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The Right of Access to Healthcare: Tracing Solidarity in the United Nations, Inter-American and European Human Rights Systems

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Abstract

The purpose of this contribution is to trace a solidaristic conceptualisation of the human right of access to healthcare and to contrast it with the minimalistic conceptualisation which is predominant in international human rights law. For the purposes of this work, a solidaristic conceptualisation of this human right is one based on de-commodification, a path that questions the public and private law divide in the context of the provision of healthcare services. This perspective is different from minimalism, an approach according to which this human right should be limited to healthcare treatments necessary for subsistence or survival. The research is carried out within adjudications and country assessments emerged in the context of the UN and the Inter-American and European human rights systems: Concluding Observations of the United Nations Committee on Economic, Social and Cultural Rights, together with decisions from the Inter-American Court of Human Rights, the European Committee of Social Rights and the European Court of Human Rights. This assessment sheds light on whether any of these bodies take an approach different to the official minimalistic perspective and gets closer to solidarity. If a solidaristic perspective based on de-commodification could lead to maximize the effectiveness and universality of social rights, solidarity could start to be considered as necessary from the point of view of human rights protection.

Keywords

International human rights law, Social rights; Right to health; Solidarity; European Committee of Social Rights; European Court of Human Rights; Inter-American Court of Human Rights; United Nations Committee on Economic Social and Cultural Rights; Indivisibility of human rights.

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1. Introduction

Social rights have been understood in a number of ways since the end of WWII. Understandings vary between an effort of de-commodification,[1] 'programmatic' provisions,[2] justiciable entitlements,[3] socio-economic interests within the context of civil and political rights,[4] and the direct and autonomous recognition of social rights as individual rights.[5] In their current official UN conceptualization, the effort to protect social rights has revolved around indivisibility – the idea that social rights have the same importance and hierarchy than civil and political rights.[6] Up to this point, the fulfilment of the right of access to healthcare (from now onwards my references to the right to health should be limited to this, more specific, human right) has

[1] The Beveridge report was instrumental to the creation of services such as the British National Health Service, which considered its task the universal provision of social services. See Tom Montgomery and Simone Baglioni, 'The United Kingdom' in Veronica Federico and Christian Lahusen (eds), *Solidarity as a Public Virtue? Law and Public Policies in the European Union* (Nomos 2018) 182.

[2] Lisa Forman, 'What future for the minimum core? Contextualising the implications of South African socioeconomic rights jurisprudence for the international human right to health' in John Harrington and Maria Stuttaford (eds), *Global Health and Human Rights: Legal and philosophical perspectives* (Routledge 2010) 63.

[3] UNCHR, 'Note Verbale Dated 5 December 1986 from the Permanent Mission of the Netherlands to the United Nations Office at Geneva Addressed to the Centre for Human Rights ("Limburg Principles")' UN Doc E/CN.4/1987/17, 8 January 1987, para 8.

[4] Ingrid Leijten, Core Socio-Economic Rights and the European Court of Human Rights (CUP 2018) 25.

[5] Optional Protocol to the International Covenant on Economic, Social and Cultural Rights, UNGA A/RES/63/117, 10 December 2008.

[6] OHCHR, 'Vienna Declaration and Programme of Action', UN Doc A/CONF.157/23, 12 July 1993, para 5; See also n 71.

been largely understood as a matter of access to justice regarding social rights' claims.[7] These claims are in turn linked to vulnerable subjects, a minimum core provision of the services associated to these rights, and the prohibition of discrimination.[8]

This work focuses on tracing a solidaristic perspective of social rights. In this perspective, social rights are about de-commodification.[9] De-commodification is solidaristic because it challenges the unequal market-based provision of services connecting in that way with the demands of universality and equality proclaimed by human rights.[10] That the commodification of social rights endangers the universality and equality of social rights is not only a theoretical claim. Empirically, this perspective has been corroborated by the unequal access to social services when these services have been privately provided.[11] For this reason, this study focuses on the legal rules demarcating and authorizing a public and private division of services.

Aware of the differences between the various social rights, I limit the scope of this work to the right to health. What this paper shall do is to trace the solidaristic perspective understood as the effort of de-commodification; namely, definitions of social rights that go beyond the lack of access to services affecting the vulnerable subject. Recognizing that payment of services constitutes the greatest barrier and the main source of the divides in contemporary neoliberal democracies, I shall concentrate on the human rights review of rules allowing the public and private law divide between paid and unpaid healthcare services. I shall limit my endeavour to the work of the United Nations Committee on Economic Social and Cultural Rights (hereafter, 'the Committee' or 'the UNCESCR Committee'), and that of the regional human rights systems both in the Americas and in Europe. In the United Nations, I shall be looking at Concluding Observations in processes of periodic review of the International Covenant on Economic, Social and Cultural Rights (hereafter, 'the Covenant'). Within the Organization of American States I shall look at the Inter-American Court of Human Rights (hereafter, 'the Inter-American Court'). Within the Council of Europe I shall look at both the European Committee of Social Rights (hereafter, 'the ECSR') and the European Court of Human Rights (hereafter, 'the ECtHR').

2. Two social rights' perspectives

2.1. Minimalism

The right to health has been largely understood as a minimum core of healthcare services aimed at subsistence or survival. The State complies with the right to health as set forth in Article 12 of the Covenant as long as this minimum of services is provided. At the same time, this can be done irrespective of the way in which the provision of healthcare services is organized (public or private).[12]

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[7] OHCHR, 'Chapter 20: Monitoring Economic, Social and Cultural Rights' UN Doc HR/P/PT/7/Rev.1, (OHCHR 2011) 28.

[8] Leijten (n 4) 220-225.

[9] Eduardo Arenas Catalán, The Human Right to Health: Solidarity in the Era of Healthcare Commercialization (Edward Elgar 2021) 87; Ricardo Garcia Manrique, La Libertad de Todos: Una Defensa de los Derechos Sociales (El Viejo Topo 2013) 240; Carlos Lema Añón, 'Derechos Sociales, ¿Para Quién? Sobre la Universalidad de los Derechos Sociales' (2010) 22(II) Derechos y Libertades 179, 202.

[10] García Manrique (n 9) 240-242.

[11] Audrey Chapman, 'The Impact of Reliance on Private Sector Health Services on the Right to Health' (2014) 16(1) Health and Human Rights Journal 122, 124.

[12] UNCESCR, 'General Comment 14 The Right to the Highest Attainable Standard of Health', UN Doc E/C.12/2004/4, 11 May 2000, 12 b).

For official interpretations of social rights, the institutional setting within which services are provided has been largely seen as something irrelevant. This view has been reinforced through a specific General Comment the UNCESCR Committee dedicated to the right to health.[13] What was being delivered – the minimum core – was the relevant thing, and this was seen as something independent of the public or private nature of the institution doing that. This minimalistic egalitarianism stems already from General Comment 3, issued in 1990.[14] According to this instrument, the discharging of State obligations had to at least respect a minimum core.[15] This also meant that any quantitative or qualitative asymmetries either in the amount or quality of public, private or mixed healthcare services beyond this minimum were, strictly speaking, not susceptible of international review within the scope of the right to health. Public-private asymmetries beyond this minimum would be only of political as opposed to legal importance.[16]

2.2. Solidarism

The principle of solidarity imbues social rights with some of the concerns that gave birth to these rights, namely, problems of material inequality, distributive and economic justice.[17] Solidarity interrogates the validity of a pre-figured divide between the public and the private realm in the provision of social rights' related services.[18] In place of presenting the problem of social rights as one where redistribution of the social product will allow to address the needs of the vulnerable individual, a conception of social rights based on solidarity puts the accent on how these social goods are produced.[19] This is necessary today because accepting this divide, and consequently limiting the application of social rights to the public realm postpones the action of social rights to a situation of relative irrelevance, where not much is at stake any more.[20] Conceptions of social rights that accept this divide entail a perspective where the relevant services are delivered via market principles while, at the same time, a set of entitlements is generated for those in situations of disadvantage or marginalization.

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[13] ibid.

[14] UNCESCR, 'General Comment 3: The Nature of States Parties' Obligations (Art 2, Para. 1, of the Covenant)', UN Doc E/1991/23, 14 December 1990.

[15] 'Thus, for example, a State party in which any significant number of individuals is deprived of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education is, prima facie, failing to discharge its obligations under the Covenant.' ibid, para 10.

[16] UNCESCR, General Comment 3 (n 14), para 8.

[17] In his recount of the influence of the French Revolution over social rights, Garcia Manrique summarizes the following elements: (1) the very extended belief that individual liberty would not be possible without education for children, work for adults and assistance to all those that require it; (2) the stipulation of social rights in declarations and constitutions; (3) legislative development of those rights, especially concerning the educational and the assistance areas; (4) tax progressivity; (5) the conscience that the realization of liberty for all would require the limitation of the right to property. Garcia Manrique (n 9) 61.

[18] In this regard, 'socio-demographic factors and social traits (e.g. age, gender, education, social class) [are important] for grasping the conditions, structures, and dynamics of solidarity'. See Nicola Maggini, 'The Social and Political Dimensions of Solidarity in Italy', in Christian Lahusen and Maria Grasso (eds), *Solidarity in Europe: Citizens' Responses in Times of Crisis* (Palgrave Macmillan 2018) 130; Relevant studies in the field of the right to health have sought to assess 'how equity gaps map onto the public/private divide within the [health] system'. See Colleen Flood and Aeyal Gross (eds) *The Right to Health at the Public/Private Divide: A Global Comparative Study* (CUP 2014) 11.

[19] Lema (n 9) 202.

[20] See Juan Amaya Castro, 'Human Rights and the Critiques of the Public-Private Distinction' (DLaws thesis, Vrije Universiteit Amsterdam 2010) ch 8.6.

From the point of view of solidarity social rights are concerned with ensuring a universal and egalitarian production of goods and services.[21] The corollary of this view is that in order to develop universal access in equal amount, social rights are about the socialization of these services and their delivery through public institutions. The added value of solidarity is thus two-fold. On the one hand solidarity challenges a prevalent notion of human rights where the rights of the weakest can be satisfied through the provision of a defined minimum considering anything going beyond that a problem of individual responsibility. On the other, stemming from the need to operationalize a more comprehensive view of distributive justice that integrates the issue of social cohesion, the validity of the public and private law divide in the delivery of healthcare services is challenged. If commercial healthcare services are a result of legislation, the rules behind the creation of these services should be considered a decision attributable to the State.[22] Different degrees of enjoyment in terms of access and quality along a public and private law divide can therefore be considered a decision attributable to the State and, as such, a topic of international human rights law concern.

3. Assessment of adjudication bodies

3.1 The United Nations Committee on Economic, Social and Cultural Rights

In this examination, I shall look at the Committee's assessments in processes of periodic review ranging from the beginnings of the work of the Committee in the early 1980s to its most recent reviews.[23]

3.1.1. First period

During the 1980s and first half of the 1990s, the UNCESCR Committee used to carry out a review of social rights which considered social rights relatively broad terms. Several times the inquiry was one which assessed public services, budget allocations or the proportion of services provided by the public sector as opposed to those offered by the private sector.[24] Oftentimes this consisted in looking at 'total expenditure on health care as a percentage of the gross national product', and comparing it with that of similar countries.[25] Moreover, comparisons looked at asymmetries in the quality provided both within the public and the private sectors, including assessments of whether services were delivered conditional to a fee

[21] This idea matches the function of social rights under the 'social democratic' regime-type of the Scandinavian countries, as identified by Gøsta Esping-Andersen. Gøsta Esping-Andersen, *The Three Worlds of Welfare Capitalism* (Polity Press 1990) 27-8.

[22] *Ximenes Lopes* case (*Ximenes Lopes v Brazil* (Merits, Reparations and Costs), Inter-American Court of Human Rights, 4 July 2006, para 146; *Case of Calvelli and Ciglio v Italy*, appl no 32967/96, 17 January 2002, para 49.

[23] My assessment extended to the latest Concluding Observations as made available on the website of the Office of the High Commissioner on Human Rights on the 30 of September of 2021. These were the ones issued on Finland and Slovakia on 30 March 2021. <https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/TBSearch.aspx?Lang=en&TreatyID=9&DocTypeID=5>.

[24] Regarding the second periodic report of Australia, see ECOSOC, 'Consideration of Reports Submitted in Accordance With Council Resolution 1988 (LX) By States Parties to the Covenant Concerning Rights Covered By Articles 10 to 12 (continued)', UN Doc E/1986/4/Add. 7, 25 April 1986, para 8; ECOSOC, 'Second Periodic Report of the Syrian Arab Republic concerning the rights covered by articles 1 to 15 of the Covenant', UN Doc E/C.12/1991/SR.7, 9 and 11, 28 November 1991, para 184.

[25] On Finland ECOSOC, 'Sessional Working Group of Governmental Experts on the Implementation of the International Covenant on Economic, Social and Cultural Rights: Summary Record of the 8th Meeting', UN Doc E/1986/WG.1/SR.8, 25 April 1986, para 69.

or provided free of charge.[26] At times, as in a report concerning Mexico, asymmetries between paid and unpaid services were slightly dismissed as 'differences in facilities'.[27]

In carrying these assessments, the institution of the National Health System was explicitly mentioned.[28] On the other hand, in a report on Cyprus, the Committee asked 'whether disadvantaged groups of the population had access to the health services in the private sector'.[29] The answer of the state representative was that the private sector was open to 'those who could afford to pay'.[30] Similarly, on a report on the Netherlands, the Committee inquired on the extent of the function of individual responsibility in the healthcare system and for people who did not have an insurance.[31]

3.1.2. Second period

From approximately 1995 to approximately 2015 the Committee remained interested in the dynamics of public expenditures.[32] Similarly, asymmetries between the public and the private sector remained an issue of concern.[33] Furthermore, inquiries into whether specific subjects were or not protected under the private healthcare sector were also addressed in this period.[34] However, structural assessments about how health expenditures in the public sector compared with those from other countries, were no longer assessed in their own merit. Rather, those assessments appeared instrumental to the question of whether or not those dynamics affected the rights of specific subjects in a position of vulnerability, disadvantage or marginalization.

In a recommendation to Hungary, the Committee required 'the State party [to] strengthen preventive health-care services and improve public services … particularly in Roma communities, and increase its efforts to address … factors contributing to the low life expectancy of Roma.'[35] At times, this vulnerability was associated either with a subjective

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[26] Regarding Colombia, see ECOSOC, 'Consideration of Reports Submitted in Accordance With Council Resolution 1988 (LX) By States Parties to the Covenant Concerning Rights Covered By Articles 10 to 12 (continued)', UN Doc E/1986/3/Add. 3, 22 April 1986, paras 3, 15, 22, 32, 35; on Portugal, see ECOSOC, 'Consideration of Reports Submitted in Accordance With Council Resolution 1988 (LX) By States Parties to the Covenant Concerning Rights Covered By Articles 10 to 12', UN Doc E/1986/6/Add.35/Rev.1, 25 April 1985, para 13; ECOSOC, UN Doc E/C.12/1991/SR.7 (n 24) paras 184-185.

[27] ECOSOC, 'Initial report of Mexico concerning the rights covered by articles 10 to 12 of the Covenant', UN Doc E/C.12/1989/SR.6, 7 and 9, 15 January 1990, para 111.

[28] For example in a report regarding Colombia, see ECOSOC, UN Doc E/1986/3/Add. 3 (n 26), para 3.

[29] ECOSOC, 'Second Periodic Report of Cyprus concerning articles 10 to 12 of the Covenant', UN Doc E/C.12/1990/Sr.2, 3 and 5, 15 January 1990, para 74.

[30] ECOSOC, UN Doc E/C.12/1990/Sr.2, 3 and 5 (n 29) para 78.

[31] On the Netherlands, ECOSOC, 'Second periodic report of the Netherlands on the rights referred to in articles 10 to 12 of the Covenant', UN Doc E/C.12/1989/4/SR.14 and 15, 15 February 1989, para 225.

[32] UNCESCR, 'Consideration of Reports Submitted by States Parties Under Articles 16 and 17 of the Covenant: Uzbekistan', UN Doc E/C.12/UZB/CO/1, 24 January 2006, para 29; moreover, taking note of social rights' democratic pedigree, the Committee expressed, in the case of Lebanon, concern for the lack of a public budget insofar that 'the current sectoral allocations no longer correspond to the needs and priorities in the State party'. See UNCESCR, 'Concluding observations on the second periodic report of Lebanon', UN Doc, E/C.12/LBN/CO/2, 23 October 2016, para 10.

[33] UNCESCR, 'Concluding observations on the initial report of Namibia', UN DOC E/C.12/NAM/CO/1, 23 March 2016, para 64.

[34] UNCESCR, 'Consideration of reports Submitted by States Parties Under Articles 16 and 17 of the Covenant: Chile', UN Doc E/C.12/1/Add.105, 1 December 2004, para 57; UNCESCR, 'Concluding observations on the second periodic report of the Czech Republic', UN Doc E/C.12/CZE/CO/2, 23 June 2014, para 15.

[35] UNCESCR, 'Consideration of Reports Submitted by States Parties Under Articles 16 and 17 of the Covenant: Hungary' UN Doc E/C.12/HUN/CO/3, 16 January 2008, para 48; see also UNCESCR, 'Concluding observations

characteristics (belonging to an 'indigenous population'[36]), but also with the social conditions in which those subjects lived ('poverty and extreme poverty'[37]). By the same token the Committee, reporting on Ireland, worried about the deterioration in health-care services due to budget cuts and the negative impact of this on the access for disadvantaged and marginalized individuals, particularly those without private health insurance.[38] A specific recommendation in this regard was to introduce common waiting lists for treatment in publicly funded hospitals for privately and publicly insured patients.[39]

While the legitimacy of the provision of healthcare services by private actors was never put into question, several critical remarks were made regarding its effects. The Committee commented with disapproval on 'the preference for a private-sector approach to the management, financing and provision of services'.[40] It also looked critically on the fact 'that a considerable part of the public budget for health … is spent on contracts for the delivery of services by … private medical facilities'.[41] Yet again, the Committee considered that the financial means allocated to the public sector were insufficient to provide 'adequate coverage for the population, in particular vulnerable groups'.[42] In a report on India, the Committee expressed concern over the 'loss of medical professionals from the public health services'.[43] In that case, the Committee recommended the State party to 'substantially increase funds allocated to public health and to provide additional incentives in order to prevent [that situation]'.[44] Perhaps more assertively the Committee questioned, in a report on the Lebanon, the 'practice of contracting out the delivery of basic services to private actors'.[45] Yet, the Committee limited itself to recommend the State to 'review' whether those practices constituted 'an optimal use of available resources to ensuring Covenant rights without discrimination'.[46] Similarly, on a report on Macedonia, the Committee recommended to monitor and control the private sector compliance with contractual agreements.[47] In a report on Uzbekistan, the Committee expressed concern over 'the transition from a free to a prepaid health system and the introduction of private insurance-based medical care'.[48] However, this was only to the extent those dynamics could 'impact negatively on low-income groups and the rural population'.[49] In its remarks concerning El Salvador, the Committee reached what it could appear as a more outspoken recommendation. After expressing criticism towards private dynamics,[50] the Committee moved to recommend to the State party to 'take the necessary

on the combined second to fourth periodic reports of the former Yugoslav Republic of Macedonia', UN Doc E/C.12/MKD/CO/2-4, 15 July 2016, para 47.

[36] UNCESCR, 'Concluding observations on the third periodic report of Guatemala', UN Doc E/C.12/GTM/CO/3, 9 December 2014, para 22.

[37] UNCESCR, UN Doc E/C.12/GTM/CO/3 (n 36) para 22.

[38] UNCESCR, 'Concluding observations on the third periodic report of Ireland', UN Doc E/C.12/IRL/CO/3, 8 July 2015, para 28.

[39] UNCESCR, E/C.12/IRL/CO/3, (n 38) para 28.

[40] UNCESCR, 'Consideration of Reports Submitted by States Parties Under Articles 16 17 of the Covenant: El Salvador', UN Doc E/C.12/SLV/CO/2, 27 June 2007, para 24;

[41] UNCESCR, E/C.12/LBN/CO/2 (n 32) para 10.

[42] UNCESCR, E/C.12/SLV/CO/2 (n 40) para 24.

[43] UNCESCR, 'Consideration of Reports Submitted by States Parties Under Articles 16 and 17 of the Covenant: India', UN Doc E/C.12.IND/CO/5, 8 August 2008, para 78.

[44] UNCESCR, E/C.12.IND/CO/5 (n 43) para 78.

[45] UNCESCR, E/C.12/LBN/CO/2 (n 32) para 11.

[46] UNCESCR, E/C.12/LBN/CO/2 (n 32) para 11.

[47] UNCESCR, E/C.12/MKD/CO/2-4, (n 35) para 48.

[48] UNCESCR, UN Doc E/C.12/UZB/CO/1 (n 32) para 29.

[49] UNCESCR, UN Doc E/C.12/UZB/CO/1 (n 32) para 29.

[50] UNCESCR, E/C.12/SLV/CO/2 (n 40) para 24.

measures to consolidate a national health system based on equity and accessibility, in accordance with article 12 of the Covenant'.[51] While this language reflects a direct causal link between the institution of the National Health System with the Covenant's Article 12, the scope of the former obligation was inevitably linked to subjective considerations ('in particular for vulnerable groups'[52]).

An important observation related to access to abortion.[53] As the assessment on Spain reflected, moral or religious convictions presented in the language of 'conscientious objection', appeared to militate against the practice of medical abortion. In that respect, the public sector appeared to not always be fit to the challenge of making medical abortion sufficiently accessible. While the private for-profit sector might be better positioned to deal with this extra-medical challenge for those who can pay, this subsequently does not mean that this sector is better equipped with the challenges that derive from economic (in)accessibility.

3.1.3.Third period

From 2015 to 2021, some *classical* issues of concern have remained. This is the case regarding public health-care expenditures as a percentage of the GDP.[54] When looking more specifically at the private sector, issues such as high out-of-pocket health expenses, request of unofficial fees for medical services, high prices of medicines and expensive private medical care have also been noted with concern.[55] As in the former period, this issue has been developed in connection with its effects over disadvantaged and marginalized groups.[56]

In some recent reports the Committee used a more eloquent language regarding equity. In a recommendation to Namibia, the Committee recommended the State to bridge 'the gap in health outcomes' from the point of view of infant and maternal mortality rates 'between the wealthiest and the most disadvantaged groups'.[57]

While in some cases the Committee makes critical reference to important commercial trends such as 'privatization' or 'contracting out', the focus is mostly on the potential negative effects

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[51] UNCESCR, E/C.12/SLV/CO/2 (n 40) para 43.

[52] UNCESCR, E/C.12/SLV/CO/2 (n 40) para 43.

[53] UNCESCR, 'Consideration of reports submitted by States parties under articles 16 and 17 of the Covenant: Spain', UN Doc E/C.12/ESP/CO/5, 6 June 2012, para 24.

[54] UNCESCR, 'Concluding observations on the fifth periodic report of Sri Lanka', UN Doc E/C.12/LKA/CO/5, 04 August 2017, para 57; UNCESCR, 'Concluding observations on the fourth periodic report of the Republic of Korea', UN Doc E/C.12/KOR/CO/4, 19 October 2017, para 11; UNCESCR, 'Concluding observations on the initial report of the Niger', UN Doc E/C.12/NER/CO/1, 4 June 2018, para 51 d); UNCESCR, 'Concluding observations concerning the initial report of the Central African Republic', UN Doc E/C.12/CAF/CO/1, 4 May 2018, para 37; UNCESCR, 'Concluding observations on the fourth periodic report of Israel', UN Doc E/C.12/ISR/CO/4, 12 November 2019, para 54

[55] UNCESCR, E/C.12/LKA/CO/5 (n 54) para 57; UNCESCR, E/C.12/KOR/CO/4 (n 54) para 44; UNCESCR, 'Concluding observations on the second periodic report of Latvia', UN Doc E/C.12/LVA/CO/2, 30 March 2021, para 38; UNCESCR, 'Concluding observations on the seventh periodic report of Ukraine', UN Doc E/C.12/UKR/CO/7, 2 April 2020, para 38.

[56] UNCESCR, E/C.12/KOR/CO/4 (n 54) para 45; UNCESCR, E/C.12/LKA/CO/5 (n 54) para 57; UNCESCR, 'Concluding observations on the initial report of Namibia', UN Doc E/C.12/NAM/CO/1, 23 March 2016, para 64; UNCESCR, 'Concluding observations on the combined second to fourth periodic reports of the former Yugoslav Republic of Macedonia', UN Doc E/C.12/MKD/CO/2-4, 15 July 2016, para 47; UNCESCR, 'Concluding observations on the initial report of Cabo Verde', UN Doc E/C.12/CPV/CO/1, 27 November 2018, para 57; UNCESCR, 'Concluding observations on the initial report of Bangladesh', UN Doc E/C.12/BGD/CO/1, 18 April 2018, paras 66 a), 67 a); UNCESCR, 'Concluding observations on the fourth periodic report of New Zealand', UN Doc E/C.12/NZL/CO/4, 1 May 2018, para 45; UNCESCR, UN Doc E/C.12/NER/CO/1 (n 54), para 51 b); UNCESCR, UN Doc E/C.12/ISR/CO/4 (n 54) para 55. See also, UNCESCR, 'Concluding observations on the third periodic report of Slovakia', UN Doc E/C.12/SVK/CO/3, 14 November 2019, para 37.

[57] UNCESCR, E/C.12/NAM/CO/1, (n 56) para 65 (a).

this may have over vulnerable subjects. In some cases, the Committee fails to come up with more assertive recommendations. For example, in a report on Korea, after mentioning the problems generated by the highly privatized health system, the Committee urges the State to ensure affordability for the disadvantaged and the marginal but without explicitly recommending to withdraw from the privatization dynamics identified as responsible for the problem.[58]

Having said this, during this period the Committee got significantly closer to the solidaristic perspective. This could be corroborated in several instances:

- Similarly to the focus on health outcomes, the Committee addressed economic disparities as a human rights problem. In some cases this was done by remarking geographical disparities in the delivery of services.[59] Aligned with this language, the Committee also showed sensitivity for socioeconomic factors impacting on the enjoyment of the right to health.[60]
- The impact of austere politics on the right to health was also addressed with the Committee criticizing the maintenance of regressive measures despite good economic conditions and moderate immigration flows.[61]
- In some cases the Committee explicitly recommended to provide some health services free of charge, including the establishment of non-contributory regimes.[62] By the same token, the policy of universal health insurance was explicitly recommended.[63]

Relevant to this analysis have been a number of remarks where the Committee has directly and indirectly approached the public and private law divide:

- The reference to the provision of access to 'high-quality health-care services' is relevant because it addresses the critical question of who enjoys high quality healthcare.[64] This inquiry implicitly touches upon the public and private law divide

[58] UNCESCR, E/C.12/KOR/CO/4 (n 54) para 44.

[59] UNCESCR, 'Concluding observations on the combined fifth and sixth periodic reports of Mexico', UN Doc E/C.12/MEX/CO/5-6, 17 April 2018, para 59 b); UNCESCR, 'Concluding observations on the sixth periodic report of Spain', UN Doc E/C.12/ESP/CO/6, 25 April 2018, para 44 a); UNCESCR, Concluding observations on the sixth periodic report of Bulgaria, UN Doc E/C.12/BGR/CO/6, 29 March 2019, paras 40-41; UNCESCR, 'Concluding observations on the second periodic report of Kazakhstan', UN Doc E/C.12/KAZ/CO/2, 29 March 2019, paras 19-20.

[60] UNCESCR, 'Concluding observations on the fourth periodic report of Ecuador', UN Doc E/C.12/ECU/CO/4, 14 November 2019, para 45; UNCESCR, 'Concluding observations on the fifth periodic report of Belgium', UN Doc E/C.12/BEL/CO/5, 26 March 2020, para 52; UNCESCR, 'Concluding observations on the seventh periodic report of Finland', UN Doc E/C.12/FIN/CO/7, 30 March 2021, para 41.

[61] UNCESCR, 'Concluding observations on the sixth periodic report of Norway', UN Doc E/C.12/NOR/CO/6, 2 April 2020, para 38. See also UNCESCR, 'Concluding observations on the fourth periodic report of Argentina', UN Doc E/C.12/ARG/CO/4, 1 November 2018, para 49.

[62] UNCESCR, UN Doc E/C.12/CAF/CO/1 (n 54), para 37 d); UNCESCR, UN Doc E/C.12/NER/CO/1 (n 54), paras 51 a), 52 b), c); UNCESCR, UN Doc E/C.12/LVA/CO/2 (n 55), para 40.

[63] UNCESCR, 'Concluding observations on the initial report of Mali', UN Doc E/C.12/MLI/CO/1, 6 November 2018, para 46 a).

[64] UNCESCR, UN Doc E/C.12/MEX/CO/5-6 (n 59) para 59 a); UNCESCR, UN Doc E/C.12/ARG/CO/4 (n 61) para 50.

because the question of who gets access to those high quality services can depend from it.

- In some cases the Committee recommended the monitoring of public and private facilities.[65] Although the reason to do this was not explained, identifying disparities is a crucial means to highlight the malfunctioning of mainstream interpretations of social rights.
- In what is possibly the most significant remark regarding the public and private law divide, the Committee stated in its observations on South Africa that:

'the Committee is concerned at the large disparities between the public and private health-care systems, with the public system at a disadvantage in relation to the number of medical professionals, medical equipment and medical expenditure, as well as between rural and urban areas in registering with the National Health Insurance Fund and accessing health-care services. It is particularly concerned at the acute lack of medical professionals and the limited range and at times inadequate quality of services provided in the public health sector, on which more than 85 per cent of the population rely.'[66]

As a result, the Committee recommended the State party to 'address the large disparities between the public and private health-care systems'.[67]

- Finally, the Committee made some noteworthy remarks to Argentina in the area of mental health services, recommending the State to replace 'the system of public and private psychiatric institutions with a comprehensive, integrated, interdisciplinary system of community-based mental health services, pursuant to the National Mental Health Plan'.[68]

3.2. The Inter-American system of Human Rights: recent developments taken by the Inter-American Court of Human Rights

After many years of understanding the protection of social rights indirectly, by means of the protection of other civil rights such as the right to life or the right to physical integrity,[69] the Inter-American Court of Human Rights inaugurated a direct and autonomous protection of social rights. Judge Eduardo Ferrer, the current President of the Inter-American Court, was the precursor of this development. In his dissenting opinion in the *Suarez Peralta v Ecuador* case,[70] Judge Ferrer expressly called on the Inter-American Court to move and to disentangle social

[65] UNCESCR, UN Doc E/C.12/CPV/CO/1 (n 56), para 57 b).

[66] UNCESCR, 'Concluding observations on the initial report of South Africa', UN Doc E/C.12/ZAF/CO/1, 29 November 2018, para 63.

[67] UNCESCR, UN Doc E/C.12/ZAF/CO/1 (n 66), para 63.

[68] UNCESCR, UN Doc E/C.12/ARG/CO/4 (n 61) para 54 (e).

[69] *Case of the Yakye-Axa Indigenous Community v Paraguay* (Merits, Reparations and Costs) Inter-American Court of Human Rights, 17 June 2005; *Case of the Sawhoyamaxa Indigenous Community v Paraguay* (Merits, Reparations and Costs) Inter-American Court of Human Rights, 29 March 2006.

[70] *Suárez Peralta v Ecuador* (Preliminary Objections, Merits, Reparations and Costs) Inter-American Court of Human Rights, 21 May 2013.

rights' own features.[71] In the *Poblete Vilches and others v Chile* case,[72] the Inter-American Court followed suit, and for the first time adopted the perspective that the respondent State had directly violated the right to health.[73]

In his dissent on the *Suarez Peralta* case, Judge Ferrer relied on Colombian case law to put forward an understanding of solidarity.[74] Yet, this perspective only reiterates the mainstream human rights idea about the need to protect vulnerable individuals and to reinforce individual justiciability in courts of law.[75] Judge Ferrer also referred to the duty to effectively regulate healthcare services (either public or private)[76] and to the connection between the right to health and the need to avoid medical malpractice.[77]

These issues came back in the *Poblete Vilches and Others v Chile* case, which concerned medical malpractice in situations of emergency. The Inter-American Court focused on access to essential healthcare services, the guarantee of effective and high quality medical care, and the duty to improve the general conditions of health for the population.[78] The Inter-American Court understood the foundation of the right to health on a 'duty to regulate' services, whether public or private in nature, as well as the need to execute national programmes seeking to provide good quality services.[79] By the same token, concerning the institutional setting apt to protect the right to health, the Inter-American Court relied on the doctrinal perspective set by the UNCESCR Committee. Thus, the Inter-American Court looked at General Comment 14 and the AAAQ standard of availability, accessibility, acceptability and quality.[80] In developing the condition of accessibility, the Inter-American Court recounted that this access should be provided without discrimination, including economic position, birth or any other social condition.[81] Here, responsibility was conceived to emerge from omissions in the duty to supervise.[82] These perspectives show that within the Inter-American system, the right to health was understood as a matter of access to essential healthcare services[83] where such a lack of access was largely associated with the notion of discrimination.[84]

Given that for most of its case law concerning the protection of rights with a socio-economic dimension the Inter-American Court had already relied in progressive realization and the non-retrogression of social rights,[85] the duty to regulate[86] and vulnerable populations,[87] the added value of declaring an autonomous violation of the right to health remains dubious in this case.

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[71] *Suárez Peralta v Ecuador* case, reasoned vote of Judge Eduardo Ferrer, Inter-American Court of Human Rights, para 27.

[72] *Poblete Vilches and others v Chile* (Merits, Reparations and Costs) Inter-American Court of Human Rights, 8 March 2018.

[73] ibid, para 176.

[74] Judge Ferrer (n 71), para 77.

[75] ibid, paras 77, 80, 87.

[76] ibid, para 90.

[77] ibid, paras 91, 94.

[78] Poblete Vilches (n 72) para 118.

[79] ibid para 119.

[80] ibid para 120.

[81] ibid para 122.

[82] ibid para 124.

[83] *Caso Cuscul Pivaral y Otros vs Guatemala*, (Preliminary Exception, Merits, Reparations and Costs) Inter-American Court of Human Rights, 23 August 2019, para 105.

[84] ibid, para 107.

[85] ibid, paras 141-142, 146-147.

[86] ibid, para 106.

[87] Sawhoyamaxa (n 69) paras 159, 170; Yakye-Axa (n 69) para 167.

Even agreeing on the necessity of doing so, remaining to link the solidarity of social rights with a reinforced duty to protect vulnerable populations or not critically assessing the public and private law divide in the provision of healthcare services, does not entail a shift from its previous case law, substance wise.

3.3. The Council of Europe

3.3.1. The European Committee of Social Rights

My analysis of the European Committee of Social Rights will be based exclusively on an analysis of the *International Planned Parenthood Federation – European Network v Italy* case. In this case, the ECSR contrasted some differences in healthcare services. In doing so, the ECSR relied both on the subjective category of women, supplemented with a nuanced comparison of the position of women as a result of intersectional or multilevel discrimination.

In *International Planned Parenthood Federation – European Network (IPPF EN) v. Italy*,[88] the ECSR found both a violation of Article 11, the provision on the right to protection of health, and a violation of this substantive provision in conjunction with the provision of Article E of the European Social Charter, which prohibits discrimination.

According to the complainant organisation, the situation that motivated the case was the large amount of medical professionals who inhibited themselves from practicing abortions on the grounds of 'conscientious objection', as established by Italian legislation (Section 9 of Act N° 194 of 22 May 1978). The ECSR considered that the way in which conscientious objection was established breached Article 11 of the Charter by rendering the goal of guaranteeing the legal right of women to have access to procedures for the termination of pregnancy ineffective.[89]

The complainant organisation took the view that Section 9 of the Italian law was designed to ensure access to abortion irrespective of whether medical practitioners would invoke their right to conscientious objection.[90] The government's failure to accommodate for the subsequently lesser amount of personnel who became available in public healthcare services, affected some women in obtaining an abortion.[91] The complainant organisation considered that all hospitals had to be equipped with the essential number of practitioners necessary to meet the demands for the voluntary termination of pregnancy.[92] To fundament its complaint, the organisation pointed out the inadequacy of the statutory framework and the measures adopted by hospitals and nursing homes in providing access to abortion.[93] The organization similarly indicated that the measures responding to the high number of objecting medical practitioners was insufficient to implement the right of women seeking the termination of their pregnancy.[94] The government, in turn, considered that the implemented measures stroke an appropriate balance between the right to health of the women seeking the termination of their pregnancy and the right to the freedom of conscience of medical practitioners who objected to this practice.[95]

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[88] European Committee of Social Rights, *International Planned Parenthood Federation – European Network (IPPF EN) v. Italy*, Complaint 87/2012, 10 March 2014.

[89] ibid, para 12.

[90] ibid, para 75

[91] ibid, para 190.

[92] ibid, para 78

[93] ibid, paras 79, 81

[94] ibid, para 86

[95] ibid, para 93.

The ECSR adjudged the case by pointing out to a series of deficiencies in the public health infrastructure. These deficiencies would have been the cause leading to a violation of the right to health. These included: decrease in the number of hospitals or nursing homes where abortions were carried out, lack of non-objecting practitioners, zones in which there was a disproportionate low number of non-objecting practitioners, excessive waiting times to access abortion services, non-replacement of medical practitioners in case of unavailability, deferral of abortion procedures, and objecting health personnel refusing to provide necessary care prior or following abortion.[96] As a result, the ECSR declared a violation of Article 11 considering that 'health facilities [had] not adopt[ed] the necessary measures to compensate for the deficiencies in service provision caused by health personnel who decide[d] to invoke their right of conscientious objection.'[97]

The ECSR found a further violation of the Charter looking at Article 11 in conjunction with Article E, the non-discrimination provision of the Charter. Here, the ECSR compared the subjective category of 'women', but it did it in light of a position which was constructed on a non-subjective basis, namely, women 'who have relatively unimpeded access to lawful abortion facilities and those who do not', and women 'seeking access to other lawful forms of medical procedures which are not provided on a similar restricted basis'.[98] The ECSR considered these different grounds as cases of 'intersectional' or 'multiple' discrimination.[99] The ECSR noted that the group of affected women saw themselves forced to move from one hospital to another within the country or to travel abroad, which in some cases was detrimental to the health of the women concerned. As a result, the ECSR held 'that the women concerned are treated differently than other persons in the same situation with respect to access to health care, without justification'.[100]

Analysis

According to the assessment of the ECSR, the problem was caused by the fact that public healthcare services were not compensated for the lesser medical personnel that became available as a result of the large number of practitioners who exercised their right of conscientious objection in cases of abortion. Even if better implementation of public healthcare services is a likely part of any solution to this problem, the way the ECSR tackled the case failed to fully address what in my view led to the challenges raised in this case. Given the way the complainant organisation filed the case, conscientious objection was one of the main legal considerations. A significant part of the case revolved around the question of what needed to be done in order not to sacrifice practitioners' right to conscientious objection vis-à-vis women's right to end their pregnancy, under the right to protection of health. This, it seems to me, is not the real problem at stake.

In circumscribing its own competence, the ECSR indicated that the scope of Article 11 concerned 'the manner in which sexual and reproductive health care services are organised in Italy' and how that would impact 'upon the enjoyment of the right to protection of health provided for under Article 11 of the Charter.'[101] Moreover, taking its cue from a judgment of the European Court of Human Rights, the ECSR,

[96] ibid, para 169.

[97] ibid, para 174.

[98] ibid, para 190.

[99] ibid.

[100] ibid, para 191.

[101] ibid, para 68.

> 'considers that once States introduce statutory provisions allowing abortion in some situations they are obliged to organise their health service system in such a way as to ensure that the effective exercise of freedom of conscience by health professionals in a professional context does not prevent patients from obtaining access to services to which they are legally entitled under the applicable legislation'.[102]

Seemingly considering that the legal rules establishing the public-private divide of healthcare services felt 'under the applicable legislation' mentioned above, the ECSR did not explicitly tackle the legal consequences of this divide. Even if in its recommendations the ECSR stated 'that the women concerned are treated differently than other persons in the same situation with respect to access to health care, without justification',[103] the asymmetries that led to this conclusion were not those existing between public and private healthcare services. The asymmetries that triggered the declaration of a violation of Article 11 in conjunction with Article E, where those that resulted from 'the lack of non-objecting medical practitioners and other health personnel in a number of health facilities in Italy'.[104]

When the ECSR, in paragraphs 174 and 191 spoke of 'health facilities', the mention was in reality referred to *public* health facilities. Admittedly, the unqualified terminology of 'health facilities' fits better with the attribution of responsibility to the Italian State. Responsibility under international law emerges from implementation of the Charter in full *throughout its territory* (emphasis added)'.[105] From this, one would think that commercial healthcare services would have to be considered legally relevant in equal terms, rather than being left out of the equation. However, given that it is only in public facilities where 'the competent authorities [could possibly] adopt the necessary measures which are required to compensate for the deficiencies in service provision caused by health personnel …',[106] it is clear that the ECSR was referring to public facilities *only*. Furthermore, challenging the public and private law divide of healthcare services is not something so simple as to be fixed by the discretional administrative power of the concerned regional authorities. Contrarily, it requires fundamental amendments of the laws concerning the structure of the domestic health system. This, the ECSR did not require in its recommendations despite the fact that this problem clearly merited it, while plausibly falling under the scope of Article 11 of the European Social Charter.

To come to the point of judging that discrimination emerged from the 'socio-economic status between women who have relatively unimpeded access to lawful abortion facilities',[107] or that 'the women concerned are treated differently than other persons in the same situation with respect to access to healthcare without justification',[108] the ECSR must have considered the practical reality of the women who were able to pay for abortion in private healthcare services. Not sufficiently accounted for, the ECSR dedicates one paragraph to address an argument made by the complainant organisation in the sense that '[w]ealthier women are inclined to avail of private clinics in Italy or in public hospitals or private clinics abroad, as they are able to afford the ensuing costs of their choice'.[109] Needless to say, under commercialized healthcare

[102] ibid, para 69.
[103] ibid, para 191.
[104] ibid.
[105] ibid, para 67.
[106] ibid, para 190.
[107] ibid, para 189.
[108] ibid, para 191.
[109] ibid, para 183.

services, women do not have difficulties in accessing healthcare services including abortion, provided that they are in the financial position to afford the corresponding fees. Despite this, the ECSR did not consider that the rules that created the public and private law divide of healthcare services were responsible in leading to this asymmetrical reality. Instead, it limited itself to the responsibility of the State to the actions and omissions within public healthcare facilities (despite its unqualified reference to 'health facilities').

Due to the fact that Italian legislation is what makes the existence of commercial healthcare services possible in that country, the source of the asymmetries in access to abortion should be traced back to those legal rules. The case did not develop this important point. When the commercial delivery of healthcare services is permitted, access to medical treatment – in this case abortion – can become fully accessible in exchange for a payment. It is the reality of women not been able to pay medical fees what most crucially helped the ECSR to concern itself with the different position of women attempting to accessing abortion. Instead, the ECSR relied on a doctrinal perspective – intersectional discrimination – which failed to account for the public and private law divide in the organization of healthcare services in Italy, avoiding the much simpler and legally stronger point that what in fact triggered the contrast were the asymmetries in Italy's public and private law divide, which allowed some women to access abortion on the basis of ability to pay, whereas less well-off women, especially immigrant women, needed to rely on the services provided by the diminished universe of the medical professionals willing to honour their medical and ethical duties.

Whether the State failed to fix this disparity by for example hiring insufficient non-objecting healthcare personnel in the public sector, is not what creates the legally relevant contrast, but merely one of the various avenues that might eventually help in addressing it.

3.3.2. The European Court of Human Rights

Analysing access to healthcare from the point of view of the case law of the ECtHR is an effort that assumes one accepts that the European Convention on Human Rights is a civil and political human rights instrument. One of the implications of this normative assertion is that the ECtHR is not supposed to directly construe social rights such as the the human right to health.[110] I do not deny that in seeking to interpret the classical rights enshrined in the European Convention the Court could impact on the way healthcare is delivered.[111]

On the other hand, interpreting the legal consequences civil rights have over healthcare should not lead one to the confusion that such an effort also unveils the actual substance of social rights. This perspective is particularly strong if one seriously follows the conclusions of the Second World Conference on Human Rights regarding indivisibility[112] or, for the same matter, the opinion of Judge Ferrer about social rights being a distinct and autonomous category of rights[113] (rather than a sort of derivative or dependable sub-species of classical rights). Implicit is the idea that the scope of civil rights must at a given point end, whereas the scope of social rights must at some point *begin*.[114]

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[110] ECtHR, *Vasileva v Bulgaria*, application number 23796/10, 17 March 2016, para 63.

[111] Colin Warbrick, see Colin Warbrick, 'Economic and Social Interests and the European Convention on Human Rights' in Mashood Baderin and Robert McCorquodale (eds), *Economic, Social and Cultural Rights in Action* (OUP 2007) 247; Leijten (n 4) 23.

[112] OHCHR, 'Vienna Declaration and Programme of Action', UN Doc A/CONF.157/23, 12 July 1993, para 5.

[113] n 71.

[114] I develop this idea in Eduardo Arenas Catalán, 'Where Do Social Rights Begin?', in Leonard Besselink (ed), *The Economic Constitution: Principles of Constitutional Democracy between Globalisation and Europeanisation* (Wolf Legal Publishers 2020) 44-8.

But this idea goes further. Indivisibility between both sets of human rights requires one to accept that as much as civil rights can have an impact on healthcare (a principal means of redress for the human right to health[115]), social rights can also impact or rearrange civil rights' means of redress. Even if the Second World Conference on Human Rights took place almost three decades ago, at the present point in time, the development of human rights reflects that Courts and legal scholars have mostly made themselves busy with finding the consequences civil rights have over social rights, and not so much vice versa. Lack of theorization, insufficient legal tools or intellectual prejudice are possible reasons to explain this underdevelopment. Be that as it may, the indivisibility of human rights requires to consider that human rights interpretation is, at the very least, something larger in scope than the interpretation of civil rights. But I would argue that indivisibility also requires to accept that the interpretation of civil rights should be carried out in ways that are respectful, deferent and amicable to the scope of social rights.

This approach presents the problem in a different light. Interpretations of the European Convention which interpret the positive obligations of civil rights with an overreaching effect are implicitly considered progressive.[116] In fact, they could be an expression of the colonization of social rights. The possibility to develop a sound jurisprudence based on the normative content of social rights might in fact be replaced by an overarching set of individual protections in the social field. And if this is so, we are getting further removed, not closer, from the goals of human rights integration, indivisibility and interdependence proclaimed in 1993.[117]

A legally sound interpretation about the work of the ECtHR with regard to the public and private law divide requires the awareness that what will ultimately be adjudicated is not a social, but a civil right. In order not to deplete the scope of social rights, a degree of restraint is necessary when conceiving the positive obligations derived from civil rights. Legally sound interpretations will be those that take the integration and indivisibility of both sets of human rights seriously. Namely, interpretations that balance on the one hand an immediate causal link between the interference and the deployment of civil rights' positive obligations while at the same time, leaving enough space to developing the scope belonging to social rights' normative content.

A brief reconstruction of the relevant case law of the ECtHR along these lines will give me an opportunity to elaborate on this balance, in the context of the public and private law divide in the field of the right of access to healthcare. One possible starting point could be *Calvelli and Ciglio v Italy*.[118] The case concerned the death of a two-day baby born in a private clinic in circumstances in which the birth had been regarded as of high risk. According to the national proceedings, the doctor in charge had made no arrangements for precautionary measures and during the birth he had absented himself for several minutes contributing to significantly reduce the new-born's chances of survival.[119] The Court stated that the positive obligations emerging from Article 2 meant that 'States needed to make regulations compelling hospitals, whether public or private, to adopt appropriate measures for the protection of their patients' lives'.[120] This line of case law is welcomed because it quashes the public and private law divide with respect to the positive obligations emerged from classical rights. These obligations can be said to apply in the field of public healthcare no matter the public or private nature of the institution.

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[115] International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966) 993 UNTS 3, art 12 (ICESCR), art 12.

[116] Natasa Mavronicola, 'Positive obligations in crisis' 7 April 2020 Strasbourg Observers, <https://strasbourgobservers.com/2020/04/07/positive-obligations-in-crisis/> last accessed 31 September 2021.

[117] Arenas Catalán (n 9) 101.

[118] *Case of Calvelli and Ciglio v Italy* (n 22).

[119] ibid, para 22.

[120] ibid, para 49

In a previous case of medical negligence – *Powell* – the Court had already acknowledged that 'it cannot be excluded that the acts and omissions of the authorities in the field of health care policy may in certain circumstances engage their responsibility under the positive limb of Article 2'.[121] Having said that, the Court added that:

> 'where a Contracting State has made adequate provision for securing high professional standards among health professionals and the protection of the lives of patients, it cannot accept that matters such as error of judgment on the part of a health professional or negligent co-ordination among health professionals in the treatment of a particular patient are sufficient of themselves to call a Contracting State to account from the standpoint of its positive obligations under Article 2'.[122]

While the personal negligence element is relevant, in order to engage the State's international responsibility under the substantive limb of Article 2, an unfit legal framework is also required. A case where this threshold was reached was *Mehmet Şentürk and Bekir Şentürk v Turkey*.[123] The case involved the death of an eight months pregnant woman and the fetus. After the woman started to experience pain, her husband took her to several hospitals, both public and private. In the various medical facilities the victim was inadequately examined and dismissed. Eventually, the husband was informed that the fetus was dead and that it had to be urgently removed as it could otherwise endanger the life of the mother. Hospitalisation, however, did not take place as prior payment of medical fees was required, which he could not afford. Confronted with this situation, the husband signed a declaration where he declined hospitalisation in order to have her wife released and be able to take her to another hospital. The Court concluded that the declaration signed by the husband declining treatment could in no 'way be considered as having been made in an informed manner or as being such as to exonerate the national bodies from their responsibility with regard to the treatment which ought to have been provided to the deceased woman.'[124]

In the view of the ECtHR, the violation of the substantive limb of Article 2 was the result of a combination of factors, namely: (a) flagrant negligence where the medical staff at that clinic was perfectly aware of the risk to the patient were she to be transferred to another hospital, (b) the investigation carried out afterwards did not shed enough light about what should be done in situations of medical emergency when the fees due could not be paid, and (c) the domestic law did not have provisions to provide medical treatment in these cases.[125] The combination of subjective (flagrant medical negligence) and objective (the domestic order legal failures) elements made it possible for the Court to reach the high threshold set in *Powell* for a violation under the substantive limb of Article 2.

One can contrast this case with *Asiÿe Genç v Turkey*,[126] a rather similar case that entailed the death of a premature new-born with breathing difficulties who ultimately died as a result of lack of coordination between hospitals, shortage of equipment – in particular incubators –and a lack of urgent medical examinations. According to the Court, these failures showed:

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[121] *Powell*, p. 18.

[122] ibid.

[123] ECtHR, *Mehmet Şentürk and Bekir Şentürk v Turkey*, application number 13423/09, 9 April 2013

[124] ibid, para 95.

[125] ibid, paras 96-97.

[126] ECtHR, *Asiÿe Genç v Turkey*, application number 24109/07, 27 April 2015.

> 'that the State had not taken sufficient care to ensure the smooth organisation and correct functioning of the public hospital service, and more generally of its system for health protection, and that the lack of places was not linked solely to an unforeseeable shortage of places arising from the rapid arrival of patients'.[127]

Given their close connection to a situation of medical emergency both *Mehmet Şentürk and Bekir Şentürk* and *Asiÿe Genç* are cases where a reasonable link with Article 2 could be drawn. Yet, *Asiÿe Genç* is closer to the end border of civil rights than *Mehmet Şentürk and Bekir Şentürk*. This is because the reason triggering the violation of the former case concerns the implementation of the State's healthcare services,[128] as it is proven by the fact that the Court considers 'sufficient' to declare the violation the fact that the only available incubator was out of order.[129] Contrarily, in *Mehmet Şentürk and Bekir Şentürk*, the Court configured the violation relying on the failure of the domestic law. Unlike the failures detected in *Asiÿe Genç*, the obstacle in *Mehmet Şentürk and Bekir Şentürk* was not one involving costs for the State, but an issue of enforcement or implementation of legal protocols. Although *Asiÿe Genç* shows a rather plausible causal link between the obstacle and the challenge to the right to life, the case dealt with specificities and priorities in the provision of healthcare services in ways strongly associated to the normative content of the human right to health. Without necessarily perceiving the problem in this fashion Judges Lemmens, Spano and Kjølbro did not concur with part of the reasoning of the judgment in that 'Article 2 of the Convention cannot be interpreted as requiring a certain standard, level or quality of treatment and equipment in public hospitals' and that 'the capacity to provide treatment as well as the level of treatment and the quality of equipment is an area where States have to make difficult decisions taking into account a number of factors, including prioritisation of needs as well as the reality of limited financial resources.'[130]

Attempts to develop a solidaristic definition of social rights begin by challenging the public and private law divide. This sub-section has shown that although the assessment of the ECtHR under Article 2 is useful to do that at the level of the right to life, such an approach will not lead to the de-commodification of healthcare services. By definition, a solidaristic effort cannot be attained when what is being promoted is the advancement of individual rights. But even if this legal path might offer protection in situations of emergency, that would be different from the possibility of developing an anti-inequality agenda as could be the case when social rights are interpreted under solidarity.

4. Conclusion

Informed by solidarity, there is the opportunity of unveiling a different notion of social rights. One which understands them as something else than survival minimums: a deeper egalitarianism where social rights are at the service of the liberty of all via de-commodification. While this understanding does not break with the progressive realization of social rights, accountability for institutional parallelisms that militate against the distributive justice of social rights remains a challenge attributable to the State.

The work of the United Nations Committee on Economic, Social and Cultural Rights reflected a perspective that has recently gotten closer to solidarity when defined in this fashion. Although

[127] ibid, para 80.

[128] ibid, para 84.

[129] ibid, para 80.

[130] *Asiÿe Genç v Turkey*. Joint Concurring Opinion of Judges Lemmens, Spano and Kjølbro, para 4.

interpretations that resort to subsistence minimums are still predominant, the Committee is becoming each time less timid to criticize commercialization dynamics such as privatization or out-of-pocket payments. The Committee has explicitly recommended the provision of specific free of charge medical services, while understanding socioeconomic disparities as a potential human rights challenge. In the most noteworthy recommendations, the Committee is critical of large disparities between parallel public and private healthcare systems and quite unequivocal in making recommendations towards the provision of universal services.

In its recent work, the Inter-American Court has attempted to disengage social rights from scopes predefined by other individual civil rights. Considering the specific value of social rights as of similar importance than classical civil rights, the Inter-American Court has sought to reveal what is exclusive in social rights. Although the theoretical value of this enterprise is significant, the Inter-American Court has relied on tools and legal techniques which have not led to a very noticeable difference from its previous case law based on positive obligations deriving from civil rights. Even when attempting to develop the notion of solidarity, what has emerged is a perspective that relies on vulnerability, non-discrimination, core minimum obligations, the notion of affordability and the obligation to regulate. The result has not been very innovative. The Inter-American Court remains understanding social rights as a duty towards the disadvantaged, one which can be fulfilled mainly by improving the subsistence minimums the public sector owes to the marginalized. Qualitative or quantitative asymmetries between the public and the private sector beyond this minimum remain untouched. Whether the Inter-American Court will update its understanding of social rights in line with the recent socioeconomic developments advanced by the UNCESCR Committee remains to be seen.

Connecting the substantive provision of the protection of health with the non-discrimination clause of the European Social Charter, the European Committee of Social Rights has managed to look at the differences in the social position of women when it comes to accessing abortion. This is a valuable legal contrast. By addressing the asymmetrical socio-economic position of women regarding abortion, the ECSR went beyond a restricted definition of equality. This was done by means of the doctrinal perspective of inter-sectional discrimination where socio-economic asymmetries became more visible. Despite the insights provided by this approach, the most relevant legal obstacle remained unaddressed. My assessment showed that State rules allowing the commercial delivery of healthcare constitute a critical source of disparities in the position of women attempting to terminate their pregnancy. Not having identified the challenges emerging from these commercial State rules remains the main limitation in the review of Article 11 of the European Social Charter in combination with its non-discrimination provision.

In my assessment of the European Court of Human Rights I have noted the importance to consider the legal nature of the European Convention on Human Rights. Awareness about the civil and political nature of this instrument is required in order not to overstep in the scope of social rights. Specifying positive obligations in the area of healthcare could entail to step into the scope of social rights if interpreted in a too overreaching way. The development of a solidaristic definition of social rights could become more difficult in a context where healthcare becomes tailor-made to individual claims.

Being serious about human rights indivisibility and integration requires to look at social rights not as a residue of other human rights, but in the light of the concerns that brought them into existence. Tracing solidarity as an issue of economic justice and distribution, could boost a deeper egalitarianism that matches the need for a new social and democratic rule of law.