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

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4 The Realization of the Right to Health: The Role of the State*

4.1. INTRODUCTION

As discussed in Chapter 2, the right to health finds recognition within an array of international and regional human rights treaties as well as in many national constitutions around the world. This has not, however, resulted in the full enjoyment of the right to health by everyone and in the appraisal of health as a legally binding right worldwide. Statistics from WHO, for example, indicate that still about 18,000 children and 800 women worldwide died every day in 2012 and in 2013 respectively, due to medical conditions that were at a large extent preventable or curable with simple medical interventions.[1] Additionally, about 8.6 million of the global population developed tuberculosis and 13 million died from that disease in 2012.[2] Thus, these and other avoidable health problems demonstrate that the realization of the right to health is a key component of the protection of health and without it health protection is just an empty promise.

Given the gravity of such concerns over time, the UN High Commissioner for Human Rights in a report of 2009 has cautioned that the realization of ESC rights, such as the right to health, demands 'action to translate the specific commitments included in legislation and other normative instruments into reality'.[3] This implies that States -primary duty holders under international law- are required to take concrete measures towards addressing the obstacles to an individual's

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* The word 'State' involves all components and all levels of public authorities.

1 See, World Health Organization, *World Health Statistics 2014*, Geneva: WHO, pp. 13 and 15.

2 Ibid., p. 16; Notably, every year almost 7 million children die under the age of five, mostly from preventable diseases. <https://m.savethechildren.net/what-we-do/health-and-nutrition>

3 UN 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.

effective enjoyment of the right to health (e.g., lack of primary health care, embedded health inequalities, resource constraints etc.).[4] For instance, Upendra Baxi, legal scholar pointedly argues that 'one may not take rights seriously if one is unable to take [human] suffering seriously'.[5]

In this chapter the focus of attention shifts to explore the enforcement of the right to health on the part of the State, in virtue of its primary and overall responsibility for realizing the right to health for all persons within its jurisdiction.[6] Therefore, an analysis of the nature of state measures required in realizing the right to health in section 4.2, as elaborated by the work of three UN human rights monitoring bodies may provide an additional insight into the realization process of the right to health at the national level. After providing an account of the nature of state measures, in section 4.3, the justiciability of the right to health with a focus on Europe, namely on the work of European Committee of Social Rights, will be explored. In section 4.4 the obligation imposed on States to internationally co-operate as a way of ensuring the realization of the right to health will be also discussed.

4.2. UN HUMAN RIGHTS MONITORING BODIES

In general, monitoring involves a systematic collection of information towards assessing States' compliance with their human rights commitments.[7] It can offer some feedback for implementation, in that the assessment of the process followed and the outcomes accomplished comprises information that can be used 'to either confirm the direction of some specific steps, or to correct them when necessary'.[8] As such, monitoring and implementation can be seen as two intertwined procedures.[9] The UN treaties provide for two primary mechanisms to monitor a State's compliance with its human rights obligations: the State reporting procedure and the individual complaints procedure.[10] In light of the aforementioned, the growing recognition of the right to health in human rights law is not enough from

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4 See, e.g., Article 2 § 1 CRC: 'States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction…'; Ch. R. Beitz, *The Idea of Human Rights*, Oxford: Oxford University Press 2009, p. 114.

5 U. Baxi, 'Taking Suffering Seriously: Social Action Litigation in the Supreme Court of India', *Third World Legal Studies* 1985, Volume 4, Article 6, pp. 107-132, p. 120.

6 Ibidem supra note 4.

7 Ibidem supra note 3, UN Doc. E/2009/90, § 5.

8 Ibid., § 8.

9 Ibid.

10 See UN website of the Office of the UN High Commissioner for Human Rights: 'Monitoring the core international human rights treaties' <www.ohchr.org/EN/HRBodies/Pages/WhatTBDo.aspx>.

its own. The work of monitoring bodies on the progress of States parties as to the implementation and compliance with their right to health obligations can perhaps constitute a potential useful procedure in that it could offer an account of the state measures required for ensuring the effective enjoyment of this right for all persons within a State's jurisdiction (see below sections 4.2.1 and 4.2.2). Generally speaking, their task involves an assessment process, *inter alia*, for the identification of (potential) inadequacies in laws/policies/practices at the national level and marks the first step for their review and alteration by the respective States (see below sections 4.2.1 and 4.2.2). Nonetheless, this is not to say that the work of monitoring bodies is beyond criticism, as several scholars have been critical of various aspects of their work (e.g. capacity, legal authority etc.).[11]

At the international level, the implementation of the right to health by the State parties is primarily monitored by UN treaty monitoring bodies related to the respective international human rights treaties that enshrine a right to health. Each of these human rights treaties has its own committee to monitor its implementation, establish interpretations, set standards and investigate infringements of the right to health.[12] In the following sections, consideration shall be given to the work of the CESCR and the CRC Committee, as these bodies monitor the compliance of States with their treaty obligations, *inter alia*, under the right to health embedded in ICESCR and CRC, respectively.[13] Additionally, both bodies have adopted General Comments (henceforth: GCs) on *the right to the enjoyment of the highest attainable standard of health* (the right to health), in order to complement the specifications about this right enshrined in respective human rights treaties, as elaborated in section 2.2.4.[14] Particularly, the respective Committees -albeit their

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[11] See, e.g., M. Sepúlveda, *The Nature of the Obligations under the International Covenant on Economic, Social and Cultural Rights*, Antwerp: Intersentia, 2003, p. 316; E. Riedel, 'The Human Right to Health: Conceptual Foundations', in: A. Clapham & M. Robinson (ed.), *Realizing the Right to Health*, Zurich: Rüffer and Rub 2009, pp. 21-39, p. 27.

[12] Ibidem supra note 10.

[13] See sections 4.2.1 and 4.2.2.; Note that the majority of the world's States have ratified ICESCR and CRC. Particularly, as at 30 June 2016, 164 States were parties to the ICESCR and 196 States were parties to the CRC.

[14] The CESCR has adopted General Comment No. 14: *The Right to the Highest Attainable Standard of Health*, UN Doc. E/C.12/2000/4, 11 August 2000 as well as other GCs relating to a right to health, *inter alia*, GC No. 22 *on the right to sexual and reproductive health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, UN Doc. E/C.12/GC/22, 2 May 2016. The CRC Committee has adopted General Comment No. 15 *on the right of the child to the enjoyment of the highest attainable standard of health,* UN Doc. CRC/C/GC/15, 14 March 2013 as well as several other GCs relating to a right to

work is sometimes quite ambiguous (see chapter 3)- have still made attempts to analyze the right to health and to guide States parties as to the content of this right and the nature of the ensuing state obligations.[15] In addition to the above treaty-based mechanism, attention shall be drawn to the work of the UN Special Rapporteur on the Right to Health[16], who is required under his/her mandate to prepare reports that offer insights into the normative framework of the right to health and, ultimately, into its effective realization.[17]

As such, the following sections will take into account the work of three UN monitoring bodies, principally the CESCR, the CRC Committee and the Special Rapporteur on the Right to Health, in an attempt to inform the scope of the meaning of the broad state obligation to realize the right to health by taking 'all appropriate means' or 'all appropriate measures' subject to a State's available resources, which is imposed by both the ICESCR (Articles 2 § 1 and 12) and the CRC (Articles 4 and 24). Note also that based also on the preceding analysis in section 3.4 on the progressive and immediate nature of state obligations resulting from the right to health, these two additional clauses could regulate the realization of this right and, thus, could function as a yardstick to evaluate the degree of realization of the right to health on the part of the State. Additionally, within the framework of the State reporting procedure several Concluding Observations (henceforth: CO) of the respective Committees -issued mainly since 2000- are taken into account by way of illustration, as these could perhaps offer States some

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health, *inter alia*, GC No. 3: *HIV/AIDS and the Rights of the Child*, UN Doc. CRC/GC/2003/3, 17 March 2003, GC No. 4*: Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, UN Doc. CRC/GC/2003/4, 1 July 2003.

15 See generally, 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 GA, 62nd Sess., Agenda Item 72(b),* UN Doc. A/62/214, 8 August 2007, § 70.

16 See, UN Commission on Human Rights, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health,* Res 2002/31, UN Doc. E/CN.4/RES/2002/31, 22 April 2002, which established the mandate of the Special Rapporteur on the Right to Health; See, also, UN Commission on Human Rights, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health,* Res 2005/24, UN Doc. E/CN.4/RES/2005/24, 15 April 2005 and UN Human Rights Council, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health,* Res 6/29, UN Doc. HRC/RES/2007/6/29, 14 December 2007, which both renewed the respective mandate for further three years.

17 These reports involve annual reports to the then Commission on Human Rights, the Human Rights Council and the UN GA, as will be discussed more elaborately in section 4.2.3; See website of the UN <www.ohchr.org/EN/HRBodies/SP/Pages/Introduction.aspx>.

guidance as to the scope of and compliance with the respective broad state obligation under the right to health.[18]

4.2.1. UN COMMITTEE ON ECONOMIC, SOCIAL AND CULTURAL RIGHTS

The CESCR is the body of 18 independent experts mandated to monitor the implementation by the State parties of the right to health (Article 12 ICESCR), among other rights embedded in ICESCR.[19] In particular, a State reporting system under the aegis of the ECOSOC was established according to Articles 16-23 ICESCR. State parties to the ICESCR are obligated to submit periodic reports on 'the measures which they have adopted and the progress made in achieving the observance of the rights recognized' in the ICESCR in accordance with the Committee's 'reporting guidelines'.[20] As mentioned earlier, the ICESCR did not provide for the establishment of a treaty monitoring body, to monitor its implementation. Such a body, the CESCR was later established, in 28 May 1985 under Res 1985/17 of the ECOSOC to fulfil the monitoring functions assigned to the ECOSOC in Part IV of the Covenant.[21] Note also by way of background that since 2013, when an Optional Protocol to the ICESCR entered into force, the protection given to ESC rights is to the same extent to that of CP rights at the UN level.[22]

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[18] As already mentioned, in 2000 in its GC No. 14 the CESCR provided an authoritative interpretation of the right to health enshrined in Article 12 ICESCR. Of note, the States mentioned reflect different levels of development. (see, UN Human Development Index: http://hdr.undp.org/en/ statistics)

[19] Website of the Office of the UN High Commissioner for Human Rights, *Monitoring the Economic, Social and Cultural Rights* <http://www.ohchr.org/EN/HRBodies/CESCR/Pages/CESCRIntro.aspx> (also cited in: <http://www.ohchr.org/EN/HRBodies/CESCR/Pages/CESCRindex.aspx>.

[20] ICESCR, New York 16 December 1966, entered into force 3 January 1976, 993 UNTS 3, Article 16 § 1.

[21] Economic and Social Council (ECOSOC) 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, Resolution 1985/17 of 28 May 1985.

[22] The ICCPR established a monitoring body (i.e., the Human Rights Committee) and had an individual communications procedure through the OP to ICCPR since 23 March 1976 when it entered into force (OP to ICCPR, adopted by GA Res. 2200A (XXI), 21 UN GAOR Supp. (No. 16) at 59, UN Doc. A/6316 (1966), 999 UNTS 302). Note that until 2013 the CESCR had no opportunity to intervene and/or consider a violation of ESC rights of victims, due to the lack of an optional protocol authorizing the Committee to this end (OP to ICESCR, adopted by GA Res. A/RES/63/117, on 10 December 2008, entered into force on 5 May 2013).

Based on Articles 16-17 ICESCR and Article 12 ICESCR States parties are required to submit periodic reports to the Committee on the implementation of the right to health provision. Initially, submission must be done within two years of the entry into force of the Covenant for a particular State party (*initial report*), and thereafter every five years.[23] In order to facilitate the reporting process of States, the Committee has drawn up a set of reporting guidelines on the content of the state reports.[24] Specifically, the initial state report must provide information with regard to the country's situation and the measures taken by the respective State to ensure that the rights contained in the ICESCR, such as the right to health, can be enjoyed by everyone. The examination of the State's report by the Committee results in the adoption by the Committee of its CO, where both an interpretation of the ICESCR provisions that can be made operational within national context and State's compliance are provided.[25] Subsequent reports must show the progress made by the State in realizing the obligations undertaken in terms of the ICESCR, including updated information on adopted administrative, legislative and other measures, as well as steps taken to address issues raised by the Committee in its CO on the State party's previous report, or in its GCs.[26] Meanwhile, beyond the examination of State reports and the adoption of respective CO, the CESCR has also adopted a number of GCs to the ICESCR, among which a GC on the Right to Health adopted by the Committee in 2000.[27]

Thereto, an attempt will be made to elucidate the scope of 'all appropriate means' being subject to 'available resources' required by States for ensuring the right to health for all persons based on the work of the CESCR, namely on interpretative tools that the Committee has developed over time. These two clauses, 'all appropriate means' and 'available resources' are identified in the formulation of broad state obligations imposed by the ICESCR (Articles 2 § 1 and 12) and are further addressed by the Committee with respect to the realization of the right of all persons to health on the part of the State.[28]

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[23] Ibidem supra notes 19 and 20.

[24] Ibid; See, UN *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*, CESCR, UN Doc. E/C.12/2008/2, 24 March 2009.

[25] See, also, UN CESCR, *General Comment No. 1: Reporting by States Parties*, UN Doc. E/1989/22, 27 July 1981.

[26] Ibidem supra note 24, UN Doc. E/C.12/2008/2, § 2.

[27] Between 1989 and June 2016 the CESCR adopted 23 GCs. The GCs of the CESCR are to be found in the UN website <www.ohchr.org/en/hrbodies/cescrindex.aspx>; As regards the normative interpretation of the right to health, contained in Article 12 ICESCR, see, Ibidem supra note 14, UN CESCR, GC No. 14.

[28] Of note, the CESCR has stressed that Article 2 ICESCR 'is of particular importance to a

(a) *'[...] by all appropriate means,* including particularly the adoption of legislative measures.'

The illustrative list of specific measures in Article 12 § 2 ICESCR, read in conjunction with the broad state obligation under Article 2 § 1 ICESCR, does not comprehensively determine the state measures to be appropriate for ensuring the effective enjoyment of the right to health by all persons within a State's jurisdiction.[29] Interestingly, as it is evident from the text, the ICESCR in its open-ended provision (i.e. Article 2 § 1) clearly places an emphasis on the adoption of legislative measures, as a way for States to realize ESC rights, like the right health. The CESCR has also recognised the essential role of legislative measures in certain instances of the realization process of ESC rights, such as in a case of protection against discrimination, as regards to vulnerable population groups, such as children and women and in the area of health.[30] The Committee has further suggested, albeit at a rather high level of abstraction, that States should consider the adoption of 'a framework law to operationalize their right to health national strategy' coupled with the establishment of national mechanisms for monitoring the implementation of the strategy and time bound targets as well as the development of appropriate benchmarks.[31]

Meanwhile, the CESCR has pointed out that the obligation to adopt legislative measures is 'by no means exhaustive of the obligations of States parties', which is also evident from the text in Article 2 § 1.[32] This means that legislation, namely

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full understanding of the Covenant and must be seen as having a dynamic relationship with all of the other provisions of the Covenant.'(GC No. 3 (infra note 30), § 1); At the CoE level, it is noteworthy that the ECSR in its case law has stipulated that state measures must be taken within reasonable time, within measurable progress and with the maximum of available resources. (see, e.g., Complaint No. 31/2005, *ERRC v. Bulgaria*, § 37)

[29] See, e.g., OP to ICESCR, GA Res 63/177 adopted on 10 December 2008, UN Doc. A/RES/63/117, 5 March 2009, annex, Article 8(4) which outlines that the CESCR, when considering the reasonableness of steps undertaken by a State to protect the rights under the ICESCR, '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'.

[30] UN CESCR, *General Comment No. 3: The Nature of States Parties' Obligations*, UN Doc. E/1991/23, 14 December 1990, § 3.

[31] Ibidem supra note 14, GC No. 14, § 56; UN CESCR, *Statement- An evaluation of the obligation to take steps to the "maximum of available resources" under an optional protocol to the Covenant*, UN Doc. E/C.12/2007/1, 10 May 2007, § 11.

[32] Ibidem supra note 30, GC No. 3, § 4. It is noteworthy that other appropriate measures involve administrative, financial, judicial, social and educational measures. (see, UN CESCR, GC No. 3, § 5 and 7); UN CESCR, General Comment No. 9: *The Domestic Application of the Covenant*, 3 December 1998, UN Doc E/C.12/1998/24, §§ 3-5 and 7.

incorporation of ESC rights, like the right to health, in domestic legal systems, is not the only measure considered 'appropriate' and required of States by which to realize these rights and, to that end, States retain a margin of discretion.[33] Here it must be conceded that this discretion in the selection of the means by the States is not unlimited as the CESCR has generally argued that 'while each State party must decide for itself which means are the most appropriate … with respect to each of the rights, the 'appropriateness' of the means chosen will not always be self-evident. It is therefore desirable that States parties… should indicate not only the measures that have been taken but also the basis on which they are considered to be the most 'appropriate' under the circumstances'.[34] In other words, in recognition of the diverse circumstances of legal and administrative systems within each State, States are afforded this margin of discretion -albeit within boundaries-.[35] Nonetheless, these general assertions of the CESCR leave open the critical question as to what kind of measures (e.g., legislative and/or administrative measures etc.) will be deemed appropriate to ensure the realization of the right to health, which is yet to be clearly answered by the Committee.

Of assistance perhaps -albeit objections have been expressed by scholars[36]- can be the application of the 'reasonableness test', as outlined by the CESCR with regard to the communications procedure under the Optional Protocol to the ICESCR. Accordingly, the CESCR shall consider the reasonableness of the measures taken by States.[37] The 'reasonableness' of the measures is qualified by a number of general factors that provide a broad framework of steps to be taken

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[33] See, ibid., GC No. 9, § 9. The CESCR notes the 'broad and flexible approach' of Article 2 § 1 ICESCR.

[34] Ibidem supra note 30, GC No. 3, § 4; Ibidem supra note 14, GC No. 14, § 53.

[35] Ibidem supra note 32, GC No. 9, § 1; Ibidem supra note 31, UN Doc. E/C.12/2007/1, § 11. Accordingly, the Committee has acknowledged that the evaluation of the obligation under Article 2 § 1 ICESCR will always respect 'the margin of appreciation of States to take steps and adopt measures most suited to their specific circumstances'.; See also, other authoritative sources, e.g., 'Maastricht Guidelines on Violations of Economic, Social and Cultural Rights' 22-26 January 1997, UN Doc. E/C.12/2000/13, 2 October 2000, Guideline 8.; See also, supra note 11, M. Sepúlveda 2003, p. 339.

[36] See, e.g., Br. Griffey, 'The "Reasonableness" Test: Assessing Violations of State Obligations under the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights', *Human Rights Law Review* 2011, 11(2), pp. 275-327, p. 319. He maintains that appropriateness, as a legal standard, sets a higher bar than 'reasonableness', in that it may require budgetary prioritization and optimization.

[37] Article 8 § 4 of the OP to ICESCR (OP to ICESCR, adopted by GA Res. A/RES/63/117, on 10 December 2008, entered into force on 5 May 2013).

to achieve this requirement. Hence, the Committee would consider factors, including the adoption of deliberate, concrete and targeted measures; the non-discriminatory and non-arbitrary manner in the selection of means; the prioritization of measures targeted to the most vulnerable groups; the time frame in which steps were taken; the allocation of available resources in accordance with human rights standards, as will be explained further below.[38] Further, the Committee would consider whether the State has adopted the least restrictive measure where there is a range of alternative policy options.[39] It is within this context that the Committee has acknowledged and considered the level of development of a respective State (i.e., domestic circumstances) for the purpose of evaluating the reasonableness of the measures taken and ensuring a context-sensitive interpretation of such measures.[40] However, in literature it is argued that an engagement with relevant domestic jurisprudence can provide considerable means by which to elucidate the notion of 'reasonableness', which could complement the abstract view taken by the Committee when applying this notion.[41]

In any case, it is important to note that whatever measures adopted by a State these must contribute to the effective realization of its right to health obligations within its jurisdiction.[42] As such, the appropriateness of the State measures is largely associated with the effectiveness requirement, albeit the assessment of which is not explicitly elucidated in the work of the CESCR.[43] Indeed, in literature

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38 Ibidem supra note 31, UN Doc. E/C.12/2007/1, § 8 (b) and (f); Ibid., Article 8 § 4 OP to ICESCR.

39 Ibid., § 8(d); Ibid., Article 8 § 4 OP to ICESCR.

40 See, e.g., UN CESCR, CO: Greece, UN Doc. E/C.12/GRC/CO/2, 27 October 2015, § 8, UN CESCR, CO: Angola, UN Doc. E/C.12/AGO/CO/3, 1 December 2008, § 26; For a similar approach as regards to all ESC rights, see also, supra note 11, M. Sepúlveda 2003, p. 337.

41 Ibid., M. Sepúlveda 2003; See, e.g., the decision of the South African Constitutional Court in *Grootboom and Others v. The Government of the Republic of South Africa and Others*, Case No: CCT 11/00, 4 October 2000, §§ 39-44. The court's decision further elaborates on the notion of reasonableness requirement. Accordingly, in light of the reasonableness requirement, the measures must: i. ensure appropriate financial and human resources, ii. be coordinated, comprehensive and coherent, iii. be reasonable both in their conception and implementation, iv. be context-sensitive, balanced, flexible and make provision for short, medium and long term needs and v. address the most urgent needs and respond to the needs of the most vulnerable.

42 Ibidem supra note 32, GC No. 9, § 5.

43 Ibidem supra note 11, M. Sepúlveda 2003, p. 337; Ibidem supra note 30, GC No. 3, § 4; See, also, other authoritative sources, e.g., 'The Limburg Principles on the Implementation of the ICESCR', UN Doc. E/CN.4/1987/17, § 20 (also available at: *Human Rights Quarterly* 1987, 9(2), pp. 122-135).

it is submitted that the Committee has not established a clear test to assess the effectiveness of the measures (administrative and others) taken by States.[44] The Committee has, however, hinted at the effectiveness requirement for example in its report for Greece, where it recommended that the State party, 'take *effective measures* to ensure that there are sufficient health-care professionals, including mental-health staff, to meet the demands in medical treatment'[emphasis added].[45]

In the meantime, the scope of appropriate means for effective realization of the right to health is likely to be also informed by the CESCR's approach foreshadowed in its reporting guidelines drawn up to facilitate States in preparing their reports under ICESCR. Under these guidelines States are expected to indicate whether they have 'adopted a national health policy and whether a national health system… is in place'.[46] It is worth bearing in mind that the CESCR in GC No. 14 has also set out a number of parameters to guide States and ensure the effective implementation of a national health policy.[47] Such a policy should *inter alia* 'be based on the principles of accountability, transparency and independence of the judiciary' and facilitate people's participation.[48] The CESCR has also provided a number of guideposts for policy action, framed in terms of priority areas that should be integrated in the realization process. Such priority areas are also identified by the CESCR in its GC No. 14 and cover a wide range of health-related topics (i.e., access to healthcare and underlying determinants of health) that needs to be addressed by States, such as child and maternal health (pre-and post-natal care and emergency obstetric services), immunization against infectious diseases, prevention, treatment and control of diseases linked to water and access to adequate sanitation etc.[49]

Nevertheless, one may argue that aside from setting out a broadly-based (unworkable at times) process to be followed by States, it would be advisable for

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44 See, e.g., Ibidem supra note 11, M. Sepúlveda 2003, p. 337.

45 UN CESCR, CO: Greece, UN Doc. E/C.12/GRC/CO/2, 27 October 2015, § 36(b).

46 UN CESCR, *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*, UN Doc. E/C.12/2008/2, 24 March 2009, annex, § 55; Note that the adoption of a national health policy is also addressed by the CESCR in its GC No. 14 as state's minimum requirement for ensuring the enjoyment of the right to health under all circumstances (GC No. 14, §§ 43(f) and 53; See, also, UN CESCR, GC No. 1 (note 25), § 4; UN CESCR, General Comment No. 5: *Persons with disabilities*, UN Doc. E/1995/22, 9 December 1994, § 13).

47 Ibidem supra note 14, GC No. 14, §§ 53-56.

48 Ibidem supra note 14, GC No. 14, §§ 54-55.

49 Ibidem supra note 46, UN Doc E/C.12/2008/2, §§ 56-57; Ibidem supra note 14, GC No. 14, §§ 12(b) and (d), 14, 16, 21-23, 43(d) and 44 (a), (b) and (e).

the Committee to concretely specify some principal health measures required by States in virtue of the progressive nature of the right to health and resource availability (see section 3.4). On the other hand, Toebes pointedly argues that this might be problematic in that the focus on particular issues, for example on health care issues, might ignore other health-related topics often just as significant for the enhancement of people's health.[50] Thereto, the argument made here is that a balanced, workable and complete perspective (i.e., primarily suited to the particular circumstances and challenges of each State) on the definition of State measures is required on the part of the Committee (e.g., in its CO). This could actually guide and direct States to set concrete (policy) priorities and tangible targets, after careful planning, upon which they can be held accountable, while at the same time avoiding inefficient use of resources and corruption (see section 3.7.2).

Such an argument can be advocated when looking, by way of example, at the approach -albeit general at times- taken by the Committee to address the health needs of vulnerable population groups. While the ICESCR does not explicitly stipulate that priority attention should be given to people belonging to disadvantaged or marginalized population groups, the CESCR has taken a different view in its GCs and CO. In a relatively general sense, the Committee has confirmed that States must give special consideration and adopt targeted measures that respond to the health needs of such groups.[51] At the same time, the Committee has declared that States have a special obligation to provide those who do not have sufficient means with necessary health insurance and healthcare facilities, and to prevent any discrimination on internationally prohibited grounds in the provision of health care.[52] Meanwhile, in a particular sense, in its GC No. 20 the Committee has also

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[50] B.C.A. Toebes *The Right to Health as a Human Right in International Law*, Antwerp/ Oxford: Intersentia/ Hart 1999, p. 143.

[51] Ibidem supra note 14, GC No. 14, §§ 18-27 (Note also that the Committee has drawn attention on the health needs of certain vulnerable population groups within society, such as women, children and adolescents, older persons, persons with disabilities and indigenous peoples.); See, also, supra note 31, UN Doc. E/C.12/2007/1, § 8(f); For similar interpretations to that of CESCR that support the prioritization of vulnerable groups on the part of the State, see also other authoritative sources, including 'the Limburg Principles on the Implementation of the International Covenant on Economic, Social and Cultural Rights' (UN Doc. E/CN.4/1987/17, supra note 43) and 'the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights' (UN Doc. E/C.12/2000/13, supra note 35).

[52] Ibidem supra note 14, GC No. 14, § 19; The Committee's approach finds support in the Limburg Principles which provide that 'special measures should be taken to advance the interest of certain groups in order that these groups enjoy the full benefit of economic, social and cultural rights' (supra note 43, §§ 36 & 39).

set out a non-exhaustive list of various vulnerable groups, being included within the scope of non-discrimination in the enjoyment of ESC rights, including the right to health. Specifically, the Committee affirmed that the rights set out in the Covenant apply to every person, including non-nationals, refugees, asylum-seekers, stateless persons, migrant workers and victims of trafficking, irrespective of legal status and documentation.[53]

In its CO the CESCR has on occasions identified the precarious situation and the need for prioritization in the area of health of vulnerable groups of the population which differ per country. This is clear in a few examples of the CESCR's work in particular countries that are mentioned below. For instance, the Committee has acknowledged 'the limited access to health services in particular in rural areas'[54] and has also expressed its concern with respect to the fact that minorities, particularly the Roma and the Turkish populations continue to be the victims of discrimination, particularly in the area of health[55] accompanied with -albeit general- recommendations that the State 'guarantee adequate access to health services'.[56] Likewise, the CESCR has also recommended that States 'provide health care to the most marginalized children and families'[57], 'take effective and appropriate measures to ensure that street children have access to …health care' and 'ensure the equitable availability of health-care facilities, particularly obstetric facilities, among the economically disadvantaged populations.[58] The CESCR has also called upon States to '(b) increase health-care funding for disadvantaged populations' as well as '(c) ensure that the people living in poverty have access to free primary health care'.[59]

All in all, it can be observed that the CESCR has tended to provide insight and recommendations slightly oriented as to the type of measures required of States to address, *inter alia*, the precarious position of certain population groups in relation to their right to health and access to health care. Nonetheless, some indications

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53 UN CESCR, General Comment No. 20: *Non-Discrimination in Economic, Social and Cultural Rights*, UN Doc. E/C.12/GC/20, 2 July 2009, § 30.

54 UN CESCR, CO: Albania, UN Doc. E/C.12/ALB/CO/2-3, 18 December 2013, § 32; CO: the Republic of the Congo, UN Doc. E/C.12/CO/Add.45, 23 May 2000, § 28.

55 UN CESCR, CO: Slovakia, UN Doc. E/C.12/SVK/CO/2, 8 June 2012, § 9; See, also UN CESCR, CO: Bulgaria, UN Doc. E/C.12/BGR/CO/4-5, 11 December 2012, § 7.

56 UN CESCR, CO: Bulgaria, UN Doc. E/C.12/BGR/CO/4-5, 11 December 2012, § 7.

57 UN CESCR, CO: Albania, UN Doc. E/C.12/ALB/CO/2-3, 18 December 2013, § 12.

58 UN CESCR, CO: Brazil, UN Doc. E/C.12/BRA/CO/2, 12 June 2009, § 24(b) and 28(e).

59 UN CESCR, CO: Brazil, UN Doc. E/C.12/BRA/CO/2, 12 June 2009, § 28 (b), (c); See, e.g., UN CESCR, CO: Gabon UN Doc. E/C.12/GAB/CO/1, 27 December 2013, § 12, 29, CO: Angola, UN Doc. E/C.12/AGO/CO/3, 1 December 2008, § 36, CO: Benin, UN Doc. E/C.12/1/Add.78, 5 June 2002, § 43.

still can be discerned from the work of the CESCR. Thereto, one may argue that the CESCR has intended to avoid opening a detailed discussion as to what constitutes 'all appropriate means' in preference for expressions of concern accompanied with rather broad recommendations at times. Nevertheless, some could argue that such broadly-based approach of the CESCR rests on: i) the recognition of the margin of appreciation for States and ii) the need to ensure the implementation of context-sensitive measures owed to particular circumstances and challenges within each State (e.g., economic austerity, economic surveillance, embedded health inequalities, vulnerable groups etc) (see also section 4.2.2).[60]

(b) '[…] to the maximum of its available resources…'

On the basis of the work of the CESCR, the preceding section attempted to identify the scope of state measures that are considered appropriate for realizing the right to health. At the same time it must be conceded that all of the measures required by a State are subject to the resources available to the respective State, namely 'to the maximum of available resources'.[61] In general, the clause 'to the maximum of its available resources' implies that the scope of these resources involves not simply financial, but a range of resources, required of States in the realization process.[62] A similar view is taken by the CESCR in its CO without, though, defining in detail the meaning of 'available resources' and the 'maximum' of these resources available to a State in question at a given time. For instance, beyond financial resources, the Committee has generally identified on several occasions that States, especially the developing ones, are required to ensure sufficient human resources, in order to realize the right to health of all persons within their jurisdictions, such as recruitment of an adequate number of skilled health care professionals available both in rural and urban areas in a country.[63] Moreover, at a rather abstract level

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[60] An analogous approach is adopted in the recommendations of the CRC Committee and the CESCR on the fulfillment of a particular state obligation to diminish infant and child mortality, see, J. Tobin, *The Right to Health in International Law*, Oxford: Oxford University Press 2012, p. 258.

[61] Article 2 § 1 ICESCR.

[62] See, authoritative sources, e.g., the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights (supra note 35), Guideline 10 (a reference is made to the 'availability of adequate financial and material resources'); The Limburg Principles on the Implementation of the ICESCR (supra note 43), § 24 (a reference is made to 'the development of societal resources').

[63] See, e.g., UN CESCR, CO: India, UN Doc. E/C.12/IND/CO/5, 16 May 2008, § 78; UN CESCR, CO: Gabon, UN Doc. E/C.12/GAB/CO/1**,** 27 December 2013, § 28; CO: the Republic

the CESCR has affirmed that a State's available resources involve 'both the resources existing within a State and those available from the international community through international cooperation and assistance'.[64] A striking example thereof perhaps constitutes the WHO, which under its Constitution is responsible, *inter alia*, for providing technical support to countries (see Part II, section 6.4.4).[65]

In the meantime, like the progressive realization clause (section 3.4), the clause of available resources may be used as an excuse by States for delaying and ultimately for not complying with their right to health obligations.[66] In virtue of the variance in the socio-economic conditions and level of development, States are given a margin of discretion -albeit not unlimited- in the evaluation of what resources are considered to be available.[67] The CESCR has the potential to assess the degree of a State's compliance with the obligation under Article 2 § 1 ICESCR on a State-by-State basis and, particularly, assess whether or not a State's assertion of resource scarcity is well-founded. In its Statement on maximum available resources the Committee has set out a number of criteria for such assessment, which are relevant for the justification of retrogressive measures (section 3.4):

(a) The country's level of development;
(b) The severity of the alleged breach;
(c) The country's economic situation, in particular whether the country was undergoing a period of economic recession;
(d) The existence of other serious claims on the state's limited resources (e.g. natural disasters);
(e) Whether the State had sought to identify low-cost options and
(f) Whether the State had sought cooperation and assistance.[68]

In light of the above criteria, we may conclude that the absence of a State's justification for the adoption of a legislation or policy that constitutes a step back

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of the Congo, UN Doc. E/C.12/1/Add.45, 23 May 2000, § 28; See, other authoritative sources, 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, Paul Hunt. UN General Assembly, 60th Sess., Agenda Item 73(b),* UN Doc A/60/348, 12 September 2005, §§ 27-29.

64 Ibidem supra note 30, GC No. 3, § 13; Ibidem supra note 31, UN Doc. E/C.12/2007/1, § 5; Ibid., e.g., CO: the Republic of the Congo, § 28; See, also, Part II, section 6.4.4, Greece signed an agreement with WHO for the purpose of planning a health care reform.

65 Article 2 (d) WHO Constitution.

66 M.C.R. Craven, *The International Covenant on Economic, Social and Cultural Rights: A Perspective on its Development*, Oxford: Oxford University Press 1995, p. 138.

67 Ibid., pp. 136-137.

68 Ibidem supra note 31, UN Doc. E/C.12/2007/1, § 10.

in the level of protection of the right to health, i.e. a reduction of public health expenditure, can be construed as a State's non-compliance with its right to health obligations. Here, it is essential to dissociate a State's unwillingness to comply with its right to health obligations under Article 12 ICESCR from a State's incapacity to do so.[69] A State's unwillingness implies a lack of commitment to meet the respective obligations under the right to health, especially in terms of making every effort to use effectively all available resources at its disposal for that purpose due to resource constraints. In its GC No. 14 the CESCR has strictly declared that a State's unwillingness can constitute a violation of the right to health.[70]

Whilst the above criteria provide a useful textual basis and draws a conceptual picture of the Committee's approach on State obligations in light of their available resources, it must be recognized that an accurate assessment of a State's situation by the Committee requires more considered attention in relation to the calculation of the maximum of a State's available resources at a given time. Instead, the CESCR has tended to adopt a somewhat haphazard approach in its CO on several Country Reports. Several of its comments in its CO are expressions of general exhortations and concern. For instance, the Committee has regularly urged States 'to significantly increase its healthcare expenditure'[71] and to 'increase expenditure for health care and … ensure universal access to health care at prices affordable to everyone'.[72] Moreover, the Committee has expressed concern that 'despite the economic growth achieved … health-care expenditures remain exceptionally low … and that a significant proportion of the population continues to have limited or no access to basic health services, resulting in alarmingly high rates of maternal and infant mortality, as well as high incidences of tuberculosis and other communicable diseases'.[73] The Committee has, however, hinted at a sustainable funding for health in its CO for particular countries where it noted the inadequate management and misallocation of resources in cases where the expenditure for military defense was to the detriment of health expenditure and other social expenses.[74]

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69 Ibidem supra note 14, UN CESCR, GC No. 14, § 47.

70 Ibid.

71 See, e.g., UN CESCR, CO: India, UN Doc. E/C.12/IND/CO/5, 16 May 2008, § 73; UN CESCR, CO: Albania, UN Doc. E/C.12/ALB/CO/2-3, 18 December 2013, § 32.

72 UN CESCR, CO: the Republic of Korea, UN Doc. E/C.12/KOR/CO/3, 29 November 2009, § 30; See, also, UN CESCR, CO: Brazil, UN Doc. E/C.12/BRA/CO/2, 29 May 2009, § 28(b).

73 UN CESCR, CO: India, UN Doc. E/C.12/IND/CO/5, 16 May 2008, § 33; See, e.g., UN CESCR, CO: Philippines, UN Doc. E/C.12/PHL/CO/4, 1 December 2008, § 17.

74 See, e.g., UN CESCR, CO: Democratic Republic of Congo, UN Doc. E/C.12/COD/Q/5, 17 November 2009, § 16; CO: Philippines, UN Doc. E/C.12/1995/7, 7 June 1995, § 21.

Nonetheless, the CESCR slightly offers any real insight as to the calculation of the maximum of a State's available resources (see also Grover's argument in below section 4.2.3). This implies that a detailed analysis of the relevant information is needed on the part of the Committee, provided the Committee has sufficient access to it from State reports (i.e., complete and reliable data) as well as a good knowledge of each country's situation (e.g., evidence-based evaluation reports from NGOs). In this respect, in literature, it is maintained that the supervision of a State's compliance is complex and raises legitimate concerns about the capability of the CESCR to respond at its supervisory role in an effective manner.[75] Thereto, it is submitted, for instance, that domestic courts could undertake the task of monitoring and supervising the adoption of retrogressive measures that affect the enjoyment of the right to health in the country in question.[76]

Meanwhile, when a State's available resources are scarce, the CESCR has tended to adopt a relatively weak approach by stressing that 'the obligation remains for a State party *to strive* to ensure the widest possible enjoyment of the relevant rights under the prevailing circumstances' [emphasis added].[77] It has, however, recognised that 'even in times of severe resources constraints whether caused by a process of adjustment, of economic recession, or by other factors the vulnerable members of society can and indeed must be protected by the adoption of relatively low-cost targeted programmes'.[78] It has also alluded to sufficient resource allocation with a primary focus on certain population groups in several of its CO on respective Country Reports, where for example, it generally urged States to increase 'its budget allocation for health'[79] and/or health-care funding in particular for disadvantaged population groups.[80]

Last but not least, we may conclude that the CESCR's work, primarily as regards its response to State reports, rather than elucidate in detail what constitutes 'the maximum of its available resources' has been confined to expressions of concern accompanied with general calls for action and recommendations to the

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75 See, for a general approach as regards to all ESC rights supra note 11, M. Sepúlveda 2003, p. 316.

76 Ibid., p. 332.

77 Ibidem supra note 30, UN CESCR, GC No. 3, § 11.

78 Ibid., § 12.

79 UN CESCR, CO: Poland, UN Doc E/C.12/POL/CO/5, 2 December 2009, § 29; CO: Angola, UN Doc E/C.12/AGO/CO/3, 20 November 2008, § 26.

80 See, e.g., UN CESCR, CO: Brazil, UN Doc. E/C.12/BRA/CO/2, 12 June 2009, § 28(b); CO: Benin, UN Doc. E/C.12/1/Add.78, 5 June 2002, § 29; CO: Tajikistan, UN Doc. E/C.12/TJK/CO/1, 23 November 2006, § 70; CO: Angola, UN Doc. E/C.12/AGO/CO/3, 20 November 2008, §§ 29, 37; CO: Kenya, UN Doc. E/C.12/KEN/ CO/1, 19 November 2008, § 32.

respective States. Such an approach is slightly directed as to elucidating the nature of the resources, let alone the amount of those required by States. (see also Grover's argument in below section 4.2.3). Nonetheless, in defence of the CESCR's approach one may maintain the position that despite its general approach at times, the Committee has attempted to concretely address a State's assertion on resource availability by developing a number of criteria for its assessment in its Statement on maximum available resources. As such, Tobin argues that the position advanced by the Committee reflects 'a dynamic understanding' of the phrase available resources, whereas human rights monitoring bodies, such as the CESCR, do not seek 'to impose or demand the adoption of a mathematical formula by states' as regards the resources allocated to health.[81] At the same time it must be perhaps conceded that still a principal indication as to the amount of resources to be allocated to health based on the distinct circumstances of each State should be provided by the Committee in its CO (see below section 4.2.3).

4.2.2. UN COMMITTEE ON THE RIGHTS OF THE CHILD

The Committee on the Rights of the Child -formed by an international treaty, the CRC- (henceforth: CRC Committee) is the UN body of 18 independent experts that monitors the implementation by the State parties of the right to health (Article 24 CRC), among other rights enshrined in CRC.[82] In particular, pursuant to Article 43 CRC, for the purpose of examining the progress made by States parties in achieving the realization of the obligations undertaken in the present Convention, there shall be established a CRC Committee, which shall carry out the functions hereinafter provided. As such, under Article 44 CRC in conjunction with Article 24 CRC on the right to health, States parties must regularly submit to the Committee reports on the measures they have adopted which give effect to the right to health and on the progress made on ensuring the respective right within two years after ratification of the Convention and then every five years. The reports made under the Article 44 CRC shall indicate factors and difficulties, if any, affecting the degree of fulfillment of the obligations under Article 24 CRC. With respect to Article 24 CRC, the CRC Committee reviews the States parties' periodic reports as well as

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[81] Ibidem supra note 60, J. Tobin 2012, pp. 229 and 253.

[82] Convention on the Rights of the Child, New York, 20 November 1989, entered into force 2 September 1990, 1577 UNTS 3; Website of the Office of the UN High Commissioner for Human Rights, *Monitoring Children's Rights* <http://www.ohchr.org/EN/HRBodies/CRC/Pages/CRCIntro.aspx>; See generally, G. Lansdown, 'The Reporting Process under the Convention on the Rights of the Child' in: P. Alston & J. Crawford, *The Future of UN Human Rights Treaty Monitoring*, Cambridge: Cambridge University Press 2000, pp. 113-128.

the complementary reports of those States parties to the optional protocols and on the basis of this examination produces a document with its Concluding Observations (henceforth: CO), where the CRC Committee addresses its concerns and recommendations in respect of individual States parties.[83]

Meanwhile, the CRC Committee publishes its interpretation of the content of human rights provisions, known as General Comments (henceforth: GCs) on thematic issues of general interest or on its methods of work as well as General Recommendations, following days of general discussion (e.g. on violence against children). The CRC Committee has been active in producing GCs relating to the right to health.[84] The CRC Committee, for example, in its GC No. 4 enunciates a specific interest in applying human rights protection to children, including the protection of the right to health. Most importantly, though, in its GC No. 15 the Committee offers an interpretation of Article 24 CRC on the right of the child to the enjoyment of the highest attainable standard of health. The CRC Committee, in its GC No. 15, has interpreted Article 24 CRC with respect to monitoring States' compliance, as requiring States to take measures to protect the right to health of children. Particularly, a State must provide certain data on the health status of children to the CRC Committee. Moreover, a State must demonstrate that it is taking steps to ensure that it adequately invests in the health of children. Additionally, a State must take steps to ensure that the health of all children is respected and protected. Individual State compliance with these actions and other obligations is reviewed by the CRC Committee, when States submit their periodic reports.[85] Accordingly, an attempt to identify the nature of state measures required for ensuring the right to health for all children beyond the specific measures that are listed in Article 24 CRC will be made based on the work of the CRC Committee which derives from its GCs as well as observations and recommendations made

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83 Ibid.

84 Ibid. In general, between 2001 and June 2016 the CRC Committee adopted 18 GCs, available at <www.ohchr.org/EN/HRBodies/CRC>. The GCs relating to the right to health are, *inter alia,* No. 3: HIV/AIDS and the rights of the child; No. 4: Adolescent health and development; No. 7: Children's rights in early childhood; No. 9: The rights of children with disabilities; No. 12: The right of the child to be heard. Most significantly, in 2013 the CRC Committee adopted GC No. 15 on children's right to health.

85 UN CRC Committee, General Comment No. 15: *The right of the child to the enjoyment of the highest attainable standard of health (art. 24),* UN Doc. CRC/C/GC/15, 17 April 2013, §§ 74, 104, 117-118; See also, UN CRC Committee, General Comment No. 5: *General measures of implementation of the Convention on the Rights of the Child (arts. 4, 42 and 44, para. 6)*, UN Doc. CRC/GC/2003/5, 27 November 2003.

on the country reports. In the following paragraphs the scope of two clauses, outlined previously, that are also found in the CRC and are recommended by the CRC Committee with respect to the fulfillment of the general obligation to guarantee the right to health for all children on the part of the State will be briefly analysed.

But first, the definition of children and four general principles will be provided that are addressed in the recommendations made by the CRC Committee regarding the implementation of the right to health of the child. Accordingly, the CRC Committee has adopted three main classifications concerning the definition of children on the basis of their age, covering early childhood, middle childhood and adolescence.[86] In particular, the CRC Committee 'proposes as an appropriate working definition of early childhood the period below the age of 8 years', namely 'all young children: at birth and throughout infancy; during the preschool years; as well as during the transition to school'.[87] Moreover, 'middle childhood' covers the period after the child's transition to school is made until the time the child is on the verge of adolescence.[88] Adolescence is the period following middle childhood that proceeds adulthood.[89] Notably, along with the above classification, the CRC acknowledges in Article 5 the responsibilities, rights and duties of both parents (or other persons legally responsible for the child) 'to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the Convention' as well as in Article 18 their primary responsibility for the upbringing and development of child.[90] These provisions highlight the role of both parents (or other persons legally responsible for the child), in circumstances where a child has not attained capacity and competency, in ensuring the child's rights, including the right to health in the context of their primary responsibility for ensuring healthy living conditions and guiding the child within health care settings in line with the child's best interests. Of note, the role of parents in realizing the right to health of the child is specified by the CRC Committee in its GC No. 15.[91]

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[86] UN CRC Committee, General Comment No. 7: *Implementing Child Rights in Early Childhood,* UN Doc. CRC/C/GC/7/Rev.1, 1 November 2005, § 8; See also, supra note 60, J. Tobin 2012, p. 219.

[87] Ibid., GC No.7, §§ 1-4.

[88] Ibid., § 8.

[89] Ibid., § 8; UN CRC Committee, General Comment No. 4: *Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, UN Doc. CRC/GC/2003/4, 1 July 2003, § 2.

[90] Ibidem supra note 82, Articles 5 & 18 CRC.

[91] Ibidem supra note 85, GC No. 15, § 78.

Meanwhile, in terms of conceptualizing the nature of the state obligation to realize the right to health for all children under Article 24 CRC, it is important to take into account other articles of the CRC, which are also considered in the observations and recommendations of the CRC Committee. Hence, we will briefly refer to the content of four general principles of the CRC, namely to the principles of best interest of the child, non-discrimination, survival and development, and participation, enshrined in CRC.[92] It is notable that these four principles, which constitute also rights set forth in the CRC, are identified as key principles by the CRC Committee, that have the potential to be applied to the interpretation of every child's right to health with the aim of guiding respective national policies towards the effective realization of the right to health.[93]

More specifically, in view of both Articles 3 and 24 CRC the best-interests principle should be a 'primary consideration' in all decision-making concerning children's health and in relation to health services (for instance, in cases dealing with waiting lists for medical treatment).[94] Nonetheless, caution must be exercised when developing and applying measures based on the best-interests principle, in that its broad interpretation could justify the application of even (traditional) practices prejudicial to the health of children.[95] In addition, the non-discrimination principle under Article 2 CRC requires children to be protected against discrimination on any ground (or a combination of grounds), including discriminatory practices on the basis of the status of their parent(s), carer(s) or other family member(s), ethnic origin, personal circumstances and lifestyle in the

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92 Ibidem supra note 85, GC No. 5, § 12.

93 The CRC Committee identified the principles of best-interests of the child, non-discrimination, survival and development, and participation as general principles in 1991 in terms of States' reporting on the realization of the rights contained in the CRC (UN Doc. CRC/C/5, 30 October 1991, § 13); See also, e.g., UN CRC Committee, GC No. 7 (supra note 86), § 13(b); For instance, see, *inter alia*, UN CRC Committee, CO: Greece, where the CRC Committee uses these principles as evaluating tools with respect to the protection of the children's right to health.

94 Ibidem supra note 82, CRC 1990; Ibid. Note that the best-interests principle is widely recognized within human rights law. For instance, the ECSR has stressed that 'when ruling on situations where the interpretation of the Charter concerns the rights of a child, the Committee considers itself bound by the internationally recognized requirement to apply the best interests of the child principle' (*Defence for Children International (DCI) v. The Netherlands,* Complaint No. 47/2008, 27 October 2009, § 29).

95 S.I. Spronk-van der Meer, *The Right to Health of the Child: An Analytical Exploration of the International Normative Framework*, Antwerp: Intersentia 2014, pp. 56-58 (citing relevant studies).

area of access to health care (see Part II, section 7.3.4). This principle is also evident in the wording of Article 24 § 1 CRC which stipulates that States shall strive to ensure that *no child* is deprived of access to health care [emphasis added].[96] Within the context of health care, for example, discriminatory practices against children due to their increased vulnerability (i.e., in the first place as persons below the age of 18) compared to other age groups in society may result in a disproportionate negative impact on their health. For this reason, the CRC Committee has generally noted that States are required to identify the factors which disadvantage certain groups of children and address them through the development of respective laws and policies.[97]

Moreover, the principle of survival and development laid down in Article 6 CRC should be considered in conjunction with health-related decisions of parents, such as the weak level of birth registration, coupled with the need for access to preventive care for children.[98] On many occasions, for instance, within the context of health care, the lack of official identity documents, namely birth registration, denies children their participation in vaccination programmes and access to regular health check-ups, and hinders access to early childhood development services and social benefits in general (see Part II, section 8.3.3).[99] This situation, in turn, results in affecting negatively life prospects and development of children and increases the risks to their survival and development. Furthermore, in view of Articles 5 and 12 § 1 CRC, children should have a say in health-related decisions affecting them in accordance with their age and level of maturity.[100] The principle of participation

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96 Ibidem supra note 82, CRC 1990.

97 Ibidem supra note 85, GC No. 15, § 11.

98 Ibidem supra note 82, CRC 1990; The linkage between Articles 6 and 24 is stipulated in the CRC Committee's general guidelines for the form and content of periodic reports, particularly under the section 'basic health and welfare'. See, UN CRC Committee, *General Guidelines Regarding the Form and Content of Periodic Reports*, 39th sess., UN Doc. CRC/C/58/Rev.1, 2005, § 31; Ibidem supra note 85, GC No. 15, § 18.

99 Ibidem supra note 86, GC No. 7, § 25; See, e.g., UN CRC Committee, CO: Romania, UN Doc. CRC/C/15/Add.199, 18 March 2003, § 32; UN CRC Committee, CO: the Former Yugoslav Republic of Macedonia, UN Doc. CRC/C/15/Add.118, 23 February 2000, § 21; UN CRC Committee, CO: the Former Yugoslav Republic of Macedonia, UN Doc. CRC/C/MKD/CO/2, 23 June 2010, §§ 32-33; UN CRC Committee, CO: Mexico, UN Doc. CRC/C/MEX/CO/3, 8 June 2006, § 32; UN CRC Committee, CO: Sudan 2010, UN Doc. CRC/C/SDN/CO/3-4, 22 October 2010, § 38; UN CRC Committee, CO: India, UN Doc. CRC/C/15/Add.228, 26 February 2004, § 39.

100 Ibidem supra note 82, CRC 1990; Ibidem supra note 85, GC No. 15, § 19; See, e.g., UN CRC Committee, CO: Zambia, UN Doc. CRC/C/15/Add.206, 2 July 2003, § 51(c).

can contribute to the reduction of fear and enhancement of understanding among children within healthcare settings.[101] It is in this context that the CRC Committee has pointedly noted that 'interventions have been found to benefit children most when they are actively involved in assessing needs, devising solutions, shaping strategies and carrying them out rather than being seen as objects for whom decisions are made'.[102] Nevertheless, at this stage, it is important to note that the principle of participation should be applied in combination with Article 5 CRC, namely the evolving capacities of the child, especially with regard to younger children. This means that in circumstances where children have not attained capacity, the parents (or other care-takers/persons legally responsible for the child) acting on behalf of those children must strike a right balance between those children's involvement in the decision-making process related to their health in line with Article 12 CRC and their primary responsibility to ensure the best interests of those children consistent also with Article 18 CRC.

All in all, the aforementioned four principles offer a normative framework and perhaps a tool for State's action in that they prescribe standards about the health process required for the treatment of children in a State's jurisdiction. Hence, it must be conceded that these principles should be translated into the content of the broad state obligation to realize the right to health of the child and given effect in relevant national health legislation and policies. Nevertheless, in light of the preceding analysis, when applying these principles, caution must be exercised against conflating their scope to justify the application of practices prejudicial to children's health, as mentioned earlier.

Accordingly, the Committee recommended that the respective state party 'involve children in formulating and implementing preventive and protective policies and programmes'; Likewise, the CESCR in its GC No. 14 (supra note 14, § 23) has recognised that children's participation is significant for the adoption of appropriate measures to secure their healthy development.; For relevant to the principle of participation provisions in human rights documents with respect to the protection of health, see, also, Annex 1.

101 Importantly, the principle of participation under Article 12(1) CRC should be applied in conjunction with Article 5 CRC (the evolving capacities of the child), which can help in determining the capacity of children to participate meaningfully in the decision-making, namely strike a right balance between children's autonomy in the decision-making and their protection from deciding against life-saving treatments; See also, for the involvement of beneficiaries in determining the nature of measures required for realizing their right to health, J. Tobin 2012 (supra note 60), p. 161.

102 UN CRC, General Comment No. 3: *HIV/AIDS and the Rights of the Child*, UN Doc. CRC/GC/2003/ 3, 17 March 2003, § 12.

(a) '[...] all appropriate legislative, administrative, and other *measures* for the implementation of the rights recognized in the present Convention… *'*

Under Article 4(1) CRC in conjunction with Article 24 CRC, the realization of the right to health requires a State to identify and undertake all appropriate measures to secure the effective enjoyment of the right to health for all children within its jurisdiction (see section 2.2.2). The same obligation stems from Articles 2 § 1 and 12 ICESCR, as elaborated in section 4.2.1. Along with the general obligation in Article 4(1), the right to health provision, Article 24 § 2 CRC, provides that the measures adopted by a State must be 'appropriate' as well as sets forth a list of illustrative and specific measures. Several relevant indications can be detected in the GCs, CO and other documents of the CRC Committee -albeit at a rather high level of obscurity as to what kind of measures the Committee considers to be 'appropriate'. In this regard, a few examples are cited subsequently.

In particular, an elaboration -even though limited- of the appropriate measures listed in Article 24 § 2 can be found in GC No. 15. For instance, the CRC Committee has argued that the right to health of all children within the context of health care cannot be restricted beyond the provision of primary health care to only emergency care, as in the case of adults. The Committee has further stressed that States are under the obligation to ensure universal coverage of quality primary health care including prevention, health promotion, care and treatment services, and essential drugs under all circumstances in the context of fulfilment of their core obligations under every child's right to health.[103] Nonetheless, the Committee has failed to detail in full the actual meaning and implementation of primary health care, whose nature has been controversial and contentious ever since its emergence (see section 2.2.3).[104]

More broadly, the CRC Committee provides some guideposts on the nature of the implementation measures in its GC No. 5.[105] These primarily include:

(a) Legislative measures requiring a comprehensive review of all (proposed and existing) domestic legislation and the recognition of the CRC within domestic legal systems (i.e., its status in relation to its applicability before national

[103] Ibidem supra note 85, GC No. 15, § 73(b); In this regard, the CESCR has stressed that States are under the obligation to provide essential primary health care to every person under all circumstances in the context of fulfillment of their core obligations under the right to health. (UN CESCR, GC No. 14 (supra note 14), § 43 & GC No. 3 (supra note 30, § 10) (see section 3.4); Further, the CESCR has noted that the provision of child health care constitutes an obligation of comparable priority (§ 44(a), GC No. 14).

[104] See, e.g., Ibidem supra note 60, J. Tobin 2012, p. 264 (citing relevant studies).

[105] Ibidem supra note 85, GC No. 5.

courts, by public authorities, in case of conflict with domestic legislation or common practice etc.).[106]

(b) Administrative measures requiring cross-sectoral coordination across and between different levels of government and civil society, in particular children and young people themselves, the development of a comprehensive national strategy based on the framework of the CRC as well as independent and self-monitoring of implementation.[107]

In the meantime, the Guidelines prepared by the CRC Committee to assist States in their reporting process under the CRC are slightly more directed in guiding States to satisfy the requirement of appropriateness. Accordingly, in assessing the appropriate character of measures taken, States are expected to indicate whether they have adopted a comprehensive national strategy for the implementation of the right to health, including efforts to combat diseases particularly among special groups of children at high risk, to address health issues of adolescents.[108] Further, States are required under the Guidelines to specify the effect of the implementation measures for the realization of the right to health by providing data with respect to a number of health indicators.[109]

In light of the above, it must be conceded that States enjoy a margin of discretion as to the selection of the measures they adopt to satisfy their obligation to secure the right to health of children, as they are better aware of their national circumstances than the CRC Committee.[110] However, States are still required to justify whatever measures they adopt as being appropriate under the prevailing circumstances within their jurisdiction. To this aim, analogously to the CESCR, the CRC Committee has endorsed the test of reasonableness for the assessment of the appropriateness of the measures taken on the part of the States for realizing progressively the right to health as well as the criteria listed by the CESCR to this end.[111] In the same broad manner as CESCR, the application of the 'reasonableness

106 Ibid., §§ 18-23.

107 Ibid., §§ 26-27, 28-36 and 46.

108 UN CRC Committee, *General Guidelines regarding the form and the content of Periodic Reports to be submitted by States Parties under Article 44, paragraph 1(b), of the Convention,* UN Doc. CRC/ C/58/Rev.1, 29 November 2005, § 32; latest version of guidelines, UN Doc. CRC/C/58/Rev.2, 25 November 2010, §§ 19(b) and 34.

109 Ibid., UN Doc. CRC/C/58/Rev.2, Annex § F 2.

110 See, e.g., A. Müller, 'Limitations to and Derogations from Economic, Social and Cultural Rights', *Human Rights Law Review* 2009, pp. 557-601, p. 565.

111 UN CRC Committee, Report on the Forty-Sixth Session, UN Doc. CRC/C/46/3, 22 April 2008, ch VII, § 90 (Day of General Discussion on 'Resources for the Rights of the Child

test' is outlined by the CRC Committee with regard to the communications procedure for children under the Optional Protocol III to the CRC.[112] Accordingly, Article 10(4) of the OP III to the CRC on communications provides that 'When examining communications alleging violations of economic, social or cultural rights, the Committee shall consider the reasonableness of the steps taken by the State party in accordance with Article 4 of the Convention. 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 economic, social and cultural rights in the Convention'.[113] As an analysis of the notion of the 'reasonableness' is to be found in the previous section in relation to the CESCR's approach which has been also adopted by the CRC Committee, it is not necessary to repeat it here.

At the same time it remains clear that the CRC Committee retains final authority to assess the course of State action or inaction, as in the case of the CESCR. This, however, alludes that the CRC Committee will have to articulate and give content to its interpretations of the appropriateness requirement in specific cases by setting concrete targets and giving specific guidelines on the measures that must be taken, when formulating its recommendations to States. In practice, in its CO, the CRC Committee has tended to avoid this discussion. Many of its comments are confined to expressions of concern (repeated calls of concern at times) accompanied with general recommendations which are slightly directed in guiding States. For example, the Committee has often expressed concern at the lack of a comprehensive policy[114] and, therefore, urged States, as found in its CO for Philippines to 'develop and implement comprehensive policies and programmes for improving the health situation of children'.[115]

Responsibility of States', 5 October 2007); Ibidem supra notes 37, 38 and 39 as regards the approach taken by the CESCR.

112 Article 10 § 4 of the OP III to CRC, adopted by the General Assembly on 19 December 2011, entered into force on 14 April 2014, UN Doc. A/RES/66/138, 27 January 2012; Ibidem supra note 95, Spronk 2014, pp. 243-249 for an elaboration of the reasonableness requirement in relation to the right to health of the child (citing relevant studies).

113 Ibid.

114 See, e.g. UN CRC Committee, CO: Lithuania, UN Doc. CRC/C/LTU/CO/3-4, 30 October 2013, § 10; CO: Andorra, UN Doc. CRC/C/AND/CO/2, 30 November 2012, § 14.

115 UN CRC Committee, CO: Philippines, UN Doc. CRC/C/15/Add.259, 21 September 2005, § 59(b); See, also, e.g. UN CRC Committee, CO: Algeria, UN Doc. CRC/C/15/Add.269, 12 October 2005, § 57(a); CO: Bangladesh, UN Doc. CRC/C/15/Add.221, 27 October 2003, § 52(a); CO: Liberia, UN Doc. CRC/C/LBR/CO/2-4, 11 December 2012, § 12; CO: Pakistan, UN Doc. CRC/C/15/Add. 217, 27 October 2003, § 53(a); CO: Guinea-Bissau, UN Doc. CRC/C/15/Add.177, 13 June 2002, § 10.

The Committee has, however, alluded that a national health policy must treat children as a heterogeneous group (e.g., by means of adoption of age-adjusted measures) in its work (i.e., GCs and CO), where it suggested three main classifications as to the definition of children on the basis of their age as well as noted the position of vulnerable children.[116] Thereto, States are required to adopt measures that are targeted and adapted to the diverse and changing health needs due to the different developmental stages of specific groups of children, whose age ranges from early childhood to adolescence, as noted earlier in this chapter. It is on this basis that the CRC Committee has noted that during early childhood States must pay attention to areas such as prenatal and post-natal health care for mothers and infants, immunization, the advantages of breastfeeding, and the encouragement of healthy lifestyle practices, involving nutrition, hygiene and sanitation and in practice has welcomed the adoption of such policies in countries.[117] Further, as regards adolescents the CRC Committee has stressed that the focus of State measures must be on additional health issues, involving reproductive health, substance abuse and mental health.[118] For example, in its CO for particular countries, the CRC Committee has often expressed concern on issues involving teenage pregnancy, information accessibility about sexually transmitted diseases, accessibility of counseling services and prevention methods.[119]

At the same time, besides the development and adoption of age-adjusted measures, the CRC Committee has on many occasions observed that States must further consider and develop targeted health interventions that respond to the special and different needs of several groups of vulnerable children.[120] Particularly,

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116 Ibidem supra note 89, GC No. 4, § 2; Ibidem supra note 86, GC No. 7, §§ 27(a)-(b); Ibidem supra note 85, GC No. 15, § 98; Ibidem supra note 60, J. Tobin 2012, pp. 219-220.

117 Ibidem supra note 86, GC No. 7, §§ 27(a)-(b); The CRC Committee welcomes the adoption of State policies, such as policies for improving early growth and development of children (See, e.g., CO: Bosnia and Herzegovina, UN Doc. CRC/C/BIH/CO/2-4, 29 November 2012, § 6(a); See, e.g. UN CRC Committee, CO: Romania, UN Doc. CRC/C/ROM/CO/4, 30 June 2009, § 65; See for a relevant approach, e.g., WHO Regional Office for Europe, *Investing in children: the European child and adolescent health strategy 2015–2020*, Copenhagen: WHO, September 2014.

118 See, e.g., UN CRC Committee, CO: Burkina Faso, UN Doc. CRC/C/15/Add.193, 9 October 2002, § 467; Ibidem supra note 14, GC No. 14, § 23 for an analogous approach adopted by the CESCR as regards adolescents.

119 See, e.g. UN CRC Committee, CO: South Africa, UN Doc. CRC/C/15/Add.122, 22 February 2000, § 31; CO: Israel, UN Doc. CRC/C/ISR/CO/2-4, 4 July 2013, § 56; CO: Lithuania, UN Doc. CRC/C/LTU/CO/3-4, 30 October 2013, § 42.

120 Ibidem supra note 85, GC No. 5, §§ 29-30; Ibidem supra note 86, GC No. 7, § 24; See,

in its CO for certain countries the CRC Committee has repeatedly expressed concern on children belonging to vulnerable groups, such as indigenous children[121], Roma children[122], asylum-seeking or refugee children[123], and children with mental health problems[124], children living in poverty[125].

All in all, we may conclude that beyond its expressions of concern accompanied with general recommendations and guideposts the work of the CRC Committee reveals no intention of itself to elaborate more fully on what constitutes 'all appropriate measures' (i.e., by way of prescribing in detail the measures required by States under the right to health), just as found earlier in the examination of the work of the CESCR. As such, the Committee's work -relatively abstract at times- represents an incomplete approach on the understanding of the clause 'all appropriate means' and it is questionable whether it offers practical insights on this issue for actually guiding States to achieve this end. Meanwhile, in defence of the CRC Committee's approach, one might suggest that the margin of discretion afforded to States can perhaps provoke a public debate[126] (i.e., a constructive dialogue) between the Committee and States as to the definition of the nature of the appropriate measures required under the right to health, whilst ensuring a context-sensitive interpretation of such measures (i.e., national circumstances and challenges).[127]

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e.g., CO: Republic of Moldova, UN Doc. CRC/C/15/Add.192, 31 October 2002, §§ 27(b) and 50(a); Ibidem supra note 60, J. Tobin 2012, p. 220; For vulnerable population groups of children in Greece, see, Chapters 7 (undocumented migrant children) and 8 (Roma children).

121 See, e.g., UN CRC Committee, CO: Canada, UN Doc CRC/C/15/Add.215, 27 October 2003, § 34.

122 See, e.g., UN CRC Committee, CO: Greece, UN Doc CRC/C/15/Add.170, 2 April 2002, § 56(e); CO: Slovakia, UN Doc. CRC/C/15/Add.140, 23 October 2000, § 35; CO: Bosnia and Herzegovina, UN Doc. CRC/C/15/Add.260, 21 September 2005, § 47; CO: Republic of Moldova, UN Doc. CRC/C/15/Add.192, 31 October 2002, §§ 26, 49.

123 See, e.g., UN CRC Committee, CO: Netherlands, UN Doc. CRC/C/NLD/CO/3, 27 March 2009, § 27; CO: United Kingdom of Great Britain and Northern Ireland, UN Doc. CRC/C/GBR/CO/4, 20 October 2008, § 25(b).

124 See, e.g., UN CRC Committee, CO: United Kingdom of Great Britain and Northern Ireland, UN Doc. CRC/C/GBR/CO/4, 20 October 2008, § 57.

125 See, e.g., UN CRC Committee, CO: China, UN Doc. CRC/C/CHN/CO/3-4, 29 October 2013, § 63.

126 See, e.g., Ibidem supra note 85, GC No. 5, § 26. Indeed, the CRC Committee has particularly noted that its work entails '*its ongoing dialogue with Governments* and with the United Nations and United Nations-related agencies, NGOs and other competent bodies' [emphasis added].

127 Ibid.; See, e.g., Ibidem supra note 60, J. Tobin 2012, p. 258; Ibidem supra note 11, E. Riedel

(b) '[…] to the maximum extent of their available resources and, where needed, within the framework of international co-operation.*'*

The right to health of children requires States to adopt a series of measures as such listed in the sub-paragraph of Article 24 CRC, dependent however upon the allocation of States' available resources, namely 'to the maximum extent of their available resources.'[128] On this issue, the work of the CRC Committee has generally identified that the term 'resources' involves not only financial resources, but also human, technological, organizational, natural and information resources, whose allocating by the State must be transparent, effectively, efficiently and participatory.[129] Importantly, this approach has been also endorsed by the CESCR, as observed previously (see section 4.2.1).

In practice, the CRC Committee has tended to adopt a rather haphazard approach in its CO as to the actual meaning of this term. Many of its comments are confined to broad calls for action which do not provide any workable solution - guidance to States on this matter. For example, the CRC Committee has urged in its CO particular States 'to ensure that appropriate resources are allocated for the health sector … for improving the health situation of children'[130], 'to ensure appropriate allocation of the financial, human and technical resources'[131], 'to allocate the necessary resources … with a view to guarantee to all children with disabilities, in particular those living in rural areas, access to … health care'[132], 'increase the resources allocated to the health sector, … for improving the health situation of children'[133] and 'take effective measures to allocate the maximum extent of available resources for social services and programmes for children, and

2009, p. 27. Note that the same abstract approach is also adopted by the CESCR if one looks at the CESCR's work on this issue (i.e., see the comment made earlier when examining the work of the CESCR).

128 Article 4(2) CRC reads as follows: '[…] With regard to economic, social and cultural rights, States Parties shall undertake such [appropriate] measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation'.

129 Ibidem supra note 111, UN CRC Committee, Report on the Forty-Sixth Session, ch VII, §§ 65 & 73-75.

130 UN CRC Committee, CO: Philippines, UN Doc. CRC/C/15/Add.259, 21 September 2005, § 59(b).

131 UN CRC Committee CO: Greece, UN Doc. CRC/C/GRC/CO/2-3, 13 August 2012, § 14.

132 UN CRC Committee CO: Republic of Guinea, UN Doc CRC/C/GIN/CO/2, 30 January 2013, § 64; CO: Guyana, UN Doc. CRC/C/GUY/CO/2-4, 5 February 2013, § 46(c).

133 UN CRC Committee CO: Republic of Guinea, UN Doc CRC/C/GIN/CO/2, 30 January 2013, § 66(a).

that particular attention be paid to the protection of children belonging to vulnerable and marginalized groups'.[134] In addition to the various -broadly phrased- calls for action in relation to the allocation of resources, other comments of the CRC Committee have tended to be limited to expressions of concern without further elaborating on the actual meaning of the term 'the maximum extent of available resources'. For instance, the CRC Committee has on many occasions expressed concern 'at the cuts in social expenditure in the national budget … and at their negative impact on health … welfare areas for children'[135] as well as at the distribution of resources to military expenses to the detriment of expenditure on children' health.[136] In a rather general and abstract sense, the CRC Committee has also suggested States to seek assistance for the realization of the right to health through international co-operation in line with Articles 4(2) and 24 § 4 CRC, which could complement the resources available at the national level.[137] Nonetheless, the Committee has expressed concern with regard to the sustainability of such resources, due to the sole dependence of developing States on foreign aid.[138]

At the same time, beyond broad exhortations and concerns, the Committee has considered the support of families as a part of the term resources by noting in its work 'the importance of systematically supporting parents and families who are among the most important *available resources* for children' [emphasis added].[139] In addition to the support of families, the Committee has identified that States are required to provide sufficient human resources for the purpose of realizing the right to health of children.[140] Put simply, this alludes that a sufficient number of

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134 UN CRC Committee, CO: Costa Rica, UN Doc. CRC/C/15/Add.117, 24 February 2000, § 14.

135 Ibid.; UN CRC Committee, CO: China, UN Doc. CRC/C/CHN/CO/3-4, 29 October 2013, § 13(a) & (b).

136 See, e.g., UN CRC Committee, CO: Sudan, UN Doc. CRC/C/SDN/CO/3-4, 22 October 2010, § 17-18.

137 See, e.g., UN CRC Committee, CO: Guinea-Bissau, UN Doc. CRC/C/15/Add.177, 13 June 2002, § 12; CO: Burkina Faso, UN Doc. CRC/C/BFA/CO/3-4, 9 February 2010, § 17(a) and (f); Ibidem supra note 111, UN CRC Committee, Report on the Forty-Sixth Session, ch VII, § 65.

138 UN CRC Committee, CO: Guinea-Bissau, UN Doc. CRC/C/15/Add.177, 13 June 2002, § 11.

139 Ibidem supra note 111, UN CRC Committee, Report on the Forty-Sixth Session, § 66. This requirement is also reflected in the wording of Article 24 § 2 (e) and (f) CRC which stresses that States must provide information and guidance to parents concerning their children's health needs.

140 See, e.g., UN CRC Committee, CO: Burkina Faso, UN Doc. CRC/C/BFA/CO/3-4, 9

adequately trained health personnel, including paediatric and specialized care practitioners, must be available to respond to the health needs of children within a State's jurisdiction. It is on this basis that the Committee has expressed concern about the structural lack of health personnel as well as the on-going 'skills drain', namely the migration of such personnel from developing States to developed States.[141]

Last but not least, the CRC Committee, rather than detail explicitly and in full what constitutes 'the maximum extent of their available resources', has been confined to general recommendations to States to ensure that expenditure on children's right to health, and particularly the most disadvantaged, constitutes a priority in state budgets.[142] This approach has been affirmed in its GC No. 15, where in a general sense States are required to secure the right to health of children 'even in the context of political or economic crisis or emergency situations' by giving priority, albeit without elaborating on the means to achieve this end (i.e., nature and way of allocation of resources).[143] The Committee has, however, hinted at the optimally distribution of existing (even scarce) resources in its preceding general recommendations where it noted the prioritization of health needs of discrete groups of children in State budgets (see also section 4.2.3).

4.2.3. UN SPECIAL RAPPORTEUR ON THE RIGHT TO HEALTH

Since 1979, special mechanisms, monitoring specific country situations or themes, such as torture, from a human rights perspective, have been established by the then Commission on Human Rights. This UN human rights body was replaced by the UN Human Rights Council (henceforth: HRC) in June 2006. These special procedures are international mechanisms, focused on the advancement of the

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February 2010, § 55; UN CRC Committee, CO: Hungary, UN Doc. CRC/C/HUN/CO/3-5, 14 October 2014, § 47.

141 See, e.g., UN CRC Committee, CO: South Africa, UN Doc CRC/C/15/Add.122, 22 February 2000, §§ 16 and 29; See other sources, 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, Paul Hunt, UN GA, 60th Sess., Agenda Item 73(b),* UN Doc. A/60/348, 12 September 2005, §§ 27-29.

142 See, e.g. UN CRC Committee: CO: Togo, UN Doc. CRC/C/15/Add.83, 21 October 1997, § 34; CO: Nigeria, UN Doc. CRC/C/15/Add.61, 30 October 1996, § 10; CO: Zambia, UN Doc. CRC/C/15/Add.206, 2 July 2003, § 16; CO: Democratic Republic of Korea, UN Doc. CRC/C/15/Add.239, 1 July 2004, § 18; Ibidem supra note 111, UN CRC Committee, Report on the Forty-Sixth Session, ch VII, § 71(a).

143 Ibidem supra note 85, GC No. 15, § 74.

enjoyment of human rights with the explicit objective of elucidating the normative framework of these rights; and the scope of State obligations arising from these rights.[144] Until 1998, the UN Special Rapporteurs have primarily focused on the promotion and protection of CP rights (e.g., the prohibition against torture, freedom of religion).[145] However, in 1998 the focus of attention of this UN special procedure shifted to the protection of ESC rights and the same year the first Special Rapporteur on the Right to Education was appointed (i.e., Katarina Tomaševski under the founding UN Res. 1998/33).[146] Then, in 2000 the appointments of two more Special Rapporteurs on the Right to Food and Adequate Housing followed.[147]

In 2002, the UN decided to establish the position of Special Rapporteur on *the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health* ('Right to Health'). The mandate of the Special Rapporteur on the Right to Health was originally established by the then UN Commission on Human Rights on 22 April 2002 by the founding UN Resolution 2002/31.[148] On the basis of this UN's decision, Paul Hunt of New Zealand was appointed in the position in August 2002 by the Chairperson of the then UN Commission on Human Rights for a term of three years (founding UN Res. 2002/31), which was renewed until July 2008 (Res. 6/29 & Res. 2005/24).[149] In June 2008 the HRC, which replaced the Commission, appointed Anand Grover of India as Special Rapporteur on the Right to Health (term: August 2008 - June 2014, when Dainius Pūras of Lithuania took over), while all existing mandates of the then UN Commission on Human Rights were transferred to this new body.

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144 See Website of the UN <www.ohchr.org/EN/HRBodies/SP/Pages/Introduction.aspx>

145 The mandates of Special Rapporteurs on the Question of Torture and on the Freedom of Religion or Belief were originally established by Res. 1985/33 and 1986/20, respectively.

146 UN Commission on Human Rights, UN Doc. E/CN.4/RES/1998/33, 17 April 1998.

147 The mandates of Special Rapporteurs on the Right to Food and Adequate Housing were originally established by Res. 2000/10 and Res. 2000/9, respectively. It is noteworthy that Special Rapporteurs on the rights essential to social determinants of health, such as education, housing, have made contributions to define respective rights (see, e.g., Report of the Special Rapporteur on the Right to Education, UN Doc. E/CN.4/2004/45, 15 January 2004 and Report of the Special Rapporteur on Adequate Housing as a Component of the Right to an adequate Standard of Living, UN Doc. E/CN.4/2002/59, 1 March 2002).

148 UN Commission on Human Rights, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health,* Res. 2002/31, UN Doc. E/CN.4/RES/2002/31, 22 April 2002.

149 Ibid.; See, also, UN Commission on Human Rights, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health,* Res. 2005/24, UN Doc. E/CN.4/RES/2005/24, 15 April 2005; Ibidem infra note 151, Res. 6/29.

However, the UN HRC reserved the right to review all mandates in the future in order to 'improve and rationalize' them.[150]

Like other Special Rapporteurs, the Special Rapporteur on the Right to Health is an independent expert, working in his/ her personal capacity, appointed to protect and promote a specific human right, the right to health and does not represent any country. The Special Rapporteur does not receive payment by the UN and can serve a maximum of two terms. The Special Rapporteur on the Right to Health has three main areas of work. In order to fulfil the mandate the Special Rapporteur on the Right to Health submits an annual report both to the UN HRC (former: Commission on Human Rights) and to the UN General Assembly on several health-related issues (thematic reports), undertakes official country and other missions (country reports) maximum two per year and receives individual complaints (reports on 'communications') of alleged violations of the right to health.[151] Moreover, the Special Rapporteur can undertake additional activities in the course of his mandate, such as attending relevant meetings organized by governments, international organizations. Resolutions may also request the Special Rapporteur to examine specific issues. For instance, Grover was requested by Res. 15/22 to examine the realization of the right to health of older persons.[152]

Given the broad range of topics employed by the Special Rapporteur on the Right to Health over the years (2002-2015), this section will limit itself to certain issues by means of which the right to health is to be implemented that are increasingly addressed in the reports of the consecutive Special Rapporteurs on the Right to Health. This refinement can add value to the interpretation of the right to health as regards the nature and scope of state measures and available resources, required for its realization.

As increasingly affirmed by Hunt central to the enjoyment of the right to health is the requirement for States to adopt a comprehensive national health strategy

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150 See, § 6 GA Res.- A/RES60/251- that replaced the Commission with the Human Rights Council; Note that the UN HRC appointed Dainius Pūras from Lithuania as Special Rapporteur on the Right to Health at its twenty-sixth session in June 2014.

151 See, UN Commission on Human Rights, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health,* Res. 2003/28, UN Doc. E/CN.4/RES/2003/28, 22 April 2003; UN Human Rights Council, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health,* Res. 6/29, UN Doc. HRC/RES/2007/6/29, 14 December 2007.

152 UN Human Rights Council, *The Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health,* Res. 15/22, UN Doc. A/HRC/RES/15/22, 6 October 2010, § 11.

through the participation of all relevant beneficiaries, including marginalized groups.[153] He has repeatedly declared that the active and informed participation of individuals and communities in health policymaking that affects them is a significant feature of the right to health.[154] A similar attitude is also adopted by Grover and Pūras in their own reports to the General Assembly and the Human Rights Council, respectively.[155] Nevertheless, Hunt has observed that effective participation of all stakeholders is a difficult task for States to perform, in that it requires both time and 'innovative arrangements' which will rely upon existing local and national democratic structures.[156] As a way to promote participation of all stakeholders, Hunt identified human rights impact assessments.[157] Particularly, he has explained that the objective of impact assessments is to inform decision-makers and the likely

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153 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, Paul Hunt, UN GA, 62nd Sess., Agenda Item 72(b),* UN Doc. A/62/214, 8 August 2007, §§ 24-25; 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 HRC, 7th Sess., Agenda Item 3,* UN Doc. A/HRC/7/11, 31 January 2008, § 89; 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, 62nd Sess., Agenda Item 10*, UN Doc. E/CN.4/2006/48, 3 March 2006, §§ 7, 25 and 49(c)(i).

154 See, e.g., Ibid.; 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 GA, 59th Sess., Agenda Item 105 (b).* UN Doc. A/59/422, 8 October 2004, § 24; Ibid., UN Doc. A/62/214, § 84; 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, 61th Sess., Agenda Item 10*, UN Doc. E/CN.4/2005/51, 11 February 2005, §§ 59-61; 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 GA, 63rd Sess., Agenda Item 67(b),* UN Doc. A/63/263, 11 August 2008, § 55 and Annex § 9.

155 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, 67th Sess., Agenda Item 70(b),* UN Doc. A/67/302, 13 August 2012, §§ 4 and 7; 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, §§ 110-111.

156 Ibidem supra note 154, UN Doc. A/59/422, § 25.

157 Ibidem supra note 153, UN Doc. A/62/214, §§ 37, 40-41 and 44; Note that Hunt has identified human rights impact assessment also as a monitoring and accountability mechanism (see, UN Doc. A/58/427, 10 October 2003, § 53(i) and UN Doc. A/59/422, 8 0ctober 2004, § 38).

affected individuals/groups so as to enhance a proposed initiative by minimizing potential negative consequences and increasing positive ones, prior to its finalization and adoption.[158] Nonetheless, several scholars have been critical of the views expressed by Hunt in relation to the notion of participation.[159] For instance, it has been commented that effective participation (i.e., active and informed participation) of *all* stakeholders [emphasis added] is 'simply unworkable' in that it demands both time and resources both of which will invariably be restricted.[160] Meanwhile, in addition to participation, much attention in the reports of the Special Rapporteurs is drawn to the notion of accountability. Hereto, all three consecutive Special Rapporteurs have emphasized the importance of effective accountability mechanisms in relation to the right to health, involving priority-setting process, in several reports since 2002.[161] For instance, Hunt has stressed that accountability is concerned with ensuring*, inter alia*, that the right to health 'is being progressively realized for all, including disadvantaged individuals, communities and populations'.[162]

Another issue that has been consistently looked at in the reports of the respective body is the concept of vulnerability in relation to the enjoyment of the right to health. It is within this context that Hunt has remarked that 'vulnerability and disadvantage are among the reasonable and objective criteria that must be applied when setting priorities'.[163] Herein, Grover has suggested that 'vulnerable groups should not be limited to those specific groups mentioned in General Comment No. 14, but should include any group that is disproportionately affected by a particular ailment or otherwise marginalized on account of its members' political, social or economic exclusion; discrimination and stigmatization suffered by that group; restrictions in law or in practice on giving informed consent or

158 Ibidem supra note 153, UN Doc. A/62/214, § 37.

159 See, e.g., U. Baxi, 'Place of the Human Right to Health and Contemporary Approaches to Global Justice', in: Harrington and Stuttaford (eds.), *Global Health and Human Rights*, London and New York: Routledge 2010, pp. 12-27, p. 18 (citing relevant studies); Ibidem supra note 60, J. Tobin 2012, p. 217.

160 Ibidem supra note 60, J. Tobin 2012, p. 217.

161 See, e.g., UN Doc. A/59/422 (supra note 154), §§ 17, 36-41; UN Doc. A/62/214 (supra note 153), § 27; UN Doc. E/CN.4/2005/51 (supra note 154), §§ 67-75; UN Doc. A/63/263(supra note 154) § 8-18 (citing relevant reports); 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 HRC, 17th Sess., Agenda Item 3*, UN Doc. A/HRC/ 17/43, 16 March 2011, § 49(g); UN Doc A/67/302 (supra note 155), § 7; UN Doc. A/HRC/ 29/33 (supra note 155), §§ 29 and 34.

162 Ibidem supra note 153, UN Doc. A/HRC/7/11, § 101.

163 Ibidem supra note 153, UN Doc. A/62/214, § 26.

exercising full autonomy by members of that group; or the group's inability to enforce rights, gain access to State benefits or enjoy regulatory protection.'[164] Of note, all three consecutive Special Rapporteurs have paid particular attention to several vulnerable groups and their prospects for enjoyment of the right to health, including women, children, members of ethnic minorities and people with a low socio-economic status.[165] For instance, Grover has observed that in terms of fulfilling the right to health, States are required to adopt and implement a national health policy that does not discriminate against non-nationals and address their special health needs.[166] By way of example, he has recommended States to 'abolish discriminatory immigration policies that require mandatory testing for health conditions, such as HIV and pregnancy, which are not based on clearly established scientific evidence and violate the right to health'.[167] He went further by stressing that States should 'delink access to health facilities, goods and services from the legal status of migrant workers and ensure that preventative, curative and emergency health facilities, goods and services are available and accessible to all migrant workers, including irregular migrant workers, in a non-discriminatory manner'.[168]

Aligned with the requirement for special attention to the position of vulnerable

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164 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, § 28; See, also, 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 HRC, 4th Sess., Agenda Item 2*, UN Doc. A/HRC/4/28/Add.2, 28 February 2007, § 73.

165 See, e.g., Ibid.; UN Doc. A/HRC/29/33 (supra note 155), §§ 35 and 44; 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, Paul Hunt. UN ESCOR, Commission on Human Rights, 59th Sess., Agenda Item 10,* UN Doc. E/CN.4/2003/58, 13 February 2003, § 66 (racial and ethnic minorities); 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, 64th Sess., Agenda Item 71(b).* UN Doc. A/64/272, 10 August 2009, pp. 13-23 (children, women, ethnic minorities, indigenous persons, persons with disabilities etc.); 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, § 31(poor and marginalized women).

166 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 HRC, 23rd Sess., Agenda Item 3,* UN Doc. A/HRC/23/41, 15 May 2013, § 11.

167 Ibid., UN Doc. A/HRC/23/41, § 76(g).

168 Ibid., UN Doc. A/HRC/23/41, § 76(h).

population groups within the context of designing and implementing (a context-sensitive) national health strategy, Hunt has repeatedly emphasized that States have to develop effective and responsive health systems as well as the critical role of health professionals to achieve this end.[169] Illuminating in this respect is his analysis on right-to-health features of a health system, where he underlines that 'at the heart of the right to the highest attainable standard of health lies an effective and integrated health system, encompassing health care and the underlying determinants of health, which is responsive to national and local priorities, and accessible to all. Without such a health system, the right to the highest attainable standard of health can never be realized' (see section 3.7).[170] In this analysis, Hunt also asserts that a health system is connected to the social determinants of health, due to its potential 'to secure sustainable development, poverty reduction, economic prosperity, improved health for individuals and populations, as well as the right to the highest attainable standard of health'.[171] At the same time it must be accepted that the development of such health system largely depends upon adequately trained health professionals whose overall task is to improve individual and public health, and who represent the human resources required by States as observed earlier.[172]

On the issue of the available resources and their allocation, Hunt has underpinned -albeit at a relatively general level- that due to the availability of resources one of the pressing challenges for the realization of the right to health is its effective integration

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169 See, e.g., UN Doc. A/HRC/7/11 (supra note 153), § 15; UN Doc. E/CN.4/2006/48 (supra note 153), § 4.

170 Ibidem supra note 153, UN Doc. A/HRC/7/11, § 15; Note that the preamble of the WHO Constitution provides that 'Governments have a responsibility for the health of their peoples, which can be fulfilled only by the provision of adequate health and social measures' (Constitution of the World Health Organization, adopted by the International Conference held in New York 22 July 1946, entered into force 7 April 1948, 14 UNTS 185).

171 Ibidem supra note 153, UN Doc. A/HRC/7/11, § 16; Note that the CSDH has also argued in its final report that a health system is an important determinant of health, which interacts with other social determinants, such as education and occupation in terms of access to health care. (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: World Health Organization 2008, pp. 8, 94).

172 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 GA, 60th Sess., Agenda Item 73(b),* UN Doc. A/60/348, 12 September 2005, §§ 8-17; 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 HRC, 4th Sess., Agenda Item 2,* UN Doc. A/HRC/4/28, 17 January 2007, § 41.

in national and international health-related policy making.[173] In fact, Grover has declared that the clause of 'available resources' has not been explicitly defined within the right to health framework or GC No. 3 of the CESCR.[174] Nonetheless, this incomplete perspective on available resources may be problematic as this term could be interpreted as a *carte blanche* by States and applied in practice in diverse ways -i.e., States could do as they please-.[175] It was on this basis that Grover argued that this clause 'could mean a State's entire gross domestic product or a specified percentage thereof, or it could be limited to the amount allocated to the State's health budget or limited to the amounts allocated to a particular health concern'.[176] In spite of this conceptual obscurity, he opined that the term 'available resources' tends to refer to 'the totality of a State's 'real' resources, involving informational, technical, organizational, human, natural and administrative resources, above and beyond budgetary allocations'.[177] In terms of reviewing the amount of available resources provided by States, Grover highlighted also the need for States to manage the existing budget efficiently by focusing on the reasonableness of the policymaking; on the impact upon vulnerable groups; on the transparency and participatory nature of such process; and to generate additional resources, which may include, for instance, changes to the State's taxation policy, smart incurrence of debt or international funding under the state obligation to internationally co-operate (see section 4.4).[178]

In the meantime it must be conceded that the realization of the right to health does not rely solely on the accumulation and increase of a State's resources, but also on the way of allocating existing (even limited) resources in a State's budget. In other words, States should make optimally use of such resources, by giving first priority to their populations' most basic health needs, including paying attention to vulnerable groups, such as undocumented migrants, minorities (Roma), regardless of resource constraints owed to external circumstances (e.g., an influx of refugees, an outbreak of an epidemic or an economic recession etc.).[179] As such,

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173 Ibidem supra note 153, UN Doc. A/62/214, §§ 11-12.

174 Ibidem supra note 164, UN Doc. A/69/299, § 21.

175 See, e.g., supra note 11, E. Riedel 2009, p. 30.

176 Ibidem supra note 164, UN Doc. A/69/299, § 21.

177 Ibid.

178 Ibidem supra note 164, UN Doc. A/69/299, §§ 21 & 75(e); 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, 67th Sess., Agenda Item 70(b),* UN Doc. A/67/302, 13 August 2012, §§ 7, 15 and 22.

179 Ibidem supra note 165, UN Doc. E/CN.4/2003/58, § 27; Ibidem supra note 164, UN Doc. A/69/299, § 29; See, generally, A. Chapman & S. Russell, *Core Obligations: Building a Framework for Economic, Social and Cultural Rights*, Belgium: Intersentia 2002.

the amount of adequate funds to be available for health should be informed by the core obligations of the right to health, which establish a 'funding baseline'.[180] Additionally, as to the way in which existing resources should be distributed within a State, Grover has recommended that the realization of the right to health should not be given priority over other competing demands on the State, as he has indicated 'available resources should imply the maximum amount of resources that can be allocated to a specific health objective without compromising other essential services', such as spending on education, social security, defence.[181] He went further by explaining that a State's decreasing budgetary allocation for its right to health obligations vis-à-vis its increasing GDP or increasing allocation to areas other than those relating to the right to health may be evidence that the State has chosen to allocate insufficient expenditure or misallocate available resources to fulfil the right to health which may amount to a violation of this right.[182] As such, Grover acknowledged that it is the burden of the State to demonstrate that the amount of its available resources does not 'permit' the fulfillment of its right to health obligations.[183] This could be achieved through the provision by the State information on the calculation of its available resources, budget allocations and state efforts to increase the available resources.[184]

From the perspective of the preceding analysis the following observations can be discerned. First, the views expressed by the consecutive Special Rapporteurs on the Right to Health in their reports are more informative in character rather than determinative as to the measures required by States. It seems that these reports endeavor to play a role in the development of the right to health primarily at a policy level by making it more tangible and operational (e.g. report on mental disability), before violations occur. It was on this basis that some scholars have been critical of the work of the Special Rapporteur. Baxi -legal scholar and being perhaps the most striking example- opined that the Special Rapporteur focuses more on policy and planning measures (i.e. policy approach) and less on legislative measures, involving the role of legislation and litigation through courts in the realization of the right to health (i.e. judicial approach - legal enforcement of the

180 Ibidem supra note 155, UN Doc A/67/302, § 9.

181 Ibidem supra note 164, UN Doc. A/69/299, § 22; Ibidem supra note 155, UN Doc. A/67/302, § 7.

182 Ibidem supra note 164, UN Doc A/69/299, § 23; Ibidem supra note 155, UN Doc A/67/302, § 6.

183 Ibidem supra note 164, UN Doc A/69/299, § 23.

184 Ibidem supra note 164, UN Doc A/69/299, § 23.

right).[185] Second, it was identified that the work of this monitoring body not only affirms the authoritative approach adopted by the CESCR in GC No. 14 (see section 3.5), but also expands the notion of certain elements of the right to health, such as the development of accountability and participation mechanisms, and looks at them in relation to specific population groups. Third, it is repeatedly indicated in the reports of this body that the adoption of a national health strategy by a State must be both comprehensive and targeted to the diverse health needs of various population groups, especially of vulnerable groups, within a State's jurisdiction if it is to be appropriate. Several groups of people have been identified for being vulnerable to violations of their right to health. As such, measures required by States have to consider the diverse aspects of all existing vulnerabilities. Fourth, the position advanced by Grover reflects a comprehensive understanding as to the meaning of the term available resources and their calculation. It was generally submitted that whatever measures adopted by a State for the purpose of realizing the right to health, these remain subject to the resources available in a State and in the case of resource constraints to the way of accumulating and allocating them on the part of the State. The first step, though, towards this aim is the calculation of the amount of the resources to be available for health within a State. Thereto, it was identified that the least/minimum amount of such resources should be informed by the core obligations of the right to health which constitute a 'funding baseline'.

All in all, it can be observed that the work of the consecutive Special Rapporteurs places an explicit emphasis on the way/process by which States should fulfil their right to health obligations and its outcomes and is less focused on the specification of principal health measures required by States. At the same time, one can argue that such an approach -albeit it has received criticism by scholars- which was also evident in the work of both the CESCR and the CRC Committee, as elaborated previously, tends to provide a common ground of understanding as to the nature of measures required by States under the right to health. Nonetheless, one may agree with a view that the role of legislative measures, litigation through courts and tribunals, which points out, *inter alia*, the justiciability of the right to health, require more considered attention in that their application is equally important to the realization of the right to health (see below section).

[185] Ibidem supra note 159, U. Baxi 2010, p. 14; As regards to the policy approach of the respective Rapporteur see, e.g., UN Doc A/HRC/29/33 (supra note 155), §§ 37-38 and 120.

4.3. EXPLORING THE JUSTICIABILITY OF THE RIGHT TO HEALTH: A FOCUS ON EUROPE

Unlike civil and political rights, the justiciability of economic, social and cultural rights is subjected to a continuous debate since the genesis of such rights.[186] Generally speaking, there are human rights bodies that argue in favor of the justiciability of ESC rights, while at the same time there are scholars who argue otherwise.[187] The CESCR in its GC No. 9 has generally acknowledged that States in terms of their obligation to give effect to the rights recognized in ICESCR must, *inter alia*, provide appropriate means of redress or remedies and appropriate means of ensuring governmental accountability.[188] Further, the Committee has recognized that 'there is no Covenant right which could not, in the great majority of systems, be considered as to possess at least some justiciable dimensions'.[189] Likewise, the former UN Special Rapporteur of the Sub-Commission on the Promotion and Protection of Human Rights on the realization of ESC rights, Türk explicitly expressed an argument for the justiciability of ESC rights. In particular, he stated that 'States should establish, whenever possible, appropriate judicial or administrative review mechanisms concerning economic, social and cultural rights. The identification of core obligations of States regarding these rights should facilitate justiciability of those economic, social and cultural rights which cannot, as yet, be considered justiciable in all States'.[190]

Importantly, judicial enforcement of the right to health is essential for people

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[186] J. Sellin, 'Justiciability of the Right to Health - Access to Medicines. The South African and Indian Experience', *Erasmus Law Review* 2009 Volume 2 Issue 4, pp. 445-464, p. 451; See, generally, 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, pp. 1-16; The term 'justiciability' is used within the context on whether an alleged violation of ESC rights can be reviewed by a judicial or quasi-judicial body (see F. Coomans 2006, p. 4).

[187] Ibid.; See, e.g., arguments for and against the justiciability on the right to equal access to health care, M. San Giorgi, *The Human Right to Equal Access to Health Care*, Cambridge/ Antwerp/ Portland: Intersentia 2012.

[188] Ibidem supra note 32, GC No. 9, §§ 1-2.

[189] Ibidem supra note 32, GC No. 9, § 10; See also, concerning the right to health: UN CESCR, GC No. 14 (supra note 14), § 1.

[190] UN, *The Realization of Economic, Social and Cultural Rights: Report of the Special Rapporteur, Danilo Türk, UN ESCOR, Commission on Human Rights, 44th Sess., Agenda Item 8,* UN Doc. E/CN.4/Sub.2/1992/16, 3 July 1992, § 224.

who are victims of a violation of their right to health and seek for protection.[191] As such, the CESCR has established in GC No. 14 that along with the obligation to adopt legislative and policy measures, States are under the obligation to provide effective remedies in order to ensure the effective enjoyment of the right to health by all persons within their jurisdiction.[192] In addition, the CESCR has elaborated that National Ombudsmen, human rights commissions, consumer forums, patients' rights associations and similar institutions must address violations of this right.[193] Interestingly, a similar position has been endorsed by the CRC Committee in its GC No. 15.[194] From the perspective of strengthening the justiciability of the right to health, the CESCR has also recommended the incorporation in the domestic legal order of international instruments that recognize the right to health.[195]

In the meantime, it is arguable that the right to health, as part of the ESC rights is hardly given the same degree of importance in a court of law or a quasi-judicial procedure as happens with CP rights.[196] In academic literature, Scheinin, for example, points out that some authors express the view that ESC rights lack 'justiciability' because their nature prevents them from being '… invoked in courts of law and applied by judges', while others base their objection to justiciability on the largely 'political', not legal character of treaty obligations.[197] As such, it is noteworthy that

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191 Ibidem supra note 14, GC No. 14, § 59. Accordingly, the CESCR has stated that 'Any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both the national and international level. All victims of such violations should be entitled to adequate reparation, which may take the form of restitution, compensation, satisfaction or guarantees of non-repetition'.

192 Ibid.

193 Ibidem supra note 14, GC No. 14, § 59.

194 Ibidem supra note 85, GC No. 15, §§ 119-120.

195 Ibidem supra note 14, GC No. 14, § 60; See, also, UN CESCR, General Comment No. 2: *International Technical Assistance Measures (art.22)*, 2 February 1990, E/1990/23, § 9; UN CRC Committee, General Comment No. 2 *(2002) on the role of independent national human rights institutions in the promotion and protection of the rights of the child*, *Official Records of the General Assembly, Fifty-ninth Session, Supplement No. 41* (A/59/41), annex VIII.

196 See, Article 2 § 1 ICESCR, where 3 clauses regulate the realization of ESC rights, such as the right to health, unlike CP rights (Article 2 ICCPR). These include the obligation 'to take steps', the obligation of progressive realization and the realization to the maximum of the available resources; See, e.g., arguments for the justiciability on the right to equal access to health care, M. San Giorgi 2012 (supra note 187).

197 M. Scheinin, 'Economic and Social Rights as Legal Rights' in: A. Eide, C. Krause & A. Rosas (eds.) *Economic, Social and Cultural Rights: A Textbook*, Dordrecht/Boston/London: Martinus Nijhoff Publishers 2001, pp. 29-54, p. 29.

the legal nature of the right to health is partly due to its connection to other human rights (see section 2.5), as it is often dealt with by adjudicatory bodies *via* civil and political rights. Such a position has been defended by academics. In an elaborate analysis of national and international jurisprudence, Hendriks notes that the right to health can be most often invoked before a court either by relying on a classical human right such as the right to life, or by claiming that the State has violated the principle of non-discrimination. Nevertheless, he concludes that courts or quasi-judicial bodies explicitly acknowledge that States are required to ensure a minimum level of health protection, (equal access to) essential health care and satisfaction of basic human needs.[198]

Over the last decades several developments have taken place at the international and regional level that enforced the justiciability of ESC rights, including the right to health.[199] As such, this section will elaborate on such developments through focusing on Europe, namely on the work of a quasi-judicial body, the European Committee of Social Rights (ECSR), the monitoring body of the (Revised) ESC.[200] In particular, at the CoE level, under the Additional Protocol to ESC, which provides a system of collective complaints, social partners and non-governmental organizations, not individuals, are entitled to lodge complaints of violations of the Charter with the ECSR.[201] In case of admissible complaints, the Committee examines them and then its decision, laid down in a report, is forwarded to the Committee of Ministers. The Committee of Ministers may then, based on this report, adopt a resolution recommending the State to take action to meet its obligations under the Charter.[202] Since 1998, within the framework of collective complaints procedure 118 complaints have been filed before the ECSR, of which around a third has addressed various health-related issues, varying from the consequences of industrial activities on health and the protection of the occupational health of workers to access to healthcare for undocumented migrants, Roma, and sexual and reproductive health education.[203] Subsequently, this collective complaints procedure in relation to the

198 A. Hendriks, 'The Right to Health in National and International Jurisprudence', *European Journal of Health Law* 1998, Volume 5, pp. 389-408, pp. 402-403.

199 Ibidem supra note 186, F. Coomans 2006, pp. 1-16, p. 2; Note that at the international level the entry into force of the OP to ICESCR on 5 May 2013 and the OP to CRC on a communications procedure on 14 April 2014 took place.

200 Article 25 (Revised) ESC.

201 The AP ESC provided a system of collective complaints, adopted 9 November 1995 (entered into force in July 1998), CETS 158; See, Articles 1-2 AP ESC.

202 Article 9(1) AP ESC.

203 Up until June 2015. See collective complaints list and state of procedure established by the

way of interpretation of the right to health is set out through an exemplary analysis of three cases, serving as a representative illustration thereof.

Accordingly, in 2004 the ECSR found that 'legislation or practice which denies entitlement to medical assistance to foreign nationals, within the territory of a State Party, even if they are there illegally, is contrary to the Charter'.[204] The Committee further stressed that health care is a prerequisite for the preservation of human dignity, which is a fundamental value in European human rights law.[205] Hence, within the context of rights and state obligations, this means that people unlawfully present in a State shall not be denied all entitlement to medical assistance and that access to health care shall not be dependent on lawful residency within the respective State.[206] However, the ECSR clarified that the reforms of the State medical assistance (Aide Médicale de l'Etat) and the Universal sickness cover (Couverture maladie universelle), namely the provision to meet certain costs of health care for an uninterrupted period of more than three months as well as treatment for emergencies and life threatening conditions can be considered sufficient to meet the criteria of Article 13 (Revised) ESC.[207] At the same time, the ECSR pointedly noted that 'the concept of emergencies and life threatening conditions is not sufficiently precise' and, thereby, in practice there are difficulties in the implementation of such provisions concerning access to medical care for undocumented migrants.[208] Nevertheless, the ECSR found that French legislation

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Committee, at: http://www.coe.int/t/dghl/monitoring/socialcharter/Complaints/Complaints_en.asp; See, e.g., Complaint No. 22/2003, *Confédération générale du travail (CGT) v. France*, Complaint No. 30/2005 *Maragopoulos Foundation for Human Rights (MFHR) v. Greece*, Complaint No. 19/2003 *World Organization Against Torture (OMCT) v. Italy* and Complaint No. 45/2007, *INTERIGHTS v. Croatia*, Complaint No. 14/2003, *International Federation of Human Rights Leagues (FIDH) v. France*, Complaint No. 69/2011, *Defence for Children International (DCI) v. Belgium*, Complaint No. 47/2008, *Defence for Children International (DCI) v. The Netherlands*, Complaint No. 46/2007, *European Roma Rights Centre (ERRC) v. Bulgaria*.

204 ECSR, *International Federation of Human Rights (FIDH) v. France*, Complaint No. 14/2003, 8 September 2004, § 32.

205 Ibid., § 31.

206 Ibid., § 32.

207 Ibid., §§ 33-34.

208 Ibid., § 34; See, also, Council of Europe, Report of the Ad hoc Working Group on Irregular Migrants (MG-AD), rapporteur: Ryszard Cholewinski, 17-18 December 2003, Doc MG-AD (2003), Strasbourg 12 March 2004, p. 15. It is argued that lack of agreement persists as to what emergency medical care encompasses. For instance, Belgium and Netherlands adopt a broad definition of this term, while Germany a narrower one.

reforms did not violate Article 13 of the Charter as undocumented migrants were not deprived of all entitlement to medical assistance. Meanwhile, the ECSR ruled that other standards apply to undocumented migrant children under Article 17 Revised ESC which protects, in a general manner, the right of children and young persons, including unaccompanied minors, to care and assistance and that French legislation reforms violated this entitlement.[209] (see also chapter 7)

In 2008, the ECSR found that the Bulgarian health insurance legislation discriminated against the most vulnerable groups, including the Roma community, due to insufficient measures to ensure health care for these groups.[210] In particular, the Committee stated that under Article 13 § 1 (Revised) ESC vulnerable people without resources in the event of sickness are entitled to free emergency, hospital, primary and specialized outpatient medical care or coverage of expenses for such types of care.[211] Further, the Committee stressed that Article 11 (Revised) ESC 'imposes a range of positive obligations to ensure an effective exercise of the right to health' and it 'assesses compliance with this provision paying particular attention to the situation of disadvantaged and vulnerable groups'.[212] In this regard, the Committee explicitly underscored health inequalities with regard to the Roma in Bulgaria. The Committee stated that Bulgaria had failed to 'take reasonable steps to address the specific problems faced by Roma communities stemming from their unhealthy living conditions and difficult access to health services'.[213] The ECSR concluded that the legislation (Health Insurance Act) violated Article 11 §§ 1, 2 and 3 (right to health) in conjunction with Article E (non-discrimination) of the Charter as well as Article 13 § 1 (right to social and medical assistance) of the Charter.[214]

In 2013, the ECSR found that Greece had violated the ESC by not responding adequately to the serious environmental pollution and the health hazards in the area of the River Asopos and near the industrial region of Oinofyta caused by liquid industrial waste.[215] Particularly, the Committee noted that 'Under Article 11 of the Charter, everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable … and that in order

[209] Ibid., §§ 36-37.
[210] ECSR, *ERRC v. Bulgaria*, Complaint No. 46/2007, 3 December 2008.
[211] Ibid., §§ 43-44.
[212] Ibid., § 45.
[213] Ibid., § 49.
[214] Ibid., §§ 44 and 51.
[215] ECSR, *International Federation for Human Rights (FIDH) v. Greece,* Complaint No. 72/2011, 23 January 2013.

to fulfill their obligations, national authorities must take specific steps'.[216] In this regard, the Committee stressed that 'in view of the threats of damage to human health of the local inhabitants, according to Article 11 §§ 1 and 3, appropriate measures aimed at removing and preventing all causes of ill-health and diseases in the region of Oinofyta should have been implemented by the Greek authorities'.[217] As such, the Committee ruled that 'these deficiencies constitute a violation of Article 11§§1 and 3 of the Charter'.[218] In addition, the Committee found that 'the Greek authorities did not take appropriate measures to provide advisory and educational facilities for the promotion of health in the present case' thus finding a violation of Article 11 § 2 of the Charter.[219]

The preceding non-exhaustive analysis of the ECSR decisions, without, though, being strictly legally binding for the respective States, invites three observations. First, the ECSR in some decisions interprets the right to health within the context of either the right to health care (Article 11, access to health care) or the underlying determinants of health (Article 11, e.g., access to uncontaminated water, food safety, reproductive and environmental health).[220] Second, some decisions rely on other health-related rights (e.g. Article 13 - the right to social and medical assistance, Article 17 -the right of children and young persons to social, legal and economic protection) where interpreted by the Committee to protect health.[221] Third, some decisions build upon both the right to health (Article 11) and other health-related rights (e.g. Article 13, Article E on non-discrimination).[222] Thereto, one may argue that the aforementioned ECSR decisions can have significant added value not only in bridging the gap between the various contentious arguments with respect to the justiciability of the ESC rights (e.g., the right to health), but also in shaping future decisions of courts and/or quasi-judicial bodies concerning ESC rights.

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216 Ibid., § 146.

217 Ibid., § 149.

218 Ibid., § 154.

219 Ibid., §§ 159-160.

220 See also, e.g., *FIDH v. Greece,* Complaint No. 72/2011, 23 January 2013; *Maragopoulos Foundation for Human Rights (MFHR) v. Greece*, Complaint No. 30/2005, 6 February 2007; *INTERIGHTS v. Croatia*, Complaint No. 45/2007, 30 March 2009.

221 See also, e.g., *FIDH v. France*, Complaint No. 14/2003; *European Roma Rights Center (ERRC) v. Bulgaria*, Complaint No. 48/2008.

222 See also, e.g., *ERRC v. Bulgaria*, Complaint No. 46/2007 *Defence for Children International (DCI) v. Belgium*, Complaint No. 69/2011, 23 October 2012; *Medecins du Monde-International v. France*, Complaint No. 67/2011.

4.4. INTERNATIONAL CO-OPERATION

Given that our world becomes highly interconnected (e.g., see international outbreaks, such as the outbreaks of swine flu in 2009, the Ebola epidemic in 2014, and the Zika virus in 2015), efforts to protect health must take into account the potential implications of international co-operation on the realization process of the right to health, an interdependent right (see section 2.5).[223] It is within this context that WHO pointedly notes that 'health is a shared responsibility, involving equitable access to essential care and collective defence against transnational threats'.[224] As such, WHO identifies the need for internationally shared responsibility for the protection of health as well as the international existence and spread of threats against the health of all people, mainly posed by infectious diseases, such as the Ebola epidemic (see section 2.2.3).[225] Such a position is well supported when looking at the 2005 International Health Regulations adopted by WHO, which expressly refer to human rights as well as concede the significance of human rights protection in case of health emergencies of international concern.[226]

Within the context of human rights law, Article 2 § 1 ICESCR obliges States to 'take steps, individually and through international assistance and cooperation, especially economic and technical' to progressively realize all economic and social rights including the right to health.[227] Likewise, Article 4 CRC affirms this broad state obligation and provides that States must take all appropriate measures to realize the rights, including the right to health, and 'where needed, within the framework of international co-operation'.[228] At the same time, in relation to the right to health of all children Article 24 § 4 CRC explicitly requires of States to promote and encourage international co-operation with a view to achieving

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223 Vienna Declaration and Programme of Action, adopted by the World Conference on Human Rights in Vienna on 25 June 1993, Part I, § 5; Ibidem supra note 14, GC No. 14, §§ 1, 3 and 40; WHO, International Health Regulations 2005- 2nd ed, Geneva: World Health Organization 2008.

224 See, World Health Organization Website 2016. <http://www.who.int/workforcealliance/members_partners/member_list/who/en>.

225 Ibidem supra note 223, WHO, International Health Regulations 2005, p. 4, § 6(2) & Annex 2; See, e.g., L.O. Gostin, 'Ebola: towards an International Health Systems Fund', *The Lancet* 2014, Volume 384, No 9951, pp. e49–e51.

226 Ibidem supra note 223, WHO, International Health Regulations 2005; See also section 2.2.3.

227 Ibidem supra note 20; See, also, UN CESCR, GC No. 3 (supra note 30), § 14. The CESCR has stressed that 'It is particularly incumbent upon those States which are in a position to assist others in this regard'.

228 Ibidem supra note 82, CRC 1990.

progressively the full realization of this right, with taking particular account of the needs of developing countries (see section 2.2.2).

Added to the respective provisions of human rights law, human rights bodies also consider international co-operation as part of the state obligations for realizing the right to health. For instance, Hunt opined that 'in addition to obligations at the domestic level developed States have a responsibility to provide international assistance and cooperation to ensure the realization of economic, social and cultural rights in low-income countries. This responsibility arises from recent conferences, including the Millennium Summit, as well as provisions of international human rights law'.[229] Nevertheless, he pointedly observed that the parameters of international co-operation are not yet fully drawn.[230] Indeed, an explicit and detailed definition of the duties of international co-operation -by way of concrete measures- is absent in the wording of the respective provisions in both ICESCR and CRC, as quoted previously.[231]

It was on this basis that human rights bodies attempted to inform the meaning and scope of this general state obligation in a way to delineate its ensuing state obligations involving particular areas of extraterritorial co-operation in realizing the right to health. In its authoritative source, GC No. 14 the CESCR has made a number of observations concerning this general State obligation, albeit at a somewhat high level of abstraction as to the measures required by States. By making a partial reference to the terminology of the tripartite typology of States' obligations (see section 3.3) the Committee attempted in a relatively haphazard fashion to elucidate the nature of the ensuing state obligations in this field. In a general sense, the Committee establishes that the State obligation for international co-operation involves the duties to respect the enjoyment of the right to health in other countries, to prevent third parties from violating this right in other countries (i.e. to protect) as well as to facilitate (i.e. a sub-category of the duty to fulfil) access to essential health facilities, goods and services in other countries, wherever possible, and provide (i.e. a sub-category of the duty to fulfil) the necessary aid when required.[232]

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[229] 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, 16 February 2004, § 45; Ibidem supra note 165, UN Doc. E/CN.4/2003/58, § 28.

[230] Ibidem supra note 172, UN Doc. A/60/348, § 60.

[231] See, e.g., E. Riedel 2009 (supra note 11), p. 30.

[232] Ibidem supra note 14, GC No. 14, § 39; Ibidem supra note 85, GC No. 15, § 86; See section 3.3 on the 'tripartite typology'(respect, protect and fulfil) of state obligations; See, e.g., as regards other ESC rights, UN CESCR, *General Comment No. 12: The right to food*, UN

This means that the level of the duty to respect would require States 'refrain *at all times* from imposing embargoes or similar measures restricting the supply of another State with adequate medicines and medical equipment. Restrictions on such goods should never be used as instruments of political and economic pressure' [emphasis added].[233] Similarly, at a relatively abstract level Hunt affirms in his report to the General Assembly that 'international assistance and cooperation require that all those in a position to assist should, first refrain from acts that make it more difficult for the poor to realize their right to health'.[234] Nevertheless, in literature, Tobin argues that such recommendations may be problematic to the extent that they allude to an absolute prohibition on sanctions and similar measures.[235] Here, we should keep in mind that such general statements, even though phrased in absolute terms, are probably to be qualified in practice when interpreted and applied by States.

In addition to the State abstention, States should ensure that the right to health is given due attention in international agreements and that these agreements do not adversely impact upon the right to health by taking steps.[236] At a rather general level, the Committee has argued that such an obligation extends to States' actions, as members of international organizations, such as the IMF, World Bank and WTO, namely in influencing lending policies, credit agreements and international measures of these institutions towards protecting the right to health.[237] Such a broad approach is also found in the work of Hunt and Grover who both generally encourage States to ensure that international agreements or policies do not adversely impact upon the right to health and that their representatives in international organizations accord primacy to the right to health as well as to the obligation of international

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Doc. E/C.12/1995/5, 12 May 1999, § 36; UN CESCR, *General Comment No. 15: The right to water*, UN Doc. E/C.12/2002/11, 20 January 2003, §§ 31, 33 and 34.

233 Ibidem supra note 14, GC No. 14, § 41; See, e.g., as regards other ESC rights, UN CESCR, GC No. 12 (supra note 232), § 37; UN CESCR, GC No. 15 (supra note 232), § 32.

234 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 GA, 59th Sess., Agenda Item 105 (b),* UN Doc A/59/422, 8 October 2004, § 33.

235 Ibidem supra note 60, J. Tobin 2012, p. 333.

236 Ibidem supra note 14, GC No. 14, § 39; See, e.g., as regards other ESC rights, UN CESCR, GC No. 12 (supra note 232), § 36; UN CESCR, General Comment No. 13: The right to education, UN Doc. E/C.12/1999/10, 8 December 1999, § 56; UN CESCR, GC No. 15 (supra note 232), § 35.

237 Ibidem supra note 14, GC No. 14, § 39; See, e.g., as regards other ESC rights, UN CESCR, GC No. 13 (supra note 236), § 56; UN CESCR, GC No. 15 (supra note 232), § 36.

assistance and co-operation in all policy making matters.[238] The preceding general statements of the human rights bodies represent an incomplete and unbalanced approach on the respective state obligation in that neither body explains in full as to how a State will ensure that the right to health is to be given due attention in international agreements.[239] As such, one can argue that the human rights bodies have tended to avoid opening this discussion in preference for rather broadly-based recommendations.

Similarly, at a rather abstract level the CESCR has also stressed that States have a joint and individual responsibility to provide disaster relief and humanitarian assistance in times of emergency, including assistance to refugees and internally displaced persons.[240] This position has been endorsed by the CRC Committee in its non-binding authoritative source, GC No. 15, where the Committee also urges States to allocate 0.7% of gross national income to international development assistance.[241] Nonetheless, it is noteworthy that at least, the preceding exhortation of the CRC Committee is to a certain extent more directed in guiding States as to the way of satisfying their respective obligation.

Last but not least, it must be conceded that the nature of the State obligation for international co-operation is not absolute as the CESCR has stressed that this obligation will depend on each State's capacity (i.e., availability of a State's resources).[242] Thereto, such phrasing gives room for more flexible interpretation and weak implementation of this international State obligation. All in all, the preceding analysis reveals that the precise nature of the State obligation for international co-operation is yet to be elucidated in detail by human rights bodies, namely by way of concrete measures required by States, since so far there is no clear and detailed textual basis for the imposition of such an obligation.

In the meantime, a crucial question is left open as to how the right to health can be realized in a world which is characterized by a persistent shortage of funds followed by a curtailment of health expenditure, economic recession, rising costs, a problem of health sector corruption and a spread of free market principles based

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238 Ibidem supra note 165, UN Doc. E/CN.4/2003/58, § 28; Ibidem supra note 172, UN Doc. A/60/348, § 63; 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 HRC, 26th Sess., Agenda Item 3,* UN Doc A/HRC/26/31, 1 April 2014, § 56 and 68(a).

239 Ibidem supra note 60, J. Tobin 2012, see for a similar argument, p. 334.

240 Ibidem supra note 14, GC No. 14, § 40; See, e.g., as regards other ESC rights, UN CESCR, GC No. 12 (supra note 232), § 38; UN CESCR, GC No. 15 (supra note 232), § 34.

241 Ibidem supra note 85, GC No. 15, §§ 88-89.

242 Ibidem supra note 14, GC No. 14, §§ 39-40 and 45.

on privatization of health and other services in both developing and developed -middle income- countries (see Part II).[243] Hence, the prospects for realizing ESC rights, like the right to health, under such conditions may not be as promising as some have believed. It becomes obvious that the realization of the right to health in such a world can be achieved through the change of inadequacies of national and international policies and by setting concrete priorities and targets (see section 4.2).[244]

Despite the existing inadequacies, several policy steps of importance have been made towards the advancement of international co-operation. For instance, States that participated in the World Summit for Social Development endorsed their commitment to eradicate poverty in the world related to health 'through decisive national action and international cooperation, as an ethical, social, political and economic imperative of human kind'.[245] Another perhaps illustrative policy step thereof was the signing of the Oslo Ministerial Declaration by the Ministers of Foreign Affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand, on 20 March 2007.[246] This initiative of the seven Ministers of Foreign Affairs, though non-binding, aimed at increasing shared awareness of the value of health as well as of a need for international co-operation towards the protection and advancement of people's health and well-being, through the existence of shared responsibility. Meanwhile, the signatories by means of an Agenda for Action in the field of public health pointed out that health must become a first priority in foreign policy and decisions at the international level and a key element in strategies for development and for fighting poverty, in order to reach the MDGs.[247] Furthermore, the European Commission, in terms of the treaty obligation to protect human health (new Article 168 TFEU, former Article 152 EC Treaty) adopted a health strategy, which encompassed a section on global health (i.e., principle 4:

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243 For an elaboration upon the privatization and corruption within a health care context, see, section 3.7 as well as sections 6.4 - 6.5, where these concepts, including the curtailment of health expenditure, are illustrated and examined by way of a country case study.

244 See, e.g., UN CESCR, GC No. 14 (supra note 14), § 40. It is stressed that 'given that some diseases are easily transmissible beyond the frontiers of a State, there is a collective responsibility on the international community to address this problem. The economically developed States parties have a special responsibility and interest to assist the poorer developing States in this regard'.

245 UN, *Report of the World Summit for Social Development*, A/CONF.166/9, 19 April 1995, commitment 2, p. 13.; See also section 2.2.3.

246 Ministers of Foreign Affairs of Brazil, France, Indonesia, Norway, Senegal, South Africa, and Thailand, 'Oslo Ministerial Declaration - Global Health: A pressing foreign policy issue of our time', *The Lancet* 2007, 369 (9750), pp. 1373-1378.

247 Ibid.

'strengthening the EU's voice in global health).[248] Its position represents a relatively balanced perspective on the promotion of co-operation on health-related issues with international organizations and countries. Its health strategy has a particular focus on the enhancement of the safety and security of the EU's citizens and on their protection against health threats by way of setting three strategic objectives to be achieved by the EU Member States.[249]

However, such promotion is still in its infancy. Under the current international economic situation, the expectation that States, through international co-operation, will ensure the realization of the right to health seems unrealistic. There is a limited transnational solidarity to promote the health of all people, given the fact that the development of a common policy may deal with the serious problems and imbalances in health expenditure created by the influence of every country's economic competence ability. For instance, pursuant to World Bank statistics in 2012 the total expenditure on health in Guinea, which was mostly affected by the recent outbreak of the Ebola epidemic (2014), was estimated only at 6.3% of GDP, compared to 9.3% of GDP in Greece and the more impressive 17.9% of GDP in the United States of America (USA).[250] Therefore, the pursuit of the realization of the right to health through international co-operation may conflict with resource constraints (a State's incapacity). The on-going debt crisis has forced many States to embrace the IMF and the World Bank, including Greece, as will be analysed in Chapter 6. As a result, the IMF and the World Bank discourage low-income States to increase the levels of health expenditure and especially due to the global financial crisis since 2009, which leaves limited space for decisions for increased international co-operation.[251]

Even 38 years ago the international community seems to be aware of these realities in that it conceded that 'the existing gross inequality in the health status

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248 Commission of the European Union, *Together for Health: a Strategic Approach for the EU 2008-2013*, White paper 630 COM, Brussels, 23 October 2007, pp. 6-10. <http://ec.europa.eu/health/ph_ overview/Documents/strategy_wp_en.pdf>

249 Ibid., p. 8.

250 World Bank, *World Bank Statistics –Health Expenditure 2012*, available at <http://data.worldbank.org/indicator/SH.XPD.TOTL.ZS> accessed 6 March 2015. Of note, total health expenditure involves the provision of health services (preventive and curative), family planning activities, nutrition activities, and emergency aid designated for health, but does not cover the provision of water and sanitation.

251 See, e.g., 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.

of people particularly between developed and developing countries as well as within countries is politically, socially and economically unacceptable and is, therefore, of common concern to all countries.'[252] Meanwhile, the current financial crisis could be an opportunity rather than an obstacle in order to introduce a new concept of promoting an international response for realizing the right to health for all people. In recent years, high-income countries in the European region have expressed their willingness to encourage the development of social health protection in the low-and middle-income countries of the world. For instance, in June 2007 at the 'G8' (the group of the eight biggest economies worldwide) summit in Heiligendamm (Germany), two European countries, Germany and France, introduced their 'Providing for Health' (P4H) initiative. By way of background, the 'Consortium on Social Health Protection in Developing Countries' -composed of the German development agency Gesellschaft für Technische Zusammenarbeit (GTZ), the ILO, and the WHO- prepared this initiative, in which France as well as other countries and organizations (e.g., the World Bank) later joined. The aim of this policy initiative (P4H) is the development and extension of social health protection (SHP) and the promotion of universal health coverage (UHC) in low- and middle-income countries worldwide.[253]

4.5. CONCLUSIONS

From this chapter it appears that the national context largely determines the specific content of measures required by States to realize the right to health within their jurisdiction. States retain a wide margin of appreciation in selecting the measures for implementing their right to health obligations. Nevertheless, it has been clearly established that there are some limits on how States seek to abide by their right to health obligations. In particular, States should demonstrate the adoption of deliberate, concrete and targeted measures; the time frame in which steps were taken; the allocation of available resources in accordance with human rights standards; the exhaustion of alternative and less restrictive measures; the non-discriminatory and non-arbitrary nature of the proposed measures; and the prioritization of the needs of the most vulnerable groups. In other words, States

252 *Declaration of Alma-Ata*, International Conference on Primary Health Care, Alma Ata USSR, 6-12 September 1978, § II.

253 GTZ-ILO-WHO Consortium on Social Health Protection in Developing Countries (2007) Website, Home page: <http://www.socialhealthprotection.org> (accessed on 2 January 2012); See also, website of P4H-Social Health Protection Network <http://p4h-network.net> (accessed on 21 April 2016)

are required to adopt a process that will determine the reasonableness of their actions (i.e. measures taken) towards realizing the right to health within their jurisdictions. Nonetheless, the notion of 'reasonableness' still remains highly generalized and requires considerably more detail for enabling the assessment of whether a State has engaged in a reasonable decision-making process for realizing the right to health within its jurisdiction. To this aim, domestic jurisprudence can be of particular assistance, in that it elaborates further on this notion and as such it could facilitate its application. In fact, in terms of the national recognition of the right to health, States must ensure that effective remedies are provided for every individual in order to give effect to his/her right to health. Despite the debate over the justiciability of the right to health in court proceedings, in Europe the work of the ECSR has produced a number of interesting (non-binding) decisions which interpret the right to health alone or in conjunction with other health-related rights. Such decisions may rightly seize the attention of future domestic court decisions regarding cases on the right to health. In any case, it is important to note that whatever measures adopted by States these must result in the effective implementation of their right to health obligations.

Meanwhile, the progressive realization of the right to health concedes that States must identify and prioritize the needs of vulnerable population groups, even in times of resource scarcity (i.e. adoption of low-cost programmes). As identified, vulnerable population groups (e.g., children, minorities and undocumented migrants etc.) do not have the same opportunities than others to achieve the highest attainable standard of health on the basis of their own efforts. They therefore require, to a larger extent than the ordinary population that States give special consideration to their special and diverse needs through the adoption of targeted measures that respond to these needs. To this aim, a comprehensive national strategy is required that is qualified by certain principles, involving the principles of accountability, transparency and participation of all beneficiaries, including marginalized groups. Note also that States' measures to realize the right to health of children must also be age-adjusted and consistent with four principles: the non-discrimination (Art. 2), the best interests of the child (Art. 3(1)), the child's right to life, survival and development (Art.6) and the child's right to express her/his views freely in all matters affecting her/him (Art.12)).

At the same, it appears that the definition of the type of state measures alone is not sufficient for States to abide by their obligations under the right to health given the progressive nature of this right and the different level of development among countries. As such, this process needs to be complemented by the clause of 'to the maximum of its available resources' within a State's jurisdiction.

Importantly, resource availability is another decisive factor that influences the degree of a State's compliance with its right to health obligations. Generally, the clause 'to the maximum of its available resources' may be seen as providing a considerable discretionary power to States as to the definition and calculation of such resources. However, this is not the case. Resources should be understood to include not only financial resources but also other types of resources, such as informational, human, natural and administrative resources. Therefore, under the obligation to make use of maximum available resources for realizing the right to health, States are required to ensure that adequate resources are available for health as well as to prioritize financing for health in their national budgets. As to the calculation of such resources, this should be primarily informed by the core content of the right to health, whose funding costs establish a 'funding baseline'. Moreover, as regards health funding prioritization, such process involves careful planning in setting concrete (policy) priorities and targets alongside other core funding commitments, such as education and social security, while avoiding misallocation/mismanagement of resources and corruption. In doing so, restrictions of States in available resources must be justified on a basis of a context-sensitive approach (i.e., country context), involving *inter alia* a country's economic situation and level of development.

In addition to national (limited at times) resources for health, States, given their level and rate of development, must sought to generate resources for health, involving financial and human resources, by means of international co-operation. It was established that international co-operation -albeit its parameters not yet fully elucidated- forms part of the state obligations for realizing the right to health. Here, it must be conceded that international co-operation cannot be overlooked due to the health consequences of poverty and financial hardship as well as the various significant transnational health risks, such as the Ebola epidemic. Meanwhile, the nature of the state obligation for international co-operation is not absolute as it was discerned that this obligation depends on each State's capacity (i.e., availability of a State's resources). This, however, alludes that developed States with greater resources and capacities at their disposal have assumed an enhanced role to realize the right to health in other less developed States.

Last but not least, it must be conceded that the limitation of the right to health in the adoption of a legislation or policy, namely a step back in the level of protection of the right to health (e.g., a reduction of public health expenditure) on the part of a State requires a justification. Otherwise, the absence of such justification can be construed as a State's non-compliance with its right to health obligations and hold the State accountable for a violation of the right to health.

Thereto, it is essential to dissociate a State's unwillingness to comply with its right to health obligations from a State's incapacity to do so.

All in all, this chapter attempted to articulate an account as to the scope of state measures required for the realization of the right to health, while keeping in mind that there is no 'one size fits all' action plan. It was illustrated that the obligations arising from the right to health largely depend on national contexts (i.e., economic situation, level of development, vulnerable groups) and have to be elucidated with greater precision in those discrete contexts. Thereto, the main burden falls on each State to adopt targeted measures for the discrete situations and groups within its jurisdiction in line with the existing domestic conditions. From this perspective, the articulation of state measures is further elaborated by way of a country case study in Part II. Particularly, the next step is to examine how the international standards set out in Part I, namely in chapters 2, 3, 4, are applied (or not) in a country case study, namely on Greece.