THE HUMAN RIGHT TO HEALTH:

A RETROSPECTIVE ANALYSIS AFTER 70 YEARS

OF INTERNATIONAL RECOGNITION

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Abstract: In 1948, the General Assembly of the United Nations adopted the first international text recognising universal human rights for all; the Universal Declaration of Human Rights. Article 25 recognises the right to an adequate standard of living, which includes the right to health and medical care. On the occasion of the 70th anniversary of the Declaration, this article presents an overview of the main developments that have been made towards understanding the content and implications of the right to health, as well as an analysis of some specific advancements that aim to facilitate the enforcement thereof. These include: a) the implication of private entities as responsible for right to health obligations; b) the Universal Health Coverage goal, proposed by the World Health Organization and included as one of the Sustainable Development Goals; and c) the individual complaints mechanism introduced by the Optional Protocol to the International Covenant on Economic, Social and Cultural Rights (adopted on the 10th December 2008, 60 years after the UDHR).

Keywords: right to health, United Nations, human rights obligations, Universal Health Coverage, individual complaints.

I. INTRODUCTION: THE RECOGNITION OF THE HUMAN RIGHT TO HEALTH

In 1948, the recently created United Nations (the UN) passed the first international text recognising universal human rights for all people; the Universal Declaration of Human Rights (in the following, the UDHR). Of the rights included, Article 25 recognises the right to an adequate standard of living, which includes the right to health and medical care: 'Everyone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social

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services'. On the 70th anniversary of the Declaration, this article analyses the main developments that have been made towards understand the implications of the right to health as well as some specific advancements that aim to strengthen its enforcement.

In 1966, almost two decades after the passing of the UDHR, two separate treaty instruments recognised civil and political rights, on the one hand, and economic, social and cultural rights on the other. The International Covenant on Economic Social and Cultural Rights (in the following, the ICESCR) came into force in 1977, including in Article 12 the recognition of the right to the highest attainable standard of physical and mental health. Other UN treaties that are narrower in scope recognise the right to health, amongst other human rights whilst focussing on the needs of specific groups. For example, the Convention on the Elimination of all Forms of Discrimination against Women of 1979 (the CEDAW, Articles 11.1.f, 12 y 14.2.b) and the Convention on the Elimination of All Forms of Racial Discrimination of 1965 (the CERD, Article 5.e.iv). Furthermore, the right to health is recognised as a human right according to other systems of protection, such as the European, the Inter American and the African human rights protection systems. For example, the European Social Charter recognises the right to protection of health in Article 11, as well as the right to social and medical assistance in Article 13[2].

This article focuses on the study of the right to health recognised by the UN system, with two main objectives. Firstly, to summarise the main developments made regarding the content and implications of the right. In this regard, the treaty body in charge of monitoring the implementation of the ICESCR is the Committee on Economic, Social and Cultural Rights (hereafter, the CESCR). The CESCR has developed the rights included in the ICESCR through the General Comments (the GC). GC No 14 focuses on the right to the highest attainable standard of health. Given this interpretation it is possible to differentiate a set of concrete rights as well as a number of elements that define what the broader right to health means. Additionally, GC No 14 develops a typology of obligations for States in order to ensure its adequate implementation. Following this introductory Section, Section 2 will focus on these developments to draw an overview of the content of the right and the obligations to ensure it. The second objective of this article is to analyse three significant developments which facilitate the implementation and enforcement of the right to health: firstly, the advancements towards the understanding of private entities as responsible for right to health obligations (analysed in section 3); secondly, the Universal Health Coverage goal, included as one of the Sustainable Development Goals (analysed in section 4) and; finally, the individual complaints mechanism regulated by the Optional Protocol to the ICESCR, that came into force on the 5th May 2013 (analysed in section 5).

[2] An analysis of the interpretation of the right to health through the study of the case law developed by the European Committee of Social Rights can be found at Lougarre, C., 2015.

II. GENERAL COMMENT NO 14 ON THE RIGHT TO HEALTH: CONTENT AND OBLIGATIONS INVOLVED

In the following, attention is paid to the content of the right to health as well as to the obligations involved. The analysis of the GC No 14 by the CESCR will be fundamental in this respect. The CESCR has conducted an accurate and comprehensive interpretative work of the rights included in the ICESCR, making it possible to consider that economic, social and cultural rights can have the same enforceability level than civil and political rights (Mendiola, 2009: 27).

II.1. Components and elements of the right to health

The content of the right to health might seem, at first glance, vague or lacking a definite content. Nevertheless, it is possible to define a set of concrete components, i.e. specific rights. The specific rights that form the right to health must necessarily comply with a number of elements or characteristics.

Firstly, the right to health can be understood as a 'cluster of rights'[3]. Article 12.1 of the ICESCR formulates the right in a broad way as the 'right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. More specifically, Article 12.2 mentions a number of measures to take in order to fully realise the right, which can be considered as examples that illustrate its content (GC No 14, para. 13). These measures are: a) The right to maternal, child and reproductive health; b) the right to healthy natural and workplace environments; c) the right to prevention, treatment and control of diseases; and d) the right to health facilities, good and services.

According to GC No 14 (para. 14 to 17), the aforementioned specific rights include, for instance, the improvement of child and maternal health, access to sexual and reproductive health services and to family planning, pre-natal and post-natal care (para. 14). Furthermore, the CESCR understands that Article 12.2.b) regarding the right to healthy natural and workplace environments not only includes measures on occupational and public health, but also attention to other social determinants such as an adequate housing and proper nutrition, discouraging the use of harmful substances (GC No 14, para. 15). Similarly, the prevention of diseases again includes attention to social determinants of health, for instance, education, economic development and gender equity. Thus, at the heart of the GC No 14 is the idea that social-economic and environmental determinants are a component of the broader right to health (GC No 14, para. 11). However, GC No 14 seems more restrictive when referring to the treatment of diseases (included in Article 12.2.c ICESCR), only mentioning the creation of a system of urgent medical care and the provision of care in emergency situations (para. 16). More extensively, the right to health services (Article 12.2.d ICESCR) should include, amongst others, access to preventive, curative and rehabilitative health services, regular screening programs, the provision of essential drugs, mental care as well as the participation of the

[3] According to Laporta, rights can be *derechos-racimo*, as inclusive of a variety of 'sub-rights' in the form of liberties, positive or welfare rights or rights to certain legal status or to public goods (Laporta, 2004: 300).

population in the provision of these services and the decision of the policies related to them (para. 17).

Secondly, the right to health should be defined by the following elements, as characteristics that the CESCR has described through the GC and that similarly apply to other ICESCR rights:

a) Availability. Sufficient quantity of functioning health care facilities, goods and services (GC No 14, para. 12a).
b) Accessibility. Health care services must be accessible to everyone without discrimination (GC No 14, para. 12b). It includes both physical and economic accessibility (or affordability). All health services must be physically reachable, including in rural areas, and accessible for all people, especially for vulnerable group populations. Likewise, health services and goods, either publicly or privately provided, must be affordable to all people, and payments must be based on the principle of equity. The element of accessibility also includes the prohibition of discrimination when accessing the right to health as well as accessible information regarding health issues.
c) Acceptability. All health facilities, goods and services must be respectful of medical ethics and of the culture of individuals and communities, as well as sensitive to gender and life-cycle requirements (GC No 14, para. 12c).
d) Quality: health care services must be scientifically and medically appropriate and of a good quality (GC No 14, para. 12d).

II.2. Types of obligations

The ratification of international human rights treaties binds States Parties to a number of commitments. Once again, GC No 14 is essential for the study of right to health obligations. However, it is worth mentioning three relevant precedents in the process of formulating the types of human rights obligations. First, the Limburg Principles on the Implementation of the ICESCR of 1986. Second, the CESCR drafts General Comment No 3 in 1990 regarding ICESCR and the nature of the obligations involved. It focuses on the obligation of progressive realization included in Article 2.1 ICESCR and differentiates between obligations of conduct and obligations of result. These obligations are further specified for the various rights in the corresponding Comments. While particularities may exist depending on the specific right, the meaning of these obligations rarely varies: general obligations include positive and negative duties (*to do* and *not to do*), which are subject to progressive realisation by States, excepting for those minimum obligations that require immediate implementation. Third, the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights of 1997 understands that there are obligations to respect, protect and fulfil as well as obligations of conduct and of result.

Regarding the implementation of the right to health, the CESCR defines in GC No 14 a typology of obligations for States Parties: general obligations, progressive realisation and minimum obligations. As for the general obligations, according to para. 33, ‘the obligation to *respect* requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health’. An example of the obligation to

respect is to refrain from limiting equal access to everyone, for instance denying access to health care services for particular groups. 'The obligation to *protect* requires States to take measures that prevent third parties from interfering with article 12 guarantees'. For instance, the obligation to protect demands the supervision of the activities of private providers to ensure that privatisation does not interfere with the implementation of the right. Finally, the obligation to *fulfil* requires States 'to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realisation of the right to health'. This implies, for example, full recognition of the right to health in the national legal systems and the adoption of a national health policy plan.

When implementing the right to health, State Parties must realise their obligations progressively. The obligation to progressive realisation is included in Article 2.1 of the ICESCR: it implies the adoption of measures to the maximum of the available resources in order to progressively achieve the fully realisation of the rights. The expression 'to take steps' used by the ICESCR is illustrative to understand what this obligation implies. Accordingly, it entails moving forwards towards the full realisation of the recognised rights. However, while it does not have immediate requirements, this must not be interpreted ignoring any significant implications. In this sense, State Parties must use their available resources as well as justify any retrogressive measures. This connects to the correlative obligation that prohibits retrogressive measures. Likewise, these measures, if taken deliberately, may also entail a violation of the Covenant provisions (Sepúlveda, 2006: 124). Añón has reflected extensively on the implications of this obligation and specifically, on the limits to the adoption of retrogressive measures affecting social rights (Añón, 2016). If these retrogressive measures are adopted, the State must prove a number of aspects, such as having considered other alternatives, the use of the available resources and the justification of the measure by reference to other rights included in the ICESCR (Añón, 2016: 76-77).

Finally, there are core or minimum obligations to be fulfilled immediately. In general, it is a core obligation to satisfy, at least, the essential level of the rights recognised in the ICESCR. Furthermore, it is generally understood that the prohibition of discrimination as well as the protection of vulnerable and marginalised groups are transversal minimum obligations, applying to all human rights. More specifically, GC No 14 is very illustrative in this respect since it provides a list of core obligations regarding the right to health. In this sense, States are strongly obliged to ensure: a) access to health services without discrimination, in particular for those vulnerable or marginalised groups; b) access to essential and adequate food; c) access to basic shelter, housing, sanitation and potable water; d) the provision of essential drugs, in line with the WHO Action Programme on Essential Drugs; e) the distribution of health services, based on the principle of equity; and; f) the implementation of a national public health strategy to address and face risks that may affect the whole population.

To summarise this section, the CESCR has defined a number of specific social rights, including the right to health, that may have previously been more ambiguous. The right to health recognised in Article 12 ICESCR includes, for example, the right to maternal, child and reproductive health; the right to healthy natural and workplace

environments; the right to prevention, treatment and control of diseases; and the right to health facilities, good and services. Furthermore, according to GC No 14, the right to health includes attention to social determinants of health. All these specific rights must be available, accessible, acceptable and of a good quality. In order to achieve all of this, States are obliged to undertake negative duties (*not to do*) such as respecting the recognised rights and refraining from adopting any retrogressive measures; as well as positive duties (*to do*), for instance, protecting and fulfilling the right to health as well as realising it progressively. Finally, a number of core or minimum obligations include negative and positive duties to be fulfilled immediately. Whether States only or third parties, such as private enterprises, are also responsible for right to health obligations is an issue that will be discussed in the next Section.

III. BUSINESS ENTERPRISES AS RESPONSIBLE FOR RIGHT TO HEALTH OBLIGATIONS?

Beyond the responsibility that lies on States, the possibility of considering third parties as responsible for human rights obligations is an issue that has been repeatedly tabled for discussion. Examples of third parties include international organisations, non-governmental organisations, transnational companies and other business enterprises. In the health sphere, the role of multinational corporations on the provision of essential drugs and health services is significantly important (Tobin, 2012: 192). For example, in the context of privatisations of health services. In such cases, responsibilities arise upon States in order to control and supervise the activity of private providers. Hallo de Wolff and Toebes defend the position that it is not only the obligation to protect the right to health (discussed in section 2), but all types of obligations (to respect, protect and fulfil) arise in order to ensure the correct functioning of health services (Hallo de Wolf and Toebes, 2016: 89; Hallo de Wolf, 2011). Beyond the States' obligations, this section focuses on the advancements that have been made so far towards the recognition of business enterprises as responsible for human rights obligations when conducting their activities in the health sphere. In this respect, whether companies are only obliged to respect the right or also to fulfil it is at the centre of the debate.

In August 2003, the Sub-Commission on the Promotion and Protection of Human Rights, as the principal subsidiary organ of the old Commission on Human Rights, elaborated the *Norms on the Responsibilities of Transnational Corporations and other Business Enterprises*. The text sets general duties for companies as well as specific obligations regarding equal opportunities, the prohibition of discrimination, the right to personal safety, labour rights, the respect to the national sovereignty, consumer rights and the protection of the environment (Weissbrodt and Kruger, 2005: 328 y ss). However, these Norms did not have any binding effects. Following the instructions of the Commission, the UN Secretary-General named, in August 2005, an expert in charge of studying the issue of the responsibilities of transnational companies and other business enterprises regarding human rights. Prof. John Ruggie, as the Special Representative for Business and Human Rights, elaborated a document including 31 principles at this respect, finally published in 2011.

The *UN Guiding Principles on Business and Human Rights* have been adopted by several companies. They distinguish between: a) the State duty to protect human rights; b) the corporate responsibility to respect these; and c) access to remedy. With regards to the corporate responsibility, the Principles state that business enterprises must respect human rights, which means that they must avoid infringing them and must address human rights impacts with which they are involved (principle No 11). In order to ensure this, enterprises must implement the corresponding policies and procedures. This aspect has been criticised, for instance, by Esteve, since no external mechanisms exist in order to ensure and to verify the compliance with human rights responsibilities (Esteve, 2011: 337-339). Furthermore, Toebes criticises that this responsibility is only limited to the duty to respect and it does not include any positive obligation to protect and to fulfil human rights (Toebes, 2015: 2016).

Additionally, in 2000, the UN Secretary-General initiated the *United Nations Global Compact*, a project that aims to involve companies and other actors in the respect of human rights and, specifically, in the compliance with basic labour and environmental standards, as well as the fight against corruption. Companies adhered to the *Global Compact* accept their responsibility to fulfil the objectives included. However, the initiative lacks any legally binding effects. Once again, monitoring the compliance with human rights goals is up to the companies involved (Esteve, 2011: 320). In this respect, the UN Joint Inspection Unit (JIU, 2010) pointed out that part of the funding of the *Global Compact* comes from the contributions made by the same companies adhered to it.

Focusing on the right to health, the CESCR states in GC No 14 that private sector as well as other non-State actors have responsibilities regarding this right (GC No 14, para. 42). Prof. Paul Hunt, as the Special Rapporteur on the right to everyone to the enjoyment of the highest attainable standard of physical and mental health, considered in a 2006 report on the responsibilities of pharmaceutical companies that 'it is inconceivable that some human rights do not place legal responsibilities on business enterprise' (A/61/338, 2006, para. 93). The Special Rapporteur also elaborated the *Human Rights Guidelines for Pharmaceutical Companies in relation to Access to Medicines* as an annex to a 2008 report (A/63/263, 2008, annex)[4]. This work was continued by Anand Grover during his mandate as the Special Rapporteur on the right to health, focusing extensively on access to medicines, intellectual property laws and free trade agreements (for instance, A/HRC/11/12, 2009).

Securing access to medicines has been an essential issue, especially since the Agreement on Trade-Related Aspects of Intellectual Property Rights (TRIPS) came into force in 1994 as a part of the Agreement that stablished the World Trade Organization. The TRIPS Agreement set minimum standards for intellectual property protection. Consequently, low and middle income countries feared the possible obstructions to accessing medicines within their territories (Nicol and Olasupo, 2012). In this respect, one of the reports written by Anand Grover as the Special Rapporteur on the right to health was the result of an expert consultation about intellectual property rights that

[4] Regarding sexual and reproductive rights: Khosla, R., Hunt, P. (2009).

obstruct in some cases access to medicines by artificially inflating prices (A/HRC/17/43, 2011). According to one of its conclusions, 'the right to health requires a company that holds a patent on a lifesaving medicine to make use of all the arrangements at its disposal to render the medicine accessible to all' (para. 47). Furthermore, it underlines how developed countries and multinational pharmaceutical corporations pressure developing countries that attempt to implement TRIPS flexibilities (para. 47). In other reports on access to medicines, the Special Rapporteur called upon the States 'to shift from the dominant market-oriented perspectives on access to medicines towards a right-to-health paradigm in promoting access to medicines' (A/HRC/23/42, 2013: para. 67). It also recommends that States should adopt price control measures to remove taxes on medicines in order to strengthen the competitiveness of the local production of medicines in order to ensure long term and affordable access (para. 70-71).

With regards to the private provision of health care services, the WHO Commission on Social Determinants on Health urges the private sector to strengthen responsibility regarding the improvement of labour conditions of health professionals, as well as to ensure that their activities (for instance, the provision of health insurance schemes) do not undermine health equity (WHO, 2013: 23). The UN Human Rights Office of the High Commissioner published a report series on globalisation, trade and human rights, one of them dealing with liberalisation of trade in services (E/CN.4/Sub.2/2002/9, 2002). According to the High Commissioner, States hold responsibilities to guarantee universal access to services, especially for the poor sectors of the population (para. 68). Furthermore, States have the right and the duty to regulate health services (para. 70). In a similar way, Prof. Paul Hunt as the Special Rapporteur on the right to health concluded a mission to the World Trade Organization with a number of recommendations on the relationship between the right to health and trade activities directed towards the old Commission on Human Rights, the Special Rapporteurs, the treaty bodies, the World Trade Organization members, international organisations and civil society (E/CN.4/2004/49/Add.1, 2004). For instance, the report insists on conducting right to health assessments when States adopt liberalisation policies (para. 80).

In conclusion, while liberalisation and privatisation of health services do not directly contravene right to health regulations, both the State and third parties must respect and realise human rights standards. Therefore, States cannot ignore their human rights obligations (De Feyter and Gómez Isa, 2005: 3-4). As the Special Rapporteur stated: 'while a State may contract the delivery of health services to a private company, it does not contract out of its right to health obligations' (A/61/338, 2006, para. 59-50). Business enterprises must respect the right to health and human rights standards. Despite the lack of regulations imposing positive obligations on business enterprises, there is a large number of recommendations from UN human rights bodies and experts insisting on the importance of undertaking human rights assessments while conducting their private activities. The next section will focus on an objective to be achieved by States that may require the co-collaboration of private enterprises; that is, the goal to ensure access to health services for all.

IV. THE UNIVERSAL HEALTH COVERAGE GOAL

The Universal Health Coverage goal (hereafter, UHC) proposed by the World Health Organization (WHO) is a significant development towards the implementation of the right to health. For the first time, health was described as a fundamental right in the WHO Constitution in 1946. Health is also defined in this text, using a social definition of health, as 'the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (International Health Conference, 1946). After decades of primarily focussing on public health concerns, WHO has shifted some attention towards human rights over the last few years. In this connection, the Universal Health Coverage proposal (hereafter, UHC) aims to ensure that all people receive the health services they need without suffering any financial hardship in paying for them.

According to Meier and Onzivu, different factors moved WHO away from legal and human rights approaches towards a main focus on international public health (Meier and Onzivu, 2013: 184). However, WHO undertook the programme 'Health for All' in the 1970s according to right to health standards (World Health Assembly, 1977). This perspective is also reflected on the Alma-Ata Declaration of 1978, underlying the importance of primary health care (International Conference on Primary Health Care, 1978) as well as on the 2000 World Health Report on health care systems (WHO, 2000). WHO has also adopted a human rights approach with regards to issues such as the attention to social determinants of health; the gender, equity and human rights programmes as well as the address of HIV issues (Meier and Onzivu, 2013: 185). In short, the interrelation between public health and human rights standards becomes clear and essential.

According to WHO, Universal Health Coverage is, by definition, the practical expression of the concern for the right to health (WHO, 2012: 3). The UHC goal was included for the first time in 2005 resulting from the 58th World Health Assembly's resolution (WHO, 2005). The State Parties committed themselves to developing suitable funding mechanisms to guarantee universal access to health care services, without suffering financial hardship. More specifically, WHO urges governments to implement a prepayment contribution mechanism, to plan the transition towards universal coverage (taking into account each country's economic, social, cultural and political circumstances) and to build collaborative nets between public and private providers in order to exchange experiences about the best health care funding models.

Five years later, the 2010 World Health Report (WHO, 2010) gave governments instructions to achieve the UHC goal. These concerned three main problems to be solved: 1) unavailability of resources; 2) direct payments for health services, and; 3) inefficient and inequitable use of resources (p. 3). Firstly, in order to increase the available resources, WHO insists on: a) improving fund collection mechanisms to make them more efficient; b) resetting State budget priorities; c) introducing innovative funding mechanisms (for instance, introducing taxes on airplane tickets, currency taxations or tobacco); and d) meeting their commitments for Official Development Assistance, to help developing countries face their budget deficit (p. 20).

Secondly, it is essential to avoid direct payments to access health care, which require payment for the service at the time of receiving it (p. 44). This objective underlines the serious consequences of direct payment requisites for people with financial difficulties. However, the goal is to avoid direct payments in all cases, introducing prepayment and pooling mechanisms (p. 40). Thirdly, WHO insists on promoting an efficient and equitable use of resources (OMS, 2010: 20). According to WHO, there is no convincing evidence that private sector facilities are more – or less – efficient than public facilities (p. 60). Amongst other strategies to reduce inefficiency, it is recommendable to increase the use of generic medicines, to monitor and publicise prices as well as to undertake impact, cost and needs-based assessments to decide between policy options (p. 63). It is also important to increase the motivation of health workers by, for instance, revising remuneration policies. Attention should also be paid on securing access to vulnerable and marginalised groups such as women, migrant or indigenous populations.

In short, according to the WHO World Health Report in 2010 and their 2012 Discussion Paper, States should address three main aspects in order to achieve UHC: 1) the extent of the population included (with the aim to cover 100% of the population); 2) the financial contribution organised by the government (with pooled funds, prepayment schemes and avoiding direct payments by patients) and; 3) the health package, including basic promotive, preventive, curative and rehabilitative health services (Ooms, Latif, Waris, 2014: 4).

The UHC goal has been supported by the UN General Assembly. In December 2012, a resolution with the title *Global Health and Foreign Policy* was passed unanimously supporting the proposal, calling on States to adopt measures to ensure all people access to health services. A few months later, WHO as well as financing and health care representatives from 27 countries met in Geneva to analyse the developments made regarding UHC. One of the issues discussed dealt with the possible prioritisation of resources for vulnerable groups in the early stages of the UHC implementation, to later include larger sectors of the population (WHO, 2013). Other international and regional texts were adopted in 2012 with the objective of recognizing the UHC goal: the Bangkok Statement on universal health coverage, the Mexico City Political Declaration on UHC and the Tunis Declaration on Value for Money, Sustainability and Accountability in the Health Sector (UN General Assembly, 2012). More recently, the importance of UHC has been reaffirmed through further Declarations, such as the 2017 ‘Tokyo Declaration on UHC: All Together to Accelerate Progress towards UHC’.

Furthermore, regarding the Post-2015 Development Agenda, universal coverage is recognised as one of the Sustainable Development Goals (SDGs): ‘Achieve universal health coverage, including financial risk protection, access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all’ (UN, 2015, target 3.8). With this recognition, once more, all UN Member States commit themselves to ensure universal health coverage for 2030. Access to health services is, however, only one of the objectives necessary to ‘ensure healthy lives and promote well-being for all at all ages’ (Goal 3). In this sense, Goal 3 also includes ensuring affordable access to medicines, increasing health financing and the recruitment

of professionals (targets 3.b and 3.c). Beyond health care services, goods and resources, ensuring other SDGs is necessary for achieving a good health status, according to the concept of social determinants of health as socio-economic causes influencing health (the *causes of the causes* of illnesses; M. Marmot, R. Wilkinson, 2006: 2). Other related goals are food security, management of water, reliable energy, decent work, reduction of inequalities or healthy environment (SDGs 2, 6, 7, 8, 10 and 13). In this connection, Chapman considers that there are practical difficulties in the achievement of the SDGs, given that the 17 goals also include a further number of specific targets (Chapman, 2015).

In relation to the WHO appeal to consider UHC as the practical expression of the right to health, the relation between human rights and the SDGs is clear[5]. Ultimately, the right to development is a human right internationally recognised by the Declaration on the Right to Development of 1986 (UN General Assembly, 1986). More specifically, the Office of the United Nations High Commissioner for Human Rights (OHCHR) contributes to the analysis of the post-2015 agenda from a human rights perspective. For instance, it is worth mentioning the 2013 OHCHR report *Who will be accountable?*. According to the *Summary table on the linkages between the SDGs and relevant international human rights instruments*, developed by the OHCHR, Goal 3 is related to the following human rights: right to life, right to health, special protection for mothers and children, right to enjoy the benefits of scientific progress and its application and international cooperation. Furthermore, right to health is linked with Goal 6 on clean water and sanitation and with those Goals related to environmental issues such as Goal 12 on responsible consumption and production, Goal 13 on climate action, Goal 14 on life below water and Goal 15 on life on land (OHCHR).

To summarise this section, after decades of primarily focussing on international public health issues, WHO proposed in 2005 the goal to achieve Universal Health Coverage, as the practical expression of the concern for the right to health. Whether the UHC goal can embrace the implementation of all the components and elements that this right requires is a debate that may be further explored. In order to ensure UHC, the State Parties commit themselves to developing suitable funding mechanisms to guarantee universal access to health care services. This will require a number of aspects to be addressed as well as specific problems to be solved, which this Section has analysed. Moreover, the UHC goal has the support of the UN General Assembly and is included in the Post-2015 Sustainable Development Goals, as target 3.8. The linkages that can be established between the SDGs, such as the UHC goal, and human rights, show the interrelation between both: every step taken to achieve Universal Health Coverage will advance the implementation of the right to health and health care. Subsequently, the discriminatory denial of access to health care will violate the right to health (as studied in Section 2). In this respect, the next Section analyses the existing monitoring mechanisms that allow possible right to health violations to be reported before the CESCR.

[5] The *Human Rights Guide to SGDs* developed by the Danish Institute for Human Rights shows the interrelation between human rights and the SDGs.

V. MONITORING THE RIGHT TO HEALTH: THE INDIVIDUAL COMPLAINTS MECHANISM

Moving on to an issue that is more directly linked to the legal enforceability and justiciability of the right to health, this section studies the CESCR mechanisms that monitor implementation of the right to health. It focuses on the individual complaints mechanism which was introduced by the Optional Protocol to the ICESCR. This mechanism allows individuals and groups of individuals to send communications to the CESCR claiming a violation of their economic, social and cultural rights. The Optional Protocol has to date been signed and ratified by 23 States, bound by its previsions and against which their citizens can allege social rights violations.

Treaty bodies use different monitoring mechanisms to evaluate the implementation of rights by the States Parties. As for the CESCR, according to Article 16 ICESCR, States must send periodic reports regarding the implementation of the rights included in the ICESCR in their territories. This means that, every five years, States report the legal, administrative, judicial and other kinds of measures that have been adopted in order to fulfil with the application of the treaty. After the State has sent the report to the CESCR, civil society and non-governmental organizations send the 'shadow report', usually contrasting the State version by reporting situations of no implementation or violations. After examining both reports, the CESCR publishes the recommendations to the State Party as Concluding Observations.

As an example, the CESCR recently assessed Spain's implementation of the rights included in the ICESCR, regarding the period 2012-2016. In order to prepare the shadow report a number of different human rights protection organizations joined together as 'Plataforma DESC'. During the process, they reviewed the situation of implementation of the rights included in the ICESCR within the Spanish territory. As a result, the Joint Report to the CESCR was presented in March 2018. The Concluding Observations to Spain were ready in April 2018 and included a list of concerns and recommendations with regards to the rights included in the Covenant. Regarding the right to health, the CESCR urged Spain to assess the impact of the 2012 health care reforms that restrict access to health care for undocumented migrants, as well as to guarantee that this group has access to all the health services they need without discrimination (recommendation No 42)[6]. In this respect, it is worth noting that, after a change in Spanish government, new health reforms were introduced in July 2018, through Royal Decree-law 7/2018, 27th July, on universal access to the National Health System, recognising access to health care for all residents in the country as well as for undocumented migrants. Regarding sexual and reproductive health, the CESCR called on Spain to ensure that all women have access to the sexual and reproductive health services needed, including access to abortion in cases of conscientious objection (recommendation No 44)[7].

[6] With regards to the Spanish reforms on access to health care introduced by Royal Decree-law 16/2012, 20th April: Lema (2014), Dalli (2018).
[7] General Comment No 20 on the right to sexual and reproductive health is very illustrative in this respect.

Apart from the reporting system, the CESCR also receives individual communications alleging violations of the rights included in the ICESCR. The individual complaints mechanism was introduced in 2008 by the Optional Protocol to the ICESCR, which came into force in 2013. Until then, the only chances that individuals had to allege right to health violations came from linking this right to other rights that were monitored by bodies such as the Human Rights Committee and the Committee Against Torture (Courtis, 2009: 49). Another option was to allege a violation of the right to health in connection with the prohibition of discrimination, through the complaints mechanisms included in specific treaties such as the Convention on the Elimination of All Forms of Racial Discrimination. This was due to the fact that there was not a direct complaints mechanism for protecting individuals against economic, social and cultural rights violations. Nevertheless, since the Optional Protocol to the ICESCR came into force, it is possible to send communications to the CESCR regarding violations of the rights included in the ICESCR, such as the right to health. This possibility can be interpreted as a sign of recognition of the relevance of social rights as human rights (Añón, 2010: 41).

According to Article 2 of the Optional Protocol, communications can be submitted by or on behalf of individuals or groups of individuals, under the jurisdiction of a State Party. Article 10 also sets the procedure for inter-State communications. With regards to the requisites for the admission of the communications, it is necessary to have exhausted all internal remedies in the State Party, unless the application of such remedies is unreasonably prolonged (Article 3.1). Other admissibility requisites are the following (Article 3.2): a) submission within one year after the exhaustion of domestic remedies; b) the facts must have taken place after the entry into force of the Protocol for the State Party concerned; c) the matter cannot be already examined by the CESCR or under another procedure of international investigation; d) compatibility with the provisions of the ICESCR; e) the communication must be founded and sufficiently substantiated, not only based on mass media reports; f) it cannot constitute abuse of the right to submit a communication; and g) it cannot be anonymous and must be presented in writing. Furthermore, the CESCR can decline to consider a case if it is not revealed that the author has suffered a clear disadvantage, unless it is a serious issue of general importance (Article 4).

According to the 'statistical survey of individual complaints dealt by the CESCR', by January 2018, 23 communications (either pending, inadmissible, discontinued cases or views) have been or are being dealt with by the CESCR. There are only 9 cases at the CESCR case law OHCHR database so far, of which 8 were against Spain and 1 was against Ecuador. However, the CESCR adopted views regarding only 2 out of the 9 cases, since the rest were found inadmissible. Focusing on the communications which alleged right to health violations, one of them dealt with an alleged medical negligence and lack of informed consent, however the relevant facts took place before the entry into force of the Protocol for Spain. Therefore, the communication was found inadmissible (Communication No 4/2014). Looking at the pending cases, there are 7 communications against Luxembourg, Italy, Spain and Ecuador, being examined by the CESCR. One of the communications is submitted against Ecuador alleging the violation of the right to health, amongst other rights (Articles 2, 6, 7 and 12), in a case regarding access to

complementary compensation established by collective bargaining agreement (Communication No 7/2015).

More recently, the Communication No 22/2017 was presented against Italy regarding a case of *in vitro* fertilization. The authors allege violation of the rights recognised in Articles 2.1, 10, 12.1.2.c) and d) and 15.2.3. After the *in vitro* fertilization cycle, only one embryo out of six was determined to be free of multiple hereditary exostosis (HME or HMO) but was graded 'average quality' with a low chance of nesting. Despite the fact that the female author declined to have this embryo transferred to her uterus, the private clinic's personnel insisted on that, according to Law 40/2004, her consent to the transfer of embryos to her uterus can only be revoked before fertilization has taken place. After being threatened with a lawsuit by the clinic, she had the embryo transferred and subsequently suffered a miscarriage. The authors requested that the clinic should donate the other embryos affected by HMO for research, however, the clinic refused this request alleging that research on embryos is prohibited (by Law 40/2004). The authors initiated a trial against the clinic to order them to surrender the embryos and in order to determine if the female's author decision not to have the embryo transferred was in conformity with the law. The case was dismissed by the Italian courts and is now pending resolution by the CESCR.

To conclude, there is a low number of individual communications before the CESCR. On one side, the Optional Protocol to the ICESCR only came into force five years ago, in 2013. On the other side, it is worth remembering that in the 10 years since the adoption of the Optional Protocol, and in the 9 years since it was opened for signature, only 23 States have ratified it, while 168 States have ratified the ICESCR. By contrast, 116 States have ratified the Optional Protocol to the International Covenant on Civil and Political Rights of 1966 that introduced the individual complaints mechanism regarding this kind of rights. These differences show that, as a general rule, States have always been, and still are, reluctant to be bound by social rights objectives, such as the right to health. Furthermore, while the complaints mechanism for civil and political rights was introduced in 1966, entering into force in 1976, it was over another four decades before a similar mechanism for social rights was introduced in 2008. Currently, speaking at least for the international community and for those 23 States Parties of the Optional Protocol to the ICESCR, the functioning of the complaints mechanism finally confirms social rights as enforceable, justiciable and equally important human rights.

VI. CONCLUSION

This article has analysed the main developments that have been made regarding the content and implications of the right to health. After this right was internationally recognised in 1948, as part of the right to a decent standard of living, the ICESCR was passed in 1966 including the right to the highest attainable standard of physical and mental health, in Article 12. The comprehensive interpretative work of the rights included in the ICESCR by the CESCR through the General Comments enables the consideration of the right to health as a defined right that comprises a distinct set of concrete elements, as discussed in Section 2. Moreover, the right demands the implementation of obligations

by States. General obligations include positive and negative duties, which are subject to progressive realisation by States, excepting for those minimum obligations that require immediate implementation. In this sense, at the very least, and regardless of economic constraints, States are obliged to satisfy the essential level of the right to health and to implement the core obligations, according to GC No 14.

Furthermore, the present article underlines three specific advancements that have the potential to strengthen the implementation and the enforcement of the right to health. Firstly, beyond the State responsibilities, considering private entities (e.g. business enterprises) responsible for human rights obligations has been repeatedly tabled for discussion. In this respect, Section 3 analyses a number of recommendations from UN human rights bodies urging business enterprises to undertake right to health assessments regarding issues such as access to medicines or the provision of health care services. Secondly, with regards to universal access to health care, the Universal Health Coverage goal, analysed in Section 4, is a significant development. It was proposed by the World Health Organization and received the recognition of the UN General Assembly in 2012. It has also been included as one of the Sustainable Development Goals for the Post-2015 Agenda.

Finally, regarding the right to health monitoring, Section 5 addresses the individual complaints mechanism introduced by the Optional Protocol to the ICESCR, as a sign of the recognition of social rights as enforceable and justiciable rights, which has been running since 2013. However, only 23 States have ratified the Optional Protocol so far and there is a low number of individual communications to date. Those who believe that economic, social and cultural rights, such as the right to health, are fundamental human rights which may be invoked before a court, have reasons to celebrate these kinds of monitoring mechanisms and also have reasons to hope that, sooner rather than later, more States commit themselves to social objectives and to the compliance with the rights recognised.

VII. REFERENCES

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