The Minimum Core Approach to the Right to Health

Progress and Remaining Challenges

AMREI MÜLLER[1]

1. INTRODUCTION

The editors of this volume raise the question of whether the human right to the highest attainable standard of physical and mental health (the right to health) set out in Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR or Covenant) remains an empty promise for a large majority of the world's population. A 2015 joint World Health Organization (WHO) and World Bank Group report measuring the world population's access to essential health services in 2013 concluded that »at least 400 million people do not have access to one or more essential health service and 6% of people in low- and middle-income countries are tipped into or pushed further into extreme poverty because of health spending.«[2] This indicates that for these people, even the so-called minimum core right to health – a right to access *essential* health goods and services – indeed remains an empty promise. Many old and new, national and universal threats to the human right to health remain to be addressed through legal and other measures.

1 Parts of this chapter build on and develop the author's previous work: Müller (2013), chapter 4 and Müller (2016a).

2 WHO/World Bank Group (2015).

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - CC BY-NC-ND

In this chapter, I would however like to present progress that has been made in conceptualising health as a human right, the implementation of which is increasingly monitored by domestic and international courts and quasi-judicial bodies. I would like to argue that international and national human rights law scholarship and practice has contributed greatly to clarifying the content of the right to health, as well as states' dynamic obligations flowing from this right. In doing so, important steps have been taken to ensure that international and domestic law can effectively protect the fundamental human interest underlying the core right to health – the interest to access at least essential health goods and services that enable human beings to lead a »good« life. The analysis focuses in particular on the contribution of the minimum core approach to the right to health that has been introduced by the UN Committee on Economic, Social and Cultural Rights' (CESCR) General Comment No. 14 on the Right to Health in 2000. It assesses how far human rights law scholarship and practice have come in developing the minimum core approach so that it can achieve its designated purpose. It also discusses the next steps that should be taken towards this aim in light of the continuing challenges to securing *everyone's* fundamental interest to have access to essential health goods and services through the effective implementation of the core right to health.

To achieve this, part 2 sets out the purpose and potential of the minimum core approach to the right to health and human rights in general. Part 3 examines some of the open questions about the minimum core approach originating from the CESCR's unclear and sometimes contradictory statements about this approach; and briefly summarises the critique of the core approach in existing human rights (legal) literature. Part 4 then shows that some of the open questions have been answered and criticism voiced has been addressed through the collective practice of (democratic) states interpreting and applying the right to health. The Committee could consolidate this practice further in an (updated) statement about the universal minimum core content of the right to health. This process has *inter alia* been facilitated by the clarification of procedural obligations under the ICESCR. In addition, political philosophers have helped to justify the internationally-defined minimum core content of the right to health, and the absolute character of this and other core human rights. Part 5 turns to discuss whether the minimum core approach can help to meet one of the main challenges that we are facing with the realization of the minimum core right to health,

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND

in particular in low-income countries: the fact that some states of jurisdiction are unable to secure even the minimum core right to health of their population because the threats to the interests protected by this right originate from outside their jurisdiction and/or because they do not have sufficient resources and capacities to realize minimum core rights. To address this, I tentatively examine how the minimum core approach could potentially help with the further specification and allocation of states' and international organisations' territorial or extra-territorial duties and responsibilities to cooperate and assist under the ICESCR, as well as with a better coordination of the implementation of these duties and responsibilities. The concluding remarks (part 6) summarise the main findings.

The method followed is that of legal interpretation of Articles 2(1) and 12 ICESCR in light of subsequent state practice (including domestic court decisions) and the interpretation offered by the CESCR and other UN treaty bodies and organizations, as well as regional human rights courts and bodies. Occasionally, the analysis will rely on arguments of political philosophers to tentatively justify the understanding of the minimum core approach to the right to health advocated here.

2. The Purpose of the Minimum Core Approach to the Right to Health Identified by the CESCR

At the start, the purpose of the minimum core approach to the right to health shall be recalled. What were the main reasons for the CESCR to adopt this approach to help interpreting the right to health in particular and economic, social and cultural rights (ESC rights) more generally? To answer this question, we have to look at the Committee's General Comment No. 3 of 1991. The Committee pronounced that the notion of »progressive realization« in accordance with »maximum available resources« set out in Article 2(1) ICESCR:

> »should not be misinterpreted as depriving the obligation of all meaningful content. […] the phrase must be read in the light of the overall objective, indeed the raison d'être, of the Covenant which is to establish clear obligations for States parties in respect of the full realization of the rights in question.«

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND

It went on to observe that:

»minimum core obligations to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights is incumbent upon every State party. 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 or housing, or of the most basic form of education is, prima facie, failing to discharge its obligations under the Covenant. If the Covenant were to be read in such a way as not to establish such a minimum core obligation, it would be largely deprived of its raison d'être.«[3]

This, together with the CESCR's pronouncements in its General Comment No. 14[4] that will be discussed in more detail below, indicates that the Committee's main reason for adopting the minimum core approach was to give the notion of »progressive realization« a clearer direction.[5] It did so by defining a minimum quantitative and qualitative threshold of enjoyment of the right to health that should be guaranteed to everyone in all circumstances as a matter of top priority,[6] and by defining relatively detailed corresponding (negative and positive) core obligations. It can strongly be assumed that the Committee wished to counter the constantly repeated traditional arguments of some states and influential academic writers[7] that the right to health and other ESC rights are not individual rights (despite the fact that they are recognised as such in the ICESCR, in other international and regional human rights treaties, as well as in domestic human rights law) but only general guidelines to lead domestic policies. Consequently, these states and academics argued that ESC rights do not give rise to concrete and legally binding obligations, primarily due to the notion of »progressive

3 E/1991/23, 14 December 1990, paras. 9 and 10.

4 E/C.12/2000/4, 11 August 2000, paras. 43–44.

5 See the reference to the raison d'être of the ICESCR in the quotes. See also: van Bueren (1999) 57; Wesson (2004), 299–300.

6 See E/1991/23, 14 December 1990, para. 10; E/C.12/2002/11, 20 January 2003, para. 6; E/C.12/GC/19, 4 February 2008, para. 60; E/C.12/2000/4, 11 August 2000, para. 47; E/C.12/1999/5, 12 May 1999, para. 17.

7 For an overview of relevant literature, a summary and critical discussion of the main arguments, see De Schutter (2010), 740–751.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND

realization« in accordance with »maximum available resources«.[8] These arguments have for very long undermined the effective protection of the right to health (and sometimes still do so[9]).

Further reasons for the CESCR's adoption of the minimum core approach can be inferred from other statements of the Committee. First, the minimum core approach promises to direct resources to where they are most needed, i.e. towards the implementation of ESC rights at a minimum level, benefitting those who have nothing or very little[10] – in the words of the Committee to the realization of ESC rights of »marginalized and disadvantaged groups and individuals«.[11] Second, the Committee has used the minimum core approach to comment on states' individual and collective (as members of international organisations) activities outside their own borders that can pose threats to the fundamental interests protected by minimum core rights, and that allegedly violate (negative) responsibilities to respect at least minimum core human rights outside their own territories. It has done so for example in the context of global trade and development policies[12] as well as security regimes.[13] At the same time, in its Statement on Poverty and the ICESCR, the CESCR observed that minimum »core obligations [rather: rights] give rise to […] international responsibilities for developed States«[14] to provide »›international assistance and cooperation, especially economic and technical‹ to enable developing countries to fulfil

8 E/1991/23, 14 December 1990, para. 9.

9 E.g. E/C.12/GBR/CO/5, 12 June 2009, para. 13; and the strong reluctance of the US to ratify the ICESCR or back UN resolutions referring to ESC rights as human rights.

10 E.g. Scott/Macklem (1992), 77; Bilchitz (2007), 189; Liebenberg (2002), 174.

11 E/C.12/GC/19, 4 February 2008, para. 59(e); E/C.12/2002/11, 20 January 2003, paras. 37(b) and (f); E/C.12/2000/4, 11 August 2000, paras. 43(a) and (f); E/C.12/1999/5, 12 May 1999, para. 28.

12 E.g. E/C.12/GC/19, 4 February 2008, para. 61; E/C.12/GC/18, 6 February 2006, para. 30; E/C.12/2002/11, 20 January 2003, para. 38; E/C.12/2000/4, 11 August 2000, para. 45; E/C.12/2001/10, 10 May 2001, paras. 16–17.

13 E.g. E/C.12/1997/8, 12 December 1997, para. 7; E/C.12/2002/11, 20 January 2003, para. 32; E/C.12/1999/5, 12 May 1999, para. 37.

14 E/C.12/2001/10, 10 May 2001, para. 16.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - CC BY-NC-ND

their core obligations.«[15] In other words, core rights also seem to trigger states' (positive) responsibilities beyond their own territories to a particular degree. Thus, the minimum core approach promises to help delineating (national) obligations and (international) responsibilities for the implementation of the core right to health and other core human rights. This is based on the recognition that often the realization of even these core rights remains difficult in countries lacking relevant capacities and resources without international assistance. This issue will be explored further in part 5.

However, the usefulness of the minimum core approach has been questioned by some legal analysists[16] and domestic courts,[17] and the CESCR did not articulate and justify its understanding of the minimum core approach very clearly. The discussion now turns to some of the conceptual questions that have been raised about and criticism voiced of the minimum core approach.

3. OPEN QUESTIONS ABOUT AND CRITIQUE OF MINIMUM CORE APPROACH TO THE RIGHT TO HEALTH

The main open questions about the minimum core approach are about the actual feasibility of determining a realistic minimum core content of the right to health, and at what level this content should be defined – the national or the international. These issues are related to the question of whether minimum core rights are absolute or relative, i.e. whether they are subject to progressive realization in accordance with maximum resources available to a particular state, or whether it is assumed that they are *per se* affordable for all countries and therefore not conditional on progressive re-

15 E/C.12/2001/10, 10 May 2001, para. 16.

16 E.g. Lehmann (2006); Kende (2003/2004); Porter (2005), 48–55. Note that this contribution cannot discuss political philosophy literature on socio-economic rights in detail.

17 First and foremost by the South African Constitutional Court; see e.g. *Minister of Health v. Treatment Action Campaign* (TAC), Judgement of 5 July 2002.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND

alization. It is also unclear whether limitations to or retrogressive measures touching upon the minimum core right to health are permitted.[18]

3.1 Questions Left Open by the CESCR

The Committee's position on these questions remains unclear. For example, in one statement the CESCR has held that »any assessment as to whether a state has discharged its minimum core obligations must take into account the resource constraints applying within a country concerned«.[19] This is only explicable if one assumes that states only violate the minimum core right to health when they fail to take measures which could be expected given their available resources, and that therefore the minimum core content of the right to health and corresponding obligations are relative, are determined at the domestic level and are subject to progressive realization. Additionally, the Committee hardly ever finds violations of minimum core rights in its concluding observations, even in states where people starve and lack the most basic form of health care; nor does it rigorously ask states to prove that they did all they could, as a matter of priority, to remedy the situation.[20] This seems to indicate that minimum core obligations are state-specific and their scope contingent upon available resources.

Conversely, other statements of the Committee suggest that it understands the minimum core right to health as an absolute internationally-defined bottom-line, below which no individual should find him/herself, and which must be implemented regardless of a state party's level of economic development. For instance, in its General Comment No. 14 on the Right to Health, it held that »a state party cannot, *under any circumstances whatsoever*, justify its non-compliance with the core obligations [...]« [em-

18 This question will not be discussed here in detail, but see Müller (2009).

19 E/1991/23, 14 December 1990, para. 10.

20 E.g. E/C.12/1/Add.48, 1 September 2000, para. 25; similarly, E/C.12/1/Add.95, 12 December 2003. Notable exceptions are E/C.12/COD/CO/4, 20 November 2009, para. 16, where the Committee refers to ›serious breaches‹ of Article 2(1) ICESCR; and E/C.12/LKA/CO/2-4, 9 December 2010, para. 28.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND

phasis added, A.M.][21] flowing from the minimum core content of the right to health that it had defined in the same General Comment.

3.2 The Academic Debate of the Core Approach

Human rights law scholarship has engaged with these questions and brought forward arguments for either defining relative state-specific minimum cores that are subject to progressive realization; or absolute international minimum cores the implementation of which is presumed to be *per se* affordable for all states, even low-income countries.

The main arguments of those supporting a nationally-defined minimum core right to health are first that it is unrealistic to require all states to implement the same minimum core, given the vast differences in levels of development around the world.[22] Low-income countries may not command sufficient resources to satisfy minimum essential levels of the right to health as defined in the CESCR general comments for everyone under their jurisdiction.[23] This argument gains force with a glance at the Committee's rather broad definition of the minimum core content of the right to health that comprises the provision of primary healthcare services, minimum essential foodstuffs, safe drinking water, adequate sanitation, essential drugs (as defined by the WHO), reproductive, maternal and child healthcare, immunisation against major infectious diseases and basic health education.[24] For high-income countries on the other hand, a universally-defined mini-

21 E/C.12/2000/4, 11 August 2000, para. 47. The Committee seems to express this absolute understanding of minimum core rights also in: E/C.12/1999/5, 12 May 1999, para. 6; E/C.12/2002/11, 20 January 2003, paras. 40, 42 and 44(c); E/C.12/GC/19, 4 February 2008, para. 65.

22 Craven (1995), 141; and Scott/Alston (2000), 250.

23 The South African Constitutional Court has rejected the minimum core approach on that basis. It found that it would be impossible for the state to provide core services immediately, e.g. in *Minister of Health v. Treatment Action Campaign* (TAC), Judgement of 5 July 2002, paras. 34–37; see also Kende (2003/2004), 622; Chapman/Russell (2002), 10, who also recognise this danger.

24 E/C.12/2000/4, 11 August 2000, paras. 43–44.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access -

mum core right to health may become a reason for inertia, as these countries could in fact implement more far-reaching obligations.[25]

Second, a state-specific minimum core right to health is required because an internationally-defined minimum core would inevitably be abstract, inflexible and a-contextual, dividing right to health theory from the real-life experience of individuals whose right to health remains unimplemented. This may result in the exclusion of some individuals from the protection of the right to health whose contextual experiences did not reflect an international standard.[26]

Third, more support for the definition of a country-specific minimum core right comes from doubts over whether it is at all possible to determine a truly universal minimum core right to health, given that no convincing criteria have been developed that might distinguish elements of the right belonging to the minimum core from those belonging to the non-core, and that would justify a prioritisation of the former. Young, for example, reviewed the shared values or needs that have been suggested as a basis for the minimum cores of socio-economic rights (including the right to health), and concluded that there »are no axioms that can deliver an uncontested minimum core«.[27]

Referring to various attempts to determine an essential minimum core through normative argument, she concludes that »the minimum core will look different to an advocate of human flourishing in comparison with an

---

25 Noted e.g. by van Bueren (1999), 59; Chapman/Russel (2002), 9; Ssenyonjo (2009), 66–67; Craven (1995), 144, who voiced the concern that when the CESCR focuses too much on minimum core obligations, it will necessarily direct its attention to developing countries, which might open it to criticism.

26 Porter (2005), 52. While Porter points to this danger in particular in the context of focusing adjudication of ESC rights on a universally-defined minimum core, it might be equally relevant for the development and adoption of other measures that aim at the implementation of minimum core obligations; see also Lehmann (2006), 188–189; this difficulty is also recognised by Liebenberg (2006), 31; Pieterse (2006), 491.

27 Young (2008), 138. She reviews different needs-based (life, survival and basic needs) and value-based (dignity, equality and freedom) approaches that aim to determine the content of a universal minimum core. See also Kende (2003/2004), 624; Lehmann (2006), 191.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND

advocate of basic survival, just as the core will look different in various instantiations of both survival and dignity«.[28]

Other scholars argue that defining a minimum core of the right to health (and human rights in general) would only make sense if it were defined as an universal, absolute standard that has to be implemented in all states, independent of their level of development.[29] First, they hold that only an international standard can fulfil the promise to bring a degree of determinacy in the notion of progressive realization.[30] There would be no difference between an obligation to define a minimum core nationally and the general obligation under Article 2(1) ICESCR to progressively realize ESC rights, as the scope of both would be dependent on available resources, and both would give states an excuse to postpone the implementation of ESC rights indefinitely.

Second, most elements of minimum core contents of socio-economic rights defined by the CESCR in its general comments can be linked to survival interests of individuals that exist regardless of the availability of resources,[31] fulfilment of which is an essential precondition for human existence and development.[32] This holds true also for the alleged minimum core content of the right to health – a right to access essential health goods and services. The implementation of minimum core rights should be part of

28 Young (2008); even Bilchitz (2007), 224, a strong advocate of a universal minimum core approach based on essential human interests (above all the interest to survive), submits that the survival interest is not suitable as a basis for determining a universal minimum core of the right to health.

29 E.g. Bueren (2002), 184; Coomans (2002), 167; Bilchitz (2007), chapter 6; Arambulo (1999), 130–135; Scott/Alston (2000), 250; Scott/Macklem (1992), 77; Ssenyonjo (2009), 66; Toebes (1999), 224; the Limburg Principles on the Implementation of the ICESCR, June 1986, para. 25.

30 Among others, van Bueren (2002), 184–185; Wesson (2004), 299.

31 E.g. Bilchitz (2007), 222.

32 This has been pointed out in a decision of the Swiss Federal Court, *V v. Einwohnergemeinde X und Regierungsrat des Kantons Bern*, BGE/ATF 121 I 367, 27 October 1995, Erwägung 2, para. (b): »Satisfying elementary human needs, such as food, clothing and shelter is a precondition for human existence and development« [author's translation]; see also Liebenberg (2005), 22; Bilchitz (2007), 187.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - [cc] BY-NC-ND

fundamental governmental functions in all countries,[33] and states – even poor states – »have to begin somewhere«.[34] It is thus justified to assume that the implementation of universal minimum core rights is affordable even for low-income countries, if necessary through international cooperation and assistance.[35] Related to the last observation, advocates of an internationally-defined minimum core content of the right to health and other ESC rights thirdly note that only an internationally-defined minimum core right to health holds promise for delineating national obligations and international responsibilities under the right to health, and for coordinating their implementation.

The summarised scholarly debate about these different understandings of the minimum core approach to the right to health has reached an impasse, and the CESCR's more recent statements have not contributed to a clarification of the Committee's understanding of the approach.[36] To move forward in the process of developing the core approach further so that it can fulfil its purpose mentioned in part 2, the following section suggests to change perspective, utilising insights from the fast-growing field of comparative international human rights law:[37] to focus on (democratic) states' practice (unilateral and multilateral practice, the latter as members of international organisations) on the right to health to determine whether an international consensus can be established on the minimum core right to health, its (abstract) content and the (abstract) obligations flowing from it.[38] This perspective recognises that international human rights law is best understood together with domestic human rights law *qua* »transnational constitu-

33 Noted by Chapman/Russell (2002), 11–12; see also *Paschim Banga Khet Majoor Samity v. State of West Bengal,* Supreme Court of India, para. 16, reflecting the opinion that what is constitutionally necessary (in this case, the provision of emergency health services to the Indian population) has to be done, regardless of limited resources.

34 As pointed out by COHRE (2003), 119; similarly, Wesson (2004), 299.

35 See e.g. Ssenyonjo (2009), 68.

36 E.g. E/C.12/2016/1, 24 June 2016.

37 See e.g. Roberts et al. (2015) and other contributions to the Volume 109(3) of the *American Journal of International Law*.

38 For a similar suggestion to proceed in this way, see Forman et al. (2013), 7–8.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND

tional law«;[39] and that international human rights comparison has become one of the main methods of interpretation in human rights practice.[40] This can be observed in international human rights courts and bodies which compare the practice of domestic courts and other authorities to establish the content of a common transnational standard and based on that, determine an international minimum human rights standard.[41] And it can also be observed in domestic courts which often discuss and take on other states' practice and common transnational human rights standards when they interpret and apply international human rights treaties.

It shall be argued that an initial search for such an international consensus on the minimum core approach firstly indicates that this consensus tentatively defines the international minimum core content of the right to health as a right to access essential health goods and services; and secondly, that this (and the core of other human rights) is to be understood as an absolute standard (4.1). Moreover, it is argued that such an understanding of the minimum core is confirmed by the procedural obligations flowing from the ICESCR, which guide domestic authorities when translating the abstract international core content of the right to health into a concrete domestic content and concrete obligations. The existence of these procedural obligations will in addition help to address many of the reasonable objections raised against an understanding of the minimum core as an universally-defined absolute standard that were summarised above (4.2).

39 For the full argument see Besson (2015a), 280–299.

40 As analysed in many contributions to Müller (2017).

41 This is most prominent in the ECtHR's »European consensus« approach; but it is also clear from the CESCR's statements, see e.g. E/1991/23, 14 December 1990, para. 10. The practice is also in line with Article 31(3) of the Vienna Convention on the Law of Treaties concerning the use of »subsequent practice« in the interpretation of treaties; and public international methods for determining customary law through analysing state practice and *opinio iuris*.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND

4. ADVOCATING A UNIVERSAL AND ABSOLUTE MINIMUM CORE RIGHT TO HEALTH: A RIGHT TO ACCESS ESSENTIAL HEALTH GOODS AND SERVICES

4.1 International Consensus

There are many domestic courts which assume the existence of minimum core contents of socio-economic and other human rights in their jurisprudence. To name but a few examples, the Colombian Constitutional Court has defined »minimum conditions for a dignified life« based on the rights to life, health, work and social security that are part of the extensive fundamental rights catalogue of the Colombian Constitution.[42] If this standard is not met through government social policy measures, Colombian courts intervene to order the immediate enforcement of relevant minimum core rights to remedy the situation, even if this results in a duty to give an individual access to certain services, goods or programmes and even if this has resource implications.[43] Similar jurisprudence is known from among others Argentina,[44] Brazil,[45] Finland,[46] Germany,[47] India,[48] Portugal[49] and Swit-

42 Langford (2008), 22; Sepulveda (2008), 147–148; Landau (2014).

43 Sepulveda (2008) cites many cases of the Colombian Constitutional Court. With regard to the right to health, the court has e.g. ordered state or private entities to provide individuals (in particular children) with medication or medical treatment necessary for the immediate protection of their right to health. It does so when this is necessary for the protection of the right to life, personal integrity, dignity or the minimum conditions for a dignified life of the person in question.

44 The Argentine Supreme Court has for instance held that: »in light of the human right to health guaranteed by the [Argentine] Constitution and international human rights treaties, statutory regulations granting access to medical services should be read as requiring health care givers to fully provide essential medical services in case of need«; cited in: International Commission of Jurists (2008), 25; similarly Courtis (2008), 163–181.

45 International Commission of Jurists (2008), 25.

46 Scheinin (2001), 51–53.

47 In its Article 19(2), the German Constitution includes a direct reference to the inviolable core of all fundamental rights protected by it. In regard to the protec-

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND

zerland.[50] This trend in domestic courts' socio-economic rights jurisprudence is confirmed by comparative law literature. Drawing conclusions from a study of ESC rights jurisprudence of 13 domestic courts, Langford established that »in broad brush terms, many adjudicators tend to enforce [...] the implicit obligation to immediately achieve a minimum level of realization [of ESC rights]«.[51] States have also expressed their support for the minimum core approach during the drafting process of the Optional Protocol to the ICESCR.[52] In addition, regional human rights courts and bodies have endorsed the minimum core approach, even if not as explicitly as the CESCR and some domestic courts. The pronouncements of the European Committee of Social Rights (ECSR) indicate that it supports the idea of a minimum core of each socio-economic right protected in the (Revised) Eu-

tion of the core of socio-economic rights, see in particular, the decisions of the German Constitutional Court (BVerfG), 1 BvL 1/09 of 9 February 2010 and 1 BvL 10/10 of 18 July 2012 in which the Constitutional Court formulated in clear terms that the state has an obligation, deriving from the Article 1(1) (human dignity) read in conjunction with the »welfare-state principle« of Article 20(1) German Basic Law, to ensure that those in need have, as a minimum, their material needs secured that are necessary for maintaining physical well-being and for enjoying minimal participation in the country's social, cultural and political life (defining a minimum subsistence level). The German Constitutional Court's jurisprudence is also discussed by O'Cinneide (2014), 175–176.

48 See e.g. *Paschim Banga Khet Majoor Samity v. State of West Bengal,* Supreme Court of India, Judgment of 6 May 1996 (on minimum core right to health); and *People's Union for Civil Liberties v. Union of India,* Writ Petition (Civil) No. 196 of 2001, Interim Order of 2 May 2003, where the Indian Supreme Court held that the right to access government food supplies of those in danger of starvation forms part of the minimum core right to food; see also Muralidhar (2008), 117–118.

49 See the analysis by O'Cinneide (2014), 176.

50 Article 12 of the Swiss Constitution; and the discussion in Häfelin et al. (2012), 294–296.

51 Langford (2008), 22; similarly, see O'Cinneide (2014), 175.

52 Report of the Open-ended Working Group to Consider Options Regarding the Elaboration of an Optional Protocol to the ICESCR on its Third Session, E/CN.4/2006/47, 14 March 2006.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - [cc] BY-NC-ND

ropean Social Charter ([R]ESC);[53] as do the pronouncements of the Inter-American Commission of/Court on Human Rights;[54] and also the European Court of Human Rights (ECtHR) refers to the minimum core or essence of rights set out in the European Convention on Human Rights (ECHR).[55] Koch notices in addition that certain statements by the ECtHR can be interpreted as recognising the notion of a minimum core right to basic health services[56] and social cash benefits[57] under the ECHR.

---

53 For more details see Mikkola (2010) at 316–317; and ECSR, *European Roma Rights Centre (ERRC) v. Bulgaria*, complaint 48/2008, decision on the merits of 18 February 2009, paras. 37–38; *European Roma Rights Centre (ERRC) v. Greece*, decision on complaint 15/2003, para. 42: »a significant number of Roma are living in conditions that fail to meet *minimum standards«* in Greece »in breach of the obligation to promote the right of families to adequate housing laid down in Article 16« [emphasis added, A. M.].

54 See the analysis by Shelton (2010), 211 *et seq.* (referring to minimum thresholds that have to be guaranteed in every state regardless of the level of economic development).

55 E.g. *Gorzelik and Others v. Poland*, judgment (Grand Chamber), appl. no. 44158/98, 17 February 2004, para. 105; *John Murray v. UK,* judgment (Grand Chamber), appl.no. 18731/91, 8 February 1996, para. 49; *Ashingdane v. UK,* judgment (Chamber), appl.no. 8225/78, 28 May 1985, para. 57; several dissenting opinions criticising majority opinions for accepting limitations to rights that affect the core/essence of these rights, e.g.: dissenting opinion of judge Loucaides to *McElhinney v. Ireland*, judgement (Grand Chamber), appl. no. 31253/96, 21 November 2001; and joint dissenting opinion of judges Wildhaber, Sir Nicolas Bratza, Bonello, Loucaides, Cabral Barreto, Tulkens and Pellonpää to *Odievre v. France*, judgment (Grand Chamber), appl. no. 42326/98, 13 February 2003, para. 11.

56 Koch (2009), 63–64.

57 Ibid., chapter 8. See also Clements/Simmons (2008), 426, concluding that »[I]n relation to complaints that disclose gross failures of the most basic socio-economic support, the Court's [ECtHR] starting point is now an unequivocal acceptance of the view that the Convention protects a core irreducible set of such rights«. This was confirmed in more recent judgments, such as *MSS v. Belgium and Greece*, judgment (Grand Chamber), appl.no. 30696/09, 21 January 2011, para. 263. However, the ECtHR remains reluctant to expand its jurispru-

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND

When it comes to the *content* of an internationally-defined minimum core right to health, developments point into the direction of accepting the right to access to essential health goods and services, also referred to as access to primary healthcare, as the minimum core content of the right to health. Leaving aside the so-called »underlying determinants of health«,[58] the following health goods and services seem to make up the international core content of the right to health:

- Access to reproductive, maternal (pre-natal as well as post-natal) and child healthcare;
- Access to immunisation against the major infectious diseases occurring in the community;
- Access to services for the prevention, treatment and control of most prevalent epidemic and endemic diseases;
- Access to essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs; and
- Access to education and information concerning the main health problems in the community, including methods of preventing and controlling them.

An emerging consensus reflecting this is based on a number of international declarations, among them the Declaration of Alma-Ata,[59] the Programme of Action of the International Conference on Population and Development (ICPD)[60] which are both referred to in the CESCR's General Comment

dence further into the socio-economic field, see e.g. *Koufaki and Adedy v. Greece*, decision (Chamber), appl. nos. 576657/12 and 557657/12, 7 May 2013.

58 E/C.12/2000/4, 11 August 2000, denotes that these underlying determinants are part of the minimum core content of the right to health (para. 43). The present author thinks that these »underlying determinants of health« are protected by the minimum core content of other human rights, e.g. the rights to food, water, housing, a clean environment and work-related rights. They should therefore not form part of the minimum core content of the right to health.

59 Declaration of Alma-Ata, 6–12 September 1978, section VII (3).

60 Programme of Action of the International Conference on Population and Development, contained in the Report of the International Conference on Population

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND

No. 14; and the more recent initiative of the International Labour Organization (ILO) on National Floors of Social Protection, among which is the access to essential healthcare;[61] as well as domestic practice commented on by the CESCR,[62] and the CESCR's General Comment No. 14.[63] The WHO has also refocused its work on supporting the provision of primary healthcare, likely to reflect a consensus of its member states.[64] A more systematic analysis of domestically defined minimum core contents of the right to health, e.g. in domestic law and in national courts' jurisprudence, could help to confirm (or refute) a consensus on the suggested international content of the minimum core right to health. Such a comparative analysis could be conducted by the CESCR in its review of domestic practice which it is presented with in the state reporting process. The Committee could more explicitly consolidate this practice into an updated statement on the minimum core content of the internationally-defined minimum core right to health.[65] The CESCR could also rely on possible regional consensuses on the minimum core content of the right to health.[66] The Committee's determination of an abstract universally-defined minimum core right to health based on domestic human rights practice and regional consensuses would

and Development, Cairo, 5–13 September 1994, A/CONF.171/13, Chapter VIII, paras. 8.4 and 8.5.

61 International Labour Conference, Recommendation 202 Concerning National Floors of Social Protection, 14 June 2012, paras. 4 and 5(a). See also the summary of the wide-ranging consensus on social protection floor in ILO (2011), 16–18.

62 See the review conducted by San Giorgio (2012), 25–28.

63 E/C.12/2000/4, 11 August 2000, paras. 43 and 44; Declaration of Alma-Ata, 6–12 September 1978, VII (3).

64 See e.g. WHO (2008) and (2013).

65 By doing this, the CESCR might also address criticism to the CESCR's current definition of the minimum core right to health set out in its General Comment No. 14, which has been criticised for its broadness and the unclear distinction it draws between »core obligations« (para. 43) and »obligations of comparable priority« (para. 44).

66 For an innovative discussion of the role of regional consensuses, see Besson (2017); Neuman (2008).

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND

also ensure the practicality[67] of this internationally-defined core right as a guideline for its implementation in particular domestic circumstances.[68]

Understanding the minimum core right to health as a right to access essential health goods and services (primary healthcare) is also supported by strong normative arguments. As noted above, the interest shared by every human being to have access to at least essential health goods and services is inherently connected to the particularly *urgent* broader human interest to survive.[69] However, due to the nature of the right to health, using the interest to survive as a basis for the minimum core content of this right in particular raises problems. Securing the interest to survive of every individual would require individualised minimum cores, given the differing health conditions of many people; and some individuals might require access to services that are hugely expensive to ensure their survival.[70] Therefore,

---

67 States' have recognised the CESCR's unique overview of ESC rights implementation in different countries around the world. More recently they named the Committee's expertise as one of the reasons why the CESCR should receive the mandate to review individual complaints under the Optional Protocol to the ICESCR. See the Report of the Open-ended Working Group to Consider Options Regarding the Elaboration of an Optional Protocol to the ICESCR on its Third Session, E/CN.4/2006/47, 14 March 2006, para. 91.

68 The need to specify minimum core duties flowing from the (abstractly) defined international minimum core right to health in light of particular domestic contexts is discussed in more detail in section 4.2 below.

69 For the full argument see Bilchitz (2007), 222, linking minimum core socio-economic rights to the essential human interest to survive and to enjoy a minimum level of well-being which are essential preconditions for human beings to have positive experiences and to pursue their purposes. See also Pogge (2002), who refers to preconditions to lead a »flourishing life«.

70 This difficulty is also recognised by Bilchitz (2007), 220–225. It should be noted that access to (expensive) secondary and primary health services are not excluded from the scope of the right to health. However, they will regularly be part of the non-core content of the right and their availability will thus be dependent on resources. Moreover, states are obliged under the ICESCR to also plan the progressive extension of health services to non-core services. For details on the relationship between core and non-core obligations flowing from the right to health, see Müller (2013), 96–99.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND

identifying a universal minimum core right to health in a reality of limited resources and capacities that will have practical relevance also for low-income countries will necessarily involve some utilitarian considerations and contain the basic health goods and services that will enable the *vast majority* of individuals to have their basic survival interest secured through such access.[71] Understanding the international minimum core content of the right to health as a right to access primary health goods and services seems justified on this basis.

Last but not least, there are indications in state practice as well as in international declarations that minimum cores constitute *absolute* minimum thresholds of each human right that must be respected, protected and fulfilled at all times.[72] In the drafting process of the OP-ICESCR, delegations participating in the consultations were of the opinion that allocating sufficient resources to the implementation of minimum core rights is an *immediate* obligation on states under the ICESCR;[73] and an introduction to the 2012 ILO strategy paper »Social Security for All – Building Social Protection Floors and Comprehensive Social Security Systems« indicates a consensus on the assumption that the implementation of these protection floors, including access to essential healthcare, is affordable for every country.[74] As will be elaborated further below, the resources for the immediate realization of minimum core rights can be made available as a result of international cooperation and assistance.[75] Domestic human rights jurisprudence also points towards the understanding of the minimum core of human rights

71 As highlighted in particular by Lehmann (2006), 190.

72 Some core rights can still be *derogated* from temporarily »in time of war or other public emergency threatening the life of the nation« (see e.g. Article 15 ECHR; Article 4 ICCPR).

73 Report of the Open-ended Working Group, first session, E/CN.4/2004/44, 15 March 2004, para. 56. The report does not, however, reveal how many delegations shared this opinion.

74 ILO (2012).

75 See the pronouncements of the CESCR in that regard in its General Comments cited, *infra* ns. 112 and 119.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND

as an absolute standard[76] which has also been called the »limits of limits«[77] to human rights, i.e. a brake to a balancing of different rights or a right against a public interest that result in the complete extinction of a human right.[78] This understanding of the absolute character of the »essence« of a human right also seems to underlie ECtHR jurisprudence when the Court observes that »limitations applied must not restrict or reduce the [right to] access [in this case: to a court] left to the individual in such a way or to such an extent that the very essence of the right is impaired«.[79] The absolute character of the minimum core right to health and other socio-economic rights is moreover strengthened by the above-mentioned urgent survival interest that underlies this right: its implementation (securing everyone's access to basic health goods and services) is urgent to avoid widespread tragic consequences.

Furthermore, not understanding the minimum core of each human right as an absolute standard would undermine the function that human rights should have in a democracy. Human rights function as egalitarian limits on democracy. Together with non-discrimination rights, the minimum core of each human right protects the basic equality of individuals against restrictions through democratic decisions.[80] This recognition also implies that the right to access essential health goods and services as the minimum core content of the right to health should be protected against governmental claims of resource scarcity, even claims of democratically elected governments. As mentioned by the supporters of a universally-defined minimum core right to health, the implementation of minimum core rights should be

---

76 E.g. the jurisprudence of the German Constitutional Court points into this direction, see the analysis by Schaks (2015); see also, for the context of Switzerland, the discussion in Häfelin et al. (2012), 296.

77 Örücü (1986), 36–59.

78 On this, see Müller (2009).

79 ECtHR, *Ashingdane v. UK,* judgment (Chamber), appl.no. 8225/78, 28 May 1985, para. 57. The Court has also argued this in the context of other rights protected by the ECHR. See the judgments cited *supra* n. 55.

80 For a full analysis of the inherent relationship between human rights, equality and democracy that also justifies the understanding of the minimum core of each human right as absolute, see the work of Samantha Besson, in particular: Besson (2011) and (2012a).

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND

part of fundamental governmental functions in all countries.[81] This also fits with the overarching obligation to fulfil human rights that requires the building of (democratic) institutions which are able to discharge the many negative and positive human rights duties flowing from international treaties, including institutions that can devise and implement health policies required for the implementation of the minimum core right to health.[82]

4.2 Domestic Specification of the Minimum Core Right to Health and the Importance of Procedural Obligations

Understanding the international minimum core content of the right to health as the right to access essential health goods and services, and understanding this core as an absolute right, does not yet address all the above-summarised objections that have been raised against the adoption of the minimum core approach. To do this, the discussion now turns to some of the procedural obligations that flow from the minimum core right to health in particular and the ICESCR in general.

One of the aforementioned main objections against the minimum core approach is that an internationally-defined minimum core right to health, e.g. in the shape set out under 4.1, would inevitably be abstract and inflexible. It would not cover the vastly differing health experiences of individuals around the world, and would thus be ineffective in changing the life to the better of human beings whose individual experiences do not resonate with the internationally-defined minimum core right to health.

Addressing this objection, it can be recalled that international human rights and corresponding obligations are regularly phrased in the abstract. Practically, in its interpretation of the international minimum core right to health and other ESC rights, the CESCR can neither cover the experiences

81 See *supra* ns. 33–34.

82 In practice, this implies the building of an effective health system that provides at least basic health goods and services to everyone under the jurisdiction of the state. See the report of the UN Special Rapporteur on the Right to Health, Paul Hunt, A/HRC/7/11, 31 January 2008. Note that this does not mean that the health system has to be fully run by the government.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - BY-NC-ND

of *all* individuals whose ESC rights are not met,[83] nor the political, economic, cultural, social and other characteristics of each and every country. It is thus states that have to concretize and detail the abstract content and duties flowing from the international core right to health for their particular domestic context, through discharging their general ICESCR obligation of reception and enforcement of ESC rights within national law. In that process, domestic conditions have to be taken into account, and concrete legal and other measures suitable for the implementation of the minimum core right to health in the particular domestic context can be determined. For example, guided by the abstract minimum core right to health set out above, states have to establish what the major infectious diseases affecting the local population actually are against which immunisation shall be provided; what the most prevalent epidemic and endemic diseases are against which preventive and curative health services shall be made accessible and controlling measures be taken; and what the most essential drugs are to which everyone shall have access to in a particular country.[84] Moreover, states need to determine concrete domestic duty-bearers – in the context of the implementation of the minimum core right to health these can include general practitioners, hospitals, medical centres, rehabilitation centres, pharmacies, pharmaceutical companies and relevant administrative bodies – allocate the duties to them, and coordinate the discharging of these duties.

The ICESCR and the Committee's interpretation of the Covenant define a number of procedural obligations which guide states in this domestic concretisation process and thus in the implementation of the minimum core right to health in practice.

First, the Committee regularly emphasises that the »*participation* of the population in all health-related decision-making at the community, national

83 This is reflected in the »jurisprudence« of the ECSR, in e.g., *European Roma Rights Centre (ERRC) v. Greece*, complaint 15/20038, decision on the merits in December 2003, paras. 21 and 25.

84 This is reflected in the CESCR's »jurisprudence«: e.g. E/C.12/1/Add.13, 20 May 1997, where the CESCR called on Russia to address the »eightfold increase in HIV-infection in 1996 as a health question of the utmost importance« (para. 40).

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND

and [even at[85]] international levels«[86] is an important aspect of the right to health [emphasis added, A.M.]. This is linked to the obligation of states to protect human rights set out in the ICESCR (and the ICCPR) in democratic systems.[87] The ICESCR's reference to a »democratic society«[88] and the link between ESC rights and political rights highlighted in Article 6(2) ICESCR reinforce this. This means that states should provide for a mechanism that allows for »participation in political decisions relating to the right to health taken at both the community and national levels«,[89] including when it comes to the concretisation of the international minimum core right to health at the domestic level, i.e. the determination of the concrete health goods and services every individual should have immediate access to within the respective states' jurisdiction. Usually, this mechanism is established in the shape of an elected parliament in line with the political participation rights of the ICCPR,[90] a fact that once more highlights the strong connection between ESC rights and political rights.

Second and relatedly, the ICESCR obliges states to adopt domestic law to concretise the minimum core right and corresponding duties at the domestic level. Article 2(1) ICESCR refers to »particularly the adoption of legislative measures« to achieve the progressive realization of the right to health.[91] This also highlights that the legislature is explicitly addressed by the ICESCR.

---

85 In reality, participation at international level remains difficult given the non-existence of relevant (democratic) international institutions.

86 E/C.12/2000/4, 11 August 2000, para. 11. The importance of participatory health-decision-making is also recognised by the European Committee of Social Rights, e.g. *Marangopoulos Foundation for Human Rights (MFHR) v. Greece*, complaint no. 30/2005, decision on the merits of 6 December 2006, paras. 216 and 219.

87 On obligations to realize human rights in a democratic system see Steiner (2008); Besson (2010).

88 Articles 4, 8(1)(a) and (c) ICESCR.

89 E/C.12/2000/4, 11 August 2000, para. 17.

90 In particular Article 25 ICCPR; see also Article 3 Protocol I to the ECHR.

91 The CESCR has explained this obligation in particular in its General Comment No. 9 (E/C.12/1998/24, 1 December 1998). This can happen (but does not have to) through the incorporation of the ICESCR into domestic law.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - CC BY-NC-ND

Third, in the specification process, including the adoption of legislative measures, states need to pay particular attention to the health needs of vulnerable and marginalised members of society.[92] This could imply a procedural obligation addressed to e.g. national parliaments to consult these groups about their most urgent health needs when the substantive minimum core content of the right to health is specified domestically. Even in well-established democratic systems so-called vulnerable and marginalised groups might not be represented sufficiently through the legislature,[93] and it might therefore be necessary that they are consulted explicitly in the process of specifying the core content to ensure that their voices are heard and their primary health needs met.

Fourth, the CESCR and national courts have established that decision-making processes about the scope of the right to healthcare and other social services needs to be transparent and based on reliable data.[94] The German Constitutional Court has, for example, determined such procedural obligations in detail addressing the legislature when it comes to the determination of the exact scope of social benefits that ensure everyone's subsistence level: the scope should be determined in a transparent and objective procedure, based on reliable data and apply a comprehensible and realistic calculation method.[95] These procedural requirements are also relevant for the determination of the substance of a domestically-concretised minimum core right to health. In the context of the right to health, this might imply consultations with public health experts to get hold of ›reliable data‹.

Fifth, states' procedural obligations include the provision of effective remedies for alleged violations of the (minimum core) right to health. Unlike the ICCPR,[96] the ICESCR does not explicitly establish a duty on state parties to provide judicial, administrative or other remedies. However, it can well be argued that such an obligation is implied also in the ICESCR:

---

92 E/C.12/2000/4, 11 August 2000, para. 43(a) and (f).

93 See e.g. a report from Germany concerning political influence of persons with low incomes, Elsässer et al. (2017).

94 E/C.12/2000/4, 11 August 2000, paras. 43(f), 55 and 36; this has also been recognised by the European Committee of Social Rights: Conclusions XV-2, United Kingdom, 599.

95 See the judgments of the German Constitutional Court, *supra* n. 47.

96 As in Article 2(3) ICCPR.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND

remedies are required to ensure the effective enforcement of the domestically concretised minimum core obligations flowing from the minimum core right to health; and the democratic system in which human rights are to be realized implies the existence of an executive, legislative and judicial power, structured *inter alia* by the separation of powers doctrine.[97] Among other, the latter suggests some judicial (or administrative) control over whether the legislature and executive comply with their obligations under the ICESCR – this can happen through enabling domestic courts and/or administrative review bodies to enforce the ICESCR directly and/or the domestic laws adopted to concretise core (and non-core) obligations flowing from Article 12 ICESCR. Such review can furthermore finetune the concretisation and contextualisation of the abstract international core right to health, as domestic courts and other review bodies can decide on a case-by-case basis whether the concretisation by the legislature/executive proves sufficient to guarantee effective access to primary healthcare services in a particular case.[98] Moreover, even when sufficiently specified through domestic law and other policy measures, this specification requires constant up-dating in line with changing socio-economic circumstances, technological and medical developments and shifting major health threats that a society is facing.[99] This reflects the *dynamic* character of human rights obliga-

97 This is most prominently developed in ECtHR jurisprudence. See e.g. *Van de Hurk v. Netherlands,* judgment (Chamber), appl.no. 16034/90, 19 April 1994, paras. 44–55

98 The decision by the German Constitutional Court, 1 BvL 1/09 vom 09.02.2010, reflects this. It *inter alia* highlights the need for taking into account the specific circumstances and unique interests of different groups (in this case children) when the amount of social cash benefits is determined allowing individuals in need to live in accordance with the national minimum subsistence level; see also Pieterse (2006), 491; Bilchitz (2007), 224–225.

99 As observed by the CESCR (E/C.12/2000/4, 11 August 2000, para. 43[f]) and recognised in the »jurisprudence« of the European Committee on Social Rights, see e.g. Conclusions I, Statement of interpretation on Article 1(1), 13; Conclusions XIII-5, Statement of Interpretation on Article 23, at 455 and Conclusions XV-2, Belgium, 99 (referring to the right to health education as set out in Art.11(2) of the ESC); and the jurisprudence of the German Constitutional Court, as clearly formulated judgment 1 BvL 1/09 of 9 February 2010.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND

tions.[100] This character indeed requires constant monitoring of the situation by domestic authorities (and, subsidiarily, by regional or international courts or quasi-judicial bodies).[101] This can regularly be done by domestic courts that, if they are given the power to review individual complaints, might become aware of changing circumstances that bring about new threats to individuals' abilities to enjoy their (minimum core) right to health. They may then interpret domestic law and/or the ICESCR dynamically to capture these changing circumstances, or call on the legislature and executive to adopt new or adapt existing laws and policy measures to this end.

In summary, these procedural obligations which guide states in the concretisation of the abstractly defined international minimum core right to health will ensure that minimum health needs of individuals are met in all countries around the world in a way that takes account of the local context. This ensures that even if it is (necessarily) defined in the abstract, the universal minimum core content of the right to health can make a difference for individuals who have varying health problems that shall be addressed urgently. At the same time, the abstract, internationally-defined minimum core can prevent arbitrariness in the domestic concretisation process, guiding the priorities of this concretisation process so that the national legal and other measures for the implementation of the minimum core right to health benefit everyone under the jurisdiction of a particular state.[102]

---

100 This has been clearly developed in the ECtHR's »evolutionary or dynamic interpretation« doctrine. For an overview, see Harris et al. (2014), 8–10.

101 Parallels can be drawn to the cooperation required by domestic authorities (the executive, legislature and judiciary) under the ECHR to secure the effective implementation of the ECHR in changing circumstances. For details see Müller (2016b).

102 This is based on the assumption that the internationally defined minimum core right to health as set out in section 4.1 above ensures access to health services that address most common health threats, and thus benefit a great number of people.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access -

5. UTILISING THE MINIMUM CORE APPROACH TO DETERMINE, ALLOCATE AND COORDINATE DOMESTIC DUTIES AND INTERNATIONAL RESPONSIBILITIES?

It can still be reasonably objected that the internationally-defined minimum core right to health as defined in section 4.1 and its domestic concretisation and implementation is unaffordable for low-income countries. Relatedly, there might be threats and obstacles to a state's ability to protect its population's minimum core right to health which originate from beyond the state's borders. Such threats may come from another state or states, international organisations and international law, or from private actors based in another state. The inability of a state to ensure universal access to primary healthcare of individuals under its jurisdiction because of structural adjustment policies pushed for by international organisations (e.g. the International Monetary Fund (IMF) or the EU) is one example in this context. Another is the state duty to ensure its population's access to essential medicines as required under the minimum core right to health which might be impossible because of high prices that pharmaceutical companies charge for essential drugs. These corporations may also invoke commercial and intellectual property rights when they decide which drugs to produce or to protect from generic production.[103] International organisations such as the World Trade Organization (WTO), the IMF or the EU have worked to develop and embed the law protecting commercial and intellectual property rights as well as international trade law that can hinder a state to protect its population's access to essential health goods and services as required under the ICESCR. To remedy this, not only other states will usually need to be involved but also the involvement of international organisations and private (pharmaceutical) corporations may be required.

In the following, it shall be argued that the minimum core approach could help to address these challenges to some extent by concretising both duties under the ICESCR that states have as members of international or-

103 The conflicts between the right to health and international law protecting intellectual property rights have been discussed in great detail, e.g. by Steffen Guise Rosina et al. (2010); Helfer (2016); A/63/263, 11 August 2008. Despite this, these conflicts have not been solved.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - CC BY-NC-ND

ganisations and (international) responsibilities to cooperate and assist in the realization of ESC rights, something which has been indicated by the statements of the CESCR.

First on states' duties as members of international organisations: International human rights law includes an obligation of states to protect individuals under their jurisdiction against human rights violations caused by international organisations of which they are members. This duty can be deduced from the Draft Articles on the Responsibility of International Organizations.[104] In their Article 61, the Draft Articles indicate that international responsibility can be attributed to states when they intentionally circumvent their human rights duties under the ICESCR (and other human rights treaties) through membership in an international organisation and through conduct of the latter. This means that states have an obligation to ensure that their membership in an international organisation and the activities undertaken by this organisation do not prevent them from protecting the rights of individuals under their jurisdiction.[105] The minimum core approach calls on states to be particularly alert when joining an international organisation whose objectives and purposes might conflict with their minimum core obligations; or when they approve activities or the adoption of legal measures by an organisation to which they are already a member, that can undermine their ability to secure minimum core rights in particular within their jurisdiction.[106] This can be relevant when it comes to measures taken for the protection of intellectual property rights as well as free trade. A heightened alertness of states when it comes to their ability to protect minimum core rights is justified by the particularly urgent human interest that underlies minimum core rights, as has been argued above.

In its current shape, international law does not include an obligation on states to ensure that international organisations do not adopt measures that

---

104 Draft Articles on the Responsibility of International Organizations (DARIO), A/RES/66/100, 9 December 2011.

105 E/C.12/2016/1, 24 June 2016, para. 5; this is clear also from the jurisprudence of the ECtHR as summarised in the commentary to Article 61 DARIO, 93–95, at http://legal.un.org/ilc/texts/instruments/english/commentaries/9_11_2011.pdf [14.06.2017].

106 The CESCR has reminded states of this obligation frequently, e.g. E/C.12/2016/1, 24 June 2016, paras. 4 and 5.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND

prevent *other* states from protecting the human rights of individuals under these other states' jurisdiction; or more generally, a duty not to create obstacles, including through the activities of private actors (e.g. multinational corporations), for other states to respect, protect and fulfil human rights of individuals under the jurisdiction of these other states.[107] The reason for this is that normally[108] the jurisdictional link between a state and individuals under the jurisdiction of another state is missing.[109] A jurisdictional link is, however, required to pose human rights obligations on a state (or on international organisation).[110]

But states, international organisations, private corporations and even individuals have *responsibilities* for the protection of human rights in all states, and, as shall be argued in the following, in particular when it comes to the protection of minimum core rights, including the minimum core right to health. The legal basis for these responsibilities are Articles 2(1), 11(2), 15(4), 22 and 23 ICESCR, all referring to the importance of international cooperation and assistance for the realization of the rights set out in the Covenant. Unfortunately, as pointed out by political philosophers, there are »few concepts in moral and political philosophy that are more slippery than that of responsibility«.[111] This is also reflected in international human rights law, where no satisfying answer has been found yet as to how the responsibility to cooperate and assist in the implementation of human rights (in particular ESC rights) which is diffusely addressed to the ›international com-

107 See A/RES/66/100, 9 December 2011; and A/RES/56/83, 12 December 2001. See also the analysis by Besson (2015b), 482–484.

108 There are rare cases where jurisdiction is shared among two states, as recognised e.g. by the ECtHR in *Catan and Others v. Moldova and Russia*, judgment (Grand Chamber), appl. nos. 43370/04, 18454/06 and 8252/05, 19 October 2012, paras. 110 and 122.

109 The Maastricht Principles on Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights, 2011, aim to close this gap, see e.g. principles 13, 21 and 23. Note, however, that the Maastricht Principles do not make a distinction between duties of states (and international organisations) of jurisdiction, and responsibilities of states, international organisations, private actors and individuals' to cooperate and assist in the realization of ESC rights.

110 Besson (2012b) and (2015b), 468-470.

111 Miller (2001), 455.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - CC BY-NC-ND

munity‹, can be made more concrete and assigned to one or more states (that do not have jurisdiction), international/regional organisations, private actors or individuals that make up the ›international community‹ in concrete cases. The statements of the Committee on these responsibilities remain very general, calling on states and »others in a position to help«[112] to cooperate and assist each other in the realization of ESC rights.[113] The Maastricht Principles go further by establishing that »states should *coordinate* with each other, including in the *allocation* of responsibilities, in order to cooperate effectively in the universal fulfilment of economic, social and cultural rights« [emphasis added, A.M.].[114] A Commentary to the Maastricht Principles moreover suggests criteria which should guide this allocation of responsibilities to different actors, among them capacity (economical, financial, technical, technological and in form of influence in international decision-making processes[115]), causality and historical ties.[116]

In addition, it can be suggested that a focus on the minimum core content of the right to health (and other ESC rights) could help to give these responsibilities a clearer direction and to allocate them more effectively to different actors, including when it comes to the coordination of the implementation of (international) responsibilities with the implementation of (national) minimum core obligations flowing from the right to health that are addressed to the state of jurisdiction. This has been suggested by the CESCR in several statements, and it has been taken up by the Maastricht Principles. The Committee observed that internationally-defined minimum

112 E/C.12/2001/10, 10 May 2001, para. 16; and E/C.12/2000/4, 11 August 2000, para. 45.

113 E.g. E/C.12/GC/19, 4 February 2008, paras. 52–58; E/C.12/GC/17, 12 January 2006, paras. 36–38; E/C.12/2002/11, 20 January 2003, paras. 30–36; E/C.12/2000/4, 11 August 2000, paras. 38–42; and E/C.12/1999/5, 12 May 1999, para. 38.

114 Maastricht Principles, 2011, principle 30.

115 This includes capacity to influence the development and entrenchment of international law that obstructs the implementation of ESC rights, like intellectual property law, trade law or law protecting foreign investments. See also E/C.12/1999/5, 12 May 1999, para. 39.

116 Maastricht Principles, 2011, principle 31; De Schutter et al. (2012), 1152–1153; Besson (2015b), 484–485.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND

core content of ESC rights »give rise to national responsibilities [rather: obligations] for all States [of jurisdiction], and international responsibilities for developed States, as well as others that are in a ›position to help‹«.[117] This suggests that the universal minimum core right to health as defined in section 4.1 above can guide states, international organizations and other actors with the capacity to help as to when their responsibility to offer assistance is *clearly* triggered:[118] when the minimum core right to health of »any significant number of individuals«[119] is not implemented in another country.[120] Complementing this, the Committee has frequently called on states of jurisdiction who lack the capacity and resources to implement the minimum core right to health to appeal to other states, international organisations and other actors for the assistance that is needed for the implementation of minimum core obligations under the right to health.[121] The particularly urgent human (survival) interests which are underlying the minimum core content of the right to health and the related fact that minimum core obligations should not be limited even by a majority decision of a democratically elected parliament make the implementation of minimum cores a legitimate focus for cooperation between domestic and foreign and/or international actors. The latter could potentially contribute to avoid the problem of possible conflict between the democratically determined health priorities in the state of jurisdiction with health priorities determined in third states which wish to discharge their international responsibilities flowing from the right to health to assist with the implementation of the right to health in another country.

---

117 E/C.12/2001/10, 10 May 2001, para. 16.

118 This does not mean that the responsibility to cooperate and assist is irrelevant in situations where non-core ESC rights are involved. For further elaboration, see De Schutter et al. (2012), 1156.

119 E/1991/23, 14 December 1990, para. 10; and E/C.12/2001/10, 10 May 2001, para. 17.

120 The role of the minimum core is recognised also Maastricht Principles, 2011, principle 32.

121 E.g. E/C.12/2007/1, 21 September 2007, paras. 5 and 10(f); and E/1991/23, 14 December 1990, para. 42. See also the Maastricht Principles, 2011, principle 34.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND

To end on a critical note: Despite the progress that has been made towards both understanding the need to allocate responsibilities to different actors more clearly and to coordinate their implementation (including with the implementation of duties of states of jurisdiction) and the potential role that the minimum core approach could play in this context, many challenges remain. It is not clear precisely where national obligations end and international responsibilities begin for the implementation of the minimum core right to health. Nor are the criteria particularly well-defined which states, international organisations and other actors should follow when making decisions about how, when and to whom they offer assistance in respecting, protecting and fulfilling the right to health when discharging their (international) responsibilities. Last, there is no reliable institutional framework through which responsibilities can be allocated fairly and their implementation coordinated[122] – something that would be needed to avoid that none of the potentially responsible actors will step in to actually discharge their responsibility when minimum core rights remain unprotected in a particular country.[123] Human rights law scholarship will need to address these questions to ensure the implementation of the right to health in all countries around the world, in particular when it comes to aspects of this right that cannot be realized in one state without the assistance of another state, international organisations or private actors – e.g. when a low-income country lacks the resources and capacities to produce essential drugs; or is pushed by international organizations to introduce structural adjustment measures that interfere with the provision of primary healthcare.

6. CONCLUDING REMARKS

The chapter sketched out the progress which human rights law scholarship and practice has made in developing and operationalising the minimum core approach to the right to health so that this approach can achieve its aim to give the right to health a meaningful content despite the »mere« obligation of states to »progressively realize« the rights of the ICESCR. While the Committee's understanding of the approach remains unclear, it has been

122 Besson (2015b), 477 and 483–484.

123 David Miller has identified this as a »protection gap«, cf. Miller (2009), 246.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND

argued that an emerging transnational consensus on the content and character of the minimum core right can be identified from the practice of domestic courts, domestic law as well as regional and international human rights courts and bodies. This consensus points into a direction of understanding the minimum core right to health as an absolute right to access essential health goods and services. More comparative research will be needed to consolidate this consensus (or refute its existence).

The discussion also shed light on the procedural obligations under the ICESCR that guide states when concretising the abstract internationally-defined content of the minimum core right to health at the domestic level, taking into account local circumstances. This concretisation process should take place within a democratic system, and material obligations flowing from the minimum core right to health have to be allocated to various domestic actors and their implementation has to be coordinated.

Last, I argued that a focus on the minimum core approach could (together with other principles and criteria) guide the specification and allocation of states', international organisations' and private entities' responsibilities to cooperate and assist in the realization of the right to health; and in the coordination of the implementation of these responsibilities of different actors, and the coordination of the implementation of responsibilities and duties of the state of jurisdiction. Such specification, allocation and coordination is urgently required to effectively realize the minimum core right to health of *everyone*, including those who live under a state's jurisdiction that cannot secure minimum core rights without international assistance and co-operation.

REFERENCES

Arambulo, Kitty (1999): *Strengthening the Supervision of the International Covenant on Economic, Social and Cultural Rights: Theoretical and Procedural Aspects,* Antwerp: Intersentia.

Besson, Samantha (2010): »The Human Right to Democracy – A Moral Defence with a Legal Nuance«, European Commission for Democracy through Law (Venice Commission), CDL-UD(2010)003, 4 May 2010, Online: http://www.venice.coe.int/webforms/documents/default.aspx?pdffile=CDL-UD%282010%29003-e [14.06.2017].

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - CC BY-NC-ND

Besson, Samantha (2011): »Human Rights and Democracy in a Global Context: Decoupling and Recoupling«, in: *Ethics & Global Politics* 4, 1 (2011), 19–50.

Besson, Samantha (2012a): »The Egalitarian Dimension of Human Rights«, in: *Archiv für Sozial- und Rechtsphilosophie, Beiheft* 136 (2012), 19–52.

Besson, Samantha (2012b): »The Extraterritoriality of the European Convention on Human Rights: Why Human Rights Depend on Jurisdiction and What Jurisdiction Amounts to«, in: *Leiden Journal of International Law* 25, 4 (2012), 857–884.

Besson, Samantha (2015a): »Human Rights and Constitutional Law: Patterns of Mutual Validation and Legitimation«, in: Cruft et al. (2015), 279–299.

Besson, Samantha (2015b): »Science without Borders and the Boundaries of Human Rights: Who Owes the Human Right to Science?«, in: *European Journal of Human Rights* 4 (2012), 462–485.

Besson, Samantha (2017): »The Influence of the Two Covenants on states Parties Across Regions – Lessons for the Role of Comparative Law and of Regions in International Human Rights Law«, in: Moeckli/Keller (2017) [forthcoming, on file with author].

Bilchitz, David (2007): *Poverty and Fundamental Rights: The Justification and Enforcement of Socio-Economic Rights*, Oxford: Oxford University Press.

Brand, Danie/Russell, Sage (Eds.) (2002): *Exploring the Core Content of Economic and Social Rights: South African and International Perspectives,* Pretoria: Protea Book House.

van Bueren, Geraldine (1999): »Alleviating Poverty through the Constitutional Court«, in: *South African Journal of Human Rights* 15 (1999), 52–72.

van Bueren, Geraldine (2002): »Of Floors and Ceilings: Minimum Core Obligations and Children«, in: Brand/Russell (2002), 183–200.

Campbell, Tom/Goldberg, David/McLean, Sheila (Eds.) (1986): *Human Rights: From Rhetoric to Reality*, New York: Basil Blackwell.

Chapman, Audrey/Russell, Sage (Eds.) (2002): *Core Obligations: Building a Framework for Economic, Social and Cultural Rights*, Antwerp: Intersentia.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - [cc] BY-NC-ND

Clements, Luke/Simmons, Alan (2008): »European Court of Human Rights – Sympathetic Unease«, in: Langford (2008), 409–427.

COHRE (2003): »Litigating Economic, Social and Cultural Rights: Achievements, Challenges and Strategies—Featuring 21 Case Studies«, Online: http://globalinitiative-escr.org/wp-content/uploads/2012/06/Litigating-ESCR-Report.pdf [14.06.2017].

Coomans, Fons (2002): »In Search of the Core Content of the Right to Education«, in: Chapman/Russell (2002), 159–182.

Courtis, Christian (2008): »Argentina – Some Promising Signs«, in: Langford (2008), 163–181.

Craven, Matthew (1995): *The International Covenant on Economic, Social and Cultural Rights: A Perspective on its Development*, Oxford: Clarendon Press.

Cruft, Rowan/Liao, Matthew/Renzo, Massimo (Eds.) (2015): *Philosophical Foundations of Human Rights*, Oxford: Oxford University Press.

De Schutter, Oliver (2010): *International Human Rights Law*, Cambridge: Cambridge University Press.

De Schutter, Oliver/Eide, Asbjørn/Khalfan, Ashfaq/Orellana, Marcos/Salomon, Margot/Seiderman, Ian (2012): »Commentary to the Maastricht Principles on Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights«, in: *Human Rights Quarterly* 34, 4 (2012), 1084–1169.

Eide, Asbjørn/Krause, Catarina/Rosas, Allan (Eds.) (2001): *Economic, Social and Cultural Rights,* Dordrecht: Martinus Nijhoff.

Elsässer, Lea/Hense, Svenja, Schäfer, Armin (2017): »Wie arm ist Deutschland wirklich? Im Armutsbericht der Regierung wurde unsere Studie zum Einfluss der Reichen auf die Politik entschärft. Dies sind unsere ungefilterten Ergebnisse«, *ZEIT ONLINE,* 19 April 2017, Online: http://www.zeit.de/2017/17/armutsbericht-deutschland-einkommen-politik-wahlen [14.06.2017].

Forman, Lisa/Ooms, Gorik/Chapman, Audrey/Friedman, Eric/Waris, Attiya/Lamprea, Everaldo/Mulumba, Moses (2013): »What Could a Strengthened Right to Health Bring to the post-2015 Health Development Agenda? Interrogating the Role of the Minimum Core Concept in Advancing Essential Global Health Needs«, in: *BMC International Health and Human Rights* 13 (2013), 1–11.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND

Frewer, Andreas/Bielefeldt, Heiner (Eds.) (2016): *Das Menschenrecht auf Gesundheit. Normative Grundlagen und aktuelle Diskurse*, Bielefeld: transcript.

Häfelin, Ulrich/Haller, Walter/Keller, Helen (2012): *Schweizerisches Bundesstaatsrecht*, Zürich: Schulthess [8th edn.].

Halliday, Terence/Shaffer, Gregory (Eds.) (2016): *Transnational Legal Orders*, Cambridge: Cambridge University Press.

Harris, David/O'Boyle, Michael/Bates, Edward/Buckley, Carla (2014): *The Law of the European Convention on Human* Rights, Oxford: Oxford University Press [3rd edn.].

Helfer, Laurence (2016): »Pharmaceutical Patents and the Human Right to Health«, in: Halliday/Shaffer (2016), 311–339

ILO (2011): »Social Protection Floor – For a Fair and Inclusive Globalisation«, Report of the ILO Social Protection Floor Advisory Group, 27 September 2011, Online: http://www.ilo.org/global/publications/ilo-bookstore/order-online/books/WCMS_165750/lang--en/index.htm [14.06.2017].

ILO (2012): »Social Security for All – Building Social Protection Floors and Comprehensive Social Security Systems«, 20 December 2012, Online: http://www.ilo.org/wcmsp5/groups/public/---ed_protect/--soc_sec/documents/publication/wcms_secsoc_34188.pdf [14.06.2017].

International Commission of Jurists (2008): »Courts and the Legal Enforcement of Economic, Social and Cultural Rights. Comparative Experience of Justiciability«, Online: http://www.humanrights.ch/upload/pdf/080819_justiziabilitt_esc.pdf [14.06.2017].

Kende, Mark (2003/2004): »The South African Constitutional Court's Construction of Socio-Economic Rights: A Response to Critics«, in: *Connecticut Journal of International Law* 19 (2003/2004), 617–629.

Koch, Ida (2009): *Human Rights as Indivisible Rights: The Protection of Socio-Economic Demands under the European Convention on Human Rights,* Leiden: Martinus Nijhoff.

Landau, David (2014): »The Promise of a Minimum Core Approach: The Colombian Model for Judicial Review of Austerity Measures«, in: Nolan (2014), 267–298.

Langford, Malcolm (Ed.) (2008): *Social Rights Jurisprudence: Emerging Trends in International and Comparative Law*, Cambridge: Cambridge University Press.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND

Langford, Malcolm (2008): »The Justiciability of Social Rights: From Practice to Theory«, in: Langford (2008), 3–45.

Lehmann, Karin (2006): »In Defense of the Constitutional Court: Litigating Socio-Economic Rights and the Myth of the Minimum Core«, in: *American University International Law* Review 22, 1 (2006), 163–197.

Liebenberg, Sandra (2002): »South Africa's Evolving Jurisprudence on Socio-Economic Rights: An Effective Tool in Challenging Poverty«, in: *Law, Democracy and Development* 6 (2002), 159–191.

Liebenberg, Sandra (2005): »The Value of Human Dignity in Interpreting Socio-Economic Rights«, in: *South African Journal of Human Rights* 21 (2005), 1–31.

Liebenberg, Sandra (2006): »Needs, Rights and Transformation: Adjudicating Social Rights«, in: *Stellenbosch Law Review* 17 (2006), 5–36.

Meyer, Lukas (Ed.) (2009): *Legitimacy, Justice and Public International Law*, Cambridge: Cambridge University Press.

Mikkola, Matti (2010): *Social Human Rights of Europe*, Porvoo: Karelactio.

Miller, David (2001): »Distributing Responsibilities«, in: *The Journal of Political Philosophy* 9, 4 (2001), 435–471.

Miller, David (2009): »The Responsibility to Protect Human Rights«, in: Meyer (2009), 232–251.

Moeckli, Daniel/Keller, Helen (2017): *The UN Human Rights Covenants at 50*, Oxford: Oxford University Press [forthcoming].

Müller, Amrei (2009): »Limitations to and Derogations from Economic, Social and Cultural Rights«, in: *Human Rights Law Review* 9, 4 (2009), 557–601.

Müller, Amrei (2013): *The Relationship between Economic, Social and Cultural Rights and International Humanitarian Law*, Leiden: Brill.

Müller, Amrei (2016a): »Die Konkretisierung von Kernbereichen des Menschenrechts auf Gesundheit. Internationale Debatten zu ›Minimum Core Obligations‹«, in: Frewer/Bielefeldt (2016), 125–168.

Müller, Amrei (2016b): »Domestic Authorities' Obligations to Co-Develop the Rights of the European Convention on Human Rights«, in: *The International Journal of Human Rights* 20, 8 (2016), 1058–1076.

Müller, Amrei (Ed.) (2017): *Judicial Dialogue and Human Rights*, Cambridge: Cambridge University Press.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - [cc] BY-NC-ND

Muralidhar, S. (2008): »India – The Expectations and Challenges of Judicial Enforcement of Social Rights«, in: Langford (2008), 102–124.

Neuman, Gerald (2008): »Import, Export, and Regional Consent in the Inter-American Court of Human Rights«, in: *European Journal of International Law* 19, 1 (2008), 101–123.

Nolan, Aoife (Ed.) (2014): *Economic and Social Rights after the Global Financial Crisis,* Cambridge: Cambridge University Press.

O'Cinneide, Colm (2014): »Austerity and the Faded Dream of ›Social Europe‹«, in: Nolan (2014), 169–201.

Örücü, Esin (1986): »The Core of Rights and Freedoms: the Limits of Limits«, in: Campbell et al. (1986), 37–59.

Pieterse, Marius (2006): »Resuscitating Socio-Economic Rights: Constitutional Entitlements to Health Care Services«, in: *South African Journal of Human Rights* 22 (2006), 473–502.

Pogge, Thomas (2002): *World Poverty and Human Rights,* Cambridge: Polity.

Porter, Bruce (2005): »The Crisis of Economic, Social and Cultural Rights and Strategies Addressing It«, in: Squires et al. (2005), 43–69.

Roberts, Anthea/Stephan, Paul B./Verdier, Pierre-Hugues/Versteeg, Mila (2015): »Comparative International Law: Framing the Field«, in: *American Journal of International Law* 109, 3 (2015), 467–474.

San Giorgio, Maite (2012): *The Human Right to Equal Access to Health Care*, Antwerp: Intersentia.

Schaks, Nils (2015): »Die Wesensgehaltsgarantie, Art. 19 II GG«, in: *Juristische Schulung* 407 (2015), 407–410.

Scheinin, Martin (2001): »Economic and Social Rights as Legal Rights«, in: Eide et al. (2001), 111–122.

Scott, Craig/Macklem, Patrick (1992): »Constitutional Ropes of Sand or Justiciable Guarantees?«, in: *University of Pennsylvania Law Review* 141, 1 (1992), 1–147.

Scott, Craig/Alston, Philip (2000): »Adjudicating Constitutional Priorities in a Transnational Context: A Comment on Soobramoney's Legacy and Grootboom's Promise«, in: *South African Journal of Human Rights* 16 (2000), 206–268.

Sepulveda, Magdalena (2008): »Colombia – The Constitutional Court's Role in Addressing Social Justice«, in: Langford (2008), 144–162.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - [cc] BY-NC-ND

Shaver, Lea (Ed.) (2010): *Access to Knowledge in Brazil: New Research on Intellectual Property, Innovation and Development*, New Heaven: Bloomsbury Imprint.

Shelton, Dinah (2010): *Regional Protection of Human Rights*, Oxford: Oxford University Press.

Squires, John/Langford, Malcolm/Thiele, Bret (Eds.) (2005): *The Road to a Remedy: Current Issues in the Litigation of Economic, Social and Cultural Rights*, Sydney: UNSW Press.

Ssenyonjo, Manisuli (2009): *Economic, Social and Cultural Rights in International Law*, Oxford: Hart.

Steffen Guise Rosina, Monica/Wang, Daniel/de Campos, Thana Christina (2010): »Access to Medicines: Pharmaceutical Patents and the Right to Health«, in: Shaver (2010), 165–213.

Steiner, Henry J. (2008): »Two Sides of the Same Coin? Democracy and International Human Rights«, in: *Israel Law Review* 41, 3 (2008), 445–476.

Toebes, Brigit (1999): *The Right to Health as a Human Right in International Law,* Antwerp: Intersentia.

Wesson, Murray (2004): »Grootboom and Beyond: Reassessing the Socio-Economic Rights Jurisprudence of the South African Constitutional Court«, in: *South African Journal of Human Rights* 20 (2004), 284–308.

WHO (2008): »World Health Report 2008: Primary Health Care (Now More Than Ever)«, Online: http://www.who.int/whr/2008/en/ [14.06.2017].

WHO (2013): »World Health Report 2013: Research for Universal Health Coverage«, Online: http://www.who.int/whr/2013/report/en/ [14.06.2017].

WHO/World Bank Group (2015): »Tracking Universal Health Coverage: First Global Monitoring Report«, Online: http://www.who.int/healthinfo/universal_health_coverage/report/2015/en/ [14.06.2017].

Young, Katharine (2008): »The Minimum Core of Economic and Social Rights: A Concept in Search of Content«, in: *Yale Journal of International Law* 33 (2008), 113–175.

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - (cc) BY-NC-ND

https://doi.org/10.14361/9783839440544-003 https://www.inlibra.com/de/agb - Open Access - CC BY-NC-ND