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

Alexiadou, E.

9 Conclusions and Recommendations

9.1. INTRODUCTION

The aim of the study was to adopt a practical perspective of the right to health (i.e., to move from theory to practice) by way of placing our focus on its implementation within a particular socio-economic and political context. For this purpose, the content of the right to health was assessed in light of a particular national reality by focusing on specific themes relevant to this reality. Particularly, this study focused on the national implementation of the right to health by the Greek State, whilst keeping in mind its particular challenges and realities.

The objective of the present chapter is to provide answers to the two research questions set out in the introductory chapter, chapter 1. Thereto, section 9.2 embarks on a discussion of the results in light of human rights law. Subsequently section 9.3 presents the conclusions of the study, while section 9.4 provides some recommendations in relation to the prospects for enhanced operationalisation and effective realization of the right to health in Greece.

9.2. DISCUSSION

As one moves from conception to the operationalisation of the right to health issues related to the implementation of state obligations imposed under this right arise, as found in this study. Indeed, the meaning of the right to health and its various aspects are far from settled. In fact, it was argued that this perhaps alludes that further elucidation and refinement (i.e., there is a need for an explicit and concrete textual basis) of state obligations stemming from the right to health and its various aspects is required, with attention paid, *inter alia*, to the vague and open-ended concept of progressive realization (see Part I sections 3.4 and 3.6). Nevertheless, this study illustrated that even though the right to health framework remains highly contested, it can provide some insight for the assessment of state practices. It was argued that the right to health requires States to actively assume responsibility,

namely to intervene in society for the purpose of gradually creating the conditions necessary for optimum population and individual health. In this respect, beyond access to health care attention should also be paid to the promotion of the underlying determinants of health whose influential role often remains overlooked by States perhaps due to a lack of awareness on their actual scope and impact upon people's health (see below section 9.3). Indeed, the underlying determinants of health, such as housing, adequate sanitation, have the potential to influence for better or for worse the health status of people.[1] It can thus be argued that the right to health is inextricably linked to other human rights (see Part I, sections 2.4, 3.2 and 4.3) which form its integral components and affirm the principle of indivisibility and interdependence of all human rights. Here it must be conceded that States must acknowledge the interdependence of all human rights in their laws and policies in order to achieve the full realization of the right to health and ensure better protection of population and individual health (see below section 9.3). At the same time in order to achieve such conditions it may be essential for States to regulate the behaviour of third parties (i.e., private actors) and to redress existing socio-economic health inequalities.

Meanwhile, in recognition of national realities and challenges aligned with the progressive nature of the right to health, it becomes clear that the national context will ultimately determine how and to what extent a State will guarantee the right to health within its jurisdiction. At this point, one could argue that in practice there is a risk of limited (or even a lack of) correlation between commitments and actions on the ground. Indeed, in Greece it was argued that the right to health framework tends to illuminate a path that the Greek State seems unwilling to follow in that few explicit references are made to the right to health by the legislature as well as policy measures for particular groups are taken irrespective of the right to health (see below section 9.3). As such, it was observed that the Greek State does not look at the right to health as an international norm. This is unfortunate, as it was found that the right to health framework allows for flexible interpretation and for a constructive dialogue between the State and the various stakeholders to identify particular health needs and to set concrete priorities to this end. In fact, it appears that in Greece commitments stemming from human rights and constitutional provisions fade when

[1] WHO/CSDH, *Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the commission on social determinants of health*, Geneva: World Health Organization, 2008, p. 1; See, e.g., P.W. Newacheck, D.C. Hughes and J.J. Stoddard, 'Children's Access to Primary Health Care: Differences by Race, Income and Insurance Status' *Pediatrics* 1996, 97 (1), pp. 26-32.

it comes to providing access to health care to some of the most vulnerable groups in society, primarily undocumented migrants and Roma children. Indeed, one finds profound health inequalities in Greece with these vulnerable population groups either denied access or receiving substandard care.

Nonetheless, when a State is being confronted with an economic crisis this situation touches upon the question why one should not anticipate on the defense that due to lack of funds this particular State does not abide by its right to health obligations. In our analysis, we have argued that resource availability cannot be used as a defense when the realization process is failing or even more as *carte blanche* for any State (rich or poor) to do as it pleases.[2] Indeed, on account of the particular economic situation the State is required to take reasonable and deliberate targeted measures towards the progressive realization of the right to health, namely to set concrete health priorities and tangible targets as a starting point. Here it must be conceded that progressive realization of the right to health *per definition* recognizes the reality that the full realization of this right may not be feasible at once or in a short period of time. Nevertheless, it was argued that even if a State decides to lean back the level of the protection of health by way of imposing austerity measures (e.g., cuts in health care spending etc.) it is required to justify its actions/inactions in light of its available resources. At the same time it was found that the State is required to consider the pressing health needs of the most vulnerable population groups within society who require more care than others by optimally prioritizing available resources while avoiding corruption, and if necessary by seeking support from the international community (e.g., WHO).

Last but not least, we acknowledged from the examination of the Greek experience that the realization of the right to health does not depend solely on the amount of the available resources but also on the way of allocating existing (even scarce) resources within the national budget to this end without though neglecting other human rights. In fact, the view taken here is that the realization of the right to health of every individual combined with the elimination of domestic health inequalities can be achieved even in non-affluent States, like Greece, irrespective of budgetary and other considerations (e.g., legal status), if taken seriously. The next section will take a closer look at the main findings of the study and offer some reflections on the meaning and compliance with the right to health framework.

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[2] See, e.g., 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. 30.

9.3. CONCLUSIONS

While States have a broad range of possible legislative, administrative and policy measures to meet their right to health obligations, it was argued that the right to health framework tends to provide insight as to the implementation process required by States to this end by regulating issues surrounding healthcare, health conditions, embedded inequalities etc. The study then identified that the components underpinning the right to health framework have the potential to inform and shape national health-related decisions and actions in terms of paying particular (priority) attention, *inter alia*, to the health needs of vulnerable and marginalised groups (e.g., Roma children, undocumented migrants etc.) at all times; to the facilitation of genuine participation of all intended beneficiaries and affected groups; to the adoption of accountability mechanisms; to the development of targeted, deliberate and concrete health policies; to the prioritization and optimization of resources, while avoiding misallocation and mismanagement of resources; to the adoption of a framework law to operationalize national health strategies; and to the collection of disaggregated data to identify health needs of discrete groups. Meanwhile, it was also submitted that given the right to health embraces also a wide range of socio-economic factors that formulate conditions in which people can lead a healthy life (GC No. 14 of the CESCR), influences such as poverty, age, ethnic and immigrant backgrounds, constitute a significant part of the realization process of the right to health. Such influences raise additional human rights concerns that States often tend to overlook them when seeking to secure health needs (e.g., see section 8.5). Last but not least, at the same time, it should be kept in mind that the process required by States remains subject to the progressive nature of the right to health and to the available resources, which highly determine the potential of the right to health framework in terms of its practical applicability in shaping health-related policy efforts and interventions.

Additionally, Part I has illustrated that there is no 'one size fits all' action plan required of States for realizing the right to health within their jurisdictions. It was found that the state obligations stemming from the right to health largely depend on national contexts (i.e., economic situation, level of development, vulnerable groups) and have to be precisely elucidated on the basis of those discrete contexts. Admittedly, the main burden falls on each State to adopt context-sensitive measures for the discrete situations and groups within its jurisdiction in line with the existing domestic conditions. However, it was observed that this development is not unlimited in that the right to health framework sets out a principal process that a State needs to follow for identifying the precise measures required, as already mentioned (see preceding observation). Overall, it was conceded that the absence

of a State's justification for the adoption of a legislation or policy that constitutes a step back in the level of protection of the right to health (i.e., adoption of retrogressive measures) can be construed as a State's non-compliance with its right to health obligations. Thereof, it can be argued that such a lack of justification dissociates a State's unwillingness to comply with its right to health obligations from a State's incapacity to do so.

Meanwhile, in Part II it was observed that Greece beyond being party to all of the primary treaties recognizing a right to health has a constitutional entrenchment of health both as a right and as a State's duty. Nevertheless, it was discussed that contrary to the human rights provisions (see chapter 2), the constitutional right to health provision (i.e., Article 21 § 3) solely establishes a general and open-ended state obligation without making any reference to specific state undertakings. In fact, it was argued that the constitutional referral to the term *citizens* in relation to the State's duty to provide health care in Article 21 § 3 generally creates a tension with the human rights framework. Indeed, it can be observed that this way of perceiving state responsibility for the health of individuals raises questions with regard to the extent of the Greek State's obligations in relation to discrete (vulnerable) population groups in society who do not possess *citizenship.* Here, the counterargument to this standpoint is that such guarantees, albeit not providing a detailed enumeration of state measures and entitlements, tend to provide more latitude for legislative and/or judicial interpretation. However, few explicit references to the right to health are to be found in case law, while at the same time there is case law with explicit references to health-related rights, namely rights being interpreted by courts to protect health (see sections 4.3 & 5.3). As such, health-related rights tend to offer more protection than the right to health itself to population and individual health. Nonetheless, on account of the content of two constitutional articles quoted in chapter 5 (see Articles 5 § 5 & 21 § 3 of the Constitution), there are elements which can be interpreted in subsidiary legislation and policy practices and ascribe a certain responsibility to the Greek State to respect, protect and fulfill the right to health. All in all, we come to the conclusion that the attachment of growing significance to the role of international law within domestic legal order as well as the constitutional recognition are significant affirmations of State obligations to foster an environment in which individuals can achieve their highest attainable standard of health.

But as inspiring and promising as the international and constitutional commitments can be, it was argued that the Greek State has failed to integrate explicitly and consistently the right to health into its health law and policymaking (see Part II, section 6.5). The (austerity) measures in the area of health generated from 2010 onwards as the State's response to the economic crisis were not formulated

and implemented within the parameters of the State's right to health obligations (see Part I, section 4.2). Here it is essential to note that this situation is partly the result of pre-existing conditions and practices (i.e., the lack of prioritization and optimization of available resources before crisis, the lack of effective accountability mechanisms against persistent corruption – see sections 6.4 & 6.5) exacerbated though by the 5-yearly economic crisis, resource scarcity and hardly manageable rising health care costs. In fact, such pre-existing practices highly demonstrate that the Greek State, besides its incapacity owed primarily to the 5-yearly economic crisis, was also unwilling to take the required measures (i.e., to set concrete priorities) under its right to health obligations even before it was hit by this crisis.

At the same time, it was also found that the introduction of austerity measures placed an increasing pressure on the functioning of the health care system. First, it was observed that the measures taken were not time bound, as their implementation indicates a permanent solution to the fight against the rising health care costs. In fact, this becomes evident when looking at the health status and health indicators in the country from 2010 onwards, namely the rising infant mortality rate and the increasing health disparities based on income. At this point, it was argued that the worrying health trends in Greece can be also related to the worsening socio-economic determinants of health which raise additional human rights concerns and are also of decisive importance for realizing the right to health, as observed earlier. These possible causes for ill-health are also avenues for future research.

So far the Greek State has also failed to demonstrate that it sought all other feasible alternatives or less restrictive measures to respond to the rising health care costs and fiscal pressures. Clearly, the Greek State has failed to involve the genuine participation of affected groups or individuals by way of establishment of participatory mechanisms easy to access, in terms of assessing their views and preferences towards the proposed (austerity) measures. The Greek State has not undertaken right to health impact assessments for the formulation and evaluation of such measures in light of the 'AAAQ' requirements and especially as regards to vulnerable population groups in society. In fact, it was argued that from the perspective of the 'AAAQ' these measures disproportionately impact on vulnerable population groups that require additional health care, such as chronically ill, elderly, pregnant women, children (e.g., with ethnic or immigrant backgrounds), undocumented migrants and drug users. Note also that in the Greek health system there is no statement of minimum level of health care, namely a package of minimum health care services to be provided under all circumstances. Thereto, when considering these alarming developments owed to the (austerity) measures introduced in the health sector especially from 2010 onwards as well as the way

of their formulation (i.e. not being reasonably justified), it can be concluded that such developments do not reflect a progression, but rather constitute a significant and evitable cause for retrogression in the enjoyment of the right to health (care) of every individual in Greece. The position taken here is that unless within the scope of its powers (i.e., its capacity) the Greek State actively intervenes to ameliorate this situation and redress the rising health inequalities (e.g., to set priorities within its health system and to allocate its limited resources to those most in need), this will certainly amount to a violation of the right to health (care).

At the same time, it was identified that Greece's economic recession and fiscal pressures as a result of its MoU associated with the growing health care costs are immensely pushing a privatization agenda. Nonetheless as emerged from the analysis (see section 6.5.1), the Greek State does not provide adequate safeguards for holding them to account for possible failures to realize the right to health, which leads to less accountability and threatens the objectives of the right to health (care). As such, due to the lack of concrete obligations for private actors combined with the lack of an articulated right to health (care) within national legal order, it is questionable whether the Greek State actually wants to abide by its right to health obligations. Admittedly, such an argument can be advocated if one considers that the national health system is rife with corruption which adds another layer of serious challenge to the realization of the right to health (care) of individuals. Indeed, in the author's view such development implicates an unjustifiable limitation of this right on the part of the State and ultimately a violation of this right.

Meanwhile, when looking at two particular population groups, namely undocumented migrants and Roma children in relation to the extent of realization of their right to health (care) in Greece (see chapters 7 and 8), we come to the conclusion that different levels of such realization exist compared to the general population within the country. Explicit references to the right to health of these groups are not made by the legislature. The challenge of mainstreaming the right to health across all health-related legislative and policy measures by paying particular attention to undocumented migrants and Roma children was discerned. It was argued that the Greek State has not integrated in a coherent and consistent manner the right to health across its national processes for these two population groups who require targeted care to their discrete needs due to their particular vulnerable position in Greece. Indeed, this alarming situation has been repeatedly criticized at the international level (see sections 7.3.6 and 8.3.4) without though resulting in these groups' right to health (care) being subject to any evaluation by the Greek State. In fact, the Greek State has not engaged in genuine and effective consultation with these population groups and/or their representatives to assess

their views as to what measures the State must undertake to secure the effective realization of their right to health. At the same time, it was discussed that the Greek State has not established effective and accessible (i.e., without fear of sanctions and/or easy to understand its formal structures) accountability mechanisms to regulate and monitor (State and non-State) actions in the health sector towards undocumented migrants and Roma children. Nonetheless, without such mechanisms the Greek State cannot be compelled to explain whether (or not) it is moving as expeditiously and effectively as possible towards the realization of its right to health duties for these groups. As a result, when looking at the overall performance of the Greek State towards undocumented migrants and Roma children, we can conclude that this is incompatible with the right to health framework. Admittedly, this situation signals dangers for individual and population health and should not remain unaddressed by the Greek State, in that it renders these population groups more vulnerable to increased health risks and a threat for others.

At the same time, the analysis carried out in both chapters revealed that in addition to the problems these two groups face in accessing health care in Greece, they also face other difficulties that impact upon their health and access to health care, and stem from the underlying determinants of health. Such developments lead to the overall conclusion that the right to health together with the corresponding rights obliges Greece to enhance the social conditions (i.e. living and housing conditions etc.) of both groups, which are significant causes of negative health outcomes. Indeed, when looking at the health status and health indicators in relation to these groups, it was found that there is a distinct lack of correlation between these two vulnerable population groups and the average person in Greece. The point to stress therefore is that such a disturbing situation reflects a non-progression of their right to health as well as reveals how social conditions largely shape health outcomes and are responsible for a major part of health inequalities within Greece.[3] Even so, it was argued that national health policies appear to be reduced to a certain number of healthcare issues (e.g. emergency treatment, sporadic immunization programmes etc.) without any relative reference to the several surrounding (socio-economic) aspects (e.g. poverty, detention conditions etc.) which constitute the overall context within which the right to health for these groups is to be implemented. Thereto in the author's view, this situation, if not justifiable, constitutes not only a clear limitation, but also a violation of the right to health of these groups.

All in all, the economic situation in Greece (i.e., resource scarcity) should not serve as a pretext for a restriction or denial of the right to health (care) for all and

[3] Ibidem supra note 1.

especially for the most vulnerable population groups. Reaching beyond the rhetoric, given the hard economic situation, in practice the Greek State has to systematically seek and implement targeted health measures that do not require extensive resources and are commensurate with its right to health obligations as well as to seek international (technical and financial) co-operation for expanding its existing capacity. When looking at the current alarming developments in Greece, one perceives a significant step back and a (potential unjustifiable) limitation in the progressive realization of the right to health (care) which is of major concern and requires more considered attention on the part of the State to challenge its key elements. In this respect, it was observed that several human rights bodies, including the CESCR and the CRC Committee, have repeatedly voiced their concerns about the rudimentary level of the integration of the right to health (care) in national legislative and policy measures. To this end no easy solutions are available that will be achieved at once and a level of legislative and administrative reform beforehand is required, as will be subsequently elaborated.

9.4. RECOMMENDATIONS

From the perspective of the preceding analysis, it can be observed that a large gap exists between national recognition of the right to health and reality (i.e. in practice). Such an observation, though, raises a critical question for exploration as well as a primary concern: what should be done on the part of the Greek State to remedy this situation? Given the gravity of domestic health concerns and the unjustifiable variance of a highly fragmented national legal framework, there is a growing need for coherence in the field of health legislation to systematically address the health inequalities and other pressing health problems that largely exist in Greece today. In order for the right to health to be effective for individuals within the Greek State, national legislation must reflect the right in such a way as to make it applicable. Hence, in addition to the two constitutional provisions and the incorporation of international treaties that set out the right to health in broad terms, a framework law (deriving from the GC No. 14 to the ICESCR) can elaborate further on this right and thus make it operational in practice (see Part I, section 4.2.1).[4] Indeed, a framework law can codify and firmly integrate international legal standards underpinning the right to health and required for its realization in national legal order and policy.[5] Thereto, the Greek State should consider adopting such a

[4] UN CESCR, General Comment No. 14: *The Right to the Highest Attainable Standard of Health*, UN Doc. E./C.12/2000/4, 11 August 2000, §§ 53-56.

[5] Ibid.; See also infra note 6.

law which would be more specific than the existing national legal framework to operationalize the right to health for every individual within its jurisdiction in a coherent and consistent way.[6] At the same time the right to health can be promoted and integrated within all national health-related legislative and policy measures, including the ones addressed to vulnerable population groups (e.g., undocumented migrants, Roma children). Meanwhile, we should keep in mind that this framework law should be accompanied with appropriate mechanisms to monitor the effective implementation of the obligations that stem from its recognition of the right to health (see below).[7]

In essence, the task of this framework law will be to identify the principal commitments to the right to health for the Greek State and a regulatory system (i.e., a system of governance) for shaping and monitoring the State's primary right to health duties and subsequently the (potential) duties of non-State actors in the field of health, sensitive to national circumstances, such as rising public deficit, health inequalities and health sector corruption (see section 3.7.1 and chapter 6).[8] To this aim, four action areas (objectives), stemming from and qualified by the right to health framework, should be determined within the framework law.[9] In fact, these four action areas could provide the basis for a subsidiary legislation / ministerial decisions and/or for the review of existing legislation / ministerial decisions. Note by way of background that the formulation of these areas is primarily based on both the ICESCR and the CRC as well as is derived and specified (to some extent) from UN Guidelines and GCs (primarily GC No. 14 of the CESCR). As such, the Greek State (as party primarily to both the ICESCR and the CRC) should, in its efforts to progressively realize the right to health, embed the following areas in the framework law:

A. In keeping with the state obligations to respect, protect and fulfil the right to health (see Part I, section 3.3 - GC No. 14 to the ICESCR), the implementation of a continuous, up-to-date and comprehensive national health strategy, i.e., responsive to population health needs and (cultural) differences (e.g. ethnic

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6 Note that this practice (i.e., the adoption of a framework law) is provided in the Constitution of Greece under Article 43 § 4 which stresses that '… these statutes shall set out the general principles and directives of the regulation to be followed…'. In fact, Greece has adopted a framework law on education in 1982 which establishes institutional arrangements for the provision of higher education in the country (Law 1268/1982, *Official Government Gazette* - ΦΕΚ issue Α′ 87/16-07-1982).

7 Ibidem supra note 4, UN CESCR, GC No. 14, § 56.

8 Ibidem supra note 4, UN CESCR, GC No. 14 §§ 55-56.

9 Ibidem supra note 4, UN CESCR, GC No. 14 §§ 53-56.

minorities); including a detailed plan for the development of the health system; and ensuring the progressive realization of the right, should:

- Focus on access to health care, but also on the determinants of health, in virtue of the inclusive nature of the right to health (see Part I, section 3.2). This implies that influences on health, involving housing and living environments, inadequate birth registration and, more generally, socio-economic inequalities in society should be addressed by the Greek State (e.g., by means of subsidiary legislation due to the wide scope of health determinants).
- Embody the 'AAAQ' framework (see Part I, section 3.5), while paying due attention to vulnerable groups in society (e.g., undocumented migrants, Roma children).
- Focus the attention on marginalised and vulnerable population groups who suffer most from health inequalities (see Part I, section 4.2). For instance, ensure that these groups are not disproportionately burdened and affected beyond their means by austerity measures taken in times of resource constraints owed to circumstances, such as an economic crisis or recession.
- Ensure effective participation of all intended beneficiaries (e.g., marginalised and vulnerable groups) in the policy development process through the identification of their most pressing health needs and concerns for the purpose of influencing health decision-making (see Part I, sections 3.5 & 4.2.3). This can be achieved through regular consultations and research with all intended beneficiaries. For example, the Greek State should seek and ensure active contribution of undocumented migrants in the identification and prioritization of key elements of their right to health by creating an environment in which this vulnerable group, because of their lack of legal status, can be involved without fear of sanctions and deportation
- Recognize a minimum core of the right to health and as such provide the following essential health-related services at all times (i.e., in times of resource scarcity) as a starting point (see Part I, section 3.4):
  - Immunization programmes against major infectious diseases;
  - Early identification and intervention in epidemic and endemic diseases;
  - Basic shelter, sanitation, supply of essential food and potable water;
  - Essential medicines;
  - Reproductive, maternal (pre-natal and post-natal care, emergency obstetric care) and child health care;
  - Education and information on pressing health problems in the community;

  - Appropriate training for medical professionals (e.g., education on health and human rights).
- Identify all responsible actors (State and non-State) and ensure their active involvement, collaboration, wherever needed, and effective regulation by delineating firmly their responsibilities, on the basis of the tripartite typology of obligations (i.e. to 'respect', to 'protect' and to 'fulfil'). For example, as regards non-State actors, on the basis of the 'obligation to protect' health under the right to health, establish legal norms for pharmaceutical corporations so as to ensure an unimpeded (affordable) access to essential medicines for every individual, especially for those with chronic diseases (see Part I, sections 3.3 & 3.7.1).
- Provide access to effective (judicial or other) remedies to right to health violations (i.e. restitution, compensation, guarantees of non-repetition and amendment of legislation, rehabilitation) (see Part I, section 4.3).
- Develop a system for the collection and provision of adequate and reliable statistical and/or other disaggregated data on health indicators to measure achievement and also within the context of seriously considering (the Greek State) its reporting obligations. For instance, such data should identify the discrete (pressing) health needs of the population aligned with its characteristics (e.g., age, gender etc.) and the capacity of health-related services in both the public and private health sector (see Part I, section 3.6).
- Promote right to health impact assessments prior the adoption and implementation of proposed health programmes and interventions to identify potential negative or positive consequences for the population (i.e. as regards their needs, access to health care, financial burden) (see Part I, section 4.2.3). For instance, if the proposed intervention involves the introduction of user fees per prescription it is essential for the Greek State to undertake an impact assessment for evaluating the consequences of such intervention, primarily its financial burden for the population, especially for vulnerable groups, including those living in poverty, those with chronic diseases, etc.

Importantly, the formulation and implementation of such a comprehensive national health strategy (primarily derived from GC No. 14 to the ICESCR) by the Greek State constitutes the means to the development of an effective health infrastructure that is accessible and responsive to all, namely meets the health needs of diverse population groups.

B. On the basis of primarily Articles 2 § 1 ICESCR and 4 CRC as well as GCs No. 3 and No. 14 of the CESCR Greece should establish a detailed national

health resource framework aligned with the national strategy for health to meet population needs. This requires the delineation of clear (financing) responsibilities on this matter involving a robust framework that should:

- Ensure adequate and sustainable funding for health.
- Generate increased resources for health (e.g., economic, human), which requires raising additional national resources by means of (budget) prioritization (e.g., prioritize health funding alongside other core funding commitments, such as education and social security) as well as international resources by means of international co-operation in light of Articles 2 § 1 ICESCR and 24 § 4 CRC (see Part I, sections 4.2 & 4.4).
- Ensure equitable distribution of health funds, namely ensure needed resources for health needs of marginalised and vulnerable groups with an emphasis on community-centered primary health care and adequate referral system (see Part I, section 4.2).
- Promote evaluation and assure greater financial accountability for the use of (public) funds (see Part I, sections 3.5 & 4.2). Importantly, health funding should be clearly defined, responsive to population needs and priorities (i.e. specifying what budget is allocated for the realization of the right to health of discrete population groups), and should utilize domestic knowledge, culture and other capacities.

Such a framework would ensure that resources devoted to health are not squandered due to corruption, misallocation and mismanagement and, overall weak financial regulation and enforcement. As such, the Greek State will focus not only on the way of increasing its resources, but also on the way of allocating existing (limited) resources in the national budget (i.e. transparently, efficiently and effectively). For example, in times of a financial crisis, the Greek State cannot absolve itself from its ultimate responsibility for realizing the right to health and introduce retrogressive measures (e.g. drastic cuts in health spending) by using scarce resources as an excuse, without first exploring every possible way to raise and increase the resources required (i.e. adopting a process for optimally prioritizing budgetary allocation, imposing taxes on alcoholic beverages, tobacco and unhealthy foods etc.) (see Part I, section 4.2.3).

C. On the basis of Article 2 § 1 ICESCR and GC No. 14 to the ICESCR, Greece should establish effective, transparent and accessible accountability mechanisms to both the public and private health sector in order to ensure that all responsible actors discharge their duties (see Part I, section 3.7.1 & Part II, section 6.5.1). Such mechanisms should also involve better coordination between responsible

actors and rigorous monitoring in relation to measures adopted for securing the right to health (see Part I, section 3.5).

D. In light of Article 2 § 1 ICESCR and GC No. 14 to the ICESCR Greece should establish a fully functional independent national review (advisory-coordinating) - monitoring body (see Part I, section 4.2.1). This body should be comprised of key national institutions (e.g., the National Observatory on the Rights of Children, the Greek Ombudsman etc.) and representatives of vulnerable groups, working in close co-operation with international organizations (e.g., the WHO, other (UN) agencies etc.). Its mandate should involve seeking assistance; sharing knowledge and experiences on best-practices; and finding solutions; identifying the necessary steps to be taken on pressing national and/or transnational health issues. At the same time, such a body would provide assistance: i) in the formulation of subsequent protocols, regulations or subsidiary legislation to regulate health-specific issues, and ii) in the revision of existing legislation in the field of health inconsistent with the right to health; oversee the implementation thereof; and address at once any unintended consequences.

Last but not least, it is important to stress that the scope of the framework law on the right to health should be elucidated by the legislature, through obtaining a concrete central objective (e.g., that of designing a health infrastructure to safeguard the health of the population, that of combating and/or eliminating health inequalities), so as not to constitute a symbolic recognition of the right to health (see Part I, section 4.2.1).[10] On the contrary, in light of GC No. 14 to the ICESCR this framework law should become a living national instrument, resulting in the identification of tangible commitments to be progressively implemented by all responsible actors (i.e., State -the primary duty bearer- and non-State actors); sensitive to national circumstances; and employed by individuals or (vulnerable) population groups as a means for redress once their right to health is violated.[11]

[10] Ibidem supra note 4, UN CESCR, GC No. 14 §§ 53-56.

[11] Ibid.