The Human Right to Health

Fundamentals of a Complex Right

MICHAEL KRENNERICH[1]

1. INTRODUCTION

Human rights as they are enshrined in public international law concern primarily the relationship between the individuals as right holders and the state as the primary duty bearer. The underlying idea behind such a human right to health is that the state refrains from compromising the health of the people, protects them against interference, and undertakes measures to ensure that healthy living and working conditions are available to the people and above all that they have access to appropriate healthcare.

2. ENSHRINING THE HUMAN RIGHT TO HEALTH IN INTERNATIONAL HUMAN RIGHTS LAW

The article commences by embarking on a short trek through the jungle of international law documents and treaties in which the human right to health is set down. The starting point is the second half of the 1940s when following the Second World War, building on corresponding historical forerun-

1 This contribution is a slightly modified translation of a German article first published in: Zeitschrift für Menschenrechte (Journal for Human Rights) 9, 2 (2015). Furthermore, see Krennerich (2016).

ners and contemporary preparatory work, modern-day human rights protection came into existence and the human right to health was incorporated within the United Nations framework.

The World Health Organization (WHO) set out already in the preamble to its 1946 constitution that each individual person has a fundamental right to the »enjoyment of the highest attainable standard of health«. In doing so the WHO defined health in a comprehensive and ambitious way as a »state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity«.[2] The WHO thereby detached itself from a *purely* biomedical understanding (and most everyday notions) of health as being the freedom from physical and mental illnesses and impairments[3] and ignited a lively expert debate, and not only among medical professionals. On the one hand, the concept of health as complete wellbeing[4] was often criticised as utopian,[5] on the other hand it remained heavily disputed what exactly such *wellbeing* consisted of.[6]

Although due to its non-binding character the WHO preamble does not strictly speaking amount to a source of law for the right to health,[7] the WHO definition is frequently used in human rights discourse.[8] Interesting issues arise not only because this approach emphasises the interconnectedness of physical, mental-psychological and social aspects of health. Also the subjective components of health inherent to wellbeing are emphasised. Understood in this way, defining health as *wellbeing* is no longer just a matter for experts. Nevertheless, not every person who feels well is healthy from a medical point of view, and not everybody who is feeling unwell is sick. As such the danger exists that the biomedical profile of health, which is imperative for healthcare in the strict sense (and which the WHO does not completely abandon) will become less selective.

2 Constitution of the World Health Organization: www.who.int/governance/eb/who_constitution_en.pdf [01.03.2017].

3 Franke (2006), 32.

4 It would possibly make more sense to understand »complete wellbeing« in the sense of a »comprehensive« rather than »total« wellbeing.

5 Instead of many: Venkatapuram (2011), 66.

6 For example Dodge et al. (2012).

7 Hestermeyer (2007), 113.

8 For example UNICEF (2002), 344; Freeman et al. (2012), 315.

As it is »only« a declaration of the UN General Assembly, also the *Universal Declaration of Human Rights* (UDHR) from 1948 was originally not binding in public international law. However, in the course of time the UDHR, which has been translated into over 300 languages, has developed a large moral, political and at least indirectly a legal importance. Its legal effect is due to the fact that it contains general legal principles and human rights norms recognised by customary international law. Well justified is also the belief that the UDHR substantiates the purpose of the UN Charter – which is binding on all UN Member States – to promote and strengthen respect and observance of human rights and fundamental freedoms for all people without discrimination.[9]

The human right to health cannot, however, be found in the UDHR in a separate article as would be expected and as was discussed in the Human Rights Commission.[10] Instead, in order to keep the UDHR short and concise, it was enshrined as part of the right to an adequate standard of living which guarantees everyone health and wellbeing, including food, clothing, housing and medical care and necessary social services (Article 25, para. 1). Contrary to the preamble of the WHO constitution, the UDHR differentiates in its wording between health and wellbeing, makes clear, however, that both are closely related. With regard to the right to health, which in the UDHR is not clearly differentiated from the other components of the right to an adequate standard of living, it should be noted that the UDHR identifies medical care as a central but not the only element of this right. Also social security, especially in cases of illness and invalidity, as well as access to healthy living conditions (food, housing, etc.) play an important role.

The right to health was later enshrined separately and with binding effect in international (treaty) law in the *International Covenant on Economic, Social and Cultural Rights* (ICESCR) from 1966 and which came into force in 1976. The ICESCR is the fundamental UN Human Rights Convention on Economic, Social and Cultural rights (ESC rights) including the right to health. In the convention, the now 165 State Parties (as of

9 On the legal nature of the UDHR see, e.g. Nettelsheim (2009).

10 Morsink (1999), 192–199. See also the collection of documents by Schabas (2013).

25.07.2017) recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (Article 12, para. 1).

Two aspects need to be emphasised here. Firstly, the ICESCR moves away from the notion of a right to *be* healthy.[11] Such a right appears to still be laid down in the preamble to the WHO constitution which talks about a state of complete physical, mental and social wellbeing. Secondly, in the ICESCR the highest attainable standard refers only to physical and mental health but not, for example, to »social wellbeing« (as intended in the original draft of the commission) or even to »moral wellbeing« (as the delegations from Afghanistan and the Philippines suggested at the time when the convention was being drawn up).[12] The social conditions are consequently rather determinants for health than their defining component.

Also, the measures stated in the non-conclusive list in the ICESCR for the realisation of the right focus on physical (and mental) health, naturally taking account of contextual conditions which can promote or impair health. The measures are aimed at reducing stillbirths and infant mortality, the healthy development of the child, environmental and industrial hygiene, the prevention, treatment and control of epidemic, endemic, occupational and other diseases, as well as people's access to medical facilities and medical attention (Article 12, para. 2). There are overlaps with the right to just and favourable working conditions and the right to social security, both of which are enshrined in separate articles.

Further UN human rights conventions also include the right to health or individual aspects of it in respect of particular problem areas or especially disadvantaged or needy population groups. The *International Convention on the Elimination of All Forms of Racial Discrimination (ICERD)* from 1966 (in force since 1969) enshrines the non-discriminatory right to public health, medical care, social security and social services (Article 5).

The *UN Convention on the Elimination of All Forms of Discrimination against Women* (CEDAW) from 1979 (in force since 1981), which until today 189 states have ratified provides in various parts of the convention for numerous measures to realise the right to health without discrimination, not only in the area of healthcare (Article 12), but also in the area of health-related education, in the workplace, in relation to family planning, in rural

11 See E/C.12/2000/4, 11th August 2000, paras. 4 and 8.

12 Saul et al. (2014), 980. See also Tobin (2012), 125.

areas and during pregnancy, when giving birth and whilst breastfeeding.[13] Several other rights concern social determinants of health.[14] By pointing out the gender dimensions of health, the convention enables human rights violations to be identified that would perhaps otherwise have remained undiscovered and to demand human rights policy measures which would possibly otherwise never have been taken (as comprehensively). This includes, for example, measures relating to reproductive and sexual health.[15]

The *UN Convention on the Rights of the Child* from 1989 (in force since 1990), which now has 196 state parties and – with the exception of the USA – has been ratified by all states worldwide recognises the right of the child to the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health (Article 24, para. 1). The convention names (not exhaustively) various measures for securing the complete realisation of the right to health, amongst other things the reduction of child and infant mortality, the securing of medical assistance and healthcare for children, the combatting of undernourishment and malnutrition, healthcare for mothers as well as various aspects of health education, hygiene, breastfeeding, accident prevention and family planning (Article 24). At the same time the UN Convention on the Rights of the Child provides for protective measures against the health-damaging economic exploitation of children and against the use of addictive drugs by children (Article 32, para. 1; Article 33). Particular obligations to protect arise in connection with the state accommodation of physically and/or mentally ill children (Article 25). Furthermore, the convention refers to the particular needs of children with disabilities, to whom the access to healthcare services must be ensured (Article 23).

The rights of persons with disabilities, including the right to health, were substantiated and differentiated in the *UN Convention on the Rights of Persons with Disabilities* from 2006 (in force since 2008). With this convention now 174 state parties recognise the right of persons with disabilities to the highest attainable standard of health without discrimination due to their disabilities. Also, the convention names – again non-exhaustively –

13 CEDAW, Article 10(h), Article 11, para. 1(f) and para. 2(d), Article 14, para. 2(b).

14 CEDAW A/54/38/REV I., 2nd February 1999; see also WHO (2008).

15 Freeman et al. (2012), 320–323.

numerous measures for the complete realisation of the right. These seek to remove discrimination when it comes to access to healthcare and also to health and life insurance – something which is often overlooked – and aims to take into consideration the specific health needs of people with disabilities (Article 25). By taking a »*diversity* approach« which sees physical and mental disability as a part of normal human life, and by aiming at the »removal of barriers« for those people who are confronted with various social barriers, the *UN Convention on the Rights of Persons with Disabilities* impressively overcomes a purely medical »deficit approach« to disability. At the same time it takes physical and mental impairments seriously enough to constitute a particular need for action for an assisted autonomy[16] in the area of health and in other areas of life. No other convention is as strongly characterised by the understanding of health as »capability« as the UN Disability Rights Convention.[17]

The conventions mentioned so far do not differentiate in their wording between persons of different nationalities. The practice of the respective states is, however, that foreigners sometimes do not enjoy the same entitlement to healthcare as nationals. The problem becomes clear in the *UN Convention on the Protection of the Rights of All Migrant Workers and Members of their Families* from 1990 (in force since 2003), notwithstanding the fact that it has been ratified by only 51 mainly African and Latin-American states, which deals with the rights of migrant workers and contains corresponding restrictions.

The treatment as equal to the citizens of the respective state is limited here to urgent medical treatment:

»Migrant workers and members of their families shall have the right to receive any medical care that is urgently required for the preservation of their life or the avoidance of irreparable harm to their health on the basis of equality of treatment with nationals of the State concerned (Article 28, sentence 1).«

16 On the concept of »assisted freedom« see the study by Graumann (2011).

17 A capabilities approach, a view held, for example, by Venkatapuram inspired by Amartya Sen with regard to health conceptualizes health as »a meta-capability, the capability to achieve a cluster of basis capabilities to be and do things that reflect a life worthy of equal human dignity.« Cf. Venkatapuram (2011), 71.

Pursuant to the convention, migrant workers may not be denied urgent treatment even if there is any »irregularity« with regard to their stay or employment in the country (Article 28, sentence 2). Equal, general access to social and healthcare services is enjoyed by migrant workers and their families only »provided that the requirements for participation in the respective schemes are met« (Article 43[e]). As such, the Migrant Workers Convention is an ambivalent document: on the one hand, it emphasises the important entitlement to the right of migrant workers to basic medical care, on the other hand it remains rooted in a legal practice, which makes comprehensive medical treatment dependent on residence status.

What remains to be mentioned is the fact that also different regional human rights conventions contain the right to health. Within the scope of the Council of Europe, in particular the European Social Charter in its original (1961/1965) and revised (1996/1998) versions should be named, and which seeks to guarantee an effective exercising of the right to the protection of health (Article 11). The supplementary protocol to the *American Human Rights Convention* (Protocol of San Salvador) from 1988, in force since 1999, also contains the right to health which in terms of the WHO is defined there as the highest level of physical, mental and social well-being (Article 10, para. 1). The *African Charter on Human and Peoples' Rights* (Banjul Charter) from 1981, which came into force in 1986, guarantees the best attainable state of physical and mental health (Article 16), whereas, for example, the *African Charter on the Rights and Welfare of the Child* from 1990, which came into force in 1999 provides for the right to *»best attainable state of physical, mental and spiritual health«* (Article 14, para. 1).

3. FUNDAMENTAL ASPECTS OF THE RIGHT TO HEALTH

In light of the many sources of law, a general interpretation of the right to health is no easy task. A suitable starting point to record the fundamentals of this right is the CESCR which is the fundamental UN human rights covenant on economic, social and cultural rights and is therefore the focal point of this article. Helpful in this respect are the comments from the UN Committee on Economic, Social and Cultural Rights founded in 1988, and which oversees the realisation of the CESCR. In 2000, the Committee

published a »General Comment« on the right to health[18] and it regularly offers its views on the realisation of social human rights by the signatory member states within the framework of the state reporting procedures. Comments and recommendations by the Committee are of course not legally binding; they do, however, provide widely recognised guidance on the up-to-date interpretation of individual ESC rights. Also, other UN human rights treaty bodies as well as UN special rapporteurs refer to them.[19]

The human right to health as it is enshrined in the CESCR entitles every person to enjoy the highest attainable standard of physical and mental health in order to lead a life in human dignity. As already mentioned, this is not simply understood as being a legal guarantee *to be healthy*. No state could possibly provide such a guarantee on the grounds alone that health is dependent on factors which the state is unable to control or which it should not be controlling for good human rights reasons. An example here might be people's genetic predisposition. Although the technical possibilities are already available to enable disease-preventing genetic correction, the (state) manipulation of genetic material has so far been taboo. Even a healthy life style can not be imposed on people, at least not in a way that takes account of human dignity and thereby also freedoms. Nevertheless, the state does have possibilities to shape the political, socio-economic and ecological conditions of health. In that sense, the human right to health stresses that people's health is not adversely affected. On the other hand, the preconditions must be created to allow everybody access to an appropriate level of healthcare and the ability to autonomously live and work healthily. This also includes information and education on matters relevant to health.

The right to health incudes first of all the freedom to make decisions relating to one's own health and body as well as the right to be free of interference with one's health. Here obvious overlaps come about with, amongst other things, the right to life,[20] as well as with the prohibition of torture and

18 E/C.12/2000/4, 11th August 2000.

19 The corresponding documents are all available in the human rights portal of the UN High Commission for Human Rights: cf. www.ohchr.org [01.10.2015].

20 Following the decisions of the ECHR the right to privacy also encompasses physical and psychological integrity as well as individual self-determination as regards the right of disposition in respect of a person's own body; cf. Kälin/ Künzli (2008), 437–439.

inhuman or degrading treatment or punishment. At the same time a number of problem areas in healthcare stand out: what, for example is the situation as regards – from a medical or the state's point of view – necessary compulsory treatment against the patient's will? Or: what could the – where necessary assisted – self-determination of those people be, who are significantly restricted when it comes to making decisions and expressing their will, for example those suffering with the later stages of dementia? [21] The concept of autonomy is central to the discussion here.[22]

The right to health further requires that conditions are established or maintained such that people can lead a healthy life. According to the UN Committee for ESC Rights this includes, for example, access to safe and potable water and adequate sanitation, an adequate supply of safe food, nutrition and housing, healthy occupational and environmental conditions, and access to health-related education and information, including on sexual and reproductive health, as well as the participation of the population in health-related decision-making.[23] Whilst there is an overlap in this respect, amongst other things with the rights to adequate food and nutrition, safe and potable water and adequate working conditions, the right to health additionally includes the entitlement to preventive, curative and palliative[24] healthcare. Healthcare that should enable everybody to enjoy the highest attainable standard of physical and mental health. With regard to healthcare and medical care, the UN Committee for ESC Rights uses – similarly to other social human rights – the categories *availability*, *accessibility*, *acceptability* and *quality* in order to substantiate the right.[25] *Availability* means the provision of functioning healthcare facilities and medical care. Although the actual conditions of these are dependent on many factors – in particular on the level of development and resources in the country – certain minimum conditions are necessary, for example safe and potable water and

21 For example Schmidhuber (2013) and (2014).

22 See also Bielefeldt (2016).

23 E/C.12/2000/4, 11th August 2000, para. 11.

24 The concept of palliative healthcare cannot yet be found in the CESCR. It is, however, to be seen as part of a comprehensive, also alleviating medical treatment. However, in General Comment No. 14, E/C.12/2000/4, 11th August 2000, para. 34.

25 E/C.12/2000/4, 11th August 2000, para. 12.

sanitation, hospitals and other healthcare facilities, trained and adequately remunerated personnel, as well as a basic supply of essential medicines in accordance with WHO standards. Everybody must also have *access* to medical facilities and treatment – in several respects:

- without discrimination, also and in particular in the case of population groups which are especially in need of protection and marginalised.
- physically, i.e. within easy reach and accessible – in particular to women, children, older people and people with chronic diseases or disabilities;
- economically – in such a way that public or private medical facilities and treatments are affordable for everybody, including poor and socially disadvantaged people;
- informed – in the sense that the people have the right to seek, receive and pass on health-relevant information as long as in doing so the personal protection of legitimate expectations is not affected.

Acceptability means that medical facilities and medical care should be provided in accordance with the principles of medical ethics, in confidence and with the aim of improving the health of those concerned. The cultural backgrounds of the individuals, but also of minorities and communities are to be respected and gender or age-related characteristics are to be specifically taken into account. Furthermore, it is required that medical facilities and medical care are appropriate and of an adequate *quality* from a scientific and medical point of view. The medical care must be provided by trained personnel and conform to medical standards for medicines, equipment, facilities and hygiene.

4. STATE OBLIGATIONS

From an international law perspective, the main responsibility for the realisation of human rights lies with the states. According to of international human rights conventions, the states are obliged to respect, protect and fulfil the human rights of individuals under their jurisdiction.[26] From an

26 I will briefly mention extra-territorial obligations later.

international law perspective,[27] the human rights are binding on all state powers, organs and institutions, irrespective of whether these are at the state, regional or local level or whether they are superordinate or subordinate authorities. The obligation of states also extends to such private actors who have been tasked with carrying out public duties or who are acting on behalf of, on instruction of or under the control of the state.[28] As a result of more recent dogmatic international law developments, the human rights thereby establish obligations to respect, protect and fulfil.

4.1 State Obligations to Respect

Obligations to respect form the core of a liberal human rights theory which protects the freedom of individuals from intervention by the state and in doing so places the defensive nature of human rights at the forefront. They oblige the states to not hinder individuals, either directly or indirectly, in the exercising of their human rights – and where they do so to remedy such interventions. This concerns above all obligations of omission.

With regard to our topic, the obligations to respect require the states to refrain from infringing the right to health themselves. The states may not therefore undertake any actions which run contrary to the right to health and »which can result in bodily harm, unnecessary morbidity and preventable mortality«.[29] What could such actions be? With regard to healthcare this encompasses generally all state actions which impede the availability, access to or adequateness and quality of healthcare to such an extent that the health of the people is endangered or harmed.

The UN Committee introduces in its *General Comment* as a key example the denial of medical treatment, and thereby focuses on a non-discriminatory, open access to healthcare. Here it needs to be examined whether laws, regulations or just the practice in public health facilities deny or hinder open access to specific population groups or individuals. This could be, for example ethnic groups or national minorities, persons with disabilities, the psychologically ill or women, but also foreign nationals,

27 Nothing is said about the question of how the responsibilities, jurisdiction and competences are divided in *national* law.

28 Kälin/Künzli (2008), 92.

29 CESCR E/C.12/2000/4, 11th August 2000, para. 50.

refugees, »irregular« migrants or prisoners. Also sometimes problematic is the organisation of healthcare for lesbians, gays, bi-, trans-, and intersexuals (in short: LGBTI persons) in particular where they must fear criminal sanctions, as is the case in many countries.

However, also the way in which people are treated in state healthcare facilities is relevant with regard to the obligations to respect. Not only denied, but also incorrect or abusive treatments can amount to violations of the right to health. In this respect we are dealing here with the appropriateness and quality of healthcare. It must be examined, for example, whether the available treatment possibilities are being exhausted and the medical standards are being adhered to. This is by no means always the case.[30] At the same time there are enough past and present examples of specific actions in state healthcare facilities which are harmful to health: these range from medical experiments with patients who have not given their consent[31] to »inappropriate institutionalization of persons with mental disabilities in psychiatric hospitals«[32] (or also, as is the case in China, for example, the misuse of psychiatric facilities as a place of custody for political dissidents) to the forced sterilisation of people with disabilities[33] or women. In Peru, for example, during Alberto Fujimoris' term in office (1990–2000), around 300,000 women and approximately 22,000 men – above all indigenes and farmers – were subjected to forced sterilisation as part of birth control without their consent and without explanation.[34] Until today there have been hardly any criminal prosecutions as demanded by those concerned.[35]

Specifically, the state obligations to respect in healthcare throw up many questions, the already mentioned problem of discrimination to name just one example. Apart from the fact that medical care needs to be adapted to the individual patients, the question arises as to what health services the

30 For example the discussion surrounding mistakes and ethics in medicine, e.g. in Frewer et al. (2013).

31 Relevant in this context are also the cross-border trials by western pharmaceutical companies in the GDR. cf. Erices et al. (2015).

32 E/CN.4/2005/51, 11th February 2005, para.. 9.

33 For example: www.enil.eu/news/sterilization-of-women-and-girls-with-disabilities-a-briefing-paper-november-2011/ [25.07.2017].

34 See on this Jaichand/O'Donnell (2010).

35 For example the press reports by Anliker (2014); Cordier (2015).

human rights entitlement to equal treatment without discrimination refers to. Surely not only to the minimum provision! But what about our Asylum Seekers Benefits Act (AsylbLG) in Germany? As long as refugees, asylum seekers and people with precarious residence status obtain healthcare services on the basis of the Asylum Seekers Benefits Act,[36] the corresponding service entitlement is limited to healthcare in cases of acute illnesses and pain, to the medical and nursing care of mothers and those who have recently given birth, as well as to officially recommended vaccinations and medically necessary preventive examinations (section 4 AsylbLG). This excludes – at least in principle – the treatment of chronic illnesses, insofar as they are not linked to conditions of pain,[37] often with serious consequences for the persons concerned. The provision of dental care is completely inadequate as well.[38] Also the psycho-social care of refugees has proven to be problematic – even before the enormous increase in the number of refugees in 2015.[39]

Even in light of legitimate regulatory interests of the state, the de jure and de facto unequal treatment of people in the health sector dependent on their nationality or residence status is to be viewed critically from a human rights point of view, especially when the resulting healthcare provision is clearly insufficient and even emergency care is hindered due to bureaucratic hurdles.[40] This is also true when it comes to migrants who are in the country »irregularly«. In principle, these people have a right to access healthcare services; in Germany, for example, by virtue of the Asylum Seekers Benefits Act. However, despite all the national peculiarities and isolated positive examples, Heinz-Jochen Zenker has determined that »everywhere there are people without papers at the lower end of access to ap-

36 Up until the law reform which came into force on 1st March 2015, this applied for a period of 48 months following entry. The reform of the law saw this period reduced to 15 months' residence in Germany.

37 Kaltenborn (2015).

38 Lindner (2015), 81.

39 BAfF (2015).

40 Cf. Lindner (2015); Misbach (2015). The federal government, however, considers the provision of healthcare to be adequate, cf. Bundestag printed paper 18/4758, 27th April 2015. Informative is also the plenary debate in the Bundestag, 115th meeting, 2nd July 2015, 11078–11093.

propriate medical care and this is inconsistent with the human rights conventions and the European Social Charter«.[41] What is more, the practice of tracing, reporting and detaining people often effectively discourages many undocumented persons from making use of healthcare services.[42]

Acts of states which are harmful and dangerous to health can also affect those parameters which influence people's health outside of the healthcare system. As already explained, the UN Committee for ESC Rights explicitly lists access to clean and potable water, adequate sanitation, safe food and accommodation, healthy working and environmental conditions and health-related information. Against this background it must be assessed to what extent health risks and health damage arise from state measures in the different policy areas (economy, energy, defence, etc.) – for example in the form of human rights impact assessments. It is also possible for state-run businesses or public infrastructure measures to infringe the right to health if health protection is neglected in the workplace or if the environment is contaminated. Joint responsibility may also arise as a result of co-operations with private companies. A landmark decision concerning this matter was passed by the African Human Rights Commission against the former military regime in Nigeria. Together with a large oil company, in the course of the national oil extraction, it had caused considerable environmental and health damage in the Niger Delta. The Commission concluded that the rights to health and to an appropriate – here: healthy – environment guaranteed by the Banjul Charter had been infringed.[43]

Also the retention or misrepresentation of health-related information can amount to a breach of state obligations to respect. The state may not hold back or falsify important or vital health information relating to the prevention of infection or epidemics or environmental disasters. From the perspective of the right to health, it was criticised, for example, that for a long time the government of Zimbabwe denied the outbreak of the cholera epidemic in 2008 and declared that it was over too early.[44] Justified human

41 Zenker (2011), 96.

42 For example Fundamental Rights Agency (2012); Mylius/Frewer (2015).

43 Communication No. 155/2001, *SERAC and CESR v Nigeria* (2001), 15th Annual Activity Report of ACHPR: 2000–2002. The case is also well-documented in the secondary literature, see for example Keetharuth (2009); Nolan (2009).

44 Zimbabwe Human Rights NGO Forum (2009).

rights criticism was also directed at the South African government under Thabo Mbeki (1999–2008) which trivialised the risk of infection from HIV and for a time even denied there was a link between HIV and AIDS.[45] Conversely, measures to contain epidemics such as mandatory quarantine in the case of Ebola patients in Sierra Leone, Guinea and Liberia in 2014 can lead to interventions in the freedom and participation rights of those concerned. It can be discussed to what extent such interventions are justified, for example, by means of the »*Siracusa Principles*« which deal with limitations or the derogation of civil and political rights in the case of such public emergencies.[46]

4.2 State Obligations to Protect

Obligations to protect consist of the state obligation to protect individuals from actual or impending infringements of their human rights by third party, normally private actors. Obligations to protect are not prohibitions to act but requirements to act. State decision-makers, however, have a wide-reaching margin of discretion and freedom when it comes to the form of such measures. As such it is not always easy to determine possible infringements of state obligations to protect. The can arise, for example, through a state's omission to act where

- public authorities have knowledge of a current or impending risk or could have done had they taken the necessary care,
- despite having such knowledge, they fail to take appropriate protective measures within the scope of the means available to them and
- at the same time countermeasures in conformity with human rights would have been possible.[47]

With healthcare, such infringements can occur, for example, when the state allows private healthcare facilities to breach medical standards or when it fails to do something to prevent harmful or ineffective medicines being in

45 See in this context the measures of the »Treatment Action Campaign«; Heywood (2009).

46 E/CN.4/1985/4, Annex (1985).

47 Kälin/Künzli (2008), 126.

circulation (as is the case in several countries). In terms of the obligations to protect, the state must adequately regulate and control private healthcare facilities, services and products to ensure that people actually obtain medical assistance and that their health is not harmed. Here the same defects can arise in principle as with state-run healthcare facilities (see above), the difference being that here the harm originates from private actors. The state obligation to protect becomes particularly evident when avoidable deaths occur in private healthcare facilities and at the same time the state has failed to fulfil its monitoring and control obligations. In this regard, there is a series of relevant decisions, for example by the Inter-American Court of Human Rights[48] or within the complaints procedure of the CEDAW.[49]

Of great significance in terms of human rights is also the question how open the access to private healthcare services must be. It is largely undisputed that also private healthcare facilities may not deny emergency treatment to anybody, but access to private services which go beyond this is commonly not possible or affordable for everybody. This is a problem particularly when at the same time there is no comprehensive public healthcare sector or where this is of a poor quality. In this case the state must ensure that a qualitatively adequate healthcare provision is accessible to everybody, either by way of respective regulation of private providers or by expanding the public healthcare sector, something which already refers to the obligations to fulfil (to be dealt with later).

Just like the obligations to respect, the obligations to protect are not limited to healthcare provision in the narrow sense, but take in also working and living conditions which also determine people's health. Here the obligations to protect refer on the one hand to an appropriate regulation and control of health protection in the workplace and on the other hand they are concerned with the protection of an intact and healthy environment against private (economic) interferences, which is crucial for people's health. Around the world harmful working conditions and cases of environmental pollution by private enterprises have been documented, be it the degradation of natural resources, in agriculture or in the manufacturing industry. Harmful working conditions in the textile industry in Southern Asia which

48 Ximenes-Lopes v. Brasil, Series C 149, 2006; see also Nolan (2009).

49 Alyne Silva Pimentel v. Brazil, CEDAW, communication No. 17/2008, judgment from 25th July 2011.

attracted public attention following the fires and factory collapses in Bangladesh and Pakistan come to mind here.[50] The problem is especially evident in developing countries and emerging markets. To make matters worse, largely informal employment relationships prevail there.

State obligations to protect for the prevention of occupational accidents and illnesses and environmental pollution can be found not only in Article 12, para. 2 (b) CESCR but also in conventions of the *International Labour Organization* (ILO). Within the scope of the Council of Europe, also a claim based on an infringement of the European Social Charter can be asserted. In the case of collective complaints against Greece, for example, the European Social Committee determined that the right to health had been infringed as – considering the scope for discretion and action allowed – the national authorities had done too little to protect residents from water and air pollution by private companies.[51] A separate problem is the often-privatised waste disposal.[52]

Furthermore, the health protection of consumers is significant. The state must prevent the distribution of consumer goods which are heavily polluted or harmful to health. At the same time in the past few years smoking bans and demands for measures to combat alcohol and drug consumption have been justified with the right to health. Demands for protection against excess weight[53] or for a »Global Convention to Protect and Promote Healthy Diets« go even further. The latter of these demands was made by the then Special Rapporteur for the right to food, Olivier de Schutter, and justified

50 Background information on the working conditions in the textile industry can be found, amongst other places, on the websites of »Clean Clothes Campaign« (www.cleanclothes.org), »Christliche Initiative Romero« (www.ci-romero.de), ECCHR (www.ecchr.eu), »medico international« (www.medico.de) and the »Fair Wear Foundation« (www.fairwear.org); see also Burckhardt (2014).

51 See the judgments on the complaints No. 30/2005 and No. 72/2011.

52 In the Southern Italian provinces of Naples and Caserta, for example, the criminal, illegal disposal of hazardous and poisonous waste was proven to have caused damage to the population's health. Cf. Camera dei deputati: D.L. 136/2013: Emergenze ambientali e industriali, 6th February 2014; Emergenze rifiuti, 21.11.2014; available at www.camera.it [01.06.2015].

53 For example the demand of the UN Committee for ESC Rights directed at Sweden: E/C.12/SWE/CO/5, 18th November 2008, para. 23.

on the basis that unhealthy diets amount to an even greater health risk than tobacco.[54] Up to now hardly any state obligations have been derived from the right to health as regards eating habits and healthy diets. There would certainly be a need for in-depth discussion as to whether and to what extent intervention in the freedoms and sphere of responsibility of individuals above and beyond the information and education obligations is possible and desirable.

The situation is different in the case of physical acts of violence. Here the UN Committee for ESC Rights obliges states – on the basis of the right to health – to combat private violence, in particular also domestic violence, and to prosecute offenders.[55] The Committee emphasises time and again the obligation to protect women and girls from sexual or other violence in very different risk situations and also makes use of other human rights: on the way to school or work or in the workplace, in search of water or sanitary facilities or also in makeshift shelters and refugee camps. In addition, the state is obliged to prevent cultural practices harmful to health, above all female genital mutilation (in short FGM). Both the UN Committee for ESC Rights and the CEDAW Committee have identified female genital mutilation as a human rights violation, although not always on the basis of the right to health.[56]

4.3 State Obligations to Fulfil

Obligations to fulfil are strictly speaking »positive rights«. They oblige the states to enable the most comprehensive exercising of human rights possible by way of active state action. It is about creating the prerequisites for the realisation of the right to health through respective statutes, institutions and procedures as well as by way of state provisions in the form of money, goods or services.

54 E.g., on 19th May 2014 in Geneva; cf. also his report on this topic: A/HRC/19/59, 26.12.2011.

55 E/C.12/2000/4, 11th August 2000, para. 51.

56 Cf. here for example the »Concluding remark« on Chad: E/C.12/TCD/CO/3, 16th December 2009, para. 19; CEDAW/C/TCD/CO/1-4, 21st October 2011, paras. 22–23. See generally on FGM also Graf (2013).

As stated at the beginning of the article, the respective human rights conventions already provide for a variety of steps to realise the right to health.[57] Accordingly, the obligations to fulfil in the area of health are diverse. They comprise initially the establishing and maintenance of medical and health-relevant infrastructures, whereby the states must ensure that necessary medical institutions, services and programmes with well-trained staff are available, accessible to everybody and that the people have access to adequate food and nutrition, accommodation, sanitation, drinking water and essential medicines. Furthermore, the human rights conventions provide for specific steps to be taken by the states to improve the health situation of the population in general and that of individual, particularly needy or vulnerable groups, for example children, mothers, the elderly or people with disabilities. It is normally not sufficient in this respect to only ensure access to medical provision. Often the socio-economic and socio-cultural conditions must be changed, which co-determine the state of health, for example poverty or social marginalisation and exclusion.

The form of the healthcare systems, whether public and/or private, as well as specific health-related policy measures lie principally within the discretion of the respective states, at least as long as they respect these human rights principles (such as transparency, participation, non-discrimination) and guarantee the general availability, accessibility, acceptability and quality of the healthcare provision.[58] Privatised or contractually outsourced healthcare services do not, however, relieve the states of their obligation to ensure this. The governments must, for example, prevent qualitatively appropriate healthcare provision from being available only to those patients who can afford it. However, according to the WHO, 100 million people are driven into poverty every year because they have to pay

57 The various human rights-related measures in the area of healthcare are not mentioned here in detail. See on this the reports and recommendations of the UN human rights organs based on the charter and the convention which can be found on the website www.ohchr.org. It is also worth reading the WHO documents which deal with the human right to health: www.who.int/topics/human_rights/en/ [01.03.2017].

58 For example Hunt/Backman (2013).

for healthcare services themselves (*out-of-pocket payments*).[59] This not only points to a strong link between the right to health and the right to social security,[60] but also often to the problem of abominable public healthcare provision. For this reason, as is, for example, reported from India, sometimes even poor people opt for fee-based private healthcare services rather than free treatment in state-run hospitals, at the same time running up enormous debts.[61]

As in the case of the right to health the realisation of the obligations to fulfil is linked with high costs, the realisation sees many countries reaching their limits. In particular, many developing countries have significant difficulties when it comes to ensuring a comprehensive provision of medical care and overcoming the partly serious defects in the healthcare system. Let alone can they afford such a comprehensive and expensive healthcare system as the developed countries. This does not though relieve developing countries of their obligation to take measures to realise the right to health progressively based on their *available resources*.[62]

The obligation to progressively realise the right progressively as provided for by the CESCR (Article 2, para. 1) takes account of the fact that faced with social problems that are difficult to overcome and scarce resources the social human rights cannot be realised overnight, especially those components of the right which require for their realisation extensive provisions of the state and long-term actions. With regard to the right to health (and other ESC rights), this applies especially to the obligations to fulfil.

However, the obligation to undertake a progressive realisation cannot serve as an excuse for failing to act at all. On the contrary, the state has the *procedural* obligation to draft specific and effective policies and to undertake measures, the *result* of which should be the goal to realise the right to health. As such, the states are obliged to develop a comprehensive national

59 See http://www.who.int/features/factfiles/universal_health_coverage/en/ [25.07.2017]. See also Heinicke et al. (2016).

60 Krennerich (2014).

61 Shankar/Mehta (2008), 155.

62 The German translation is based on a comprehensive concept of resources which is not limited to just financial resources, but includes all kinds of resources; cf. also Klee (2000), 122–129; Engbruch (2008), 108.

health strategy without delay by way of a participatory and transparent process in order to address the existing (and to be identified) healthcare problems in the respective country.

Additionally, as far as possible, several core obligations must be realised immediately.[63] According to the UN Commission for ESC Rights this at least includes access to medical institutions and medical care without discrimination as well as access to a minimum amount of basic nutrition, to accommodation, sanitation and safe drinking water and provision of basic medicines. On top of this there is a fair distribution of medical facilities and medical care, with the particular problem of deficits in rural areas being the focus here.[64] The Committee views the following aspects as having a similar priority: healthcare in relation to reproductive health, motherhood and children, vaccinations against infectious diseases, measures to prevent, treat and combat epidemic and endemic illnesses, education and information about essential health programmes in the community and an adequate training of healthcare personnel.[65]

Building on this, measures must be taken to realise the right to health continually and comprehensively. The obligation of a progressive realisation – at the time enshrined with a considerable amount of progress-oriented optimism – is not in conformity with an absolute prohibition of regression, however, unavoidable setbacks are in need of explanation. Ultimately it is of vital importance that the state actually uses its resources – and thereby an appropriate proportion of the state's shares and possible international aid – for the realisation of the right to health. The view of the UN Committee for ESC Rights is that a state that is not willing to do this violates its obligations under Article 12 CESCR.[66]

Of course it must always be established what constitutes appropriate resources. The wording of the CESCR which obliges the respective state to exhaust the »*maximum of its available resources*« is not particularly helpful. It is clear that a state cannot utilise all of its resources for the realisation of individual human rights, however important these may be. The obligation to exhaust all resources exists based on the premise that the state is left

63 Müller (2016).

64 E/C.12/2000/4, 11th August 2000, para. 43.

65 Ibid., para. 44.

66 Ibid., para. 47.

with sufficient means to undertake its various tasks (and also for the realisation of other human rights). Accordingly we are concerned here with the weighting of goals as well as the distribution and use of available resources.[67]

In practice, it quickly becomes apparent that the political setting of priorities and the spending policy of many states urgently need human rights corrections. To put it casually, if we look at what the states spend money on whilst at the same times millions of people are dying of avoidable and treatable illnesses it is not difficult to see that from a human rights point of view many resources are being wrongly distributed, not used, and certainly not exhausted. There is much potential for criticism in the demand to make use of a maximum of available resources as faced with continuing social problems it obliges the states to mobilise more resources for the realisation of social human rights. Significantly, within the scope of the reporting procedures on the CESCR, the UN Committee for ESC Rights regularly requests states to make more resources available for health care provision. These discussions can be made more objective by way of national human rights budgeting and systematic country comparisons, even though the use of considerable means alone does not guarantee an appropriate realisation of the human right to health.

The UN Committee for ESC Rights does not give a conclusive answer to the question at what point the human right to health has been completely realised. The demand for the »highest attainable level of health« leaves many questions unanswered. Since the health of an individual person is dependent on a variety of contingents and therefore factors which can be influenced, the conditions for a healthy life can, in principle, always be further improved. Pragmatically, one must therefore view the realisation of the human right to health as a continuous process which is based on the respective medical and health standards which are determined and further developed on a national or international level. It is, however, evident that the human right to health is not limited to basic levels of care. The right of every person to attain the highest level of health possible therefore serves as

67 The problem of »Prioritization of health interventions and respect of human rights« was addressed amongst other things by the UN Special Rapporteur on the right to food in his report to the UN General Assembly from 8th August 2007. A/62/214, paras. 11–32.

a critical corrective so that comprehensive medical care and healthy working and living conditions are not reserved for certain groups within society.

4.4 The International Dimensions of the Right to Health

The realisation of the right to health within the respective states is heavily influenced on an international level – both positively and negatively. On the one hand, there are various endeavours in international health policy, in development cooperation and within the framework of humanitarian aid cooperation to improve the provision of healthcare to people particularly in developing countries and disaster areas. The CESCR in fact obliges the states to cooperate in this way. On the other hand, international policy and legal provisions can also affect the realisation of the right to health, for example in the form of credit terms or trade and patent regulations. The UN Committee for ESC Rights explicitly points to the international obligation of states to not compromise the right to health in other countries in the course of bilateral and multilateral cooperation. The states are therefore also obliged to duly acknowledge the right to health when signing international treaties and as members of international organisations.

Legal requirements in respect of patents within the framework of the World Trade Organisation's so-called TRIPS Agreement have, for example, often been criticised in the past. For instance, Holger Hestermeyer stated that the legal entitlement to »access to medicine« is a component of the human right to health and life; that patent regulations – which WTO members are obliged to adhere to – have led to higher prices for new medicines; that higher prices have made it more difficult for poorer population groups in particular in developing countries to gain access to medicines, therefore amounting also to a human rights infringement; that such an intervention cannot be sufficiently justified, not even by way of the protection of moral and material interests of the authors of scientific works (within the meaning of Article 15, para. 1 CESCR), as this does not protect the patents of pharmaceutical companies.[68] Corresponding flexible TRIPS regulations

68 Hestermeyer (2007). The UN Committee for ECS Rights has already clarified in its *General Comment* No. 17 on Article 15(1)c) of the CESCR that such patent rights are not human rights and that the state has an obligation to protect people

in the form of compulsory licenses and parallel imports in order to solve such conflicts (»*health safeguards*«) are effectively thwarted.[69]

Also the subject of criticism are some savings measures by international lenders, as regarding the right to health cutbacks in the health and social sectors as foreseen by the internationally effected austerity programme in the 1980s and 1990s in Latin America and other world regions can seriously violate the »*do not harm* principle« and thereby also the lenders' extra-territorial obligations to respect. The main responsibility for the states' financial misery commonly lies with the national governments which ultimately also decide how much will be saved and in what areas; in many places, however, pressure from international lenders has aggravated the misery in the area of health. If the public healthcare system collapses altogether then urgent countermeasures must be taken.

Whilst the extra-territorial obligations to respect already throw up a number of questions, it is disputed to what extent the states are obliged above and beyond these to support other states in realising the human right to health (and other social human rights). Even governments which are heavily involved in development co-operations do not want to be obliged to do so under international law. We can therefore be curious as to what significance the *Maastricht Principles on Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights* will take on, that were formulated by around 40 experts on international law and human rights from all over the world on 28th September 2011 at the University of Maastricht.[70] The principles take up guidelines which UN committees and UN Special Rapporteurs have already formulated without binding effect and acknowledge comprehensive extraterritorial obligations on the part of states to respect, protect and fulfil.[71] Further reaching are calls for »global

from excessive prices for essential medicines; cf. E/C.12/GC/17, 12th January 2006. See also Schneider (2006), 162–170.

69 See for example People's Health Movement et al. (2014), 288–299.

70 The German translation can be found in *Zeitschrift für Menschenrechte* 6, 2 (2009), 184–195.

71 Also Coomans/Künnemann (2012); de Schutter et al. (2012); Krennerich (2013), 124–128.

social rights« which should regulate international and transnational relations.[72]

5. OUTLOOK

If human rights are to have an effect, they have to be actively claimed. For this reason, human rights empowerment is necessary. This denotes a process, in the course of which the right holders acquire the capacity to claim and assert human rights for themselves and others effectively. The main recipient of human rights claims are the respective states which are the primary duty bearers. Their readiness and ability to realise the human rights must be claimed and enhanced. However, also non-state actors such as commercial enterprises are noticeably being made accountable for human rights. Those concerned and their support groups generally have a wide range of possibilities to act available to them when it comes to asserting their human rights claims in the face of resistance.

From a legal point of view the right is especially characterised by the fact that it can be asserted through the courts. With an increasing recognition of the for a long time contested justiciability of social human rights,[73] in the past few years an increasing number of possibilities to claim have become available. The amount of case law on social human rights in general and in particular on the right to health has grown considerably. By now there are numerous judgments and decisions which either directly or indirectly concern the right to health.[74] Interestingly, these refer not only to obvious discrimination situations and the infringement of obligations to respect and protect, but sometimes also to the benefits entitlements of those concerned.[75] Empirically it must also be examined who actually takes re-

72 For example Fischer-Lescano/Möller (2012).

73 Krennerich (2013), 116–123.

74 Cf. the databases at www.globalhealthrights.org and www.escr-net.org. See also Gauri/Brinks (2008); Langford (2009); Yamin/Gloppen (2011); Hogerzeil et al. (2013) and the work with three volumes by Clérico et al. (2013).

75 The German Federal Government is, however, sticking to the legal interpretation that no guarantee claims to specific benefits can be derived from the CESCR; cf. Bundestag printed paper 18/4758, 27th April 2015.

course to the courts, how the courts decide and whether the corresponding judgments are acted on appropriately and result in sustainable effects.

It is almost as important that the human right to health is claimed and asserted by way of political means, for example through protests and campaigns or through lobbying and advocacy work. Without underestimating the significance of influential landmark judgments, fundamental, structural reforms with the goal of achieving a better and more comprehensive respect, protection and guarantee for the social human rights such as the right to health are primarily secured politically, and here it is mostly about conflicts of power and distribution. Ideally the (quasi-) judicial and the political enforceability of the right to health should complement each other. On the one hand, political demands to realise human rights gain in legitimacy and force as a result of the legal entitlements being positively enshrined in law and possibly subject to claims in the courts.[76] For this, as a rule, an active civil society is of great significance.

To what extent the possibilities of demanding and claiming the right to health are used depends first of all on the organisational potential and capacity to act of civic groups and social movements, however, also constitutional structures and civic freedoms are necessary. Many governments restrict the scope of activity of the civil society and attempt to suppress human rights entitlements. The spectrum here ranges from complete repression to co-optation. Between these there are open and subtle forms of obstruction, for example legal and administrative restrictions on the freedom of assembly, association and opinion or also the targeted diffamation, stigmatisation or criminalisation of persons and groups who promote human rights (in UN jargon: *human rights defenders*).[77]

As such it is all the more important to organise and support civic commitment and human rights empowerment with solidarity, which is why

76 The already mentioned *Treatment Action Campaign* (TAC) in der Republic of South Africa demonstrates impressively how political and legal measures can complement each other in order to assert the right to a medical and medicinal treatment of HIV/AIDS patients despite considerable resistance; Heywood (2009).

77 Forum Menschenrechte (2012) and the reports of the previous special rapporteurs on *human rights defenders*, available from the human rights portal: www.ohchr.org [01.07.2015].

great significance is attached to transnational human rights networks which provide a link between the local and global levels. With regard to the right to health, for example the *People's Health Movement* is one such global network.[78] It is not, however, about »exporting« supposed western human rights into »foreign countries«. The starting point and point of reference for solidary support is always the struggles of the people locally and protest against injustice, oppression, exploitation and hardship they have suffered, and who – implicitly or explicitly – point to their right to live a humane, liberal and autonomous life in community with others. The human right to health is most certainly a part of this.

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78 For example Turiano/Smith (2008);www.phmovement.org [25.07.2017].

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