The right to health : a human rights perspective with a case study on Greece

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1 General Introduction

1.1. BACKGROUND AND PROBLEM

Regardless of age, gender, legal status, socio-economic or ethnic background, health is a significant aspect of the human condition. Health together with social determinants (e.g., adequate living conditions, housing etc.) provides the foundations for an individual leading a decent life. Illuminating is the argument that '… ill health is both a cause and a consequence of poverty: sick people are more likely to become poor and the poor are more vulnerable to disease and disability… Good health is central to creating and sustaining the capabilities that poor people need to escape from poverty. A key asset of the poor, good health contributes to their greater economic security. Good health is not just an outcome of development: it is a way of achieving development…'.[1] Thereby, the formulation of health as a right is an essential element for ensuring the human well-being and for living a life in dignity.[2]

Seven decades since its initial recognition in the preamble to the Constitution of the World Health Organization (henceforth: WHO), the definition of health as a right has gained growing supremacy at the international level, despite the absence of consensus on its existence as a legally binding right, its normative content and its implementation in practice.[3] In 1946, the WHO was the first international

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1 UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt. UN ESCOR, Commission on Human Rights, 59th Sess., Agenda Item 10*, UN Doc. E/CN.4/2003/58, 13 February 2003, §§ 45-46.

2 See, e.g., UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Anand Grover, UN GA, 69th Sess., Agenda Item 69 (b),* UN Doc. A/69/299, 11 August 2014, §§ 71 & seq.

3 As regards views that embrace the right to health and its particular aspects, see, e.g., P. Hunt & G. Backman, 'Health Systems and the Right to the Highest Attainable Standard of Health'

organization that stressed that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'.[4] Since then, the right to health is firmly enshrined in international law.[5] In fact, health as a right has been reiterated in numerous legally binding international and regional human rights treaties as well as in national constitutions worldwide (see chapter 2). Most of these human rights treaty provisions define State obligations concerning a wide range of health-related issues, *inter alia* health care, reproductive health, child health, environmental health and occupational health (see chapter 2). Meanwhile, the recognition of health as a right represents a significant step in protecting people's health and well-being and is indispensable for the exercise of other human rights.[6] Indeed, it is acknowledged that the increasing significance of health as a right is partly due to its connection to other human rights, as it is often dealt with by adjudicatory bodies *via* civil and political rights (e.g., the right to life).[7] Nonetheless, to the extent that the right to health constitutes itself a basis for lodging claims, courts or other (quasi)-judicial bodies affirm that States are required to ensure a minimum level of health protection, (equal access to) essential health care and satisfaction of basic human needs.[8]

Yet, despite the growing international recognition of health as a right, in practice the issue of how this right will be effectively realized by States is still a

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Health and Human Rights 2008, Volume 10 (1), pp. 81-92, pp. 84-85 (core obligations); D. Bilchitz, *Poverty and Fundamental Rights: The Justification and Enforcement of Socio-Economic Rights*, Oxford: Oxford University Press 2007, pp. 223-224 (minimum core of socio-economic rights); As regards views that are critical of the right to health and its particular aspects, see, e.g., T. Goodman, 'Is there a Right to Health?' *Journal of Medicine and Philosophy* 2005, 30(3), pp. 643-662; K.G. Young, 'The Minimum Core of Economic and Social Rights: A Concept in Search of Content' *The Yale Journal of International Law* 2008, volume 33, pp. 113-175; Note also that 'skepticism' as to the meaning, elements and practice (e.g., universality) exist for all human rights, see, e.g., Ch. R. Beitz, *The Idea of Human Rights*, Oxford: Oxford University Press 2009, pp. 2-7.

4 WHO Constitution adopted by the International Conference - New York 1946, preamble.

5 UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Paul Hunt, UN ESCOR, Commission on Human Rights, 60th Sess., Agenda Item 10*, UN Doc. E/CN.4/2004/49/Add.1, 1 March 2004, § 15.

6 UN CESCR, *General Comment No. 14: The Right to the Highest Attainable Standard of Health*, UN Doc. E/C.12/2000/4, 11 August 2000, § 1.

7 See, e.g., A. Hendriks, 'The Right to Health in National and International Jurisprudence', *European Journal of Health Law* 1998, Volume 5, pp. 389-408, p. 402.

8 Ibid., p. 403.

challenge.[9] In fact, in 2012 about 18,000 children died each day from diseases that were to a large degree preventable and curable.[10] The realization process implies action mainly on the part of States, as being primary duty holders under human rights law, to translate commitments into decisions with a view to defining, determining and having a positive impact on people's well-being.[11] In essence, the recognition of health as a right at the national level establishes a primary and ultimate responsibility for the State in ensuring access to health care and the preconditions of health for every individual within its jurisdiction.

At the same time, the effective realization of the right to health on the part of States by way of translation of human rights law into compatible national law and operational health-related policies and practices, remains a tough issue. The implementation of stringent economic policies imposed by international financial organizations, such as the International Monetary Fund (henceforth: IMF), leaves no space for national decisions for effective realization of the right to health of all individuals and especially of those who are marginalised and disadvantaged, as the health and human rights perspective is largely absent in such policies.[12] Indeed, the policies of the IMF, for instance, which *inter alia* strengthen privatization,

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9 See, e.g., UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Anand Grover, UN GA*, 66th Sess., Agenda Item 69(b), UN Doc. A/66/254, 3 August 2011; Ibidem supra note 6, UN CESCR, § 5; CSDH, *Closing the gap in a generation: Health equity through action on social determinants of health. Final Report of the Commission on Social Determinants of Health*, Geneva: WHO 2008.

10 World Health Organization, *World Health Statistics 2014*, Geneva: WHO, p. 13.

11 Ibidem supra note 3, Ch. R. Beitz 2009, p. 114; See, Convention on the Rights of the Child (CRC) (New York, 20 November 1989, entered into force 2 September 1990, 1577 UNTS 3) Article 2(1): 'States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction…'; Economic and Social Council, *Report of the High Commissioner for Human Rights on implementation of economic, social and cultural rights,* UN DOC. E/2009/90, 8 June 2009, § 34; Ibidem supra note 6, GC No. 14.

12 Working group on IMF programs, *Does the IMF constrain health spending in poor countries? Evidence and an agenda for action*, Washington, D.C.: Center for Global Development and Health Spending, June 2007; Regarding concerns about privatization in health sector, see, e.g., S. Gruskin & D. Tarantola, 'Health and Human Rights' in: R. Detels, J. McEwen, R. Beaglehole & H. Tanaka (eds), *The Oxford Textbook of Public Health*, 4th ed. Oxford: Oxford University Press 2002, pp. 311-335; See generally, M. Darrow, *Between Light and Shadow: The World Bank, the International Monetary Fund and International Human Rights Law*, Portland/Oxford: Hart Publishing 2003, p. 53 (Chapter III - the Importance of the Question: Comments on the Human Rights Impacts of the IFIs' Policies and Activities); P. O'Connell, 'The Human Right to Health in Age of Market Hegemony in: J. Harrington & M. Stuttaford

often result in the further impoverishment of poor and marginalised people; and in the widening of health inequalities within and between countries (see Part II), by increasing the well-being of some people while having severe impacts on other people's health due to the non-fulfillment of their pressing health needs.[13] On this issue, at the World Summit for Social Development, it was pointedly noted that external debts have crippled the social efforts of middle-income countries[14] in a way that increased constraints, including fiscal and political ones on States, have resulted in a reduction of the programmes and activities of these States.[15] Particularly, in some countries, the principle of universal free provision of services, involving health care, education and water supply, has been replaced by user fees and privatization.[16] As such, serious impediments to social development, several of which were identified by the Summit, still persist, such as chronic hunger, malnutrition, endemic, communicable and chronic diseases.[17]

In light of the above, we should move the discussion beyond the international formulation and dimension of the right to health and look more specifically at the definition and implementation of this right at a national level. Thereto, we need to consider and evaluate the normative content of the right to health in view of national realities and challenges (i.e., to assess the status of this right in a national context), such as poverty, privatization, embedded inequalities etc. The challenge then is to learn more about how these standards are to be operationalised in a particular national context and what role, if any, these standards can play in policy making in order to secure the right of everyone to the highest attainable standard of health. Within this overall setting, this study aims at identifying the standards in human rights law for realizing the right to health on the part of the State and how a particular country, Greece, has given effect (or not) to the right to health framework in light of its own reality and specific conditions (e.g., resource constraints, economic austerity, health sector privatization, corruption and vulnerable groups). The advancement of the realization of the right to health will be benefited from the

(ed.), *Global Health and Human Rights: Legal and Philosophical Perspectives*, London: Routledge 2010, pp. 190-209.

13 Ibid. Note that 'health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups' (WHO definition <www.who.int/hia/about/glos>)

14 UN, *Resolution adopted by the General Assembly - S-24/2. Further initiatives for social development*, UN Doc. A/RES/S-24/2, 15 December 2000, § 41.

15 Ibid., § 42.

16 Ibid., § 36.

17 Ibid., p. 5, § 3.

attention at national level. Specifically, such an approach will help us acquire a greater understanding of the content of the right to health in practice with the ultimate aim of securing the right of everyone to the highest attainable standard of health. At the same time, the discussion of the Greek experience can assist in identifying possible 'implementation gaps'[18] and opportunities in this area and as such, it can contribute to the emerging dialogue on best-practices and shortcomings in relation to the understanding and the operationalisation of the right to health framework among different countries worldwide.[19]

Note by way of background that Greece is located at the south-east of Europe, at the southern end of the Balkan Peninsula and covers an area of 131,957 sq. km, of which 80 percent is mountainous.[20] The population of the country in 2014 was approximately 10,992,589 million, representing 2.2% of the total EU population.[21] Life expectancy at birth in Greece was at 80.7 years in 2012, half a year higher than the OECD average (80.2 years).[22] Nevertheless, life expectancy in Greece remains lower than that in several other EU countries (such as Italy, Spain and France), where life expectancy exceeds 82 years.[23] Greece is a unitary State and its political system is parliamentary republic, established by the 1975 Constitution (in Greek: Syntagma, henceforth: the Constitution), which is the supreme national law and has been amended three times since its adoption.[24] Importantly, the Constitution provides for the principle of separation of powers under its Article 26

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18 UN, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health: Report of the Special Rapporteur, Dainius Pūras, UN HRC, 29th Sess., Agenda Item 3,* UN Doc. A/HRC/29/33, 2 April 2015, § 40; Another reason to opt for Greece has been of course that the author has easy access to Greek legal system.

19 See generally, e.g., B. Toebes, R. Ferguson, M. Markovic & O. Nnamuchi, *The Right to Health - A Multi-Country Study of Law, Policy and Practice*, The Hague: T.M.C. Asser press/Springer 2014; C.M. Flood & A. Gross, *The Right to Health at the Public/Private Divide: A Global Comparative Study*, Cambridge: Cambridge University Press 2014.

20 Available at <http://europa.eu/about-eu/countries/member-countries/greece/index_en.htm>

21 Ibid.

22 Organization for Economic Cooperation and Development, *OECD Health Statistics 2014*, Paris: OECD <www.oecd.org/health/healthdata>.

23 Ibid.

24 Article 1 § 1 of the Constitution of Greece (1975-1986-2001-2008), as revised by the parliamentary resolution of 27 May 2008 of the VIIIth Revisionary Parliament and published in the *Official Government Gazette* - ΦΕΚ issue A′ 120/27-06-2008. The texts of the Constitution of Greece are the Official translation of the Hellenic Parliament available at <www.hellenicparliament.gr>; For an elaborate analysis of the Greece's constitutional history see, K.G. Mavrias & A.M. Pantelis, *Constitutional texts- Greek and Foreign*, Athens - Komotini: Ant. N. Sakkoulas 1981, pp. 7-219.

placed in the section entitled 'Structure of the State'.[25] Accordingly, the legislative powers shall be exercised by the Parliament and the President of the Republic.[26] The executive powers shall be exercised by the President of the Republic and the Government.[27] Lastly, the judicial powers shall be exercised by Courts of Law which are distinguished into administrative, civil and criminal Courts (Art. 93 § 1 of the Greek Constitution) and are organized in three levels of hierarchy (i.e., in three instances): i) the Supreme Courts, which are the highest courts in Greece and encompass the Supreme Civil and Criminal Court (in Greek: Areios Pagos), the Council of State (Supreme Administrative Court, in Greek: Symvoulio tis Epikrateias, StE), the Court of Audit (in Greek: Elegktiko Synedrio), the Supreme Special Court (in Greek: Anotato Eidiko Dikastirio), ii) the Courts of Appeals (higher and appellate Courts) and iii) the Courts of First Instance (lower Courts).[28] Meanwhile, for the purposes of our study it is essential to note that in the section entitled 'Structure of the State' it is also provided that after ratification by statute international treaties as a whole become part of the national legal order and prevail over any contrary provision of the law in Greece.[29] Hence, Greece has a clear constitutional provision stipulating the applicability and status of international treaties *vis-à-vis* national law. International treaties have no direct validity in national law until they are incorporated into the national legal system. As regards the European perspective of Greece, since 1975 Greece actively participates in the European integration process on the basis of Article 28 §§ 2 and 3 of the Constitution within the context of limiting its national sovereignty. Since 1 January 1981, Greece is an EU member State, thereby constituting one of the frontier States of the EU.[30]

Economically speaking, since 2010 Greece is experiencing a severe financial crisis owed to a large budgetary deficit and for that reason has been undergoing major economic restructuring.[31] Being confronted with this hardly manageable

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[25] Ibid.

[26] The legislative procedure involving the Parliament is set out in Articles 70-80 of the Constitution and the President of the Republic in Article 42 of the Constitution.

[27] Of note, legislative and executive powers are interdependent in virtue of Article 26 of the Constitution which provides that both powers shall be exercised by the President of the Republic.

[28] The functioning (organization and jurisdiction) of the judicial power is elucidated in Section V of the Constitution, namely in Articles 87-100A of the Constitution.

[29] Article 28 § 1 of the Constitution.

[30] Greece signed its Treaty of Accession to the EU in 1979 and ratified the EC treaties by Law 945/1979 (*Official Government Gazette* - ΦΕΚ issue Α′ 170/27-07-1979) with a large majority (3/5 of the total number of the members of Parliament) required under Article 28 § 2 of the Constitution.

[31] European Commission, *The Economic Adjustment Programme for Greece,* European

situation, in May 2010 Greece signed a three-year agreement (2010 - June 2013), being renewed in March 2012 for another two years (2012-2014, later extended to the end of June 2015), with a tripartite committee, consisting of the International Monetary Fund, the European Commission and the European Central Bank in order to regain its financial stability (collectively also known as the 'Troika').[32] This agreement is known as the 'Memorandum of Understanding'[33] (MoU) and introduces gradually a variety of austerity measures. Particularly, the implementation of the MoU has significant financial implications on several areas of public services, including the area of health in Greece. One of the most significant measures taken involves the reform of the national health system. Since the signing of the MoU between the Greek State and the tripartite committee, the health sector has been undergoing several changes, primarily including the curtailing of public health expenses and the merger of the public health sector. As regards the costs, in 2012 total health care expenditure in Greece corresponded to 9.3 % of the GDP, equal to the OECD average and lower than that in several other EU countries, such as the Netherlands, Germany and France.[34] As regards the type of funding of health care, in 2012 67% of health expenditure in Greece was funded by public sources, which is below the average of 72% in OECD countries and remains lower than that in a number of EU countries, such as the Netherlands, Germany, Austria and France.[35] Health spending in Greece has reduced in each of the years since the emergence of the economic crisis, especially in both 2010 and 2012 fell by 25% from the level

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Economy - occasional papers No. 61, Brussels: European Commission May 2010; European Commission, *The Second Economic Adjustment Programme for Greece,* European Economy - occasional papers No. 94, Brussels: European Commission March 2012.

32 Ibid.; Note also that given the continuing financial crisis in Greece on 19 August 2015 a third MoU- agreement was signed between Greece and the European Commission acting on behalf of the European Stability Mechanism (ESM), which covers a 3-year period, namely from August 2015 until August 2018 (see, European Commission, *The Third Economic Adjustment Programme for Greece*, Brussels: European Commission August 2015).

33 For a definition on the nature of the MoU, see, e.g., A. Aust, *Handbook of International Law* (2nd ed.), Cambridge: Cambridge University Press 2010, pp. 53-55. Accordingly, the MoU embodies a bilateral or multilateral (operational) agreement which expresses an intended common line of action in most areas of international relations (i.e. trade, aid, defence, finance etc.) between the signatory parties (States and/or international organizations). The MoU often comes into effect on signature, although the legal consequences depend on the circumstances and the terms of each MoU.

34 Ibidem supra note 22.

35 Ibid.

in 2008.[36] In light of the above statistics, it becomes obvious that the total health care expenditure in Greece reaches the OECD average as the Greek citizens pay a relatively high percentage of their income on health compared to citizens of other EU countries, such as the Netherlands and France.[37] Nevertheless, such developments primarily from 2010 onwards concerning the area of health in Greece raise issues of great concern related to health inequalities among the population.[38]

1.2. RESEARCH OBJECTIVES, QUESTIONS AND OUTLINE

This study is directed at discussing the internationally guaranteed right to health mainly from the angle of States obligations and specifically as it occurs within an existing state practice (i.e., the state practice of Greece) in order to bring the highest attainable standard of health closer to reality. The main questions that will be analyzed in this thesis are:

(a) What primary standards derive from the right to health on the basis of human rights law?
(b) Is the right to health being (effectively) implemented in Greece (or not)?

For this reason the present study is organized in two main parts (i.e., Part I & Part II), each dealing with separate research questions and consisting of various chapters. But first, in this introductory chapter, the problem statement and research questions of the study are addressed. Subsequently, in Part I, chapter 2, chapter 3 and chapter 4 are dedicated to analyze the right to health framework, primarily by exploring the normative content of the right to the highest attainable standard of health in human rights law and its implications for the States. In particular, chapter 2 embarks on the task of developing a meaning of the right to health by focusing on*:* 'How is health defined as a right in human rights law in terms of clarifying the ensuing state obligations for its effective realization?' At the core of chapter 2 lies the formulation of health as a right at the international, regional and national level. The discussion of the various documents at the international, regional and national level will offer an insight into the definition of health as a right and the duties of the State, as primary duty holder, to take measures for its effective realization within its jurisdiction. Notably, the provisions enshrining the right to health are primarily directed at the State parties to the various human rights

[36] Ibid.
[37] Ibid.
[38] For concerns on health inequalities in Greece expressed by human rights bodies, see, e.g., UN CESCR, CO: Greece, UN Doc. E/C.12/GRC/CO/2, 27 October 2015, §§ 7-8.

instruments and its recognition represents a step in strengthening its enjoyment by every individual. As such, despite the several conflicting views on its nature and various aspects, the internationally guaranteed right to health obligates States to create favorable conditions for the achievement and maintenance of the highest attainable level of health of all human beings. Ultimately, it will be argued that the right to health can be enforced by other rights that address integral components of this right. Thus, the human rights framework providing for the right to health as well as the connection between the right to health and other human rights will be set out in chapter 2.

Subsequently, chapter 3 will answer the question: 'what standards can be identified from the interpretation of the content of the right to health for its effective realization on the part of the State?' Importantly, understanding the content of the right to health imparts an understanding of what steps -implementation measures- are required primarily on the part of the State in order to realize the right to health at a country level. The task of establishing a normative account of the right to health undertaken in chapters 2 and 3 will be supplemented by the analysis followed in chapter 4. Chapter 4 will focus on the realization process of this right on the part of the State primarily on the basis of the work of human rights bodies, by answering the question: 'How are the standards derived from the interpretation of the normative framework of the right to health concerning respective State's obligations informed by the work of human rights bodies?' Chapter 4 shall explore a number of parameters placed around the realization process of the right to health on the part of the State. Focus will be placed on access to health care as a way to achieve the right to health, although, where relevant, reference to the underlying determinants of health will be made. Given the broad range of issues that can potentially be addressed, the study will limit itself to a selection of topics. Therefore, attention is paid to the work of three international monitoring bodies by examining respective reports, of one regional body by exploring the justiciability of the right to health with a focus on Europe as well as to the implications of international co-operation, as a means for ensuring the right to health. The work of these bodies -albeit abstract and haphazard at times- can provide an account of how the right to health framework can be operationalised at national level, namely how this framework can shape the state measures for realizing the right to health for every individual within a State's jurisdiction.

Note that the State is the primary focus of international law when it comes to enforcement and responsibility.[39] This means that the realization of the right to

[39] Ibidem supra note 11.

health is dependent upon each State's commitment to create favorable conditions in line with its capacity (i.e., available resources, budget allocation), cultural values and its translation into operational health policies, programmes and other health-related interventions. Building on the analysis of chapters 2, 3 and 4 of Part I, the next step is to learn about how this norm is operationalised (or not) at a country level in view of particular challenges (i.e., involving economic austerity, health sector privatization and corruption, vulnerable groups etc.). Generally, Part II, consisting of chapters 5, 6, 7 and 8, discusses the right to health within a specific situation. This will be achieved by finding out to what extent Greece recognizes the existence of a right to health and what measures Greece has taken (or not) to ensure its effective realization within its jurisdiction. The research questions here are: 'Does Greece have a commitment to health and is Greece bound by a right to health under international law? If so, (how) has Greece given effect to its binding right to health obligations for securing the health of the population as a whole? Whether the Greek State can afford to accomplish its international commitments? Are certain population groups in Greece being left out and, if so, to what extent?'

Specifically, in chapter 5, the extent to which there is a sense of state responsibility towards the right to health of every individual in the Constitution of Greece (i.e., a State's commitment) will be explored. Additionally, in the subsequent chapters, we will discuss whether this goal (i.e. the State's commitment), with emphasis on particular research topics, has been achieved and if so, we will elucidate its nature within the national context. Note that these research topics are of specific relevance to the country in question and constitute enduring concerns of respective human rights bodies. Thereby, in chapter 6, attention is paid to the advancement of the population's health as a whole in terms of the State's obligation to provide for a health infrastructure (i.e., a National Health System) under the 'AAAQ' requirements, a significant component of the internationally guaranteed right to health.

Subsequently, in chapters 7 and 8 we will go one step further and examine certain vulnerable population groups, namely undocumented (or in an irregular situation/non-documented) migrants and Roma children, whose particular situation is identified and is noted with concern by respective human rights bodies in their reports addressed to Greece. Note that both population groups face primarily a double vulnerability: undocumented migrants as migrants and as persons in an irregular situation; and Roma children as children (i.e., below the age of 18) and as persons belonging to an ethnic minority (i.e., Roma). Specifically, in the respective chapters the position of these groups in Greece in relation to their right to health and access to health care will be discussed. By going through this analysis, Greece's compliance with its respective binding international obligations will be examined.

Finally, chapter 9 will sum up the main findings of the present study and draw a conclusion concerning the prospects for enhanced operationalisation and effective realization of the right to health at the national level. Last but not least, this study is supplemented by two annexes (i.e., Annex 1 & Annex 2) which require a note of explanation. Particularly, Annex 1 in addition to the right to health identifies many other human rights that are significant and connected to health. Moreover, Annex 2 consists of a table involving the ratification of relevant for the case study human rights documents that include a right to health as well as their integration in the respective domestic legal order.

1.3. METHODOLOGY

Part I contains a legal analysis of the relevant international and regional legal documents on health as a right as well as relevant scientific literature. This part of the study is mainly based on official documents of human rights bodies at the UN level and at the regional level (primarily at the European level), on a literature research and a case-law analysis. These sources tend to provide further clarification on the content and realization process of the right to health, namely determine what steps are required on the part of the State to effectively realize the right to health of individuals within its jurisdiction. In particular, Part I is based on a discussion of the relevant legal sources (i.e., treaties, conventions, national constitutional law etc.), documents of UN human rights and European monitoring bodies (i.e., General Comments, Concluding Observations on the Country Reports, Conclusions of the European Committee of Social Rights and Reports etc.) and other sources, including UN Conferences, which provide standards and useful interpretation material for the right to health, primarily the state obligations arising from it. At this point, it is worth bearing in mind that all relevant sources, examined in Part I, are not of equal legal status. Strictly speaking, this means that a treaty carries superior legal weight compared to General Comments and/or documents containing Concluding Observations (i.e., treaty bodies' interpretations and views which do not have binding legal authority *per se* - see sections 2.2.4 & 4.2). In addition, it is important to acknowledge that the scope and legal status of a legal source, for example of a treaty, remains limited when ratifications to this source are scarce (e.g., MWC). On the contrary, when a legal source (treaty) has been ratified by the majority of the countries worldwide (e.g., ICESCR and CRC) this is reflective of the broader recognition of its status and of the great extent of its legal weight (see chapter 2). Clearly, all sources, elaborated in Part I for the interpretation of the various formulations of the right to health and its realization process do not bear the same legal weight.

Understandably, the methodology applied in Part I highly reflects the treaty interpretation methods as laid down in Articles 31 (*'general rule of interpretation'*) and 32 (*'supplementary means of interpretation'* particularly the *travaux préparatoires*) of the Vienna Convention on the Law of Treaties.[40] Indeed, pursuant to Article 31 (1) of the Convention 'a treaty shall be interpreted in good faith in accordance with the ordinary meaning to be given to the terms of the treaty in their context and in the light of its object and purpose'.[41] In fact, in addition to the text of the treaty, Article 31(2) determines that the 'context' shall include its preamble and annexes, any agreement made between all the parties in connection with the treaty and any instrument made by one or more parties and accepted by the other parties as an instrument related to the treaty.[42] Together with the context, Article 31(3) establishes that any subsequent agreement between the parties regarding the interpretation of the treaty, any subsequent practice in the application of the treaty which establishes the agreement of the parties regarding its interpretation as well as any relevant rules of international law must also be taken into account.[43]

At the same time, the methodology applied in Part II includes literature research, a study of existing national law, policy and case-law analysis. Moreover, for the purpose of the study of the state practice, that stands central to this part of the study (i.e., Greece's practice), thorough research has been conducted based on existing reports of the WHO, UNICEF, OECD, Frontex, European Union Agency for Fundamental Rights, NGOs (e.g., ERRC, MdM, MSF) etc. An analysis of the extent of harmonization of national law-policy in Greece with international and European standards is included, on the basis of official national texts of laws and policies (e.g., official records of Greek parliament's sessions, reports of the Greek Ombudsman, Ministerial Decisions etc.).

All in all, the sources of information on which this study is based were acquired by means of extensive and detailed (library and digital) research. All but the sources concerning national law-policy are in the English language. This research covers the period between (July) 2010 and (June) 2015 which has been used as a cut-off

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40 Vienna Convention on the Law of Treaties, Vienna 23 May 1969, entry into force 27 January 1980, 1155 UNTS 331. Note also that Vienna Convention generally reflects customary international law (See, e.g., M.C.R. Craven, *The International Covenant on Economic, Social and Cultural Rights: A Perspective on its Development*, Oxford: Oxford University Press 1995, p. 3).

41 Ibid.

42 Ibid.

43 Ibid.

date for considering sources of information; nevertheless, later relevant notable developments have been occasionally included.

Finally, given that the meaning and normative content of the internationally guaranteed right to health are further elucidated (see Part I), I hope that confining Part II to a particular state practice (i.e., the practice of Greece) will help the study gain in depth on how this norm is to be implemented on the part of a State in view of a particular national reality (e.g., economic austerity, health sector privatization and corruption, vulnerable groups and embedded inequalities etc.). Note that, despite the challenge of difference between countries (e.g. size and economic development etc.), the outcomes of the present study on themes many of which exist (to some extent) in every country[44] by facing similar problems may help to formulate, review or fully replace national health policies, laws and focus efforts with the ultimate objective the effective realization of the right to health on the part of States (i.e., positive impacts on the health and well-being of all individuals over the world).

1.4. TERMINOLOGY

As stated previously, this study deals with the formulation of health as a right in human rights law and its operationalisation at the national level through the examination of national laws and implementation measures of a certain country, Greece. Accordingly, this study uses the term 'right to health', as its use may be more appropriate and therefore potentially useful when it comes to define health as a right due to its multi dimension, even though in literature there is little consensus on the terminology of this right (see Part I, chapter 3).[45] Importantly, the term 'right to health' embraces the following dimensions: access to health care and underlying determinants of health, such as access to clean drinking water and food, adequate housing and living conditions, health promotion as well as specific state responsibilities to secure the health of individuals. Notably, this term reflects the broad notion of health as a right found in the WHO Constitution as well as embedded in Article 12 of the International Covenant of Economic, Social and Cultural Rights (ICESCR, 1966), which embraces a wide range of measures to be

[44] Ibidem supra note 19.

[45] As regards various arguments on the terminology of the right to health, see, e.g., V.A. Leary, 'The Right to Health in International Human Rights Law' *Health and Human Rights* 1994, 1, 1, pp. 25-56, pp. 28-31(citing relevant studies); See, Chapter 3 for an understanding of the distinctive features and meaning of health as a right.

taken by States, covering not only access to health care, but also access to the underlying conditions for health.[46]

Other terms used to define health as a right, involve 'the right to health care' and 'the right to protection of health' (see Part I, chapter 2), which in literature are considered to be more realistic and workable terms than the broadly-based term 'right to health'.[47] Notably, the (Revised) European Social Charter (ESC) employs the term 'protection of health' (Article 11) instead of using the terms 'right to health' or 'right to the enjoyment of health'. The use of the term 'protection' embraces positive state obligations to take measures with a view to ensuring the *effective exercise of the right to protection of health.* This means that States must bear responsibility in ensuring improvement of public health; availability and access to health care; fair distribution of the social determinants of health; and adoption of preventive and educational measures to protect the health of individuals.[48] In this sense, the Charter of Fundamental Rights of the European Union (CFREU) also uses the term 'human health protection' in its Article 35 (see Part I, section 2.3). Note that this term encompasses an entitlement to (preventive and curative) health care, while at the same time it gives rise to a corresponding duty within all Union policies and activities.[49] Likewise, the Treaty on the Functioning of the European Union (TFEU) employs the term 'human health protection' in its new Article 168 (former Article 152 TEC) and requires that human health is protected in all Union policies and activities.[50] This means that the EU is under the obligation to co-operate and work with EU Member States towards improving public health, preventing illness and diseases, removing sources of danger to physical and mental health.[51] On the basis of the respective provision human health protection is, thereby, a treaty obligation. Meanwhile, the scope of

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46 Ibidem supra note 6, GC No. 14, § 11.

47 See e.g., B. Toebes, Towards an Improved Understanding of the International Human Right to Health, *Human Rights Quarterly* 1999, Volume 21, pp. 661-679, p. 662 (citing relevant studies); Ibidem supra note 45, V.A. Leary 1994.

48 European Social Charter 1961(Revised), adopted on 3 May 1996, entered into force on 1 July 1999, 2151 UNTS 277, ETS 163; See also, The right to health and the European Social Charter, Information document prepared by the secretariat of the ESC, March 2009.

49 Charter of Fundamental Rights of the European Union, Doc. 2000/C 364/01, available at: <http://www.europarl.europa.eu/charter/pdf/text_en.pdf>

50 Consolidated Version of the Treaty of on the Functioning of the European Union, *Official Journal of the European Union*, 26 October 2012, Doc. 2012/C 326/47. Available at <www.eur-lex.europa.eu>

51 Ibid., Article 168 § 1.

the content of the term 'to protect' is rather limited.[52] In particular, the obligation to protect constitutes one of the three different types of obligations imposed on States parties in order to implement the right to health at the national level. In terms of the obligation *to protect* States are required to take all necessary measures to prevent third parties from the infringement of the right to health (see Part I, section 3.3).[53]

[52] See, e.g., B.C.A. Toebes, *The Right to Health as a Human Right in International Law*, Antwerp/Oxford: Intersentia/Hart 1999, p. 20.

[53] Ibidem supra note 6, § 33.