the rights secured by the State. Consequently, the gist of Protocol No. 12 ECHR is to do just what was tried to be avoided when adopting the ECHR: the ECtHR can now make binding judgements on economic, social and cultural rights beyond the narrow scope of the substantive provisions of the ECHR.[161]

Notwithstanding the great importance of this application for a more ample protection against discrimination and the topic of the present study, the adoption of Protocol No. 12 ECHR is still politically controversial in several Member States of the CoE. To date, no more than 18 Member States have ratified the Protocol, mostly countries from Eastern Europe. From the old members of the CoE, only Finland, Luxembourg, the Netherlands and Spain have ratified Protocol No. 12 ECHR. The other Member States seem to wait to see how Protocol No. 12 ECHR will be applied by the ECtHR.

Hitherto, in only one case, the case of *Sejdić and Finci* v. *Bosna and Herzegovina*, the ECtHR has substantively dealt with Article 1 Protocol No. 12 ECHR.[162] In other cases in which Protocol No. 12 ECHR was claimed to be violated, the cases were declared inadmissible under Article 35 ECHR as Protocol No. 12 ECHR was not ratified by the respondent State.[163] And in another case, *Savez Crkava "Riječ Života" and others* v. *Croatia*, the ECtHR only determined whether Article 1 Protocol No. 12 ECHR was applicable to the case in hand.[164] This case concerned the complaint of a number of Reformist churches which, unlike other religious communities in Croatia, could not provide religious education in public schools and nurseries or obtain official recognition of their religious

[158] Explanatory Report to Protocol No. 12 to the Convention for the Protection of Human Rights and Fundamental Freedoms, 4 June 2000, E.T.S. No. 177, para. 20.
[159] Explanatory Report to Protocol No. 12 to the Convention for the Protection of Human Rights and Fundamental Freedoms, 4 June 2000, E.T.S. No. 177, para. 29.
[160] Maes 2003, p. 167.
[161] Tomuschat 2007, p. 23.
[162] *Sejdić and Finci* v. *Bosna and Herzegovina*, Application Nos. 27996/06, 34836/06, 22 December 2009.
[163] *E.g. Ilu and others* v. *Turkey,* Application Nos. 29545/06, 15306/07, 30671/07, 31267/07, 21014/08, 62007/08, 7 December 2010, para. 33.
[164] *Savez Crkava "Riječ Života" and others* v. *Croatia*, Application No. 7798/08, 9 December 2010.

marriages as the domestic authorities refused to conclude an agreement with them regulating their legal status. The applicants alleged violations of Article 14 *juncto* Article 9 ECHR, of Article 9 ECHR taken alone, of Article 1 Protocol No. 12 ECHR, of Article 6 ECHR, and of Article 13 ECHR.

The ECtHR holds that a complaint has to fall within one of the four categories mentioned in the explanatory report for Article 1 Protocol No. 12 ECHR to be applicable.[165] These categories include cases where a person is discriminated against: i) in the enjoyment of any right specifically granted to an individual under national law, ii) in the enjoyment of a right which may be inferred from a clear obligation of a public authority under national law, iii) by a public authority in the exercise of discretionary power, and iv) by any other act or omission by a public authority. All of the complaints except one were considered to fall under these categories and therefore, Article 1 Protocol No. 12 ECHR was applicable. After that finding, the ECtHR continued with its assessment on the merits. As the measures were already considered to amount to discrimination in breach of Article 14 *juncto* Article 9 ECHR the ECtHR considered that it unnecessary to examine these issues separately under Protocol No. 12 ECHR.[166]

This conclusion can at least be regarded as remarkable. Why would the ECtHR make the effort to consider whether Article 1 Protocol No. 12 ECHR is applicable to the complaints under consideration, but not deal with the issues under the same Protocol after finding that it is applicable? The only logical reason that can be found for this is that the ECtHR wants to provide further clarification on its approach in assessing cases under Protocol No. 12 ECHR.

Thus far, *Sejdić and Finci* v. *Bosna and Herzegovina* is the only case in which the ECtHR has substantively dealt with Article 1 Protocol No. 12 ECHR.[167] The applicants were Bosnian nationals of Roma and Jewish ethnicity. They complained that, despite possessing experience comparable to the highest elected officials, the Constitution of Bosnia and Herzegovina prevented them from being candidates for the Presidency and for the House of Peoples of the Parliamentary Assembly solely on the ground of their ethnic origins.

In applying Article 1 Protocol No. 12 ECHR to this case the ECtHR expounds for the first time on the meaning and application of this non-discrimination clause. First, it holds that the meaning of the term 'discrimination' as laid down in Article 1 Protocol No. 12 ECHR is identical to that of Article 14 ECHR. Secondly, it states that the notions of discrimination prohibited by Article 14 ECHR and by Article 1 Protocol No. 12 ECHR are to be interpreted in the same

[165] *Savez Crkava "Riječ Života" and others* v. *Croatia*, Application No. 7798/08, 9 December 2010, para. 104.
[166] *Savez Crkava "Riječ Života" and others* v. *Croatia*, Application No. 7798/08, 9 December 2010, para. 115.
[167] *Sejdić and Finci* v. *Bosna and Herzegovina*, Application Nos. 27996/06, 34836/06, 22 December 2009.

way.[168] Accordingly, as Article 14 ECHR is already found to be violated, the ECtHR finds that Article 1 Protocol No. 12 ECHR is infringed for the same reasons.

As the very first of its kind, the ECtHR does not lay down specific or deviating principles, standards or tests that can be considered to be applicable to future cases concerning general discrimination.[169] It clarifies that it applies a similar approach to cases when adopting Protocol No. 12 ECHR as it does under Article 14 ECHR. Although more cases have to be awaited on the application of Protocol No. 12 ECHR, it seems that the entry into force of Protocol No. 12 ECHR has no consequences for the assessment method of alleged discriminatory measures under the ECHR.

5.3 Concluding Remarks and the Significance of Article 1 Protocol No. 12 ECHR for the Justiciability of the Right to Equal Access to Health Care

The potential of Protocol No. 12 ECHR lies in the fact that it provides for an autonomous discrimination clause and allows therefore, the ECtHR to pronounce binding rulings on economic, social and cultural rights beyond the scope of the substantive provisions of the ECHR.

Consequently, the gist of Protocol No. 12 ECHR is to do just what was tried to be avoided when adopting the ECHR: the ECtHR can now make binding judgements on economic, social and cultural rights beyond the narrow scope of the substantive provisions of the ECHR. This expansion of the case law of the ECtHR by this protocol is of great importance to future cases about unequal access to health care.

Although more cases have to be awaited on the application of Protocol No. 12 ECHR, especially in relation to elements of economic, social and cultural rights, it seems that the entry into force of Protocol No. 12 ECHR has no consequences for the assessment method of alleged discriminatory measures under the ECHR. The ECtHR can be expected to apply the same assessment method as it adopts under Article 14 ECHR. Nevertheless, since entry into force of Protocol No. 12 ECHR it can be expected to be less difficult to lodge a complaint of unequal access to health care with the ECtHR. This possibility even provides for a more direct effect of the integrated approach as Protocol No. 12 ECHR can be applied without it being necessary that the facts of a case fall under one of the substantive provisions of the ECHR.

[168] *Sejdić and Finci* v. *Bosna and Herzegovina*, Application Nos. 27996/06, 34836/06, 22 December 2009, paras. 55, 56.
[169] *Sejdić and Finci* v. *Bosna and Herzegovina*, Application Nos. 27996/06, 34836/06, 22 December 2009, Separate Opinion, p. 44.

6 CONCLUSIONS

In its monitoring practice, the ECtHR indicates to adopt a clear assessment model when assessing a case under Article 14 ECHR. The first phase of this model consists of a test of comparability to assess whether the applicant is in a similar position as the person or group he refers to. Moreover, this first phase also includes the assessment of whether persons whose situations are significantly different are treated equal (substantive unequal treatment) or whether equal treatment has the effect of unequal treatment (indirect unequal treatment). The second phase of the ECtHR's assessment model includes a test of the legitimacy of the aim, and a proportionality test.

The practical application of this assessment model shows many defects. The same picture emerges from the analysis of the cases in which the ECtHR deals with elements of economic, social and cultural rights under Article 14 ECHR. Nevertheless, the degree of assessment adopted in these cases shows a more consistent and predictable pattern. After analysing the cases dealing with elements of economic, social and cultural rights, four categories of approach with regard to the degree of assessment under Article 14 ECHR can be distinguished. These clarify the approach of the ECtHR and contribute to the predictability of the outcome of a case. The first category can be considered as the basic approach in which the Member States enjoy a very wide margin of appreciation under Article 14 ECHR. If a case falls under this category, the respondent State is considered to be in a better position than the ECtHR to assess what measures are necessary in specific circumstances. However, if the distinction at issue is based on a suspect ground, the margin of discretion is reduced and the ECtHR generally adopts a very weighty reasons test. This category is identified as the second degree. The third category comprises cases in which the distinction is exclusively based on a suspect ground. In these cases the margin of discretion is very restricted. The fourth category is characterised by cases in which the distinction is not only based on a suspect ground but in which a consensus among Signatory States is also considered to be present, rejecting this ground. These cases are marked by a very high degree of assessment under Article 14 ECHR. A possible future case concerning unequal access to health care can fall under one of these four categories as well.

It is not straightforward that a case about unequal access to health care is justiciable by the ECtHR. The ECHR does not grant a right to economic, social or cultural rights nora right to equal access to health care. However, it is not impossible either. By the integrated approach adopted by the ECtHR under Article 14 ECHR, the provision enshrined in it can serve as a tool against discrimination in the accessibility of socio-economic entitlements. If a State provides for health care entitlements or sets up a health care system, Article 14 ECHR can apply.

It is difficult to draw concrete conclusions regarding the assessment of a future case concerning unequal access to health care under Article 14 ECHR as well as regarding what differences in treatment with regard to this right can be justified

and what have to be considered to amount to discrimination. Considering what is justified remains case specific and depends on various factors that have to be balanced in order to determine whether a difference in treatment amounts to a violation of Article 14 ECHR. Nevertheless, several factors have been highlighted that can play a role in such a case and that can determine the degree of assessment adopted by the ECtHR.

The general aims put forward by a State can be expected to be accepted by the ECtHR as being legitimate, such as maintaining financial stability, protection of rights of others, protection of public health and protection of the traditional family unit. However, if a distinction is based on a suspect ground, the margin of discretion granted to a respondent state is restricted. In line with this, the fact that the ECtHR also recognises substantive equality and indirect discrimination to fall under the scope of protection of Article 14 ECHR is important for a possible future case about unequal access to health care. An applicant may attempt to show that an apparently neutral treatment in accessing health care leads to indirect discrimination on the basis of a suspect ground as this requires 'very weighty reasons' to be brought forward by the State. Such a case would fall under the second category of the degree adopted in the assessment under Article 14 ECHR. No criteria are provided for establishing whether a ground for distinction is considered a prohibited ground for distinction. Nevertheless, if a difference in treatment in accessing health care is based on gender, birth out of wedlock, religion, sexual orientation, property, nationality, marital status, race, disability or health status, it is more difficult for the State to avoid a finding of breach of Article 14 ECHR. Finally, the fact that the ECtHR takes into account a great number of human rights instruments to establish whether a common ground is present, is of great importance for a future case about unequal access to health care. Consequently, the entire framework set out in Chapter II on the right to health care can be taken into consideration for this purpose. If a common ground exists between the Member States of the CoE which disapproves of a certain difference in accessing health care, the degree of assessment will be very high and the margin of appreciation granted to the respondent state rather restricted, and consequently it will be difficult to avoid a negative ruling.

Due to the entry into force of Protocol No. 12 ECHR it can be expected to be less difficult to lodge a complaint on unequal access to health care with the ECtHR. This possibility even provides for a more direct adoption of the integrated approach as Protocol No. 12 ECHR can be applied to such cases beyond the narrow scope of the substantive provisions of the ECHR. This direct adoption of the integrated approach is also adopted by the HRCee when assessing cases under the autonomous non-discrimination provisions enshrined in Article 26 ICCPR. It resembles what was determined by Scott as the related interdependence by which Article 26 ICCPR and Article 1 Protocol No. 12 ECHR apply to a right provided by another treaty than the ICCPR and the ECHR respectively. The integrated approach

adopted by the HRCee in the assessment of cases under Article 26 ICCPR shall be discussed in further detail in Chapter X.

CHAPTER X
THE JUSTICIABILITY OF THE RIGHT TO EQUAL ACCESS TO HEALTH CARE AT THE HUMAN RIGHTS COMMITTEE

1 INTRODUCTION

The ICCPR contains two general provisions dealing with non-discrimination and equality: Article 2 and Article 26 ICCPR. Article 2 ICCPR is an ancillary provision. By contrast, Article 26 ICPPR contains an autonomous prohibition of discrimination and a right to equality before the law and equal protection by the law.[1] Consequently, the scope of Article 26 ICCPR is not limited to the rights enshrined in the ICPPR; it prohibits discrimination by law or in fact in any field regulated and protected by public authorities.

Individuals who claim to be the victim of a violation by a Member State of the prohibition of discrimination under the ICPPR can lodge a complaint with the HRCee.[2] Communications of the HRCee have no binding force and there is no mechanism for the enforcement of its rulings. Nevertheless, in comparison to the general non-discrimination clauses of the ECHR, and especially Article 14 ECHR, the scope of the protection of Article 26 ICCPR is wider. It is applicable to rights outside the scope of the civil and political rights enshrined in the ICCPR including rights protected by other human rights treaties, such as the ICESCR. Moreover, it extends to its Member States located around the world.[3]

Under Article 26 ICCPR, the HRCee adopts the integrated approach in a direct manner in cases relating to the enjoyment of economic, social and cultural rights. These cases predominantly deal with complaints concerning social security.[4] Other examples are cases with regard to conscientious objection to military service, education subsidies, and the right to property.

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[1] Art 26 ICCPR reads: 'All persons are equal before the law and are entitled without any discrimination to the equal protection of the law. In this respect, the law shall prohibit any discrimination and guarantee to all persons equal and effective protection against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.'

[2] The OP ICCPR also provides for the competence of the HRCee to examine inter-State communications. Nevertheless, this will not be dealt with in the present study.

[3] As held by the HRCee in Communication No. 998/2001, *Rupert Althammer et al.* v. *Austria*, para. 8.4: 'The Committee on earlier occasions has already decided that the independent right to equality and non-discrimination embedded in Article 26 of the Covenant provides a greater protection than the accessory right to non-discrimination contained in Article 14 of the European Convention.'

[4] Vandenhole 2005, p. 14, 15.

The application of Article 26 ICCPR to economic, social and cultural rights is of great importance for the justiciability of the right to equal access to health care. Consequently, the adjudicatory practice of the ICCPR under Article 26 ICCPR shall be set out in paragraph 2. The case law of the HRCee under Article 26 ICCPR mainly applies to elements outside the scope of the other provisions of the ICCPR. Therefore, it is not necessary to separately evaluate how this prohibition of discrimination is adopted in general to substantive provisions of the ICCPR. Subsequently, the findings of paragraph 2 will be analysed in relation to the justiciability of the right to equal access to health care in paragraph 3.

2 THE HUMAN RIGHTS COMMITTEE AND ITS ASSESSMENT OF CASES CONCERNING UNEQUAL TREATMENT AND NON-DISCRIMINATION UNDER ARTICLE 26 ICCPR

Initially, Article 26 ICCPR was considered to be a classic non-discrimination provision, prohibiting discrimination based on one of the rights enshrined in the ICCPR.[5] Consequently, the HRCee adopted a restraint approach in applying Article 26 ICCPR to cases concerning elements of economic, social and cultural rights.[6] This approach drastically changed in the *Dutch Unemployment Benefits Act* cases of 1987. These cases include the cases *S.W.M. Broeks* v. *the Netherlands*, *F.H. Zwaan-de Vries* v. *the Netherlands* and *L.G. Danning* v. *the Netherlands.*[7] The HRCee explains that Article 26 ICCPR does not merely duplicate the guarantees provided in the ancillary non-discrimination provision of Article 2 ICCPR. It clarifies that the provision of Article 26 ICCPR prohibits discrimination in law or in practice in any field regulated and protected for by public authorities. Therefore, it is concerned with all the obligations imposed on States with regard to their legislation and the application thereof. Hence, via Article 26 ICCPR, the ICCPR also applies to matters that are referred to or covered by other international instruments. As such, as was the case in these communications, the way a Member State fulfils its obligations under *inter alia* the ICESCR can become, by way of Article 26 ICCPR, object of examination by the HRCee as well. Nevertheless, the HRCee added to this approach that the non-discrimination provision of Article 26 ICCPR does not in itself comprise any obligation with respect to the matters that may be provided or protected by legislation. For example, Article 26 ICCPR does not require its Member States to enact legislation in relation to or provide for social security.

[5] Edelenbos 2009, p. 79.
[6] Ando 2004, p. 209.
[7] Communication No. 172/1984, *S.W.M. Broeks* v. *the Netherlands*; Communication No. 182/1984, *F.H. Zwaan-de Vries* v. *the Netherlands*; Communication No. 180/1984, *L.G. Danning* v. *the Netherlands*.

However, if such legislation is adopted, it must comply with Article 26 of the ICCPR.[8]

The *Dutch Unemployment Benefits Act* cases of 1987 were considered revolutionary. In contrast to what was initially considered about the scope of Article 26 ICCPR, these communications of the HRCee clarify that Article 26 ICCPR truly provides an autonomous non-discrimination clause.[9] Moreover, it then became evident that the HRCee can also intervene in the field of economic, social and cultural rights, which was initially considered as a field in which States enjoyed total discretion.[10]

Two years after the adoption of the communications on the *Dutch Unemployment Benefits Act* cases, the HRCee consolidated its approach on non-discrimination and equal treatment in General Comment 18 (GC No.18).[11] GC No. 18 includes the various elements that were set out in the *Dutch Unemployment Benefits Act* cases; Article 26 ICCPR provides an autonomous right to equality before the law and equal protection by the law without discrimination as well as an ancillary prohibition of discrimination in that it also applies to rights that are protected in human rights instruments other than the ICCPR, and if a differentiation is based on reasonable and objective criteria, it does not amount to a violation of Article 26 ICCPR. In addition, it provides another criterion for assessment of whether a difference in treatment amounts to discrimination: a difference in treatment will not only not constitute discrimination if the criteria for such difference in treatment are reasonable and objective, but neither if the aim of the treatment is to achieve a purpose which is legitimate under the ICCPR.[12]

In assessing alleged violations of Article 26 ICCPR, the HRCee applies the criteria set out in GC No. 18. In addition, although not made explicit, the HRCee seems to adopt a comparability test as well. The comparability test includes that the HRCee examines whether the applicant is in a similar position as the group of persons he refers to and whether they are indeed treated differently. For this assessment, the HRCee verifies that the applicant belongs to an identifiably distinct category of persons before considering whether they are in a comparable situation.[13]

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[8] Communication No. 172/1984, *S.W.M. Broeks* v. *the Netherlands*, paras. 4.2, 12.1, 12.3, 12.4, 13; Communication No. 182/1984, *F.H. Zwaan-de Vries* v. *the Netherlands*, paras. 4.2, 12.1, 12.3, 12.4, 13; Communication No. 180/1984, *L.G. Danning* v. *the Netherlands*, paras. 4.2, 12.1, 12.3, 12.4, 13. The same holds for the right to property: Although the right to property as such is not protected by the ICCPR, a specific act or omission in relation to property can still entail a breach of the ICCPR if it is discriminatory and therefore violates Article 26 ICCPR. See: Communication No. 516/1992, *Alina Simunek* v. *Czech Republic*, para. 11.3; Communication No. 586/1994, *Josef Frank Adam* v. *Czech Republic*, para. 12.2.

[9] Tyagi 2011, p. 649.

[10] Edelenbos 2009, p. 78.

[11] Tomuschat 2004, p. 225; A/45/40, General Comment No. 18 (1989), 10 November 1989, *Non-discrimination*, para. 12.

[12] A/45/40, General Comment No. 18 (1989), 10 November 1989, *Non-discrimination*, paras. 1, 8, 12, 13.

[13] Communication No. 273/1988, *B.d.B. et al.*v. *the Netherlands*, para. 6.7.

As held by the Committee members F.A. Urbana and B. Wennergren in *Hendrika S. Vos* v. *the Netherlands*; 'whenever a difference in treatment does not affect a group of people but only individuals, a provision cannot be deemed discriminatory as such; negative effects on one individual cannot then be considered to be discrimination within the scope of Article 26'.[14]

After it has been established that the applicant belongs to an identifiably distinct category of persons, the HRCee can continue with the comparability test by assessing the comparability of the position of the author and the group of persons he refers to. For example, in the case of *Jacob and Jantina Hendrika van Oord* v. *the Netherlands* which dealt with a case about pension entitlements, the HRCee observed that the categories of persons that were being compared, were distinguishable.[15] Therefore, the HRCee found that the facts presented by the author of the communication did not raise an issue under Article 26 ICCPR.

The HRCee also takes into account indirect discrimination under Article 26 ICCPR. GC No. 18 provides that the term 'discrimination', as used in the ICCPR, should be understood to imply any distinction whether it has the purpose or effect of nullifying or impairing the recognition, enjoyment or exercise by all persons on an equal footing, of all rights and freedoms.[16] By referring to 'purpose or effect' the HRCee clarified that both intentional and non-intentional discrimination can fall under the non-discrimination provisions of the ICCPR and that that discrimination can also include indirect discrimination.[17] Consequently, an apparently neutral treatment that in effect leads to unequal treatment can fall under the protection of Article 26 ICCPR.

Some years before the adoption of GC No. 18, the HRCee referred for the first time to indirect discrimination in the case of *Karnel Sing Bhinder* v. *Canada*.[18] The applicant in this case complained that a rule of the Canadian National Railway Company, requiring workers in certain jobs to wear protective helmets, indirectly

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[14] Communication No. 218/1986, *Hendrika S. Vos* v. *the Netherlands*, Individual Opinion submitted by Committee members F.A. Urbina and B. Wennergren, paragraph 1. Another Communication, in which this criterion was dealt with, but on an implicit basis, is the case of Communication No. 747/1997, *Dr. Karel Des Fours Walderode* v. *Czech Republic*, para. 8.3.

[15] Communcation No. 658/1995, *Jacob and Jantina Hendrika van Oord* v. *the Netherlands*, paras. 8.5, 8.6; Communication No. 415/1990, *Dietmar Pauger* v. *Austria*, para. 7.4; Communication No. 297/1998, *H.A.E.d.J.* v. *the Netherlands*, para. 8.2. Other examples are: Communication No. 267/1987, *M.J.G.* v. *the Netherlands*, para. 3.2; Communication No. 402/1990, *Maria Brinkhof* v. *the Netherlands*, para. 9.4; Communication No. 196/1985, *Ibrahima Gueye et al.* v. *France*, para. 9.2; Communication No. 454/1991, *Enrique Garcia Pons* v. *Spain*, para. 9.5.

[16] A/45/40, General Comment No. 18 (1989), 10 November 1989, *Non-discrimination*, para. 7.

[17] Davidson 2004, p. 165; Vandenhole 2005, p. 57. The fact that the HRCee does not consider discriminatory intent to be an essential characteristic of discrimination was already ruled in Communication No. 182/1984, *F.H. Zwaan-de Vries* v. *the Netherlands*, para. 16, and also in later cases: Communication No. 208/1986, *Karnel Sing Bhinder* v. *Canada*, para. 6.1; Communication No. 516/1992, *Alina Simunek* v. *Czech Republic*, para. 11.7; Communication No. 295/1988, *Aapo Järvinen* v. *Finland*, para. 6.5.

[18] Communication No. 208/1986, *Karnel Sing Bhinder* v. *Canada*, para. 6.1.

discriminated against Sikhs as their religion requires them to wear turbans. The HRCee implicitly recognised that this rule constituted indirect discrimination. Nevertheless, it considered the purposes of the rule put forward by the Canadian State, *i.e.* protection from injury and electric shock, as justifiable. In other cases that were adopted after the adoption of GC No. 18 too, the HRCee implicitly referred to indirect discrimination before recognising the concept of indirect discrimination more explicitly in the case of *Mrs. Alina Simunek et al.* v. *Czech Republic*.[19] This case is part of a number of communications claiming that a Czech Act, which introduced a regime of restitution for property unlawfully confiscated by the communist regime differentiated among the victims, based on their nationality and place of residence. In these cases, the former Czechoslovak State itself was found to be responsible for the departure of the applicants from the national territory as they were made victims of political persecution.

However, it was not until 2003 that the HRCee explicitly recognised and invoked indirect discrimination and elucidated its approach in applying this concept. In the case of *Rupert Althammer et al.* v. *Austria* of 2003, the applicants held that abolishing monthly household entitlements affected retired persons more heavily than active employees.[20] In reply to this claim, the HRCee held that 'a violation of Article 26 can also result from the discriminatory effect of a rule or measure that is neutral at face value or without intent to discriminate. However, such indirect discrimination can only be said to be based on the grounds enumerated in Article 26 of the Covenant if the detrimental effects of a rule or decision exclusively or disproportionally affect persons having a particular race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.'

In the cases set out above, both the comparability test and the assessment of whether a treatment has a disproportionate adverse effect on a certain category of persons are dealt with before continuing with the consideration of whether the alleged distinctions are based on objective and reasonable criteria. Although the HRCee does not make explicit whether it distinguishes several phases of assessment, the comparability test and the assessment of whether there is indirect unequal treatment can be considered to form the first phase of the assessment under Article 26 ICCPR.[21] The HRCee is very inconsistent in applying this first phase: the cases set out above are just a few examples in which the HRCee does apply the

[19] Vandenhole 2005, p. 60; Communication No. 418/1990, *Cavalcanti Araujo-Jongen* v. *the Netherlands*, para. 7.4; Communication No. 295/1988, *Aapo Järvinen v Finland*, para. 6.5; Communication No. 516/1992, *Alina Simunek* v. *Czech Republic*, para. 11.7.

[20] Communication No. 998/2001, *Rupert Althammer et al.* v. *Austria*, para. 10.2; Communication No. 976/2001, *Cecilia Derksen* v. *the Netherlands*, para. 9.3. Likewise, in the case of *Cecilia Derksen* the HRCee sets out that indirect discrimination is 'related to a rule or measure that may be neutral on its face without any intent to discriminate but which nevertheless results in discrimination because of its exclusive or disproportionate adverse effect on a certain category of persons' and is therefore also prohibited by Article 26 ICCPR.

[21] Vandenhole 2005, p. 45-46.

comparability test as well as the test of indirect unequal treatment and in which the criterion of the applicant belonging to an identifiably distinct category of persons are set out. In most of its cases, though, the comparability test is entirely lacking. In these cases, the HRCee only states that the differential treatment is based on reasonable and objective criteria. Implicitly, it thereby recognises that the applicant is in an equal position to the category of persons he refers to and that they are treated differently.[22] In its assessment of indirect discrimination the HRCee provides some criteria: it can result from the effect of a rule or measure, and it has to be based on one or more of the grounds enumerated in Article 26 ICCPR.

The conclusion about the way in which the HRCee adopts what can be designated as the first phase of the assessment under Article 26 ICCPR, also applies to the way in which the assessment of the legitimate aim is accomplished. This criterion is often lacking and the HRCee does not make explicit whether it applies this criterion. Nevertheless, there are cases in which the HRCee recognises the importance of this criterion. For example, in a case about the refusal of a pension transfer of the deceased life partner of the applicant, the HRCee states that the Australian government did not adduce any evidence which would point to the existence of factors justifying such a distinction and therefore declare that the distinction amounts to a violation of Article 26 ICCPR.[23] Moreover, in other cases the aim of the distinction is examined either implicitly or more explicitly.

The HRCee provides for some clarification as to what aims can possibly be considered to be legitimate under Article 26 ICCPR to justify a specific difference in treatment; administrative convenience and giving effect to a long-standing tradition cannot justify a difference in treatment,[24] whereas the nature of alternative service for conscientious objectors, the need for a special training in order to accomplish that service,[25] the convenience for the conscientious objectors,[26] and the

[22] For example, this is the case in Communication. No. 395/1990, *M. Th. Sprenger* v. *the Netherlands*. This case dealt with a complaint of Ms. Sprenger who claims to be a victim of a violation of Article 26 ICCPR as she was denied co-insurance under the Health Insurance Act, which distinguished between married and unmarried couples, whereas other social security legislation already recognised the equality of status between civil unions and official marriages. The HRCee only states that it finds the differential treatment to be based on reasonable and objective criteria. Implicitly, it therefore recognises that married couples and cohabitants are equal and in this case were treated differently.

[23] Communication No. 941/2000, *Mr. Edward Young* v. *Australia*, para. 10.4; Communication No. 1361/2005, *X* v. *Colombia*, para. 7.2.

[24] Communication No. 196/1985, *Ibrahima Gueye et al.* v. *France*, para. 9.5; Communication No. 666/1995, *Frédéric Foin* v. *France*, para. 10.4; Communication No. 689/1996, *Maille* v. *France*, para. 10.4; Communication No. 919/2000, *Mr. Michael Andreas Müller and Imke Engelhard* v. *Namibia*, para. 6.8.

[25] Communication No. 666/1995, *Frédéric Foin* v. *France*, para. 10.4.

[26] Communication No. 295/1988, *Aapo Järvinen v Finland*, para. 6.5

protection of the physical safety of personnel and passengers[27] were deemed to constitute legitimate aims.

However, the HRCee adopts a highly casuistic approach and considers that 'it is necessary to judge every case on its own facts'.[28] Consequently, the case law of the HRCee with regard to Article 26 ICCPR developed on an *ad hoc*, case by case basis and without providing clarification on its reasoning.[29] This casuistic approach is also reflected in the assessment of whether a difference in treatment is reasonable and objective. As ruled in the *Dutch Unemployment Benefits* cases of 1987 and as consolidated in GC 18, the assessment of whether the criteria for a difference in treatment are objective and reasonable, serves as another criterion to define whether a treatment constitutes a violation of Article 26 ICCPR.[30] This criterion is repeated over and over again by the HRCee in its communications on Article 26 ICCPR.

However, the practical application of this phase shows some defect as well. In most of its cases, the HRCee has only stated in a general sense whether it considers a specific differentiation to be objective and reasonable.[31] In other cases, the HRCee bases its findings on whether a difference is objective and reasonable, on the legitimacy of its aim.[32] As such, it combines the examination of the legitimate aim with the requirement of reasonableness and objectivity of a difference in treatment. In *Ibrahima Gueye et al.* v. *France,* which deals with a difference in treatment between pension entitlements of former Senegalese soldiers and former French soldiers who both served in the French army, the HRCee only refers to the purpose of the distinction put forward by the State in concluding that there are no reasonable and objective criteria.[33] And in *Love* v. *Australia* concerning an age-based retirement policy for pilots of a State-owned Australian airline, the HRCee considers the aim of the policy, namely maximising safety to passengers, crew and persons otherwise affected by flight travel, constitutes a legitimate aim.[34] Consequently on the basis of this aim, the HRCee finds that the distinction is based

[27] Communication No. 208/1986, *Karnel Sing Bhinder* v. *Canada*, para. 7.4; Communication No. 983/2001, *J.K. Love, W.L. Bone, W.J. Craig, and P.B. Ivanoff* v. *Australia*, para. 8.3; Communication No. 854/1999, *Manuel Wackenheim* v. *France*, para. 7.4.
[28] Communication No. 965/2000, *Mr. Mümtaz Karakurt* v. *Austria*, para. 8.6.
[29] Davidson 2004, p. 174; Vandenhole 2005, p. 46, 47.
[30] Communication No. 172/1984, *S.W.M. Broeks* v. *the Netherlands*, para. 13; Communication No. 182/1984, *F.H. Zwaan-de Vries* v. *the Netherlands*, para. 13; Communication No. 180/1984, *L.G. Danning* v. *the Netherlands*, para. 13; A/45/40, General Comment No. 18 (1989), 10 November 1989, *Non-discrimination*, para 13.
[31] Communication Nos. 406/1990, 426/1990, *Oulajin and Kaiss* v. *the Netherlands*, para. 7.4; Communication No. 218/1986, *Hendrika S. Vos* v. *the Netherlands*, para. 12; Communication No. 1565/2007, *Aurélio Gonçalves et al.* v. *Portugal*, paras. 7.4, 7.5.
[32] Communication No. 295/1988, *Aapo Järvinen v Finland*, paras. 6.5, 6.6; Communication No. 418/1990, *Cavalcanti Araujo-Jongen* v. *the Netherlands*, para. 7.4.
[33] Communication No. 196/1985, *Ibrahima Gueye et al.* v. *France*, para. 9.5.
[34] Communication No. 983/2001, *J.K. Love, W.L. Bone, W.J. Craig, and P.B. Ivanoff* v. *Australia*, para. 8.3.

on objective and reasonable considerations and that there is no violation of Article 26 ICCPR.

Nevertheless, there are some examples of cases in which this phase is dealt with more elaborately as the HRCee also interprets the reasonableness and objectivity criterion in terms of proportionality.[35] In *Müller and Engelhard* v. *Namibia* the HRCee assesses the complaint of Mr. Müller who wants to assume the surname of his wife.[36] Under the Namibian Aliens Act, women wanting to assume their husbands' surname are able to do so without following a procedure, whereas men have to follow a described and much more cumbersome procedure of application to a government service. The Namibian State submits that this differentiation is reasonably justified as the act gives effect to a long-standing tradition in the Namibian community that the wife normally assumes the surname of her husband. In contrast, the HRCee holds that this argument cannot justify the difference in treatment and states that it is not reasonable as 'at any rate the reason for the distinction [has] no *sufficient* importance in order *to outweigh* the generally excluded gender-based approach'.[37]

And in two more recent cases, proportionality is taken into account more explicitly. In the case *Gillot* v. *France* the question arose whether it is reasonable to deny the applicants the right to vote in a referendum about the future of New Caledonia, a French overseas community, based on their ties with the territory.[38] The HRCee submits that 'the evaluation of any restrictions must be effected on a case-by-case basis, having regard in particular to the purpose of such restrictions and the principle of proportionality' and ruled that the restrictions on the electorate resulting from the criteria used respected the criterion of proportionality.[39] In *Jacobs* v. *Belgium* the HRCee deals with a complaint about the imposition of gender quota for appointment to the High Council of Justice. [40] The HRCee finds that 'a reasonable proportionality is maintained between the purpose of the gender requirement, namely to promote equality between men and women in consultative bodies; the means applied and its modalities […]; and one of the principal aims of the law, which is to establish a High Council made up of qualified individuals'. Consequently, it rules that the act under consideration met the requirements of objective and reasonable justification.[41]

In general, it is difficult to draw concrete conclusion on the adoption of Article 26 ICCPR by the HRCee which are transferable to other cases. First of all, the adoption of the comparability test is inconsistent. In addition, the test of the

[35] Vandenhole 2005, p. 54.
[36] Communication No. 919/2000, *Mr. Michael Andreas Müller and Imke Engelhard* v. *Namibia*.
[37] Communication No. 919/2000, *Mr. Michael Andreas Müller and Imke Engelhard* v. *Namibia*, para. 6.8.
[38] Communication No. 932/2000*, Ms. Marie-Hèléne Gillot et al.* v. *France*.
[39] Communication No. 932/2000*, Ms. Marie-Hèléne Gillot et al.* v. *France*, paras. 13.2, 13.17.
[40] Communication No. 943/2000, *Guido Jacobs* v. *Belgium*.
[41] Communication No. 943/2000, *Guido Jacobs* v. *Belgium*, para. 9.5.

legitimate aim is often lacking as well and the HRCee does not make explicit whether it applies this requirement. And finally, the test of reasonable and objective justification is applied on an *ad hoc* basis without providing much clarification, or its outcome is based on the presence or absence of a legitimate aim. However, there are some examples in which the objectivity and reasonability of a distinction are set out more elaborately as it is interpreted in terms of proportionality.

Unfortunately, the practical application of Article 26 ICCPR hinders the predictability and transferability of the findings to other cases. In *Karakurt* v. *Austria* the HRCee clarifies its approach by ruling that no general rules can be drawn from comparable cases as 'it is necessary to judge every case on its own facts'.[42] There are however some elements that can be observed to be regularly addressed in the communications of the HRCee that seem to influence its findings. These are the elements of what can be called 'own choice criterion' and the ground for distinction.

The so-called 'own choice criterion' can be determined as the extent to which the applicant has a choice of membership of the group against which the distinction is directed. As set out before, it is important that the applicant belongs to an identifiably distinct category of persons for his complaint to be admissible under Article 26 ICCPR.[43] Moreover, the possibility of having the choice to form part of such a group plays an important role in the assessment of whether a difference in treatment is reasonable and objective. In the early case of *Danning* v. *the Netherlands* a difference in insurance benefits payments made between married and cohabiting couples was found to be based on objective and reasonable criteria.[44] In reaching this conclusion, the HRCee observes that 'the decision to enter into a legal status by marriage, which provides, in the Netherlands law, both for certain duties and responsibilities, lies entirely with the cohabiting persons'. Later, in two other cases against the Netherlands on social security payments, the HRCee draws the same conclusion.[45] In *Derksen* v. *the Netherlands*, the HRCee considers the fact that the applicants have no choice in belonging to a certain category of persons to be a key element in finding that there is no reasonable ground for the distinction made.[46] This case that deals with a complaint on a difference in treatment between half-

[42] Communication No. 965/2000, *Mr. Mümtaz Karakurt* v. *Austria*, para. 8.4.
[43] Communication No. 218/1986, *Hendrika S. Vos* v. *the Netherlands*, Individual Opinion submitted by Committee members F.A. Urbina and B. Wennergren, para. 1.
[44] Communication No. 180/1984, *L.G. Danning* v. *the Netherlands*, para. 14.
[45] Communication. No. 395/1990, *M. Th. Sprenger* v. *the Netherlands*, paras. 7.3, 7.4; Communication No. 602/1994, *Cornelis Hoofdman* v. *the Netherlands*, para. 11.4. The HRCee ruled: 'the committee observes that the decision to enter into a Legal status by marriage, which provides under Dutch law for certain benefits and for certain duties and responsibilities, lies entirely with the cohabitating persons. By choosing not to enter into marriage, the author has not, in law, assumed the full extent of the duties and responsibilities incumbent on married persons. Consequently, the author does not receive the full benefits provided for by law to married persons. The Committee finds that this differentiation does not constitute discrimination within the meaning of Article 26 of the Covenant.'
[46] Communication No. 976/2001, *Cecilia Derksen* v. *the Netherlands*, para. 9.3.

orphans whose parents were married and those whose parents were not married in relation to the benefits under the General Widows and Orphans Law of the Netherlands. In *Lindgren et al.* v. *Sweden*, the fact that the applicants freely choose to send their children to private schools for which the Swedish municipality concerned does not provide funds whereas it does for public education, is found to be decisive in ruling that there is no violation of Article 26 ICCPR.[47]

A second element that has an influence on the assessment of the HRCee in cases concerning alleged violations of Article 26 ICCPR is the ground of the distinction. Article 26 ICCPR provides that all persons are to be protected against discrimination on any ground such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth. The communications of the HRCee have dealt with most of these grounds for distinction of which sex is one of the central issues especially in relation to social security.[48] Moreover, as the words 'other status' indicate, the discriminatory grounds of distinction in Article 26 are not limitative. Differential treatment based on other grounds might equally be found to be proscribed by this autonomous prohibition of discrimination. The HRCee has not been very explicit in defining if it considers a ground for distinction to fall under the term 'other status' and determination is effected on a case by case basis.[49] However, some guidance can be found in the case of *B.d.B. et al.* v. *the Netherlands* in which the HRCee once again clarifies that the criterion to be part of a specific group or category of persons is vital.[50] In this case about a difference in treatment of a group of physiotherapists in relation to the way in which social

[47] Communication Nos. 298/1988, 299/1988, *G. and L. Lindgren et al.* v. *Sweden.* The same was decisive, although in less explicit terms, in Communication No. 191/1985, *Carl Henrik Blom* v. *Sweden.* By contrast, in the east European restitution cases, the responsibility of the State for political persecution which forced the authors to leave the country made it unreasonable to impose requirements of residence and citizenship as a precondition to receive compensation for confiscation of property. Communication No. 516/1992, *Alina Simunek* v. *Czech Republic*, para. 11.6, Communication No. 586/1994, *Josef Frank Adam* v. *Czech Republic*, para. 12.6;Communication No. 857/1999, *Blazek et. al.* v. *Czech Republic,* para. 5.8.

[48] Vandenhole 2005, p. 115. Sex: Communication Number 172/1984, *S.W.M. Broeks* v. *the Netherlands*; Communication No. 182/1984, *F.H. Zwaan-de Vries* v. *the Netherlands*; Communication No. 218/1986, *Hendrika S. Vos* v. *the Netherlands*; Communication No. 415/1990, *Dietmar Pauger* v. *Austria*; Communication No. 919/2000, *Mr. Michael Andreas Müller and Imke Engelhard* v. *Namibia*; Language: Communication No. 760/1997, *J.G.A. Diergaardt* v. *Namibia*; Religion: Communication No. 208/1986, *Karnel Sing Bhinder* v. *Canada*; Communication No. 694/1996, *Ariek Hollis Waldman* v. *Canada*; Political or other opinion: Communication No. 295/1988, *Aapo Järvinen v Finland*; Communication No. 666/1995, *Frédéric Foin* v. *France*; Communication No. 689/1996, *Maille* v. *France*; Communication No. 402/1990, *Maria Brinkhof* v. *the Netherlands*; National or social origin: Communication No. 516/1992, *Alina Simunek* v. *Czech Republic*; Communication No. 586/1994, *Josef Frank Adam* v. *Czech Republic*; Communication No. 774/1997, *Robert Brok et al.* v. *Czech Republic*; Communication No. 196/1985, *Ibrahima Gueye et al.* v. *France*; Communication No. 747/1997, *Dr. Karel Des Fours Walderode* v. *Czech Republic*; Communication No. 965/2000, *Mr. Mümtaz Karakurt* v. *Austria*; Birth: Communication No. 976/2001, *Cecilia Derksen* v. *the Netherlands*.

[49] Davidson 2004, p. 172.

[50] Communication No. 273/1988, *B.d.B. et al.*v. *the Netherlands*, para. 6.7.

security contributions are regulated under Dutch social security legislation, the HRCee finds that this group is treated differently. However, as it notes that the applicants do not claim that 'their different treatment was attributable to their belonging to any identifiably distinct category which could have exposed them to discrimination on account of any of the grounds enumerated or "other status" referred to in Article 26 of the Covenant' it finds the applicants' case inadmissible.[51] Over the years, the HRCee accepted many grounds to fall under the open category of 'other status'. These comprise, *inter alia*, marital status, age, being foster or natural parent, being employed and unemployed, having a law degree or not, public or private nature of schools, and dwarfism.[52] Moreover, the HRCee clarifies that it considers sexual orientation to fall under the ground of sex as enshrined in Article 26 ICCPR.[53]

In relation to the grounds that fall under the protection of Article 26 ICCPR, the HRCee stated that 'a different treatment based on one of the specific grounds enumerated in Article 26, clause 2 of the Covenant […] places a heavy burden on the State party to explain the reason for the differentiation'.[54] Therefore, the HRCee is expected to adopt a more intense scrutiny when assessing cases in which a difference in treatment is based on one of these inherently suspect grounds for distinction. However, this does not emerge from the communications of the HRCee. This can partly be explained by the fact that all grounds of discrimination enumerated in Article 26 ICCPR are designated as such.

The same holds for the degree of assessment in general. It is often unclear how the degree of assessment and the margin of appreciation play a role in the considerations of the HRCee. A possible higher degree of assessment is not made explicit and is not discernable from its communications. In relation to a margin of discretion granted to respondent States, there are, however, more indications that can be observed in the communications of the HRCee. For example, the HRCee clarifies that Article 26 ICCPR does not apply to all forms of indirect discrimination in the field of social security. In *P.P.C.* v. *Netherlands* and in other cases, the

[51] Communication No. 273/1988, *B.d.B. et al.*v. *the Netherlands*, para. 6.7.
[52] Marital status: Communication No. 180/1984, *L.G. Danning* v. *the Netherlands*; Communication No. 602/1994, *Cornelis Hoofdman* v. *the Netherlands*; Communication. No. 395/1990, *M. Th. Sprenger* v. *the Netherlands*; Age: Communication No. 983/2001, *J.K. Love, W.L. Bone, W.J. Craig, and P.B. Ivanoff* v. *Australia*; Foster and natural parents: Communication Nos. 406/1990, 426/1990, *Oulajin and Kaiss* v. *the Netherlands*; Employed and unemployed: Communication No. 418/1990, *Cavalcanti Araujo-Jongen* v. *the Netherlands*; Persons with or without a law degree: Communication No. 865/1999, *Gomez* v. *Spain*; Public or private schools: Communication Nos. 298/1988, 299/1988, *G. and L. Lindgren et al.* v. *Sweden*; Communication No. 191/1985, *Carl Henrik Blom* v. *Sweden*; Dwarfism: Communication No. 854/1999, *Manuel Wackenheim* v. *France*.
[53] Communication No. 941/2000, *Mr. Edward Young* v. *Australia*; Communication No. 1361/2005, *X* v. *Colombia*.
[54] Communication No. 919/2000, *Mr. Michael Andreas Müller and Imke Engelhard* v. *Namibia*.

HRCee rules that 'the scope of Article 26 does not extend to differences in result in the application of common rules in the allocation of benefits'.[55]

By this approach in relation to the result of the application of common rules in the allocation of benefits, the HRCee limits the autonomous application of Article 26 ICCPR to elements of economic, social and cultural rights. According to some Committee members, such a cautious approach is correct. In *Oulajin and Kaiss* the members Herndl, Müllerson, N'Diaye and Sadi agreed with this approach of the HRCee in their individual opinion in which they also reacted to the approach of the HRCee in the *Dutch Unemployment Benefits Act* cases of 1987.[56] In their individual opinion they held: 'With regard to the application of Article 26 of the Covenant in the field of economic and social rights, it is evident that social security legislation, which is intended to achieve aims of social justice, necessarily must make distinctions. It is for the legislature of each country, which best knows the socio-economic needs of the society concerned, to try to achieve social justice in the concrete context. Unless the distinctions made are manifestly discriminatory or arbitrary, it is not for the Committee to reevaluate the complex socio-economic data and substitute its judgement for that of the legislatures of States parties.' And in this individual opinion in the Case of *Joseph Frank Adam* Committee member Ando set out: [T]he Covenant [does not] define or protect economic rights as such. This means that the HRCee should exercise utmost caution in dealing with questions of discrimination in the economic field.'[57] However, in general, the communications of the HRCee do not really highlight this cautious approach which can be considered to provide the Member States with a sort of margin of appreciation.[58] It is unclear how these approaches influence the approach of the HRCee and the outcome of subsequent cases.

3 ARTICLE 26 ICCPR AND THE RIGHT TO EQUAL ACCESS TO HEALTH CARE

In its communications the ICCPR adopts a direct integrated approach under Article 26 ICCPR in relation to economic, social and cultural rights. This possibility is provided for by the designation of Article 26 ICCPR to be of an autonomous, non-ancillary character. In the previous paragraph, the way in which Article 26 ICPPR was applied in these cases has been analysed. This was done in order to be able to apply these findings to a possible future case concerning unequal treatment in relation to access to health care before the HRCee.

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[55] Communication No. 212/1986, *P.P.C.* v. *the Netherlands*, para. 6.2; Communication No. 297/1998, *H.A.E.d.J.* v. *the Netherlands*, para. 8.2; Communication Nos. 406/1990, 426/1990, *Oulajin and Kaiss* v. *the Netherlands*, para. 7.5; Communication No. 478/1991, *A.P.L.v.d.M.* v. *the Netherlands*, para. 6.4.
[56] Communication Nos. 406/1990, 426/1990, *Oulajin and Kaiss* v. *the Netherlands*, individual opinion of K. Herndl, R. Müllerson, B. N'Diaye, and W. Sadi.
[57] Communication No. 586/1994, *Josef Frank Adam* v. *Czech Republic*, individual opinion N. Ando.
[58] Tomuschat 2004, p. 242.

As set out, the effective application of the assessment by the HRCee of communications under Article 26 ICCPR shows various defects. Not only is the adoption of these phases highly casuistic, in the majority of cases various phases of the assessment under Article 26 ICCPR are missing or poorly argued. In terms of transparency, certainty and predictability of the jurisprudence of the HRCee in its communications this is considered unsatisfactory. Moreover, unfortunately these factors strongly diminish the transferability of the criteria adopted and the outcome of these cases to other cases. Consequently, it is very hard to draw concrete conclusions on the assessment of a future case concerning unequal access to health care under Article 26 ICCPR. This is regrettable considering the potential of the autonomous character of the non-discrimination and equality provision of Article 26 ICCPR and the HRCee's integrated approach.

There are, however, some careful and rather general statements that can be made in relation to a possible future case concerning unequal access to health care: it is important that the applicant of such a case is part of an identifiably distinct group of persons, the ground for distinction should fall under the scope of Article 26 ICCPR, the degree of assessment is indicated to be based on whether the ground for distinction is considered to constitute a suspect ground, the nature of the legitimate aim can have an influence, it can be decisive whether the applicant hasthe choice to be part of a specific group of persons and finally, the scope of Article 26 ICCPR does not extend to indirect discrimination in the application of common rules in the allocation of benefits.

First of all, it is important that the author of a complaint on unequal access to health care under Article 26 ICCPR renders plausible that he or she is part of an identifiably distinct category of persons. This criterion is convincing; if one claims to be treated differently, this claim has to be made in reference to another person or group of persons which is treated the way the applicant considers himself to have to been treated. As such, the applicant identifies himself as being part of that group.

Secondly, whether the author of a communication belongs to an identifiably distinct category of persons is also important for determining whether a ground for distinction falls under Article 26 ICCPR under ‘other status’. In addition to the grounds provided for by Article 26 ICCPR the HRCee accepted many other grounds to fall under this open norm. Age, being foster or natural parent, being employed or unemployed, having a law degree or not, public or private schools, and dwarfism have been considered to fall under ‘other status’.[59] Moreover, the HRCee

[59] Marital status: Communication No. 180/1984, *L.G. Danning* v. *the Netherlands*; Communication No. 602/1994, *Cornelis Hoofdman* v. *the Netherlands*; Communication. No. 395/1990, *M. Th. Sprenger* v. *the Netherlands*; Age: Communication No. 983/2001, *J.K. Love, W.L. Bone, W.J. Craig, and P.B. Ivanoff* v. *Australia*; Foster and natural parents: Communication Nos. 406/1990, 426/1990, *Oulajin and Kaiss* v. *the Netherlands*; Employed and unemployed: Communication No. 418/1990, *Cavalcanti Araujo-Jongen* v. *the Netherlands*; Persons with or without a law degree: Communication No. 865/1999, *Gomez* v. *Spain*; Public or private schools: Communication Nos. 298/1988, 299/1988*G. and*

clarifies that it considers sexual orientation to fall under sex as enshrined in Article 26 ICCPR.[60] Thus far, in determining whether a ground for distinction can be considered to fall under the denomination of 'other status' the HRCee only provides the criterion that in order to be considered to be exposed to discrimination on the basis of this designation the applicant has to belong to an identifiably distinct category of persons.[61] Consequently, cases concerning the accessibility of health care in which this criterion is met and the distinction is based on a ground enlisted in Article 26 ICCPR or falling under 'other status' can be expected to be assessed under Article 26 ICCPR.

Thirdly, the HRCee has indicated that it considers the grounds for distinction that are listed in Article 26 ICCPR to constitute suspect grounds of distinction. As such, a different treatment based on one of these grounds places a heavy burden on the respondent State to explain the reason for differentiation. Consequently, in a case concerning unequal access to health care the HRCee can be expected to adopt a higher degree of assessment if a difference in treatment is based on one of these grounds. However, hitherto this intense scrutiny does in practice not emerge from the case law of the HRCee under Article 26 ICCPR.

Fourthly, no specific criteria are given for the assessment of whether the aim pursued by a distinction can be considered as legitimate. In addition, the HRCee adopts a highly casuistic approach. Nevertheless, the list of aims that were thus far considered to be legitimate can serve as examples of aims that can be considered legitimate in cases concerning unequal access to health care as well. Moreover, on the basis of the aims that were considered legitimate it is concluded that the more objective the aim of the distinction is, the more chance it has of being considered legitimate under the ICCPR. Thus, for example, safety of personnel and public order can be considered to be more objective an aim than an administrative convenience for the State.

Fifthly, in contrast to the limited number of cases in which the legitimacy of the aim of a distinction is explicitly dealt with, the test of reasonableness and objectivity of a difference in treatment is applied to almost every case. However, the jurisprudence on this phase of the assessment under Article 26 ICCPR too is developed on an *ad hoc*, case by case basis by the HRCee without it providing clarification of its considerations. The only criterion of interest for a future case about unequal treatment in accessing health care that can be distilled from the jurisprudence on this phase, is the so-called 'own choice criterion'. This criterion, which was first applied in the early *Danning* case, can be defined as the extent to which the author of a communication has a choice of membership of the group

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L. Lindgren et al. v. *Sweden*; Communication No. 191/1985, *Carl Henrik Blom* v. *Sweden*; Dwarfism: Communication No. 854/1999, *Manuel Wackenheim* v. *France*.

[60] Communication No. 941/2000, *Mr. Edward Young* v. *Australia*; Communication No. 1361/2005, *X* v. *Colombia*.

[61] Communication No. 273/1988, *B.d.B. et al.*v. *the Netherlands*, para. 6.7.

against who the distinction in treatment is directed.[62] Until now, this criterion has only been adopted in relation to marital status in the field of social security benefits. This is a ground for distinction that falls under the denomination of 'other status' under Article 26 ICCPR. If the 'own choice criterion' is adopted in a possible future case about unequal access to health care when assessing the reasonableness and objectivity of a distinction made, this could apply to the ground of marital status. It is, however, unclear how this would apply to other grounds for distinction.

Finally, in relation to indirect discrimination the HRCee made a statement that can be of importance for a future case concerning unequal treatment in accessing health care, namely that the scope of Article 26 ICCPR does not extend to indirect unequal treatment in the application of common rules in the allocation of benefits. With this definition, the HRCee limited the autonomous scope of Article 26 ICCPR. Therefore, a possible future case concerning unequal access to health care has little chance of success if it claims an alleged violation of indirect discrimination in this field of social security. This is regrettable as in a great number of States a health care system is at place which provides its citizens at least with some basic health care. If a certain rule, policy or treatment would lead in effect to unequal treatment which is considered to constitute a violation of Article 26 ICCPR, it seems this cannot be adjudicated by the HRCee. Nevertheless, as the HRCee appears to be inconsistent in its application of Article 26 ICCPR it can also be that if, for example, a difference is based on a suspect ground of discrimination, it would adopt another approach as it indicates to adopt a higher degree of assessment if a distinction is based on a suspect ground.

4 CONCLUSIONS

The autonomous character of Article 26 ICCPR was assigned to it in the so-called *Dutch Unemployment Benefits Act* cases of 1987. Although these rulings were considered to be revolutionary it is difficult to state whether this is actually the case. On the one hand, this possibility provides for a much broader scope of protection than for example the general non-discrimination clauses of the regional ECHR. The *Dutch Unemployment Benefits Act* cases of 1987 conveyed the message that Article 26 ICCPR is of an autonomous character and therefore, the HRCee is not precluded from considering cases that are related to instruments other than the ICCPR or that fall outside the scope of the other provisions of the ICCPR. Consequently, the HRCee provided itself with the possibility to adopt a direct integrated approach by applying Article 26 ICCPR to cases that deal with elements of economic, social and cultural rights without it being required that a substantive ICCPR Article is concerned. On the other hand, the practical applicability of this possibility shows many defects. Not only is the adoption of the various phases highly casuistic, in most of the cases several phases of the assessment under Article 26 ICCPR are

[62] Communication No. 180/1984, *L.G. Danning* v. *the Netherlands*, para. 14.

missing or poorly argued. In terms of transparency, certainty and predictability of the HRCee's jurisprudence this can be considered as unsatisfactory. As such, it is very difficult to draw concrete conclusions on the assessment of cases under Article 26 ICCPR. This is regrettable considering the potential of the autonomous character of the non-discrimination and equality provision of Article 26 ICCPR under which the HRCee can adopt a direct integrated approach.

Nevertheless, several elements regularly addressed can be discerned that can be of importance in the light of the justiciability of the right to equal access to health care by the HRCee. These include the considerations of whether the applicant of such a case is part of an identifiably distinct group of persons, that the scope of Article 26 ICCPR does not extend to indirect discrimination in the application of common rules in the allocation of benefits, what is the nature of the legitimate aim, and the freedom of choice of the applicant to be part of the group of persons against whom the distinction in treatment is directed.

In a case relating to unequal access it is important that the applicant renders plausible that he or she is part of an identifiably distinct category op persons. The HRCee has not provided any criteria for when it considers an applicant to be part of a group of persons, except the unequal treatment has to affect more than one individual. Furthermore, the HRCee has ruled that the scope of Article 26 ICCPR does not extend to indirect discrimination in the application of common rules on the allocation of benefits. Therefore, a possible future case concerning unequal access to health care has little chance of success if it claims an alleged violation of indirect discrimination in this field of social security. This is regrettable as in a great number of States a health care system is at place which provides its citizens with at least some basic health care. Nevertheless, as the HRCee appears to be inconsistent in its application of Article 26 ICCPR it can also be that if, for example, a difference is based on a suspect ground for discrimination, it will adopt another approach. The nature of the aim pursued by a difference in treatment can have an influence on the outcome of a case as well. It appears that the more objective the aim of the distinction is, the more chance it has of being considered legitimate under the ICCPR. Finally, it is decisive whether the applicant has the choice to be part of a specific group of persons against whom the distinction in treatment is directed. If the applicant in a case concerning unequal access to health care has the choice to form part of this group or not, this can lead to the distinction being found reasonable and objective and Article 26 ICCPR thus not violated. However, until now, this criterion has only been adopted in relation to marital status in the field of social security benefits. It is therefore unclear how it will be applied in cases in which a difference in treatment is based on another ground.

CHAPTER XI
GENERAL CONCLUDING OBSERVATIONS AND RECOMMENDATIONS

1 INTRODUCTION

This study has analysed the justiciability of the human right to equal access to health care. The reason that prompted this subject of research was the criticism of several human rights experts with regard to the introduction of economic measures in reforming health care systems and their effects on the right to equal access to health care. Moreover, not much study had yet been conducted with regard to the justiciability of this right, which is vital for victims of a violation of their human right to equal access to health care. It is important that a judicial or quasi-judicial body can adjudicate their complaints in this regard. The aim of the research in hand was to examine how cases concerning unequal access to health care could be dealt with by judicial and quasi-judicial human rights bodies and to provide for the elements that can be expected to play a role in the assessment of such cases.

In conducting this research, it soon became clear that, in order to meet this objective, it was necessary to explore the discussion and practice of the justiciability of economic, social and cultural rights and to focus on the adjudicatory practice of the European Committee of Social Rights, the ECtHR and the HRCee in cases dealing with equality and non-discrimination and dimensions of economic, social and cultural rights. Consequently, this study has been set out in three parts that each deal with one research question. The conclusions regarding these research questions are set out in the following paragraph. Subsequently, paragraph 3 presents some final remarks and recommendations are presented.

2 CONCLUSIONS

Part I sets out the framework of the human right to equal access to health care in order to answer the research question: *What is the human right to equal access to health care and how is it enshrined in human rights law?*

The framework of the right to equal access to health care consists of the human rights to health and health care which are firmly embedded within human rights law. From the analysis of this framework and the State obligations resulting from the right to health care, it emerged that its core content is of fundamental concern. The core content of a right encompasses the minimum entitlements under its scope. With regard to the right to health and the right to health care, States have to realise the scope of this right progressively and to the maximum of available

resources. However, States have an immediate obligation to realise the core content of both rights. Likewise, limitations, derogations and retrogressive measures with regard to the right to health and the right to health care should not affect the core content of these rights.

The core content of the right to health and the right to health care consists of, *inter alia*, the accessibility of health care on a non-discriminatory and equitable basis. These elements are part of the right to equal access to health care and are also recurring elements in the other provisions regulating State obligations in relation to both the right to health and the right to health care. For example, under their obligation to respect, to protect, and to fulfil these rights, States should not take measures or adopt policies that limit access to health care in a discriminatory manner. Moreover, States have to protect their citizens from discrimination if health care is provided by others than the State itself, in order for them to have access to health care on an equal basis. In addition, these elements form an essential part of the criteria that can be applied to measure whether health care is actually accessible.

The analysis of the various elements that relate to the accessibility of health care lead to the definition of the right to equal access to health care as adopted in the present study: The human right to equal access to health care consists of both a formal conception as well as a substantive conception of equality in accessing health care. Equity is part of the substantive conception of equality. It takes into account the specific needs of certain individuals or groups in society in accessing health care and can stipulate that it is necessary to take positive measures. If a specific measure or treatment leads to unequal access to health care – directly or indirectly - for which no justification can be found, discrimination arises. Direct and indirect discrimination violate the right to equal access to health care and are therefore prohibited within human rights law.

The distinction between inequality and discrimination proves to be vital for the justiciability of the right to equal access to health care. The various equality and non-discrimination provisions are found to apply to the provisions providing the right to health care. As a result, by virtue of a human rights provision prohibiting discrimination, the right to equal access to health care is justiciable.

The justiciability of the right to equal access to health care is complex. The human right to equal access to health care is one of the economic, social and cultural human rights. Ever since the emergence of these rights their justiciability has been subject of debate. Moreover, in contrast to civil and political rights, the number of human rights bodies with which a complaint regarding an alleged violation of economic, social and cultural rights can be lodged directly, is limited and the establishment of new bodies is subject to political resistance.

In order to gain more insight into the justiciability of economic, social and cultural rights in general and the right to health care specifically, the following research question is discussed in part II of the present study: *What arguments are brought forward with regard to the justiciability of economic, social and cultural rights and how are these rights, including the human right to health care*

adjudicated in practice by the various judicial and quasi-judicial human rights bodies?

The conclusion is that it is artificial to hold on to the non-justiciability of economic, social and cultural rights as those advocating against it do. The European Committee of Social Rights received many complaints under the collective complaints system of the ESC and RESC. Consequently, it has dealt with several cases concerning alleged violations of economic, social and cultural rights, including the right to health care.

In addition to the adjudicatory practice of the European Committee of Social Rights, it is found that both the HRCee and the ECtHR recognised in their early jurisprudence that there is no watertight division between civil and political rights on the one hand and economic, social and cultural rights on the other. Subsequently, both bodies adopted an integrated approach in their case law by protecting and taking into account dimensions of economic, social and cultural rights *via* civil and political rights. The HRCee articulated and adjudicated on various elements of economic, social and cultural rights under the substantive provisions of the ICCPR, including the right to health care. Moreover, the autonomous non-discrimination provision enshrined in Article 26 ICCPR was designated to be directly applicable to other rights than those provided for by the ICCPR and applied, hence, also in cases concerning economic, social and cultural rights. The ECtHR, the only judicial human rights body that can make legally binding judgements, contributed to the justiciability of economic, social and cultural rights as well. In its case law it addressed fundamental questions concerning the responsibilities of States in relation to the elements of the right to health care and other economic, social and cultural rights. Yet, both the HRCee and the ECtHR adopted a restrained position in adjudicating such elements. In general, a wide margin of appreciation was granted to the respondent States. Especially the ECtHR seemed to be reluctant in making any statements in cases concerned with the allocation of limited State resources. Only in exceptional circumstances these bodies considered a lack of the elemental provisions that are part of the right to health care, to constitute a violation of a civil or political right.

Two manners of adopting the integrated approach were distinguished from the cases of the HRCee and the ECtHR: a direct integrated approach and an indirect integrated approach. By the direct manner, the autonomous non-discrimination clause of the ICCPR was directly applied to rights protected by other human rights instruments. By the indirect integrated approach economic, social and cultural rights including the right to health care were taken into account when dealing with the substantive provisions of the ICCPR and the ECtHR. An indirect integrated approach was also adopted by the application of the ancillary non-discrimination provision of Article 14 ECHR to substantive provisions of the ECHR under which elements of economic, social and cultural rights are taken into account.

Both the direct and indirect integrated approach adopted by the HRCee and the ECtHR have been found to be of great importance for the justiciability of the

right to equal access to health care. Due to the integrated approach, elements of the right to health care can be justiciable under the ancillary prohibition of discrimination enshrined in the ECHR and the autonomous provisions of non-discrimination of the ICCPR and the ECHR. Therefore, in addition to the adjudicatory practice of the European Committee of Social Rights, both the HRCee and ECtHR are subject of research in the third part of the present study.

Part III aims at answering the research question: *What elements can be expected to play a role in the justiciability of cases with regard to the human right to equal access to health care at the European Committee of Social Rights, the European Court of Human Rights and the Human Rights Committee?*

It appears to be difficult to draw concrete conclusions with regard to the assessment of possible future cases concerning the right to equal access to health care by these bodies and what differences in treatment in accessing health care can be considered justified or to constitute discrimination. To determine what is justified eventually remains case-specific and the assessment of the cases analysed shows that the outcome of this assessment depends on many different factors that have to be balanced. Nevertheless, various factors and lines of reasoning were discerned that can play a role in cases about the right to equal access to health care.

From the case law of the European Committee of Social Rights it emerges that it places great emphasis on equal treatment and non-discrimination. It stresses repeatedly that these principles are not only fundamental rights but are also prerequisites for the effective enjoyment of the rights enshrined in the ESC and the RESC. The European Committee of Social Rights recognised both direct and indirect discrimination to be subject to its review. However, it has hitherto mainly dealt with cases concerning indirect discrimination. As such, it focuses on the effects of legislation and other measures on groups with heightened vulnerabilities. In many of these cases it rules that adequate steps have to be taken in order to ensure that the rights enshrined in the ESC and RESC, are actually accessible by and to all on an equal basis. These conclusions can also apply to cases concerning the accessibility of health care.

In the few cases in which the European Committee of Social Rights has thus far ruled about unequal access to health care, the meaning of the term ‘accessibility by and to all on an equal basis’ has been clarified. It emphasises that legislation or practices which deny entitlements to medical assistance to people unlawfully present within the territory of a State party, and especially to children, are contrary to the ESC and the RESC. Nevertheless, in spite of this, Article E RESC does not serve the purpose to claim entitlements to rights enshrined in the RESC for those unlawfully present in a Member State. Consequently, these persons do not have an equal right to health care under the RESC in comparison to those legally residing in a Member State. In all other circumstances, Article E RESC is applicable to claims on the right to equal access to health care. In the only case about unequal access to health care for those legally residing in a State hitherto dealt with by the European Committee of Social Rights, it indicated that this

provision is applicable to at least the core content of the right to health care. In addition, this core content was found to have to be provided free of charge to those in need of health care but without resources.

One of the most important findings for the justiciability of the right to equal access to health care resulting from the analysis of the case law of the ECtHR is its approach with regard to the applicability of the prohibition of discrimination to dimensions of economic, social and cultural rights. The ECtHR states to adopt an integrated approach to these rights under the prohibition of discrimination enshrined in Article 14 ECHR. If a State provides socio-economic entitlements or sets up a system of entitlements, it must do so in a manner which is compatible with Article 14 ECHR. Consequently, in cases in which this criterion was met, this non-discrimination provision served as a tool against discrimination in the accessibility of socio-economic entitlements.

Examining the cases in which the ECtHR applies Article 14 ECHR to general cases and to dimensions of economic, social and cultural rights, aims at providing criteria and elements that can be expected to play a role in future cases about unequal access to health care. This, however, turns out not to be easy. In adjudicating cases under Article 14 ECHR, the ECtHR adopts an assessment model established in its early case law. The application of the phases of this assessment model shows many defects: the phases were frequently abolished, findings were often not clarified and the adopted criteria were generally not provided for. This strongly diminishes the predictability of the assessment and the adoption of these phases in cases concerning unequal access to health care.

The factors determining the intensity of the assessment, and thereby the margin of appreciation granted to a respondent State, were found to be applied in a more consistent manner. The cases in which the ECtHR dealt with elements of economic, social and cultural rights show various approaches that can be divided into four categories. When cases with regard to unequal access to health care are dealt with by the ECtHR these will in principle fall under the first category. In such cases the ECtHR is seen to adopt a highly restrained attitude as Member States are found to be in a better position than an international court to evaluate the local needs and conditions. However, in cases in which the distinction is based on a suspect ground, less discretion will be granted to the respondent State. At least the following grounds of distinction were considered to constitute suspect grounds: gender, birth out of wedlock, religion, sexual orientation, property, nationality, marital status, race, and disability. Cases concerning unequal access to health care in which the distinction is based on one of these grounds, fall under this second category of strictness of assessment under Article 14 ECHR. The fact that the ECtHR also recognises indirect discrimination to fall under Article 14 ECHR is considered to be of importance for such cases as well. A justification of a distinction based on a suspect ground, whether directly or indirectly requires for ‘very weighty reasons’ to be brought forward by the State. This leads to a restricted margin of appreciation for the respondent State and a very strict assessment under

Article14 ECHR, which increases the chance of Article14 ECHR being found to be violated.

Another important factor for a case concerning unequal access to health care that was found to determine the strictness of the assessment adopted under Article 14 ECHR is the common ground factor. Whether there is a common ground depends on the presence or absence of a consensus between Member States of the CoE on the subject at issue on which the ECtHR has to decide. A case concerning unequal access to health care falls under the fourth category of the intensity adopted when a common ground exists between the various Member States of the CoE that rejects the specific unequal treatment, and in which the difference in treatment is based on a suspect ground. If this is the case, Article 14 ECHR can be expected to be considered to have been violated. From the analysis of recent developments in the case law of the ECtHR it was deduced that a broad array of human rights sources can serve to establish whether a common ground is present concerning the accessibility to health care. In fact, the entire framework of the right to equal access to health care provided in this research can serve to establish whether a common ground is present concerning the accessibility of health care. Examples are the provisions concerning the right to health care, equality and non-discrimination as enshrined in the ESC and RESC, ICESCR and the Convention on Human Rights and Biomedicine.

The ECtHR also dealt with two complaints about unequal treatment under the autonomous non-discrimination provision enshrined in the recently established Protocol No. 12 ECHR. From these cases it was concluded that in substantive terms, Protocol No. 12 ECHR adds nothing new to the framework of international and regional human rights law. The provision of Article 1 Protocol No. 12 ECHR is almost identical to Article 14 ECHR and the same assessment model as under Article 14 ECHR was applied to these cases. Nevertheless, the great potential of Article 1 Protocol No. 12 ECHR lies in the fact that in contrast to the adoption of Article 14 ECHR, the ECtHR can now attend to matters in which no direct link needs to be made to the substantive provisions of the ECHR. Consequently, although only time can tell, it is expected to be less difficult to lodge a complaint concerning unequal access to health care with the ECtHR.

Protocol No. 12 ECHR provides for the possibility of adopting a direct integrated approach to economic, social and cultural rights, including the right to health care. This direct integrated approach was also adopted by the HRCee when assessing cases under the autonomous non-discrimination provision enshrined in Article 26 ICCPR. Much was expected from the application of this provision to economic, social and cultural rights. However, analysis of these cases shows that no conclusions can be drawn regarding the assessment of cases under Article 26 ICCPR. The HRCee adopts a highly casuistic approach and in the majority of Article 26 ICCPR cases the phases of the assessment model adopted were either missing or extremely poorly argued. Moreover, hardly any indications were provided with regard to the strictness of the assessment in cases dealing with

complaints about discrimination. As such, it is difficult to conclude concretely what elements can be expected to play a role in the justiciability of cases about the human right to equal access to health care before the HRCee. Nevertheless, the HRCee shows to be remarkably lucid about the scope of protection of the concept of indirect discrimination with regard to the application of common rules in the allocation of benefits: Article 26 ICCPR does not extend to indirect discrimination resulting from the application of common rules with regard to the allocation of benefits. It would therefore seem that cases relating to indirect discrimination in applying the general rules of health care systems have little chance of success before the HRCee.

Considering the great potential of the direct integrated approach adopted under Article 26 ICCPR for cases concerning the right to equal access to health care it is regrettable that the application of Article 26 ICCPR in the case law of the HRCee shows many defects. Moreover, also in terms of transparency, certainty and predictability of the jurisprudence of the HRCee, this is considered unsatisfactory.

3 FINAL OBSERVATIONS AND RECOMMENDATIONS

From this study emerges what has been emphasised by many other authors: economic, social and cultural rights are justiciable. In addition, it is concluded that the right to equal access to health care and to elements thereof can be subject to review by judicial and quasi-judicial human rights bodies. Collective complaints in this regard can be lodged at the level of the CoE with the quasi-judicial European Committee of Social Rights. Furthermore, the right to equal access to health and to elements thereof can be subject to review under the direct and indirect integrated approach adopted by the quasi-judicial HRCee and the judicial ECtHR. Since the recognition of the integrated approach in the early jurisprudence of these bodies it evolved over time and is expected to evolve in the future, *inter alia* due to the recent entry into force of Protocol No. 12 ECHR.

The fact that the European Committee of Social Rights, the ECtHR and the HRCee recognise indirect discrimination to be subject to their review is of great importance for the right to equal access to health care. If legislation and other measures in the field of health care are neutral word, the effect of it can amount to discrimination. By emphasising the importance for States to be aware of the effects their choices and adopted policies have on the accessibility of certain entitlements such as health care, a much broader scope of protection against discrimination is offered. Moreover, it provides the possibility to actually take into account and respond to specific health care needs. According to the author of this study medical need should be one of the most important factors determining the accessibility of health care. Health care needs are unequally distributed amongst individuals, mainly determined by life's lottery. Consequently, the distribution of health care should be in accordance with actual needs and not so much on factors such as economic status and social position.

The European Committee is thus far leading in the application of the concept of indirect discrimination. It frequently emphasises that positive actions are needed so that the provisions of the ESC and RESC are actually accessible to everyone, including to those with special needs. In this respect it is desirable that the OP ICESCR soon enters into force. By this, an individual complaint procedure will be established that can fill the current gap due to the impossibility to directly lodge a complaint at international human rights level with a body entitled to adjudicate complaints concerning economic, social and cultural rights.

However, the fact that complaints with regard to the right to equal access to health care will probably, be more and more often subject to review by judicial and increasingly quasi-judicial human rights bodies is obviously not sufficient for the implementation and protection of the human right to equal access to health care. It is of the utmost importance that attention is paid to the implementation of all facets of the human right to health care and its corresponding State obligations when implementing the right to health care, and in reshaping health care systems. It goes without saying that cost containment is a necessary measure in the present time reality of scarce resources in health care. However, that in itself is not a sufficient basis for reforming health care systems. The human rights approach perceives health care as a means to serve the health and well-being of human beings, and considers this to be indispensable to exercise other human rights. Moreover, it sets standards of equity and universality and pays attention to vulnerable people in society, which should be at the basis of health care reform.

This study has not only provided answers, it has also raised new questions. The focus of the research conducted in this book is on the obligation of States with regard to the implementation and protection of the right to equal access to health care and the justiciability of this right in cases against Member States of the ESC and RESC, ICCPR, and ECHR. Nevertheless, the right to equal access to health care can also be violated, not only by the State, but also by private individuals. The perception of the State as the provider of health care and the protector of the human right to equal access to health care is related to a much more abstract level than the daily practice of access to health care. In their enjoyment of the right to health care, citizens and individual patients mainly deal with health care providers and in case a health care insurance system is in place, also with their health insurer. What is clear is that fundamental rights including the right to equal treatment and the prohibition of discrimination can have a horizontal effect, namely between private individuals. Moreover, in various international and regional human rights jurisprudence it is recognised that this principle can be found to be violated if a State does not adequately protect equal treatment and does not prevent, punish or redress discrimination in horizontal relations.[1] However, further research on this matter is

[1] *e.g.* A/45/40, General Comment No. 18 (1989), 10 November 1989, *Non-discrimination*, para. 9; *97 members of the Gldani Congregation of Jehovah's Witnesses and 4 Others* v. *Georgia*, Application No. 71156/01, 3 May 2007; *Sečič* v. *Croatia*, Application No. 40116/02, 31 May 2007.

required in order to discover what the effect of the recognition of horizontal effect within human rights law has on the scope of protection of the right to equal access to health care. Especially in times when health care systems are increasingly transformed from public systems into private law systems by which health care is provided on a private basis, it is of the utmost importance that a close eye is kept on the effects of such systems on the human right to equal access to health care.

NEDERLANDSE SAMENVATTING

HET FUNDAMENTELE RECHT VAN DE MENS OP GELIJKE TOEGANG TOT GEZONDHEIDSZORG

Deel A – Algemene introductie en wettelijk kader

Het recht op gelijke toegang tot gezondheidszorg is een fundamenteel beginsel dat deel uitmaakt van het mensenrecht op gezondheidszorg. Voor slachtoffers van een schending van dit recht op gelijke toegang tot gezondheidszorg is het belangrijk dat een klacht in dit verband juridisch toetsbaar is door een (quasi-)rechterlijke orgaan. De juridische toetsbaarheid, de zogenaamde *justiciability*, van mensenrechten draagt bij aan de bescherming en de verwezenlijking van het recht op gelijke toegang tot gezondheidszorg en geeft vorm aan de betekenis van dit recht.

Het onderhavige onderzoek is gericht op de *justiciability* van het fundamentele recht op gelijke toegang tot gezondheidszorg. Doel is antwoord te vinden op de vraag hoe zaken betreffende een vermeende schending van het recht op gelijke toegang tot gezondheidszorg verwacht kunnen worden te worden behandeld door (quasi-)rechterlijke organen en welke elementen een rol spelen bij de *justiciability* hiervan. Dit onderzoek tracht dat antwoord te geven middels het beantwoorden van een drietal deelvragen welke in drie separate delen worden behandeld. Ieder deel bestaat uit meerdere hoofdstukken.

Deel A behandelt de deelvraag: *Wat is het recht van de mens op gelijke toegang tot gezondheidszorg en hoe is dit recht vastgelegd in mensenrechtenverdragen?*

Het recht van de mens op gelijke toegang tot gezondheidszorg is een essentieel element van het recht op gezondheidszorg, dat op zijn beurt deel uitmaakt van het brede kader van het recht op gezondheid. In **hoofdstuk 2** worden de inhoud en de betekenis van het recht op gezondheid en het recht op gezondheidszorg verhelderd. Het wettelijke kader van deze rechten is bestudeerd waarbij onderscheid is gemaakt tussen het internationale VN-mensenrechtenniveau en het regionale niveau waarmee wordt gerefereerd naar de Raad van Europa (CoE). Dit onderscheid wordt in de rest van het onderhavige onderzoek als zodanig aangehouden. VN-verdragen die het recht op gezondheid en gezondheidszorg bevatten, zijn onder meer het

Internationaal Verdrag inzake Economische, Sociale en Culturele Rechten (ICESCR), het Internationaal Verdrag inzake de Uitbanning van alle Vormen van Discriminatie van Vrouwen (CEDAW), het Verdrag inzake de Rechten van het Kind (CRC) en het Verdrag inzake de Rechten van Personen met een Handicap (CRPD). Op het niveau van de CoE zijn het Europees Sociaal Handvest (ESC) en het Herziene Europees Sociaal Handvest (RESC) de belangrijkste en meest bekende verdragen waarin deze rechten zijn vastgelegd. Bestudering van dit wettelijk kader en van de periodieke statenrapportages zoals beoordeeld door de desbetreffende toezichthoudende organen, helpt de rechten die individuen kunnen ontlenen aan deze rechten, in kaart brengen. Hierbij wordt een indeling gehanteerd bestaande uit drie lagen: de kerninhoud (*core content*), de algemene inhoud (*scope*) en de overlap (*overlap*) met andere mensenrechten.

De verplichtingen die staten ingevolge het recht op gezondheidszorg hebben, worden vervolgens beschreven in **hoofdstuk 3**. Allereerst wordt ingegaan op de mate waarin deze verplichtingen van staten dienen te worden gerealiseerd. Ten tweede wordt het soort mensenrechtenverplichtingen van staten verduidelijkt aan de hand van de tripartiete typologie van verplichtingen zoals die in de mensenrechtendoctrine tot ontwikkeling is gekomen: de verplichting tot 'respect' (*to respect*), tot 'bescherming' (*to protect*) en tot 'verwezenlijking' (*to fulfil*). Ten derde komen de criteria aan bod die kunnen worden onderscheiden om te bepalen of er daadwerkelijk toegang tot gezondheidzorg is. Deze betreffen onder meer de beschikbaarheid, toegankelijkheid zonder discriminatie, financiële toegankelijkheid, fysieke toegankelijkheid en kwaliteit.

Uit de analyse van het wettelijke kader van het recht op gezondheid en het recht op gezondheidszorg en de staatsverplichtingen inzake deze rechten komt duidelijk naar voren dat de *core content* van fundamenteel belang is. Staten hebben een onmiddellijke verplichting deze kerninhoud te realiseren. Daarenboven mogen eventuele beperkende maatregelen of een achteruitgang in de bescherming van deze rechten de kerninhoud van dit recht nooit aantasten.

De kerninhoud van het recht op gezondheid en gezondheidszorg bestaat onder meer uit de toegankelijkheid van gezondheidszorg op een rechtvaardige wijze en zonder discriminatie. Deze aspecten maken deel uit van het recht op gelijke toegang tot gezondheidszorg en zijn terugkerende elementen in het wettelijke kader van het recht op gezondheid en gezondheidszorg en de bepalingen met betrekking tot staatsverplichtingen inzake deze rechten. **Hoofdstuk 4** omvat de analyse van deze elementen. Deze heeft geleid tot de definitie van het mensenrecht op gelijke toegang tot gezondheidszorg zoals gehanteerd in het onderhavige onderzoek: Het mensenrecht op gelijke toegang tot gezondheidszorg bestaat uit zowel een formele als een materiële notie van gelijkheid in de toegang tot gezondheidszorg. Rechtvaardigheid maakt onderdeel uit van de materiële benadering van gelijkheid. Deze neemt de specifieke behoefte van bepaalde individuen of groepen aanwezig in de samenleving in aanmerking hetgeen het nemen van positieve maatregelen kan vereisen teneinde de toegankelijkheid van gezondheidszorg voor deze individuen en

groepen te realiseren en/of waarborgen. Indien een specifieke maatregel of behandeling leidt tot een ongelijke toegang tot gezondheidszorg - direct of indirect - waarvoor geen rechtvaardiging kan worden gevonden, dient deze te worden aangemerkt als discriminatoir. Zowel directe als indirecte discriminatie zijn in strijd met het recht op gelijke toegang tot gezondheidszorg en leiden daarom tot schending van dit mensenrecht.

Voorafgaande analyse leidt tot de conclusie dat de beginselen van gelijkheid en non-discriminatie van fundamenteel belang zijn voor de juridische toetsbaarheid van het recht op gelijke toegang tot gezondheidszorg; krachtens het verbod op discriminatie is het recht op gelijke toegang tot gezondheidszorg *justiciable*.

Deel B: De juridische toetsbaarheid van economische, sociale en culturele rechten: debat en praktijk

Dit deel van het onderzoek is gericht op het beantwoorden van de volgende deelvraag: *Welke argumenten worden aangevoerd met betrekking tot de juridische toetsbaarheid van economische, sociale en culturele rechten, en hoe worden deze rechten, waaronder het recht op gezondheidszorg, in de praktijk getoetst door de verscheidene (quasi-)rechterlijke organen?*

De juridische afdwingbaarheid van het mensenrecht op gelijke toegang tot gezondheidszorg is complex. Dit volgt in grote mate uit de scheiding tussen enerzijds economische, sociale en culturele rechten en anderzijds burger- en politieke rechten. In tegenstelling tot burger- en politieke rechten is de juridische toetsbaarheid van economische, sociale en culturele rechten, waaronder het recht op gezondheidszorg, onderwerp van een uitvoerige discussie.
De scheiding tussen economische, sociale en culturele mensenrechten en burger- en politieke rechten is onder andere tot uiting gekomen in de historische evolutie van de *justiciability* van mensenrechten. Het aantal (quasi-)rechterlijke organen waarbij rechtstreeks een klacht betreffende een vermeende inbreuk op een economisch, sociaal of cultureel recht kan worden ingediend, is beperkt en de oprichting van nieuwe organen stuit op politieke weerstand. Desalniettemin is de scheiding tussen economische, sociale en culturele rechten en burger- en politieke rechten in feite niet zo strikt. De afgelopen decennia hebben verschillende (quasi-)rechterlijke organen die de bevoegdheid hebben zich uit te spreken over mogelijke schendingen van burger- en politieke rechten, economische, sociale en culturele rechten en elementen daarvan getoetst onder burger- en politieke rechten. Hiertoe behoort ook het recht op gezondheidszorg en elementen daarvan. In het onderhavige onderzoek wordt gesproken over de toetsing van economische, sociale en culturele rechten door deze organen wanneer: i) de bepalingen waaraan zij vermeende schendingen toetsen economische, sociale en culturele rechten bevatten, of ii) wanneer de bepalingen waaraan zij vermeende schendingen toetsen direct van toepassing zijn

op economische, sociale en culturele rechten die zijn opgenomen in andere verdragen. Wanneer bepalingen waaraan een vermeenden schending getoetst wordt niet direct van toepassing kunnen zijn op economische, sociale en culturele rechten opgenomen in andere verdragen, maar waarbij wel elementen van deze rechten worden getoetst onder bijvoorbeeld burger- en politieke rechten, wordt dit omschreven als de toetsing van elementen van economische, sociale en culturele rechten.

In **hoofdstuk 5** wordt aandacht besteed aan de argumenten van de aanhangers en tegenstanders van de *justiciability* van economische, sociale en culturele rechten. Daarnaast wordt uitvoerig ingegaan op een groot aantal van deze zaken zoals behandeld door (quasi-) rechterlijke organen op het niveau van de VN en de CoE. Vervolgens wordt in **hoofdstuk 6** een analyse gemaakt van de *justiciability* van het recht op gezondheidszorg en elementen daarvan door (quasi-)rechterlijke organen op internationaal en regionaal mensenrechtenniveau. Hieruit komt een aantal belangrijke elementen naar voren. Ten eerste wordt duidelijkheid verkregen over de criteria die het ECSR hanteert voor de beoordeling van de staatsverplichtingen inzake het ESC en het RESC. Het ECSR is tot op heden het enige rechtsprekende orgaan dat direct belast is met het toezicht op de naleving door staten van hun verplichtingen betreffende economische, sociale en culturele rechten. Bij het ECSR kunnen enkel collectieve klachten aanhangig worden gemaakt. Ten tweede wordt geconstateerd dat voornamelijk het VN-Mensenrechtencomité (HRCee) en het Europese Hof voor de Rechten van de Mens (ECtHR) verschillende elementen en dimensies van het recht op gezondheidszorg hebben beoordeeld onder bepalingen betreffende burger- en politieke rechten. In tegenstelling tot de collectieve klachtenprocedure bij het ECSR, kunnen bij het ECtHR en de HRCee ook individuele klachten aanhangig worden gemaakt. Voorbeelden van bepalingen waaronder elementen van het recht op gezondheidszorg zijn getoetst, zijn het recht op leven (art. 6 van het Verdrag inzake Burgerrechten en Politieke Rechten (ICCPR), art. 2 Europees Vedrag tot bescherming van de Rechten van de Mens (ECHR)), het verbod op folteringen en wrede, onmenselijke of vernederende behandeling of bestraffing (art. 7 ICCPR, art. 3 ECHR), en het recht op eerbiediging van privé-, familie- en gezinsleven (art. 17 ICCPR, art. 8 ECHR). Ten derde wordt geconcludeerd dat het verbod op discriminatie uit artikel 26 ICCPR autonome werking heeft. Daarmee is deze bepaling van toepassing op bepalingen uit andere internationale mensenrechtenverdragen dan het ICCPR, waaronder het ICESCR waarin het recht op gezondheidszorg is vastgelegd. Hetzelfde geldt voor artikel 1 van het twaalfde optionele protocol behorend bij het ECHR (Prot. No. 12 ECHR) dat recentelijk in werking is getreden en waarin ook een autonoom verbod op discriminatie is vastgelegd. Dit kan uiteraard van grote betekenis zijn voor de *justiciability* van het recht op gelijke toegang tot gezondheidszorg.

De toetsbaarheid van economische, sociale en culturele rechten in het algemeen en het recht op gezondheidszorg in concreto via de burger- en politieke

rechten zoals toegepast door het ECtHR en de HRCee, vloeit voort uit de erkenning van de ondeelbaarheid van mensenrechten en wordt aangeduid met de term *integrated approach*, ofwel 'geïntegreerde benadering'. De *integrated approach* is onderwerp in **hoofdstuk 7**. Het fenomeen *integrated approach* wordt gedefinieerd als de mogelijkheid van het beschermen, of in ieder geval in aanmerking nemen, van economische, sociale en culturele rechten bij het beschermen van mensenrechten die expliciet zijn opgenomen in de verdragen waaraan getoetst wordt in een onderhavige zaak. Twee vormen van het toepassen van de *integrated approach* worden onderscheiden: een directe en een indirecte. Middels de directe *integrated approach* worden autonome bepalingen rechtstreeks toegepast op rechten die worden beschermd door andere verdragen betreffende mensenrechten. Bij een indirecte benadering worden elementen van economische, sociale en culturele rechten getoetst en beschermd onder niet-autonome bepalingen.

In de literatuur is de *integrated approach* beschreven, maar een normatieve uitleg of verklaring van dit verschijnsel is zeldzaam. Craig Scott en later ook Ida Koch hebben het beschreven. Beide benaderingen worden uiteengezet. Zij gaan uit van de ondeelbaarheid van alle mensenrechten en streven een zogenaamde *contextual interpretative analysis* na voor een effectieve bescherming van alle mensenrechten: wetstekst in context geplaatst. Om de rechten van de mens op juiste wijze te beschermen heeft zowel het EctHR als de HRCee de concrete feiten in zaken, oftewel de context, in aanmerking genomen. Aangezien deze concrete feiten een uitleg verlangden waarin aanspraken op economische, sociale en culturele rechten werden meegenomen, werd de strikte scheiding tussen de twee traditionele categorieën mensenrechten verlaten.

Deel C: De juridische toetsbaarheid van het recht van de mens op gelijke toegang tot gezondheidszorg

In deel C van het onderhavige onderzoek staat de volgende onderzoeksvraag centraal: *Welke elementen kunnen naar verwachting een rol spelen in de juridische toetsbaarheid van het mensenrecht op gelijke toegang tot gezondheidszorg in zaken voor het Europees Comité voor Sociale Rechten, het Europees Hof voor de Rechten van de Mens en het VN-Mensenrechtencomité?*

Het ECSR is het onderwerp van **hoofdstuk 8**. Het (quasi-)rechterlijke ECSR is niet alleen het enige orgaan direct belast met het toezicht op de naleving door staten van hun verplichtingen ingevolge economische, sociale en culturele rechten, maar het is tot op heden ook het enige orgaan dat daadwerkelijk klachten met betrekking tot ongelijke toegang tot gezondheidszorg heeft behandeld. Het betreft drie zaken over de toegang tot gezondheidszorg voor mensen die zich onrechtmatig binnen het grondgebied van een lidstaat bevinden. Hoewel er meer zaken inzake een vermeende schending van het recht op gelijke toegang tot gezondheidszorg moeten worden afgewacht om concrete conclusies te kunnen trekken over de toepassing van

het verbod op discriminatie op het recht op gezondheidszorg, kunnen wel al een aantal voorlopige conclusies worden getrokken. Zo zijn wetgeving en/of andere praktijken welke alle medische hulp en zorg aan vreemdelingen ontzeggen, in strijd met het ESC en het RESC. Daarbij dient speciale aandacht te worden geschonken aan de situatie van minderjarige vreemdelingen. Het is echter wel gerechtvaardigd om een onderscheid te maken tussen deze groep mensen en anderen die aanwezig zijn in een betreffende lidstaat. Als zodanig is verduidelijkt dat artikel E RESC, waarin het verbod op discriminatie is neergelegd, niet het doel dient om aanspraak te maken op economische, sociale en culturele rechten zoals opgenomen in het RESC voor hen die zich onrechtmatig binnen het grondgebied van een lidstaat bevinden. Verder heeft het ECSR benadrukt dat binnen het bereik van het verbod van indirecte discriminatie ook moet worden begrepen dat kwetsbare groepen zonder financiële middelen en met behoefte aan gezondheidszorg tenminste toegang moeten hebben tot gratis spoedeisende hulp, eerstelijnszorg en noodzakelijke ziekenhuiszorg of een dekking van de kosten voor deze vormen van zorg. Deze zorg moet worden beschouwd als de kerninhoud van het recht op gezondheidszorg zoals neergelegd in het RESC.

In **hoofdstukken 9** en **10** wordt de jurisprudentie van het ECtHR en de HRCee in detail onderzocht om te beoordelen op welke wijze deze organen vermeende schendingen van het verbod op discriminatie toetsen. Dit in het algemeen en in het bijzonder in zaken waarin economische, sociale en culturele rechten of elementen daarvan een rol spelen. Uit deze analyse komt naar voren welke elementen een rol kunnen spelen in de toetsbaarheid van een mogelijke zaak betreffende ongelijke toegang tot gezondheidszorg.

Het ECtHR hanteert een indirecte *integrated approach* onder het niet-autonome artikel 14 ECHR en past een directe *integrated approach* toe onder het autonome artikel 1 van Prot. No. 12 ECHR. Het ECtHR is het enige rechtsprekende mensenrechtenorgaan dat bevoegd is om bindende uitspraken te doen inzake mensenrechtenschendingen. Ondanks het feit dat het ECHR geen economische, sociale en culturele rechten bevat, is het vaste rechtspraak dat zogauw een staat ertoe overgaat instanties in het leven te roepen of bepaalde rechten toe te kennen, dit op niet-discriminerende wijze en in overeenstemming met artikel 14 ECHR moet gebeuren. Dientengevolge fungeert artikel 14 ECHR als waarborg tegen discriminatie bij de toegang tot de sociaal-economische rechten waarvan het ECtHR als de bewaker kan worden beschouwd.

Het ECtHR hanteert een duidelijk toetsingsmodel op grond van artikel 14 ECHR. Hierbij wordt allereerst bekeken of de betrokken personen zich in een vergelijkbare positie bevinden. Ten tweede wordt beoordeeld of er een objectieve en redelijke rechtvaardiging gevonden kan worden voor het betreffende onderscheid. Hiervoor wordt onderzocht of het verschil in behandeling een legitiem doel dient en of er een proportionele verhouding bestaat tussen dat doel en de gebezigde maatregelen. Uit de analyse van de toepassing van dit toetsingsmodel door het ECtHR wordt geconcludeerd dat die toepassing vele gebreken vertoont.

Verschillende fasen worden regelmatig achterwege gelaten, bepaalde bevindingen worden niet uiteengezet en de gehanteerde criteria worden niet toegelicht.

De mate waarin getoetst wordt, en daarmee de mate aan discretionaire bevoegdheid (*margin of appreciation*) toegekend aan een lidstaat, wordt meer consequent toegepast. Uit de zaken waarin het ECtHR elementen van economische, sociale en culturele rechten heeft getoetst, is een aantal gradaties van toetsing te onderscheiden die verdeeld worden in vier categorieën. Welke categorie zal worden toegepast in een zaak betreffende de toegankelijkheid van gezondheidszorg, is gerelateerd aan de mate van aanwezigheid van bepaalde factoren.

In beginsel zal een dergelijke zaak onder de eerste categorie vallen: Het ECtHR zal een zeer terughoudende houding aannemen en daarmee een ruime *margin of discretion* toekennen, zeker in zaken waarin het een oordeel moet geven over de verdeling van schaarse middelen. Echter, in de gevallen waarin het onderscheid is gebaseerd op een verdachte grond, wordt minder discretionaire bevoegdheid toegekend aan de betreffende lidstaat. 'Zeer gewichtige redenen' (*very weighty reasons*) dienen te worden aangedragen voor een rechtvaardiging van een dergelijk onderscheid. Indien hiervan sprake is, zal de betreffende zaak onder de tweede categorie van de intensiteit van toetsing vallen. Het feit dat het ECtHR daarbij erkent dat ook indirecte discriminatie wordt beschermd door artikel 14 ECHR, is van groot belang voor zaken inzake ongelijke toegang tot gezondheidszorg. Een andere factor die van groot belang is voor een zaak betreffende ongelijke toegang tot gezondheidszorg, is de 'gemeenschappelijke factor' (*common ground factor*). De aanwezigheid van deze *common ground factor* wordt bepaald door de mate van consensus tussen of binnen de lidstaten van de CoE over de toelaatbaarheid van de ongelijke behandeling in een onderhavige zaak. Indien er sprake is van een dergelijke consensus tussen of binnen de lidstaten welke een specifieke ongelijke behandeling in de toegankelijkheid van gezondheidszorg afwijst en waarbij ook sprake is van onderscheid op basis van een verboden grond, kan artikel 14 ECHR geacht worden te zijn geschonden. In dat geval is er sprake van toetsingsgraad vallend binnen de vierde en zwaarste categorie. Ondanks dat de toegepaste graad van toetsing van een zaak betreffende de toegankelijkheid van gezondheidszorg altijd afhankelijk zal zijn van de specifieke feiten van de onderhevige zaak, wordt geconcludeerd dat de mate van aanwezigheid van deze factoren de voorspelbaarheid van een dergelijke zaak in positieve zin beïnvloeden.

Tot op heden heeft het ECtHR twee klachten betreffende een vermeende schending van het verbod op discriminatie behandeld onder de autonome non-discriminatiebepaling die is opgenomen in artikel 1 Prot. No. 12 ECHR. Op basis van deze zaken wordt geconcludeerd dat dit verbod op discriminatie vrijwel identiek is aan artikel 14 ECHR en dat hetzelfde toetsingsmodel wordt toegepast in dergelijke zaken. Het grote potentieel van artikel 1 Prot. No. 12 ECHR ligt echter verscholen in het feit dat in tegenstelling tot de non-discriminatiebepaling van artikel 14 ECHR, het ECtHR het verbod op discriminatie rechtstreeks kan toepassen

op rechten die zijn beschermd in andere verdragen waarmee het een directe *integrated approach* kan toepassen.

De directe *integrated approach* wordt ook door de HRCee toegepast. De HRCee is een quasi-rechterlijk orgaan dat toeziet op de naleving van het ICCPR. In een reeks zaken uit 1987 werd een autonome werking toegekend aan artikel 26 ICCPR waarin het verbod op discriminatie is neergelegd. Er werd veel verwacht van de toepassing van deze bepaling op economische, sociale en culturele rechten. Echter, op basis van de analyse van de zaken van het HRCee wordt vastgesteld dat er geen concrete conclusies getrokken kunnen worden ten aanzien van de beoordeling van zaken op grond van artikel 26 ICCPR. De HRCee hanteert een zeer casuïstische benadering en in het leeuwendeel van deze zaken wordt het toetsingsmodel niet toegepast of worden bevindingen zeer mager toegelicht. Bovendien wordt er nauwelijks duidelijk gemaakt welke graad van toetsing wordt gehanteerd en welke factoren hierin een rol spelen. Het is daarom moeilijk om te komen tot concrete conclusies betreffende de elementen die verwacht kunnen worden een rol te spelen in de *justiciability* van het recht op gelijke toegang tot gezondheidszorg. Gezien het grote potentieel dat is gelegen in de directe *integrated approach* die is toegekend aan de werking van artikel 26 ICCPR voor zaken betreffende het recht op gelijke toegang tot gezondheidszorg, is het te betreuren dat de jurisprudentie van de HRCee vele gebreken vertoont. In termen van transparantie, rechtszekerheid en voorspelbaarheid van de rechtspraak van de HRCee wordt dit bovendien beschouwd als onbevredigend.

In **hoofdstuk 11** worden de bevindingen van de voorafgaande hoofdstukken kort samengevat en de belangrijkste conclusies gepresenteerd. Op basis van de voorafgaande analyse wordt geconcludeerd dat economische, sociale en culturele rechten *justiciable* zijn. Daarnaast wordt gesteld dat het mensenrecht van ieder mens op gelijke toegang tot gezondheidszorg en elementen van dat recht onderworpen kunnen worden aan de toetsing door (quasi-)rechterlijke mensenrechtenorganen. Echter, het enkele feit dat klachten met betrekking tot het recht op gelijke toegang tot gezondheidszorg naar waarschijnlijkheid in toenemende mate getoetst worden en kunnen worden door deze organen, is uiteraard niet voldoende voor het realiseren en beschermen van dit recht. Het is van het grootste belang dat bij het instellen en hervormen van gezondheidszorgsystemen aandacht wordt besteed aan alle facetten van het fundamentele recht op gezondheidszorg en de verplichtingen die staten dientengevolge hebben. De mensenrechtelijke benadering ziet gezondheidszorg als een manier om gezondheid en welzijn van mensen te borgen en beschouwt dit als onontbeerlijk voor de uitoefening van andere fundamentele rechten. Bovendien stelt het rechtvaardigheids- en gelijkheidsnormen en besteedt het speciale aandacht aan kwetsbare mensen in de samenleving, hetgeen aan de basis moet liggen van ieder instellen en hervormen van gezondheidssystemen.

BIBLIOGRAPHY

Alkema and Rop 2002
E.A. Alkema and A.C. Rop, 'Gelijk zijn en gelijk krijgen. Aspecten van gelijkheid in de rechtspraktijk', in: M. Kroes, J.P. Loof, and H.M.Th.D. ten Napel (eds.), *Gelijkheid en rechtvaardigheid. Staatsrechtelijke vraagstukken rondom 'minderheden'*, Deventer: Kluwer 2002, p. 31-77.

Ando 2004
N. Ando, 'The Evolution and Problems of the Jurisprudence of the Human Rights Committee's Views concerning Article 26', in: N. Ando (ed.), *Towards Implementing Universal Human Rights. Festschrift for the Twenty-Fifth Anniversary of the Human Rights Committee*, Leiden: Martinus Nijhoff Publishers 2004, p. 205-224.

Arambulo 1999
K. Arambulo, *Strengthening the Supervision of the International Covenant on Economic*, *Social and Cultural Rights. Theoretical and Procedural Aspects*, Antwerp: Intersentia 1999.

Arambulo 2003
K. Arambulo, 'Giving Meaning to Economic, Social and Cultural Rights: A Continuing Struggle', *Human Rights and Human Welfare* 2003, p. 111-123.

Asher 2004
J. Asher, *The Right to Health: A Resource Manual for NGOs*, London: Commonwealth Medical Trust 2004.

Backman et al. 2008
G. Backman, P. Hunt, R. Khosla, C. Jaramillo-Strouss, B. Mekuria Fikre, C. Rumble, D. Pevalin, D. Acurio Páez, M. Armijos Pineda, A. Frisancho, D. Tarco, M. Motlagh, D. Farcasanu, and C. Vladescu, 'Health systems and the right to health: an assessment of 194 countries', *Lancet* 37, 13 December 2008, p. 2047-2085.

Bayefsky 1990
A.F. Bayefsky, 'The principle of equality or non-discrimination in international law', *Human Rights Law Journal* 1990-1-2, p. 1-34.

Bell 2006
M. Bell, 'Combating Discrimination through Collective Complaints under the European Social Charter', *European Anti-Discrimination Law Review* 2006-3, p. 13-19.

Boot and Knapen 2005
J.M. Boot and M.H.J.M. Knapen, *De Nederlandse Gezondheidszorg*, Houten: Bohn Stafleu van Loghum 2005.
Chapman 1994
A.R. Chapman, 'Preface', in: A.R. Chapman (red.), *Health Care Reform: A Human Rights Approach*, Washington D.C.: Georgetown University Press 1994, p. vii-x.
Chapman 1997-1998
A.R. Chapman, 'Conceptualizing the right to health. A violations approach', *Tenner Law Review* 1997-1998 p. 389-418.
Chinkin 2006
C. Chinkin, 'Health and human rights', *Public Health* 2006-suppl. 1, p. 52-60.
Chirwa 2003
D.M. Chirwa, 'The right to health in international law: its implications for the obligations of state and non-state actors in ensuring access to essential medicine', *South African Journal on Human Rights* 2003-4, p. 541-566.
Clements and Simmons 2008
L. Clements and A. Simmons, 'European Court of Human Rights. Sympathetic unease', in: M. Langford (ed.), *Social Rights Jurisprudence. Emerging Trends in International and Comparative Law*, New York: Cambridge University Press 2008, p. 409-427.
Coomans 1997
F. Coomans, 'Stap voor stap: naar een versterkt toezicht op de naleving van het Internationaal Verdrag inzake Economische, Sociale en Culturele rechten', *NJCM-Bulletin* 1997-5, p. 553-568.
Coomans 2006
F. Coomans, 'Some Introductory Remarks on the Justiciability of Economic and Social Rights in a Comparative Constitutional Context', in: F. Coomans (ed.), *Justiciability of Economic and Social rights. Experiences from Domestic Systems*, Antwerp - Oxford: Intersentia 2006, p. 1-16.
Coomans 2007
A.P.M. Coomans, *Identifying the Key Elements of the Right to Education: A Focus on its Core Content*, London: Childs Right Information Network (CRIN) 2007.
Cullen 2009
H. Cullen, 'The Collective Complaints System of the European Social Charter. Interpretative Methods of the European Committee of Social Rights', *Human Rights Law Review* 2009-1, p. 61-93.
Council of Europe
Non-discrimination: A human right. Seminar marking the entry into force of Protocol No. 12, Strasbourg: Council of Europe Publishing 2006.
Courtis 2008
C. Courtis, *Courts and the Legal Enforcement of Economic*, *Social and Cultural Rights. Comparative Experiences of Justiciability*, Geneva: International Commission of Jurists 2008.

Courtis 2009
C. Courtis, 'Standards to Make ESC Rights Justiciable. A Summary Exploration', *Erasmus Law Review* 2009-4, p. 379-395.
Davidson 2004
S. Davidson, 'Equality and Non-Discrimination', in: A. Conte, S. Davidson, and R. Burchill (eds.), *Defining Civil and Political Rights. The Jurisprudence of the United Nations Human Rights Committee*, Hants/Burlington: Ashgate Publishing Limited 2004, p. 161-181.
Den Exter and Hermans 1998
A. Den Exter and H. Hermans, 'Constitutional Rights to Health Care. The Consequences of Placing Limits on the Right to Health Care in Sereveral Western and Eastern European Countries', *European Journal of Health Law* 1998-3, p. 261-289.
Den Exter and Hermans 1999
A. Den Exter and H. Hermans, 'The Right to Health Care: A Changing Concept?', in: A. Den Exter and H. Hermans (eds.), *The Right to Health Care in Several European Countries*, London: Kluwer Law International 1999, p. 1-9.
Den Exter 2002
A. Den Exter, 'The Right to Health Care in International Law', in: A. Den Exter and J. Sándor (eds.), *Frontiers of EU Health Law. Yearbook* 2002, Rotterdam: Erasmus University Press 2002, p. 12-26.
De Schutter 2002
O. De Schutter, 'The Protection of Social Rights by the European Court of Human Rights', in: P. Van der Auweraert, T. De Pelsmaeker, J. Sarkin, and J. Vande Lanotte (eds.), *Social*, *Economic and Cultural Rights: An Appraisal of Current European and International Developments*, Antwerp/Apeldoorn: Maklu 2002, p. 207-239.
Edelenbos 2009
C. Edelenbos, 'The Human Rights Committee's Jurisprudence under Article 26 of the ICCPR: The Hidden Revolution', in: J.T. Möller (ed.), *International Human Rights Monitoring Mechanisms: Essays in Honour of Jakob Th. Möller*, Leiden: Martinus Nijhoff Publishers 2009, p. 76.
Eide 1987
A. Eide, *The New International Economic Order and the Promotion of Human Rights. Report on the Right to Adequate Food as a Human Right*, United Nations Commission on Human Rights 1987.
Eide 1989
A. Eide, 'Realization of Social and Economic Rights and the Minimum Threshold Approach', *Human Rights Law Journal* 1989-1-2, p.35-51.
Eide 2001
A. Eide, 'Economic, Social and Cultural Rights as Human Rights', in: A. Eide, C. Krause, and A. Rosas (eds.), *Economic*, *Social and Cultural Rights. A Textbook*, Dordrecht: Martinus Nijhoff Publishers 2001, p. 9-28.

Eide 1992
A. Eide, 'Article 25', in: A. Eide, A. Gudmundur, G. Melander, L.A. Rehof, and A. Rosas, *The Universal Declaration on Human Rights. A Commentary*, Oslo: Scandinavian University Press 1992, p. 385-403.
Farha 2008
L. Farha, 'Committee on the Elimination of Discrimination Against Women. Women Claiming Economic, Social and Cultural Rights - The CEDAW Potential', in: M. Langford (ed.), *Social Rights Jurisprudence. Emerging Trends in International and Comparative Law*, New York: Cambridge University Press 2008, p. 553-568.
Garner 2004
A.G. Garner, *Black's Law Dictionary*, St. Paul MN: Thomson West Group 2004.
Gerards 2005
J.H. Gerards, *Judicial Review in Equal Treatment Cases*, Leiden: Koninklijke Brill NV 2005.
Goffin et al. 2008
T. Goffin, P. Borry, K. Dierickx, H. Nys, 'Why eight EU Member States signed, but not yet ratified the Convention for Human Rights and Biomedicine', *Health Policy* 2008, p. 222-233.
Gómez Isa 2005
F. Gómez Isa, 'Globalisation, Privatisation and Human Rights', in: K. De Feyter, F. Gómez Isa (red.), *Privatisation and Human Rights in the Age of Globalisation*, Antwerp/ Oxford: Intersentia 2005, p. 9-31.
Gomien 2005
D. Gomien, *Short guide to the European Convention on Human Rights*, Strasbourg: Council of Europe Publishing 2005.
Green 2001
M. Green, 'What We Talk About When We Talk About Indicators: Current Approaches to Human Rights Measurement', *Human Rights Quarterly* 2001 p. 1062-1097.
Hendriks 1998
A.C. Hendriks, 'The Right to Health in National and International Jurisprudence', *European Journal of Health Law* 1998-4, p. 389-408.
Hendriks 1994
A.C. Hendriks, 'Disabled Persons and their Right to Equal Treatment: Allowing Differentiation While Ending Discrimination', *Health and Human Rights* 1994a-2, p. 152-173.
Hendriks 1999
A.C. Hendriks, *Gelijke toegang tot de arbeid voor gehandicapten*, Deventer: Kluwer 1999.
Hendriks 2001
A.C. Hendriks, 'Patients' rights and access to health care', *Medicine and Law* 2001 p. 371-378.

Hendriks 2001a
A.C. Hendriks, 'Gelijke toegang tot zorg. Van ideaal naar recht', *Tijdschrift Voor Gezondheidsrecht* 2001, p. 55-64.
Hendriks 2009
A.C. Hendriks, 'Patients' rights and access to health care', *Medicine and Law* 2001 p. 371-378.
Henrard 2008
K. Henrard, 'Equality of Individual', in: R. Wolfrum (ed.), *Max planck encyclopedia of public international law*, New York: Oxford University Press 2008.
Henrard 2008a
K. Henrard, *Mensenrechten vanuit internationaal en nationaal perspectief*, The Hague: Boom Juridische uitgevers 2008a.
Henrard 2009
K. Henrard, 'Introduction: The Justiciability of ESC Rights and the Interdependence of all Human Rights', *Erasmus Law Review* 2009-4, p. 373-378.
Holtmaat 2004
H.M.T. Holtmaat, 'Een pleidooi voor het maken van onderscheid tussen discriminatie en ongelijke behandeling', in: R. Holmaat (ed.), *Gelijkheid en (andere) grondrechten*, Deventer: Kluwer 2004, p. 67-96.
Huls 2004
N. Huls, 'Access to Health', *Review Digest Human Rights & Human Welfare*, Graduate School of International Studies, University of Denver 2004, p. 20-46.
Jägers 2002
N. Jägers, *Corporate Human Rights Obligations. In Search of* Accountability, Antwerp: Intersentia 2002.
Khaliq and Churchill 2008
U. Khaliq and R. Churchill, 'The European Committee of Social Rights. Putting flesh on the bare bones of the European Social Charter', in: M. Langford (ed.), *Social Rights Jurisprudence. Emerging Trends in International and Comparative Law*, New York: Cambridge University Press 2008, p. 428-452.
Koch 2003
I.E. Koch, 'The Justiciability of Indivisible Rights', *Nordic Journal of International Law* 2003 p. 3-39.
Koch 2005
I.E. Koch, 'Dichotomies, Trichotomies or Waves of Duties?', *Human Rights Law Review* 2005-1, p. 81-103.
Koch 2006
I.E. Koch, 'Economic, Social and Cultural Rights as Components in Civil and Political Rights: A Hermeneutic Perspective', *International Journal of Human Rights* 2006-4, p. 405-430.

Koch 2009
I.E. Koch, *Human Rights as Indivisible Rights. The Protection of Socio-economic Demands under the European Convention on Human Rights*, Leiden: Martinus Nijhoff Publishers 2009.
Langford 2008
M. Langford, 'The Justiciability of Social rights: From Practice to Theory', in: M. Langford (ed.), *Social Rights Jurisprudence. Emerging Trends in International and Comparative Law*, New York: Cambridge University Press 2008, p. 3-45.
Langford and King 2008
M. Langford and J.A. King, 'Committee on Economic, Social and Cultural Rights. Past, Present and Future', in: M. Langford (ed.), *Social Rights Jurisprudence. Emerging Trends in International and Comparative Law*, New York: Cambridge University Press 2008, p. 477-516.
Lawson 2010
R. Lawson, 'Dwelling on the Threshold: On the Interaction between the European Convention on Human Rights and the Biomedicine Convention.', in: A.P. den Exter (ed.), *Human Rights and Biomedicine,* Antwerp: Maklu 2010, p. 23-36.
Leary 1994
V.A. Leary, 'Defining the Right to Health Care', in: A.R. Chapman (red.), *Health Care Reform. A Human Rights Approach*, Washington D.C.: Georgetown University Press 1994, p. 87-105.
Leary 1994a
V.A. Leary, 'The Right to Health in International Human Rights Law', *Health and Human Rights* 1994a-1, p. 24-56.
Leary 1995
V.A. Leary, 'The Right to Complain: the Right to Health', in: F. Coomans and F. Van Hoof (eds.), *The Right to Complain about Economic*, *Social and Cultural Rights*, Utrecht: Netherlands Institute of Human Rights 1995, p. 87-102.
Lie 2000
R.K. Lie, 'Human rights, equity and health sector reform: final report', *Arrows for Change* 2000, p. 1-38.
Lie 2004
R.K. Lie, 'Health, human rights and mobilization of resources for health', *BMC International Health and Human Rights* 2004-4, p. 1-8.
Loenen 1998
T.Loenen, *Het gelijkheidsbeginsel*, Nijmegen: Ars Aequi Libri 1998.
Loof 2005
J.P. Loof, *Mensenrechten en staatsveiligheid. Verenigbare grootheden? Opschorting en beperking van mensenrechtenbescherming tijdens noodtoestanden en andere situaties die de staatsveiligheid bedreigen*, Nijmegen: Wolf Legal Publishers 2005.

Maes 2003
G. Maes, *De afdwingbaarheid van sociale grondrechten,* Antwerp-Groningen-Oxford: Intersentia 2003.
M. Mackintosh and M. Koivusalo 2005
M. Mackintosh and M. Koivusalo, 'Health Systems and Commercialization: In Search of Good Sense', in: M. Mackintosh and M. Koivusalo (red.), *Commercialisation of Health Care: Global and Local Dynamics and Policy Responses*, Hampshire: Palgrave 2005, p. 3-21.
Mantouvalou 2005
V. Mantouvalou, 'Work and Private Life: Sidabras and Dziautas v. Lithuania', *Erasmus Law Review* 2005, p. 573-585.
Müller 2009
A. Müller, 'Limitations to and Derogations from Economic, Social and Cultural Rights', *Human Rights Law Review* 2009, p. 557-601.
Neier 2006
A. Neier, 'Social and Economic Rights: a Critique', *Human Rights Brief 2006*-2, p. 1-3.
Nolan, Porter and Langford 2007
A. Nolan, B. Porter, and M. Langford, 'The Justiciability of Social and Economic Rights. An Updated Appraisal', *CHRGJ Working Paper* 2007, p. 1-36.
Otto 2001
D. Otto, 'Defending Women's Economic and Social Rights: Some Thoughts on Indivisibility and a New Standard of Equality', in: I. Merali and V. Oosterveld (eds.), *Giving Meaning to Economic*, *Social*, *and Cultural Rights*, Philadelphia: University of Pennsylvania Press 2001, p. 52-67.
Palmer 2009
E. Palmer, 'Protecting Socio-Economic Rights Through the European Convention on Human Rights: Trends and Developments in the European Court of Human Rights', *Erasmus Law Review* 2009-4, p. 397-425, p. 398.
Partsch 1982
K.J. Partsch, 'Fundamental principles of human rights. Self-determination, equality and non-discrimination', in: K. Vasak (ed.), *The International Dimensions of Human Rights*, Connecticut: Greenwood Press 1982, p. 61-86.
Petrova 2006
D. Petrova, 'Implementing Anti-Discrimination Law and the Human Rights Movement', *Helsinki Monitor* 2006, p. 19-38.
Pillay 2005-2006
N. Pillay, 'Right to health and the Universal Declaration of Human Rights', *The Lancet* 2008, p. 2005-2006.

Prouvez 2008
N. Prouvez, 'Committee on the Elimination of Racial Discrimination. Confronting Racial Discrimination and Inequality in the Enjoyment of Economic, Social and Cultural Rights', in: M. Langford (ed.), *Social Rights Jurisprudence. Emerging Trends in International and Comparative Llaw*, New York: Cambridge University Press 2008, p. 517-539.
Roach 2008
K. Roach, 'The Challenges of Crafting Remedies for Violations of Socio-Economic Rights', in: M. Langford (ed.), *Social Rights Jurisprudence. Emerging Trends in International and Comparative Law*, New York: Cambridge University Press 2008, p. 46-58.
Roscam Abbing 1979
H.D.C. Roscam Abbing, *International Organizations in Europe and the Right to Health Care*, Deventer: Kluwer 1979.
Scheinin 2001
M. Scheinin, 'Economic and Social Rights as Legal Rights', in: A. Eide, C. Krause, and A. Rosas (eds.), *Economic*, *Social and Cultural Rights*, The Hague: Kluwer Law International 2001, p. 29-54.
Scheinin 2005
M. Scheinin, 'Justiciability and the Indivisibility of Human Rights', in: J. Squires, M. Langford, and B. Thiele (eds.), *Road to a Remedy: Current Issues in the Adjudication of Economic*, *Social and Cultural rights*, Sydney: UNSW Press 2005, p. 17-26.
Scheinin 2008
M. Scheinin, 'Human Rights Committee. Not only a Committee on Civil and Political Rights', in: M. Langford (ed.), *Social Rights Jurisprudence. Emerging Trends in International and Comparative Law*, New York: Cambridge University Press 2008, p. 540-552.
Schoukens 2008
P. Schoukens, 'The Right to Access Health Care: Health Care According to International and European Social Security Law Instruments', in: A.P. den Exter (ed.), *International Health Law. Solidarity and Justice in Health Care*, Apeldoorn-Antwerp: Maklu 2008, p. 17-48.
Scott 1989
C. Scott, 'The Interdependence and Permeability of Human Rights Norms: Towards a Partial Fusion of the International Covenants on Human Rights', *Osgoode Hall Law Journal* 1989-4, p. 769-878.
Scott 1999
C. Scott, 'Reaching Beyond (Without Abandoning) the Category of "Economic, Social and Cultural Rights"', *Human Rights Quarterly* 1999, p. 633-660.
Sellin 2009
J. Sellin, 'Justiciability of the Right to Health - Access to Medicines. The South African and Indian Experience', *Erasmus Law Review* 2009-4, p. 445-464.

Sepúlveda 2003
M. Sepúlveda, *The Nature of the Obligations under the International Covenant on Economic, Social and Cultural Rights*, Antwerp: Intersentia 2003.
Shue 1980
H. Shue, *Basic Rights. Subsistence*, *Affluence*, *and U.S. Foreign Policy*, New Jersey: Princeton University Press 1980.
Steiner and Alston 2000
H.J. Steiner and P. Alston, *International Human Rights in Context: Law*, *Politics*, *Morals. Texts and Materials*, Oxford: Oxford University Press 2000.
Toebes 1999
B.C.A. Toebes, 'Towards an Improved Understanding of the International Human Right to Health', *Human Rights Quarterly* 1999, p. 661-679.
Toebes 1999a
B.C.A. Toebes, *The Right to Health as a Human Right in International Law*, Antwerp: Intersentia 1999a.
Toebes 2001
B.C.A. Toebes, 'The Right to Health', in: A. Eide, C. Krause, and A. Rosas (eds.), *Economic*, *Social and Cultural Rights*, The Hague: Kluwer Law International 2001, p. 169-190.
Tomasevski 1995
K. Tomasevski, 'Health Rights', in: A. Eide, C. Krause, and A. Rosas (eds.), *Economic*, *Social and Cultural Rights. A Textbook.* Dordrecht: Martinus Nijhoff Publishers 1995, p. 125-142.
Tomuschat 2004
C. Tomuschat, 'The Human Rights Committee's Jurisprudence on Article 26 - A Phyrrhic Vicotry?', in: N. Ando (ed.), *Towards Implementing Universal Human Rights. Festschrift for the Twenty-Fifth Anniversary of the Human Rights Committee.* Leiden: Martinus Nijhoff Publishers 2004, p. 225-250.
Tomuschat 2007
C. Tomuschat, 'Civil and Political Rights - Economic, Social and Cultural Rights. Complementarity and Opposition', in: K. Koufa (ed.), *Multiculturalism and International Law: 2004 international law session*, Athens: Sakkoulas Publications 2007, p. 3-48.
Tomuschat 2007a
C. Tomuschat, *Human Rights. Between Idealism and Realism*, New York: Oxford University Press 2007.
Tyagi 2011
Y. Tyagi, *The UN Human Rights Committee: Practice and Procedure*, Cambridge: Cambridge University Press 2011.
Vasey 2009
V. Vasey, 'Access to Health Care in Bulgaria: Marginalisation of Roma', *Roma Rights Journal* 2009-1, p. 59-61.

Van Bueren 2008
G. Van Bueren, 'Committee on the Rights of the Child', in: M. Langford (ed.), *Social Rights Jurisprudence. Emerging Trends in International and Comparative law*, New York: Cambridge University Press 2008, p. 569-587.
Vandenbogaerde andVandenhole 2010
A. Vandenbogaerde, W. Vandenhole, 'The Optional Protocol to the International Covenant on Economic, Social and Cultural Rights: An *Ex Ante* Assessment of its Effectiveness in Light of the Drafting Process', *Human Rights Law Review* 2010-2, p. 207-237.
Vandenhole 2005
W. Vandenhole, *Non-Discrimination and Equality in the View of the UN Human Rights Treaty Bodies*, Antwerp/ Oxford: Intersentia 2005.
Van Loof 1984
G.J.H. Van Hoof, 'Legal Nature of Economic, Social and Cultural Rights: A Rebuttal of Some Traditional Views', in: P. Alston and K. Tomasevski (eds.), *The Right to Food*, Utrecht: Martinus Nijhoff Publishers 1984, p. 97-110.
Venediktov 1998
D. Venediktov, 'Primary Health Care. Alma-Ata and After', *World Health Forum* 1998, p. 79-81.
Waldron 1993
J. Waldron, *Liberal Rights. Collected Papers 1981*-1991, Cambridge: Cambridge University Press 1993.
Wentholt 1999
K. Wentholt, 'Formal and Substantive Equal Treatment. The Limitations and the Potential of the Legal Concept of Equality', in: T. Loenen and P.R. Rodrigues (eds.), *Non-Discrimination Law. Comparative Perspectives*, The Hague: Kluwer Law International 1999, p. 53-63.
World Health Organization
World Health Organization, *25 Questions and Answers on Health and Human Rights,* 2002.
Wouters 2009
J. Wouters, M. Vidal, *Een klachtenprotocol bij het VN-Verdrag inzake economische*, *sociale en culturele* rechten, Instituut voor Internationaal Recht, Katholieke Universiteit Leuven 2009.

TABLE OF CASES

Human Rights Committee

Communication Number 172/1984, *S.W.M. Broeks* v. *the Netherlands*
Communication No. 180/1984, *L.G. Danning* v. *the Netherlands*
Communication No. 182/1984, *F.H. Zwaan-de Vries* v. *the Netherlands*
Communication No. 191/1985, *Carl Henrik Blom* v. *Sweden*
Communication No. 196/1985, *Ibrahima Gueye et al.* v. *France*
Communication No. 208/1986, *Karnel Sing Bhinder* v. *Canada*
Communication No. 212/1986, *P.P.C.* v. *the Netherlands*
Communication No. 218/1986, *Hendrika S. Vos* v. *the Netherlands*
Communication No. 267/1987, *M.J.G.* v. *the Netherlands*
Communication no. 271/ 1988 and 271/1988, *Barrett and Sutcliffe*
Communication No. 295/1988, *Aapo Järvinen v Finland*, para. 6.5.
Communication No. 273/1988, *B.d.B. et al.*v. *the Netherlands*
Communication Nos. 298/1988, 299/1988 *G. and L. Lindgren et al.* v. *Sweden*
Communication No. 321/1988, *Thomas* v. *Jamaica*
Communication No. 395/1990, *M. Th. Sprenger* v. *the Netherlands*
Communication No. 402/1990, *Maria Brinkhof* v. *the Netherlands*
Communication Nos. 406/1990, 426/1990, *Oulajin and Kaiss* v. *the Netherlands*
Communication No. 415/1990, *Dietmar Pauger* v. *Austria*
Communication No. 418/1990, *Cavalcanti Araujo-Jongen* v. *the Netherlands*
Communication no. 428/1990, *Bozize* v. *Central Africa Republic*
Communicatoin No. 454/1991, *Enrique Garcia Pons* v. *Spain*
Communication no. 458/1991, *Albert Womah Mukong* v. *Cameroon*
Communication No. 478/1991, *A.P.L.v.d.M.* v. *the Netherlands*
Communication No. 516/1992, *Alina Simunek* v. *Czech Republic*
Communication no. 527/1993, *Lewis* v. *Jamaica*
Communication No. 586/1994, *Josef Frank Adam* v. *Czech Republic*
Communication No. 592/1994, *Clive Johnson* v. *Jamaica*
Cmmunication No. 602/1994, *Cornelis Hoofdman* v. *the Netherlands*;
Communication no. 610/1995, *Henry* v. *Jamaica*
Communication No. 613/1995, *Leehong* v. *Jamaica*
Communication no. 647/1995, *Pennant* v. *Jamaica*
Communication No. 653/1995, *Colin Johnson* v. *Jamaica*

Communication No. 658/1995, *Jacob and Jantina Hendrika van Oord* v. *the Netherlands*
Communication no. 663/1995, *Morrison* v. *Jamaica*
Communication No. 666/1995, *Frédéric Foin* v. *France*
Communication no. 668/1995, *Smith and Stewart* v. *Jamaica*
Communication no. 688/1996, *Arredondo* v. *Peru*
Communication No. 689/1996, *Maille* v. *France*
Communication No. 694/1996, *Ariek Hollis Waldman* v. *Canada*
Communication no. 253/1997, *Kelly* v. *Jamaica*
Communication No. 747/1997, *Dr. Karel Des Fours Walderode* v. *Czech Republic*
Communication No. 760/1997, *J.G.A. Diergaardt* v. *Namibia*
Communication no. 763/1997, *Yekaterina Pavlovna Lantsova on behalf of her son Vladimir Albertvich Lantsov* v. *the Russian Federation*
Communication No. 774/1997, *Robert Brok et al.* v. *Czech Republic*
Communication no. 775/1997, *Brown* v. *Jamaica*
Communication No. 297/1998, *H.A.E.d.J.* v. *the Netherlands*
Communication no. 845/1998, *Kennedy* v. *Trinidad and Tobago*
Communication No. 854/1999, *Manuel Wackenheim* v. *France*.
Communication No. 857/1999, *Blazek et. al.* v. *Czech Republic*
Communication No. 865/1999, *Gomez* v. *Spain*
Communication no. 900/1999, *Mr. C.* v. *Australia*
Communication No. 919/2000, *Mr. Michael Andreas Müller and Imke Engelhard* v. *Namibia*
Communication No. 932/2000*, Ms. Marie-Hèléne Gillot et al.* v. *France*
Communication No. 941/2000, *Mr. Edward Young* v. *Australia*
Communication No. 943/2000, *Guido Jacobs* v. *Belgium*
Communication No. 965/2000, *Mr. Mümtaz Karakurt* v. *Austria*
Communication No. 976/2001, *Cecilia Derksen* v. *the Netherlands*
Communication No. 983/2001, *J.K. Love, W.L. Bone, W.J. Craig, and P.B. Ivanoff* v. *Australia*
Communication No. 998/2001, *Rupert Althammer et al.* v. *Austria*
Communication no. 1153/2003, *Karen Noelia Llantoy Huamán* v. *Peru*
Communication no. 4/2004, *Ms. A.S.* v. *Hungary*
Communication No. 1361/2005, *X* v. *Colombia*
Communication No. 1565/2007, *Aurélio Gonçalves et al.* v. *Portugal*

European Court of Human Rights

Case "relating to certain aspects of the laws on the use of languages in education in Belgium" v. *Belgium,* Application Nos. 1474/62, 1677/62, 1691/62, 1769/63, 2126/64, 23 July 1968
Kjeldsen, Busk Madsen and Pedersen v. *Denmark,* Application Nos. 5095/71, 5920/72, 5926/72, A.23, 7 December 1976

Handyside v. *the United Kingdom*, Application No. 5493/72, 7 December 1976
Airey v. *Ireland*, Application No. 6289/73, A. 032, 9 October 1979
Marckx v. *Belgium*, Application No. 6833/74, 13 June 1979
Rasmussen v. *Denmark,* Application No. 8777/79, 5 July 1983
James and others v. *the United Kingdom,* Application. No. 8793/79, 21 February 1986
Karlheinz Schmidt v. *Germany,* Application No. 13580/88, 18 July 1994
Gaygusuz v. *Austria,* Application No. 17371/90, 19 September 1996
Petrovic v. *Austria*, Application No. 20458/92, 27 March 1998
Botta v. *Italy* Application no. 21439/93, 24 February 1998
Gerger v. *Turkey,* Application No. 24919/94, 8 July 1999
Jane Smith v. *the United Kingdom,* Application No 25154/94, 18 January 2001
Cyprus v. *Turkey,* Appication no. 25781/94, 10 May 2001
Keenan v. *the Unted Kingdom*, App. No. 27229/95, 3 April 2001
Christine Goodwin v. *the United Kingdom*, Application No. 28957/95, 11 July 2002
Kelly and others v. *the United Kingdom*, Application No. 30054/96, 4 May 2001
D. v. *the United Kingdom*, Application No. 30240/96, 2 May 1997
Sahin v. *Germany,* Application No. 30943/96, 8 July 2003, *EHRC* 2001/81, with annotation Gerards.
Calvelli and Ciglio v. *Italy,* Application no. 32967/96, 17 January 2002
Salgueiro da Silva Mouta v. *Portugal*, Application No. 33290/96, 21 December 1999
Price v. *the United Kingdom*, App. No. 33394/96, 10 July 2001
Thlimmenos v. *Greece,* Application No. 34369/97, 6 April 2000
Wessels-Bergervoet v. *the Netherlands*, Application No. 34462/97, 4 June 2002
Demir and Baykara v. *Turkey,* Application No. 34503/97, 12 November 2008
Kück v. *Germany* Application no. 35968/97, 12 June 2003
Willis v. *the United Kingdom*, Application No. 36042/97, 11 June 2002, *EHRC*2002/62 with annotation Gerards.
Fretté v. *France*, App. No. 36515/97, 26 February 2002
Zehnalova and Zehnal v. *Czech Republic*, Application No. 38621/97, 14 May 2002
Fogarty v. *the United Kingdom*, Application No. 37112/97, 21 November 2001, *EHRC* 2002/4 with annotation Heringa and Gerards.
L. and V. v. *Austria*, Application Nos. 39392/98, 39829/98, 9 January 2003
Karner v. *Austria,* Application No. 40016/98, 24 July 2003
Koua Poirrez v. *France*, Application No. 40892/98, 30 September 2003
Karara v. *Finland,* Application no 40900/98, 29 May 1998
Odièvre v. *France*, Application No. 42326/98, 13 February 2003
Runkee and White v. *the United Kingdom,* Application Nos. 42949/98, 53134/99, 10 May 2007
Nachova v. *Bulgaria,* Application Nos. 43577/98, 43579/98, 26 February 2004
Bensaid v. *the United Kingdom,* Application no. 44599/98, 6 February 2001
Powell v. *the United Kingdom*, Application No. 45305/99, 4 May 2000

S.C.C. v. *Sweden* , Application no. 46553/99, 15 February 2000
McGlinchey a.o. v. *the United Kingdom,* App no 50390/99, 29 April 2003
Vo. v. *France*, Application No. 53924/00, 8 July 2004
Sidabras and Džiautas v. *Lighuania,* Application Nos. 55480/00, 59330/00, 27 July 2004
Angelova and Iliev v. *Bulgaria*, Application No. 55523/00, 26 July 2007
Andrejeva v. *Latvia,* Application No. 55707/00, 18 February 2009
D.H. and others v. *Czech Republic*, Application No. 57325/00, 13 November 2007
S.H. and others v. *Austria,* Application No. 57813/00, 1 April 2010
Niedzwiecki v. *Germany,* Application No. 58453/00, 25 October 2005
Hoogendijk v. *the Netherlands*, Application No. 58641/00, 6 January 2005, *EHRC* 2005/24, with annotation Gerards.
Kjartan Ásmundsson v. *Iceland*, Application No. 60669/00, 12 October 2004
Glass v. *the United Kingdom* Application No. 61827/00, 9 March 2004
Palau-Martinez v. *France*, Application No. 64927/01, 16 December 2003, *EHRC* 2004/ 9, with annotation Gerards.
Nitecki v. *Poland*, Application no. 65653/01, 21 March 2002
Stec and others v. *the United Kingdom,* Application Nos. 65731/01, 65900/01, 12 April 2006
Luczak v. *Poland,* Application No. 77782/01, 27 November 2007
Pretty v. *the United Kingdom,* Application No. 2346/02, 29 April 2002
Zarb Adami v. *Malta,* Application No. 17209/02, 20 June 2006
P.B. and J.S. v. *Austria,* Application No. 18984/02, 22 July 2010
Zeman v. *Austria,* Application No. 23960/02, 29 June 2006
Sentges v. *the Netherlands* Application no. 27677/02, 8 July 2003
Walker v. *the United Kingdom,* Application No. 37212/02, August 2006
E.B. v. *France,* Application No. 43546/02, 22 January 2008
Pentiacova and 48 others v. *Moldova* Application no. 14462/03, 4 January 2005
Oršuš and others v. *Croatia*, Application No. 15766/03, 16 March 2010, *ECHR* 2010/59 with annotation Gerards.
Gelfmann v. *France* App no. 25875/03, 14 December 2004
Glor v. *Switzerland,* Application No. 13444/04, 30 april 2009
Nart v. *Turkey,* Application No. 20817/04, 6 May 2008
Schalk and Kopf v. *Austria*, Application No. 30141/04, 24 June 2010
Evans v. *the United Kingdom,* Application No. 6339/05, 10 April 2007
Paulík v. *Slovakia*, Application No. 10699/05, 10 October 2007
Burden v. *the United Kingdom*, Application No. 13378/05, 29 April 2008
N. v. *UK*, Application No. 26565/05, 27 May 2008
Carson and others v. *the United Kingdom,* Application No. 42184/05, 16 March 2010
Weller v. *Hungary*, Application No. 44399/05, 31 March 2009
Soltysyak v. *Russia,* Application No. 4663/05, 10 February 2011
Yakovenko v. *Ukraine* App no. 15825/06, 25 October 2007

Sejdić and Finci v. *Bosna and Herzegovina*, Application No. 27996/06, 34836/06, 22 December 2009
Schlumpf v. *Switzerland*, Application No. 29002/06, 8 January 2009
Ilu and others v. *Turkey,* Application Nos. 29545/06, 15306/07, 30671/07, 31267/07, 21014/08, 62007/08, 7 December 2010
J.M. v. *the United Kingdom,* Application No. 37060/06, 28 September 2010
Aleksanyan v. Russia, Application no. 46468/06, 22 December 2008
Clift v. *the United Kingdom,* Application No. 7205/07, 13 July 2010
Clift ECtHR 13 July 2010, *EHRC* 2010/ 94 with annotation Gerards.
Muñoz Díaz v. *Spain*, Application No. 49151/07, 8 December 2009
Tănase v. *Moldova*, Application No. 7/08, 27 April 2010
Andrle v. *Czech Republic*, Application No. 6268/08, 17 February 2011
Savez Crkava "Riječ Života" and others v. *Croatia*, Application No. 7798/08, 9 December 2010.
Tarkoev and others v. *Estonia*, Application Nos. 14480/08, 47916/08, 4 November 2010
Zubczewski v. *Sweden*, Application No. 16149/08, 12 January 2010
Zubczewski ECtHR 12 January 2010, *EHRC* 2010/52 with annotation Brems.
Peterka v. *Czech Republic*, Application No. 21990/08, 5 May 2008
Lalmahomed v. *the Netherlands*, Application No. 26036/08, 22 February 2011
Kiyutin v. *Russia,* Application No. 2700/10, 10 March 2011

European Committee of Social Rights

Complaint No. 6/1999, *Syndicat national des Professions du tourisme* v. *France*
Complaint No. 13/2002, *Autism Europe* v. *France*
Complaint No. 14/2003, *International Federation of Human Rights Leagues (FIDH)* v. *France*
Complaint No. 15/2003, *European Roma Rights Center* v. *Greece*
Complaint No. 16/2003 *Confédération Française de l'Encadrement (CFE CGC)* v. *France*
Complaint No. 26/2004, *Syndicat de Agrégés de l'Enseignement Supérieur (SAGES)* v. *France*
Complaint No. 27/2004, *European Roma Rights Centre* v. *Italy*
Complaint No. 31/2005, *European Roma Rights Centre* v. *Bulgaria*
Complaint No. 33/2006, *International Movement ATD Fourth World* v. *France*
Complaint No. 39/2006, *European Federation of National Organisations working with the Homeless (FEANTSA)* v. *France*
Complaint No. 41/2007, *Mental Disability Advocacy Center (MDAC)* v. *Bulgaria*
Complaint No. 42/2007, *International Federation of Human Rights Leagues (IFHR)* v. *Ireland*
Complaint No. 46/2007, *European Roma Rights Centre (ERRC)* v. *Bulgaria*

European Roma Rights Centre (ERRC) v. *Bulgaria* ECSR 3 December 2008, *NJCM-Bulletin* 34 (2009) 6 with annotation of Hendriks.
European Roma Rights Centre (ERRC) v. *Bulgaria* ECSR 3 December 2008, *EHRC* 2009/92 with annotation of Henrard.
Complaint No. 49/2008, *International Centre for the Legal Protection of Human Rights (INTERIGHTS)* v. *Greece*
Complaint No. 50/2008, *Confédération Française Démocratique du Travail (CFDT)* v. *France*
Complaint No. 51/2008, *European Roma Rights Centre (ERRC)* v. *France*
Complaint No. 58/2009, *Centre on Housing Rights and Evictions (COHRE)* v. *Italy*
Complaint No. 61/2010, *European Roma Rights Centre (ERRC)* v. *Portugal*

TABLE OF TREATIES AND DECLARATIONS

United Nations Treaties and Declarations

Constitution of the World Health Organization Adopted by the International Health. Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States (*Off. Rec. Wld Hlth Org*., 2, 100), and entered into force on 7 April 1948.
Convention against Torture and other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) Adopted and opened for signature, ratification and accession by General Assembly Resolution 39/46 of 10 December 1984.
Convention concerning Discrimination in Respect of Employment and Occupation, ILO Convention 111, adopted 25 June 1358.
Convention concerning Equality of Treatment for National and Foreign Workers as regards Workmen's Compensation for Accidents, ILO Convention 19, adopted 5 June 1925.
Convention concerning Equality of Treatment of Nationals and Non-Nationals in Social Security, ILO Convention 118, adopted 28 June 1962.Convention concerning Equal Remuneration for Men and Women Workers for Work of Equal Value, ILO Convention 100, adopted 9 June 195.
Convention concerning Occupational Safety and Health and the Working Environment, ILO Convention 155, adopted 2 June 1981.
Convention concerning Maternity Protection, ILO Convention 103, adopted 28 June 1952.
Convention concerning Medical Care and Sickness Benefits, ILO Convention 130, adopted 25 June 1969.
Convention concerning Minimum Standards of Social Security, ILO Convention 102, adopted 28 June 1952.
Convention on the Elimination of Discrimination Against Women (CEDAW) Adopted and opened for signature, ratification and accession by General Assembly Resolution 34/180 of 18 December 1979.
Convention on the Elimination of Racial Discrimination (CERD) Adopted and opened for signature, ratification and accession by General Assembly Resolution 2106 (XX) of 21 December 1965.
Convention on the Rights of Persons with Disabilities (CRPD) Adopted and opened for signature, ratification and accession by General Assembly Resolution A/RES/61/106 of 13 December 2006.

Convention of the Rights of the Child (CRC) Adopted and opened for signature, ratification and accession by General Assembly Resolution 44/25 of 20 November 1989.
Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6-12 September 1978.
International Covenant on Economic, Social and Cultural Rights (ICESCR) Adopted and opened for signature, ratification and accession by General Assembly Resolution 2200 A (XXI) of 16 December 1966.
International Covenant on Civil and Political Rights (ICCPR) Adopted and opened for signature, ratification and accession by General Assembly Resolution 2200 A (XXI) of 16 December 1966.
Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights, UN doc. E/CN.4/1987/17.
Optional Protocol to the International Covenant on Economic, Social and Cultural Rights (ICESCR) adopted by the General Assembly by Resolution A/RES/63/117, 10 December 2008.
Optional Protocol to the International Covenant on Civil and Political Rights (ICCPR) adopted by the General Assembly Resolution 2200A (XXI), 21 U.N. GA OR Supp. (No.16), UN Doc. A/63161966, 999 U.N.T.S. 302, 16 December 1966.
Optional Protocol to the International Covenant on the Elimination of Discrimination against Women (CEDAW), adopted by General Assembly Resolution A/RES/54/4, 15 October 1999.
Optional Protocol to the International Covenant on the Rights of Persons with Disabilities (CRPD), adopted by General Assembly Resolution A/RES/61/106, 13 December 2006.
Maastricht Guidelines on Violations of Economic, Social and Cultural Rights, January 22-26 1997.
Universal Declaration of Human Rights (UDHR) Adopted and proclaimed by General Assembly Resolution 217 A (III) of 10 December 1948.

Council of Europe Treaties and Declarations

Additional Protocol to the European Social Charter, Strasbourg 5 May 1988, E.T.S. 128.
Convention for the protection of human rights and Dignity of the Human Being with regard to the Application of Biology and Medicine, Oviedo, 4.IV.1997 (DIR/JUR (96) 14), E.T.S. 164.
European Convention for the Protection of Human Rights and Fundamental Freedoms, 4 November 1950, entry into force: 3 September 1953, E.T.S. 005.
European Convention on Social and Medical assistance and protocol thereto, 11 December 1953, E.T.S. 14.
European Code of Social Security, adopted 16 April 1964, E.T.S. 048.

European Social Charter (ESC), 18 October 1961, entry into force: 26 February 1965, E.T.S. 35.
European Social Charter (Revised) (RESC) 3 May 1996, entry into force: 1 July 1999, E.T.S. 163.
Protocol to the Convention for the Protection of Human Rights and Fundamental Freedoms as amended by Protocol No. 11, 20 March 1952, E.T.S. 155.
The Brussels Convention on the Establishment of Maternal Affiliation of Natural Children and the European Convention on the Legal Status of Children born in or out of Wedlock, 15 October 1975, E.T.S. 085.

UNITED NATIONS DOCUMENTS

Concluding Observations Committee on Economic, Social and Cultural Rights

Azerbaijan, E/C.12/1/Add.104, 26 November 2004
Albania, E/C.12/ALB/CO/1, 22 November 2006
Angola, E/C.12/AGO/CO/3, 20 November 2008
Australia, E/C.12/AUS/CO/4, 20 May 2009
Azerbaijan, E/C.12/1/Add.104, 26 November 2004
Belgium, E/C.12/BEL/CO/3, 21 November 2007
Benin, E/C.12/BEN/CO/2, 16 May 2008
Bolivia, E/C.12/BOL/CO/2, 16 May 2008
Brazil, E/C.12/1/Add.87, 23 May 2003
Brazil, E/C.12/BRA/CO/2, 29 May 2009
Chile, E/C.12/1/Add.105, 26 November 2004
China, E/C.12/1/Add.107, 13 May 2005
Cyprus, E/C.12/CYP/CO/5, 18 May 2005
Cambodia E/C.12/KHM/CO/1, 20 May 2009
Democratic Republic of Congo, E/C.12/COD/Q/5, 17 November 2009
Ecuador, E/C.12/1/Add.100, 14 May 2004
El Salvador, E/C.12/SLV/CO/2, 21 November 2006
France, E/C.12/1/Add.72, 23 November 2001
France, E/C.12/FRA/CO/3, 16 May 2008
Greece, E/C.12/1/Add.97, 14 May 2004
Hungary, E/C.12/HUN/CO/3, 15 May 2007
India, E/C.12/IND/CO/5, 16 May 2008
Italy, E/C.12/1/Add.103, 26 November 2004
Kenya, E/C.12/KEN/CO/1, 19 November 2008
Kuwait, E/C.12/1/Add.98, 14 May 2004
Latvia, E/C.12/LVA/CO/1, 15 May 2007
Madagasgar, E/C.12/MDG/CO/2, 19 November 2009
Malta, E/C.12/1/Add.101, 26 November 2004
Monaco, E/C.12/MCO/CO/1, 19 May 2006
Nepal, E/C.12/NPL/CO/2, 16 May 2007
Nicaragua, E/C.12/NIC/CO/4, 20 November 2008
Norway, E/C.12/1/Add.109, 13 May 2005
Serbia and Montenegro, E/C.12/1/Add.108, 18 November 2008

Slovenia, E/C.12/SVN/CO/1, 25 November 2005
Tajikistan, E/C.12/TJK/CO/1, 23 November 2006
The former Yugoslav republic of Macedonia, E/C.12/MKD/CO/1, 22 November 2006
The Netherlands, E/C.12/NLD/CO/3, 17 November 2006
The United Kingdom, E/C.12/GBR/CO/5, 22 May 2009
Ukraine, E/C.12/UKR/CO/5, 20 November 2007
Uzbekistan, E/C.12/UZB/CO/1, 25 November 2005
Philippines, E/C.12/PHL/CO/4, 21 November 2008
Republic of Korea, E/C.12/KOR/CO/3, 29 November 2009
Zambia, E/C.12/1/Add.106, 3 May 2005

Economic and Social Council

UN Standard Minimum Rules for the Treatment of Prisoners, Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its Resolutions 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977.
Resolution 1985/17 of 28 May 1985, *Review of the composition, organization and administrative arrangements of the Sessional Working Group of Governmental Experts on the Implementation of the International Covenant on Economic, Social and Cultural Rights.*
E./C12/2008/2, 24 March 2009, *Guidelines on treaty-specific documents to be submitted by State parties under articles 16 and 17 of the international covenant on economic, social and cultural rights.*

Human Rights Council

E/C.12/2007/1, 10 May 2007, *An evaluation of the obligations to take steps to the "maximum of available resources" under an Optional Protocol to the Covenant.*

General Assembly

UN General Assembly Resolution 32/130, "Alternative approaches and ways and means within the UN system for improving the effective enjoyment of human rights and fundamental freedoms" (16 December 1977).
Body *of Principles for the Protection of All Persons under Any Form of Detention of Imprisonment*, Adopted by General Assembly Resolution 43/173 of 9 December 1988.
UN General Assembly Resolution 44/130, "Indivisibility and interdependence of economic, social, cultural, civil and political rights" (15 December 1989).

UN General Assembly Resolution 45/135, "International Covenants on Human Rights" (14 December 1990).
General Assembly marks 60 years of universal human rights declaration by adopting its own, pledging to enhance dialogue among peoples, General Assembly GA/10795, press release 10 December 2008.

General Comments Committee on Economic, Social and Cultural Rights

E/1991/23, General Comment 3 (1990), 14 December 1990, *The nature of State parties obligations*.
E/C.12/1995/5, General Comment 12 (1995), 12 May 1999, *The right to food.*
E/C.12/1999/10, General Comment 13 (1999), 8 December 1999, *The right to education*.
E/C.12/2000/4, General Comment 14 (2000), 11 May 2000, *The Right to the Highest Attainable Standard of Health*.
E/C.12/2002/11, General Comment 15 (2002), 20 January 2003, *The right to water*.
E/C.12/GC/20, General Comment 20 (2009), 2 July 2009, *Non-discrimination in economic, social and cultural rights.*

General Comments Human Rights Committee

A/37/40, General Comment 6 (1982), 30 April 1982, *Right to life*.
A/37/40, General Comment 7 (1982), 30 May 1982, *Torture or cruel, inhuman or degrading treatment or punishment*.
A/45/40, General Comment No. 18 (1989), 10 November 1989, *Non-discrimination.*
A/47/40, General Comment No. 20 (1992), 10 March 1992, *Prohibition of torture and cruel inhuman treatment.*

OHCHR

HRI/MC/2006/3, 10 May 2006, *Harmonized guidelines on reporting under the international human rights treaties, including guidelines on a common core document and treaty-specific document.*
HRI/GEN/2/Rev.5, 29 May 2008, *Compilation of Guidelines on the Form and Content of Reports to be submitted by State parties to the International Human Rights Treaties.*

State Reports submitted to the Committee on Economic, Social and Cultural Rights

State report of the Netherlands submitted to the Committee on Economic, Social and Cultural Rights, E/1994/104/Add.30, 23 August 2005.

Reports Special Rapporteurs

E/CN.4/2004/49, 16 February 2004, *The right of everyone to the enjoyment of the highest attainable standard of physical and mental health Report of the Special Rapporteur, Paul Hunt.*
E/CN.4/2005/51, 11 February 2005, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt*.
E/CN.4/2003/58, 13 February 2003 *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Paul Hunt.*
A/66/254, 3 August 2011, *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health, Anand Grover.*

World Conferences

World Health Organization, *Primary Health Care: Report of the International Conference on Primary Health Care,* Alma-Ata, USSR, 6-12 September 1978, Health For All Series No. 1, 1978, Chapter 3, para. 50.
Report of the International Conference on Population and Development, Cairo, 5-13 September 1994, A/CONF.171/13: Report of the ICPD (94/10/18).

COUNCIL OF EUROPE DOCUMENTS

Committee of Ministers

Form for reports to be submitted in pursuance of the 1961 European Social Charter and the 1988 Additional Protocol, 26 March 2008.
Recommendation No. R (92) 6, 'Acoherent policy for people with disabilities, 9 April 1992.
Recommendation No. R (99)21, 'Ccriteria for the management of waiting lists and waiting times in health care', September 1999.
RecChs(2001)1 on Collective Complaint No. 6/1999 *Syndicat national des Professions du tourisme* v. *France*, 31 January 2001.

Conclusions of the European Committee of Social Rights

Under the ESC
XV-2 Belgium, 2001
XIX-2 Croatia, 2009
XIX-2 Czech Republic, 2009
XVII-2 Denmark, 2005
XIX-2 Germany, 2009
XVII-2 Latvia, 2005
XVIII-2 Latvia, 2007
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Ireland (2007)
Italy (2003)
Italy (2007)
Italy (2009)
Lithuania (2009)
Romania (2009)
Turkey (2005)
Turkey (2009)

Explanatory Reports

Explanatory Report to the Convention for the protection of Human Rights and dignity of the human being with regard to the application of biology and medicine (Convention on Human Rights and Biomedicine), 1 December 2009, E.T.S. No. 164.
Explanatory Report to Protocol No. 12 Convention for the Protection of Human Rights and Fundamental Freedoms, 4 June 2000, E.T.S. No. 177.
Explanatory Report to the Protocol No. 14 to the Convention for the Protection of Human Rights and Fundamental Freedoms, Amending the control system of the Convention, 12 May 2009, C.E.T.S. No. 194.

Parliamentary Assembly

Recommendation 1626 (2003), 'Reform of health care systems in Europe: reconciling equity, quality and efficiency', 1 October 2003.
Recommendation 1503(2001), 'Health conditions of migrants and refugees in Europe', 14 March 2001.
Recommendations 1470 (2000) and 1474 (2000), 'Situation of gays and lesbians and their partners in respect of asylum and immigration in the member states of the Council of Europe' 30 June 2000.

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