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THE HUMAN RIGHT TO HEALTH AND UNIVERSAL HEALTH COVERAGE

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Human rights are fundamental and inalienable rights, "inherent to all human beings, regardless of race, sex, nationality, ethnicity, language, religion, or any other status. Everyone is entitled to these rights, without discrimination"[1]. Human rights are codified in the Universal Declaration of Human Rights, adopted in December 1948 by the United Nations, and they comprise rights of a political, social, civil, cultural and economic nature.

Among human rights, there is also the human right to health. Being recognised as a human right, also the right to health is an inalienable right that every human being is entitled to. Health has been defined by the World Health Organization in the preamble of its Constitution as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"[2]. Therefore, "the right to health is not to be understood as a right to be healthy"[3]. On the contrary, it has to be understood as "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"[4]. This right to the enjoyment of the highest attainable standard of physical and mental health has been recognised as "one of the fundamental rights of every human being"[5] by the World Health Organization, and it has to be enjoyed by every human being without any form of discrimination.

The human right to health is officially recognised at the international, regional and often also at the national levels. It is indeed possible to find it in many documents at both the international and regional levels, and it also included in several national constitutions[6].

However, although the right to health is recognised and protected, too often it is merely a theoretical right. Indeed, in many countries and for many people worldwide health is still a privilege rather than an actual right. The international system has acknowledged the existence of this discrepancy between theory and practice concerning the human right to health, and it is therefore working towards a better and more effective way to implement this right.

One of the possible ways towards a better implementation of the human right to health is

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1 UNITED NATIONS, *Human Rights*, available online.

2 Preamble to the Constitution of WHO as adopted by the International Health Conference, New York, 19 June - 22 July 1946; signed on 22 July 1946 by the representatives of 61 States (Official Records of WHO, no. 2, p. 100) and entered into force on 7 April 1948. The definition has not been amended since 1948.

3 UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), Par. 8, 11 August 2000, E/C.12/2000/4.

4 UN General Assembly, International Covenant on Economic, Social and Cultural Rights, art. 12.1, 16 December 1966, United Nations, Treaty Series, vol. 993, p. 3.

5 Preamble to the Constitution of WHO, *op. cit.*

6 POTTS, H., & HUNT, P. H. *Accountability and the right to the highest attainable standard of health*, 2008.

through Universal Health Coverage, which is also part of the Sustainable Development Goals. Indeed, through Universal Health Coverage it will be possible to guarantee to all people access to the basic and essential health services needed without having to incur into financial difficulties, and regardless of their personal characteristics, such as gender, age, ethnicity, race, religion, social status and sexual orientation.

1. The Right to Health in International Law

The right to health has been recognized as one of the fundamental rights of every human being, and as such it is protected in several declarations and conventions, at the international, regional, and national levels.

At the international level there are several international human right treaties, declarations, conventions and covenants dealing with the human right to health. Some of them are of general application, dealing with the right to health as referred to every human being, while others have a more specific application, dealing with the right to health as referred to specific groups, such as children, women or people affected by disabilities[7].

The documents at the international level that recognise and protect the human right to health are the Universal Declaration of Human Rights, the International Covenant on Economic, Social and Cultural Rights, the Declaration of Alma-Ata, the Convention on the Rights of the Child, the Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of All Forms of Discrimination Against Women, the Convention on the Rights of Persons with Disabilities, and the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families[8].

The right to health is recognised as a human right, and it is therefore included in the Universal Declaration of Human Rights of 1948. Article 25 of the Declaration affirms that "everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control"[9].

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7 *Ibidem.*

8 AIFA , *International Treaties and the Right to Health*, 2016, available online.

9 UN General Assembly, Universal Declaration of Human Rights, Art. 25, 10 December 1948, 217 A (III).

The human right to health is recognized also in the International Covenant on Economic, Social and Cultural Rights of 1966, whose article 12 recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"[10]. This article also presents which are the fundamental steps that states need to take in order to achieve the complete implementation of the right to health, such as the reduction of child mortality, the improvement of children's health, and the prevention and treatment of various diseases[11].

A further international document dealing with the human right to health is the Declaration of Alma-Ata, arising from the International Conference on Primary Health Care which took place in September 1978. This Declaration stresses "the need for urgent action by all governments, all health and development workers, and the world community to protect and promote the health of all the people of the world"[12]. In the Declaration of Alma-Ata, health is defined as "a state of complete physical, mental, and social well-being"[13], and it is furthermore recognized as a fundamental human right[14]. Therefore, "the attainment of the highest possible level of health is a most important world-wide social goal"[15]. The Declaration of Alma-Ata also stresses the important role of the people, who "have the right and duty to participate individually and collectively in the planning and implementation of their health care"[16], and that of national governments, which "have a responsibility for the health of their people"[17].

The international conventions and declarations discussed above are all of general application. It is however necessary to take into account also those conventions and declarations with a more specific application.

The right to health is recognised also in article 24 of the Convention on the Rights of the Child of 1989, which interprets it as "the right (…) to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health"[18]. This Convention also underlines states' obligation to ensure that the right to health and to healthcare, and thus also the right to access health services, is ensured to every child[19].

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10 UN General Assembly, International Covenant on Economic, Social and Cultural Rights, *op. cit.*

11 *Ivi*, art. 12.2.

12 Declaration of Alma-Ata, International Conference on Primary Health Care, Alma-Ata, USSR, 6–12 September 1978, 2004.

13 *Ivi*, art. 1.

14 *Ibidem*.

15 *Ibidem*.

16 *Ivi*, art. 4.

17 *Ivi*, art.5.

18 UN General Assembly, Convention on the Rights of the Child, art. 24.1, 20 November 1989, United Nations, Treaty Series, vol. 1577, p. 3.

19 *Ibidem*.

Furthermore, article 24 of the Convention on the Rights of the Child also suggests which measures states should take in order to achieve the full implementation of the right to health[20]. These measures include reducing infant and child mortality; ensuring the provision of essential medical care to all children; fighting sickness and malnutrition; ensuring pre- and post-natal medical care for mothers; guaranteeing access to information and education to everyone in society, especially to children and parents; and developing preventive healthcare[21].

The human right to health is also dealt with in article 5 of the Convention on the Elimination of All Forms of Racial Discrimination of 1965. In this article, the right to health is listed together with other economic, social and cultural rights, and takes the specific form of a right to medical care and public health[22]. The Convention specifies that this right has to be guaranteed to "everyone, without distinction as to race, colour, or national or ethnic origin"[23].

The fact the right to health has to be guaranteed to everyone, without distinction of personal characteristics, is stressed also in the Convention on the Elimination of All Forms of Discrimination Against Women of 1979, especially in article 12 and article 14 of such convention. Article 12 of the Convention on the Elimination of All Forms of Discrimination Against Women claims that states have to "take all the appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services"[24]. This article also claims that states have to provide women with the necessary services related to the pre-natal period, i.e. pregnancy, as well as the post-natal period[25]. The right to health is discussed also in article 14 of the Convention on the Elimination of All Forms of Discrimination Against Women, which underlines that states have to pay particular attention to the situation of rural women, to the problems they have to deal with and to their role concerning the financial survival of their families[26]. Therefore, states have to "take all appropriate measures to eliminate discrimination against women in rural areas in order to ensure, on a basis of equality of men and women, that"[27], among other things, "they (…) have access to adequate health care facilities, including

[20] *Ivi*, art. 24.2.
[21] *Ibidem*.
[22] UN General Assembly, International Convention on the Elimination of All Forms of Racial Discrimination, art. 5 (e)(iv), 21 December 1965, United Nations, Treaty Series, vol. 660, p. 195.
[23] *Ivi*, art. 5.
[24] UN General Assembly, Convention on the Elimination of All Forms of Discrimination against Women, art. 12.1, 18 December 1979, A/RES/34/180.
[25] *Ivi*, art. 12.2.
[26] *Ivi*, art. 14.1.
[27] *Ivi*, art. 14.2.

information, counselling and services in family planning"[28], and also that they "enjoy adequate living conditions, particularly in relation to housing, sanitation, electricity and water supply, transport and communications"[29].

Another international document dealing with the right to health and its protection is the Convention on the Rights of Persons with Disabilities of 2006. Article 25 of this Convention recognizes that people affected by "disabilities have the right to the enjoyment of the highest attainable standard of health, without discrimination on the basis of disability"[30]. Therefore, people affected by disabilities have to be provided with the same medical services and programmes as to other people[31], as well as with the specific medical services they need because of their conditions[32], without incurring into any form of discrimination related to their disabilities.

Finally, the human right to health is dealt with also in the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families of 1990. The Articles in which the Convention deals with the right to health are article 28, article 43, and article 45. In article 28 migrant workers and members of their families are ensured "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"[33]. The provision of this urgent medical care has to be provided without any form of discrimination, and regardless of eventual irregularities in their stay or employment[34]. Article 43 of the Convention guarantees an equal treatment to migrant workers in relation to access to various services, including also health services[35]. Equal treatment in relation to access to various services, including also health services, is guaranteed also to members of the families of migrant workers in article 45[36].

1.1 The International Covenant on Economic, Social and Cultural Rights and its General Comment No. 14

Notwithstanding the undoubted importance of all the international documents discussed above, the most comprehensive articulation of the human right to health is laid out in the

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28 *Ivi*, art. 14.2 (b).
29 *Ivi*, art. 14.2 (h).
30 UN General Assembly, Convention on the Rights of Persons with Disabilities, art. 25, 13 December 2006, A/RES/61/106, Annex I.
31 *Ivi*, art. 25 (a).
32 *Ivi*, art. 25 (b).
33 UN General Assembly, International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families, art. 28, 18 December 1990, A/RES/45/158.
34 *Ibidem*.
35 *Ivi*, art. 43.
36 *Ivi*, art. 45.

International Covenant on Economic, Social, and Cultural Rights. This International Covenant is a multilateral treaty signed by the United Nations General Assembly in December 1966, although it only came into force in January 1976. It deals with economic, social, and cultural rights, therefore dealing also with the right to health. The International Covenant on Economic, Social and Cultural Rights deals with the human right to health in Article 12, which affirms "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"[37]. Article 12 also lays out a series of steps that states need to take in order to achieve the full implementation of the right to health. Thus, in order to achieve the full realization of the human right to health, states have to take steps necessary for reducing infant mortality's rate, for improving industrial and environmental hygiene, for preventing, controlling and treating various diseases, and for creating the conditions necessary for ensuring health services to all people in the event of illness[38].

The task of monitoring compliance with the International Covenant on Economic, Social, and Cultural Right is entrusted to the United Nations Committee on Economic, Social, and Cultural Rights. In August 2000 this Committee issued the General Comment 14, which deals with Article 12 of the International Covenant., i.e. the article claiming "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"[39]. This general comment provides an authoritative guidance on how states have to implement the obligations arising from Article 12. General Comment 14 acknowledges that health is a fundamental human right, and therefore it has to be ensured to everyone[40]. The human right to health is claimed to be "indispensable for the exercise of other human rights"[41], as well as "closely related to and dependent upon the realization of other human rights"[42]. General Comment 14 recognises that there are many different ways and approaches to implement the human right to health, "such as the formulation of health policies, or the implementation of health programmes developed by the World Health Organization (WHO), or the adoption of specific legal instruments"[43]. It also affirms that the human right to health has to be based on an adequate and comprehensive definition of health. Indeed, health has to be understood as "a state of complete physical, mental and social well-being and not merely the absence of disease

37 UN General Assembly, International Covenant on Economic, Social and Cultural Rights, *op. cit.*
38 *Ivi*, art. 12.2.
39 *Ibidem*.
40 UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), *op.* cit., par. 1.
41 *Ibidem*.
42 *Ivi*, par. 3.
43 *Ivi*, par. 1.

or infirmity"[44], and it is also necessary to include within the definition of health all the "socio-economic factors that promote conditions in which people can lead a healthy life", as well as "the underlying determinants of health, such as 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"[45]. General Comment 14 presents the interpretation of the right to health given by the United Nations Committee on Economic, Social and Cultural Rights as the most adequate one. This "Committee interprets the right to health (…) as an inclusive right extending not only to timely and appropriate health care but also to the underlying determinants of health"[46]. Therefore, General Comment 14 specifies that the right to health is not merely a right to be healthy, but rather it "contains both freedoms and entitlements. The freedoms include the right to control one's health and body (…) and the right to be free from interference (…). By contrast, the entitlements include the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health"[47]. The Comment also specifies that the concept of "the highest attainable standard of health" encompasses "both the individual's biological and socio-economic preconditions and a State's available resources". This is because it is necessary to take into consideration both the genetics characteristics of people and their lifestyles, as well as what the State can actually afford to provide and ensure to the people[48].

In General Comment 14, the United Nations Committee on Economic, Social and Cultural Rights also talks about the various interconnected and fundamental elements of the right to health, and it further specifies that the exact application of these elements depends on the general situation in each state[49] . The fundamental elements of the right to health recognised by the Committee are availability, accessibility, acceptability, and quality. Availability requires "functioning public health and health-care facilities, goods and services, as well as programmes, (…) to be available in sufficient quantity within the State". Although "the precise nature of the facilities, goods and services will vary depending on numerous factors (…) they will include, however, the underlying determinants of health, such as safe and potable drinking water and adequate sanitation facilities, hospitals, clinics and other health-related buildings, trained medical and professional personnel receiving domestically

[44] *Ivi*, par. 4.
[45] *Ibidem*.
[46] *Ivi*, par. 11.
[47] *Ivi*, par. 8.
[48] *Ivi*, par. 9.
[49] *Ivi*, par. 12.

competitive salaries, and essential drugs"[50]. Accessibility requires "health facilities, goods and services (…) to be accessible to everyone without discrimination, within the jurisdiction of the State". Accessibility is characterised by four overlapping dimensions: non-discrimination, physical accessibility, economic accessibility, and information accessibility. Therefore, access to health facilities, goods and services has to be ensured to everyone, in particular to "the most vulnerable or marginalized sections of the population", and it has to be ensured without any form of discrimination whatsoever. Health facilities, goods and services have to be accessible from a physical and an economic pints of view. Indeed, they have to "be within safe physical reach for all sections of the population", as well as "affordable for all". Therefore, "payment for health-care services (…) has to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially disadvantaged groups". The last dimension of accessibility, i.e. information accessibility, concerns "the right to seek, receive and impart information and ideas concerning health issues"[51]. The third fundamental element of the human right to health acknowledged by the Committee is acceptability, meaning that "all health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality and improve the health status of those concerned"[52]. The fourth and last fundamental element is quality, and it requires "health facilities, goods and services" to "be scientifically and medically appropriate and of good quality", thus requiring "skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation"[53].

In General Comment 14, the United Nations Committee on Economic, Social and Cultural Rights also lays out some obligations of States Parties towards the right to health. These obligations are divided into four categories: general legal obligations, specific legal obligations, international obligations, and core obligations.

After having dealt with States' obligations, General Comment 14 deals with the possible violations of the right to health as expressed by article 12 of the International Covenant on Economic, Social, and Cultural Rights, and then with how this right can be implemented at the national level.

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[50] *Ivi*, par. 12 (a).
[51] *Ivi*, par. 12 (b).
[52] *Ivi*, par. 12 (c).
[53] *Ivi*, par. 12 (d).

General Comment 14 ends with a part dedicated to the obligations of actors other than States parties. In this part, the United Nations Committee on Economic, Social, and Cultural Rights underlines the important role of various United Nations agencies and programmes, particularly the role of the World Health Organization "in realizing the right to health at the international, regional and country levels"[54], as well as the role of the United Nations Children's Fund (UNICEF) in protecting the right to health of children. Of notable importance is also the role of the international financial institutions such as the World Bank and the International Monetary Fund.

1.2 The Constitution of the World Health Organization and the Fact Sheet No. 31

The World Health Organization is the United Nations' body that deals with health and health care, and therefore also with the right to health. The World Health Organization specifically deals with the human right to health in its Constitution, which was adopted by the International Health Conference held in New York in July 1946, and came into force almost two years later, in April 1948.

The Constitution of the World Health Organization begins with the acknowledgement of some principles that are considered as "basic to the happiness, harmonious relations and security of all peoples"[55]. In these principles, "the States Parties to the Constitution declare (…) that health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity", and that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being, without distinction of race, religion, political belief, economic or social condition"[56]. They further recognize the fundamental importance of health in achieving peace and security, and acknowledges that cooperation among people and states is necessary. States parties also underline that "the achievement of any State in the promotion and protection of health is of value to all", as well as an "unequal development in different countries in the promotion of health and control of diseases (…) is a common danger"[57]. States Parties also highlight the utmost importance of ensuring a healthy development of children, "the extension to all peoples of the benefits of medical, psychological and related knowledge"[58], and "informed opinion and active co-

[54] *Ivi*, par. 63.
[55] Preamble to the Constitution of WHO, *op. cit.*
[56] *Ibidem*.
[57] *Ibidem*.
[58] *Ibidem*.

operation on the part of the public"[59]. Finally, they recognize that national "governments have a responsibility for the health of their peoples, which can be fulfilled only by the provision of adequate health and social measures"[60].

After having presented the founding principles of the World Health Organization, the Constitution states its objective, which "shall be the attainment by all peoples of the highest possible level of health"[61].

Moving forward, the Constitution lists the various functions of the World Health Organization, deals with its membership and associate membership, and presents how its work is divided among three organs, i.e. the World Health Assembly, the Executive Board, and the Secretariat, thereafter describing the role and duties of each of them. The Constitution further presents the role of committees, and deals with conferences, headquarters, regional arrangements, budget and expenses, voting, reports submitted by the States, legal capacities, privileges and immunities, relations with other organizations, amendments, interpretation, and entry into force. The Constitution of the World Health Organization does not dedicate a chapter or a consistent part to the right to health, which is however clearly stated in the founding principles.

However, the World Health Organization has dedicated great attention to the human right to health, for example dealing with it in some fact sheets. Of notable importance is the Fact Sheet No. 31 of 2008, issued by the World Health Organization together with the United Nations Office of the High Commissioner for Human Rights. This fact sheet is divided in four main parts, and it deals with what the right to health is, how it applies to specific groups, which the obligations on states and the responsibilities of others towards the right to health are, and how to monitor the right to health and hold states accountable.

The first part of Fact Sheet No. 31 concerns the analysis of what the human right to health is, and begins laying out the main aspects of the right to health. According to the Fact Sheet No. 31, "the right to health is an inclusive right"[62], meaning that it does not include only access to health care and health services, but also "a wide range of factors that can help us lead a healthy life", i.e. the so-called underlying determinants of health, which include access to potable water, adequate sanitation, appropriate nutrition, decent housing, healthy working and

[59] *Ibidem*.
[60] *Ibidem*.
[61] Constitution of WHO as adopted by the International Health Conference, art. 1, New York, 19 June - 22 July 1946.
[62] UN Office of the High Commissioner for Human Rights (OHCHR), Fact Sheet No. 31, The Right to Health, 1 (A), June 2008, No. 31.

environmental conditions, health-related education and information, and gender equality[63]. This part of Fact Sheet No. 31 also specifies that the human right to health contains both freedoms, such as "the right to be free from non-consensual medical treatment, (…) and to be free from torture and other cruel, inhuman or degrading treatment or punishment", and entitlements, which include "the right to a system of health protection providing equality of opportunity for everyone to enjoy the highest attainable level of health", "the right to prevention, treatment and control of diseases, "access to essential medicines", "maternal, child and reproductive health, "equal and timely access to basic health services", "the provision of health-related education and information", and "participation of the population in health-related decision-making at the national and community levels"[64]. Fact Sheet No. 31 also underlines that "health services, goods and facilities must be provided to all without any discrimination"[65], and that these "services, goods and facilities must be available, accessible, acceptable and of good quality"[66]. This means that health services, goods and facilities have to be available in sufficient amount, as well as physically and financially accessible. Furthermore, they have to be acceptable from a medical and cultural point of view, as well as of good quality and appropriate from a medical and scientific point of view. Still in this first part, Fact Sheet No.31 takes into consideration some common misconceptions concerning the human right to health, and it therefore specifies that the right to health and the right to be healthy are two different and separate rights, that although it is a tangible programmatic goal, the right to health also imposes some immediate obligations on States, and that even if a country has a difficult financial situation, it still has to work for the implementation of the right to health[67]. Thereafter, Fact Sheet No. 31 deals with the relation between the human right to health and other human rights, specifying that "human rights are interdependent, indivisible and interrelated"[68]. Indeed, "the right to health is dependent on, and contributes to, the realization of many other human rights", such as "the rights to food, to water, to an adequate standard of living, to adequate housing, to freedom from discrimination, to privacy, to access to information, to participation, and the right to benefit from scientific progress and its applications"[69]. This first part of Fact Sheet No. 31 also shows that the principle of non-discrimination applies to the human right to health, and ends with the presentation of the

[63] *Ibidem*.
[64] *Ibidem*.
[65] *Ibidem*.
[66] *Ibidem*.
[67] *Ivi*, 1 (B).
[68] *Ivi*, 1 (C).
[69] *Ibidem*.

international declarations and conventions that recognize and protect the human right to health.

The second part of Fact Sheet No. 31 focuses on how the human right to health applies to specific group, in particular to women, children and adolescents, persons with disabilities, migrants, and persons living with HIV/AIDS. Indeed, these groups of people can often suffer from discriminatory measures, which might prevent them from accessing health services and medicines. Therefore, particular attention has to be devoted to these groups, in order to make sure that they can enjoy their human right to health without facing any form of discrimination[70]. For what concerns women, Fact Sheet No. 31 underlines how they "are affected by many of the same health conditions as men, but (…) experience them differently". Indeed, they often have to face various "forms of discrimination, barriers and marginalization, in addition to gender discrimination". It is therefore necessary to eliminate any form "of discrimination against women in health care" and to ensure "equal access for women and men to health-care services"[71]. Concerning children and adolescents, Fact Sheet No. 31 underlines that these groups are characterised by "particular health challenges related to the stage of their physical and mental development", which make them particularly exposed to the risks of malnutrition and infectious diseases, as well as of "sexual, reproductive and mental health problems". Fact Sheet No. 31 stresses States' obligations "to reduce infant and child mortality, and to combat disease and malnutrition", as well as States' responsibilities to promote "children's physical and psychological recovery and social reintegration"[72]. The third group dealt with in this second section of Fact Sheet No. 31 is the group of people with disabilities. In the whole world more than 650 million people are affected by a disability[73], but most of them "have long been neglected and marginalized by the State and society"[74]. They often face several difficulties in enjoying their human right to health, and States are therefore under a duty "to promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by persons with disabilities, including their right to health"[75]. Fact Sheet No. 31 also deals with how the human right to health applies to migrants, who often face a limited enjoyment of their right to health due to their condition of migrants. Many States "have defined their health obligations towards non-citizens in terms of 'essential care'

[70] *Ivi*, 2.
[71] *Ivi*, 2 (A).
[72] *Ivi*, 2 (B).
[73] *Ivi*, 2 (C).
[74] *Ibidem*.
[75] *Ibidem*.

or 'emergency health care' only"[76]. Fact Sheet No. 31 underlines that all migrants "have the right to emergency medical care", which have to "be provided [to them] regardless of (…) their stay or employment". Furthermore, States have to "respect the right of non-citizens to an adequate standard of physical and mental health", therefore "refraining from denying or limiting their access to preventive, curative and palliative health services"[77]. The last group of people dealt with in this section of Fact Sheet No. 31 is the group of people living with HIV/AIDS, who nowadays are about 33 million people[78] and are often subject to discrimination and stigma. Fact Sheet No. 31 stresses that States have to prohibit discrimination based on people's health status, including HIV/AIDS status, and to protect people affected by HIV/AIDS from being discriminated against.

The third section of Fact Sheet No. 31 deals with the obligations of states and the responsibilities of others towards the right to health. States have some general obligations towards the human right to health, namely progressive realization, taking steps towards the realization of the right to health, and core minimum obligations. Fact Sheet No. 31 presents States' obligations as divided in three categories: the obligation to respect, the obligation to protect, and the obligation to fulfil.

This section of Fact Sheet No. 31 ends with the responsibilities of other actors towards the human right to health. These actors are "individuals, intergovernmental and non-governmental organizations (NGOs), health professionals, and business"[79]. Fact Sheet No. 31 specifically analyses the role of some United Nations agencies and of the private sector.

The last part of Fact Sheet No. 31 focuses on the ways the human right to health can be monitored and how states can be held accountable. It is here stressed the fundamental importance of accountability mechanisms in order to make sure that States respect their obligations towards the right to health. These monitoring and accountability mechanisms can be at the national, regional and international levels. At the national level, the monitoring of the human right to health and the accountability of the State can take place through administrative, policy and political mechanisms, as well as through judicial mechanisms, and through national human rights institutions. At the regional level, the right to health is ensured and protected by various regional human rights conventions and treaties. Finally, monitoring at the international level takes place through the United Nations treaty bodies and the United Nations Special Rapporteur on the right to the highest attainable standard of health.

[76] *Ivi*, 2 (D).
[77] *Ibidem*.
[78] *Ivi*, 2 (E).
[79] *Ivi*, 3 (C).

2. The Right to Health at the Regional Level

As already said before, the human right to health has been recognized as one of the fundamental rights of every human being, and as such it is protected in several declarations and conventions, at the international level, but also at the regional one[80].

One of these regional instruments is the African Banjul Charter on Human and Peoples' Rights of 1981, whose article 16 states that "every individual shall have the right to enjoy the best attainable state of physical and mental health"[81], and that the State Parties have to adopt the measures necessary to ensure and protect the health of their people[82].

Another regional instrument dealing with the right to health is the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights of 1988, commonly known as the Protocol of San Salvador. This Protocol deals with the right to health in article 10, in which it is affirmed that "everyone shall have the right to health, understood to mean the enjoyment of the highest level of physical, mental and social well-being"[83]. Article 10 of this protocol also claims that health is a public good[84], and presents some measures that have to be taken by States Parties in order to guarantee the implementation of the right to health. Among these measures, there are the provision of primary health care, the "extension of the benefits of health services to all" citizens, universal immunization, prevention and treatment of diseases, health education of the population, and "satisfaction the health needs of the highest risk groups and of" the poor[85].

2.1 The Right to Health in European Law

Further regional instruments dealing with the right to health can be found at the European level. Here, the right to health is considered as one of the fundamental rights guaranteed and protected by the European Union, and as such is included in the Charter of Fundamental Rights of the European Union, which lays out all the fundamental rights protected in the European Union. The Charter was proclaimed in 2000, and became legally binding in December 2009. The Charter of Fundamental Rights of the European Union deals with the right to health in article 35, although it only takes into account the right to health care. Indeed,

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80 POTTS, H., & HUNT, P. H., *op. cit.*

81 Organization of African Unity (OAU), African Charter on Human and Peoples' Rights ("Banjul Charter"), art. 16.1, 27 June 1981, CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 (1982).

82 *Ivi*, art. 16.2.

83 Organization of American States (OAS), Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights ("Protocol of San Salvador"), art. 10.1, 16 November 1999, A-52.

84 *Ivi*, art. 10.2.

85 *Ibidem*.

according to article 35, "everyone has the right to access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices"[86].

Notwithstanding the great importance of the Charter of Fundamental Rights of the European Union, this is not the most important document concerning the human right to health at the European level. Indeed, the European document which deals more specifically with the right to health is the European Social Charter.

The European Social Charter, signed in 1961 and revised in 1996, is a treaty of the Council of Europe which guarantees the fundamental social and economic human rights related to education, employment, housing, welfare, social protection, and, of course, health. The European Social Charter stresses the importance of ensuring these rights on a non-discriminatory base, paying particular attention to the protection of marginalized or vulnerable groups[87]. The European Social Charter is based on a set of basic rights and principles, among which there is also the right to health. Indeed, the Charter claims that "everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable"[88]. The article of the Charter specifically dealing with the human right to health is article 11, the right to protection of health. In this article, the Parties agree to take appropriate measures in order to eliminate as much as possible the causes of ill-health, to prevent as much as possible diseases and accidents, and to ensure the provision of facilities focused on the promotion of good health[89].

3. The Right to Health at the National Level

The human right to health is recognized and protected also at the national level in many national constitutions[90].

From a study ran by S. K. Perehudoff in 2008, some very interesting data concerning the extend of national commitment to the human right to health emerge. In order to assess the

86 European Union, Charter of Fundamental Rights of the European Union, art. 35, 26 October 2012, 2012/C 326/02.
87 Council of Europe, Preamble of the European Social Charter, 18 October 1961 (revised in 1996), ETS 35 (revised version: ETS 163).
88 Council of Europe, European Social Charter, Part 1 par. 11, 18 October 1961 (revised in 1996), ETS 35 (revised version: ETS 163).
89 *Ivi*, art. 11.
90 POTTS, H., & HUNT, P. H., *op. cit.*

extent of national commitment to the human right to health, S. K. Perehudoff analysed national constitutions. She managed to analyse 186 constitutions, i.e. the accessible one. The analysis of these constitutions revealed that of the 186 constitutions analysed, 135 (73%) include some form of health provisions, 95 (51%) specify the rights to health facilities, good and services, and 4 (2%) include essential medicines as part of the health rights[91]. Of all the 186 constitutions analysed, it has emerged that the most comprehensive ones concerning the human right to health are the Constitutions of Honduras (1982), Panama (1972, amended in 1994), South Africa (1996, amended in 2003) and Uganda (1995), although none of them fulfil all the steps or core contents of the human right to health as laid out in international law[92]. The national constitutions including the most binding health provisions, and thus imposing "the highest State duty or individual entitlement to the health rights", are the Constitutions of Azerbaijan (1995), Cameroon (1972, amended in 1996), Congo (1992), Democratic Republic of the Congo (2006), Mexico (1917), Sri Lanka (1978), and Vietnam (1992)[93]. The national constitutions including the highest "number of health rights, human rights principles (i.e. accountability, equality, attention to vulnerable groups, participation), and guiding principles (i.e. affordability, accessibility, availability, quality, acceptability)" are the Constitutions of Cuba (1992), Dominican Republic (1966, amended in 2000), Ecuador (1998), Ethiopia (1994), Peru (1993), Philippines (1987), and Venezuela (1976, amended in 2004)[94]. It is interesting to notice that none of these countries are among the most developed ones, which unexpectedly are often the ones recognising less rights. For example, the Constitutions of Canada, Australia, United States of America, United Kingdom, Germany, France, Norway, Sweden, New Zealand, and Japan do not include any provision concerning the right to health[95].

91 PEREHUDOFF, S. K., *Health, human rights & national constitutions*, 2008, p. 17.
92 *Ivi*, 81.
93 *Ivi*, 61.
94 *Ivi*, 71.
95 *Ivi*, 19.

Chapter 2 – The Implementation of the Human Right to Health

From the previous chapter, it emerges clearly that health is recognized as a human right, and it has been recognized as such in several international, regional, and national documents. However, it is not enough to merely recognize the existence of a human right. Indeed, after having been recognised, that human right has to be implemented. Therefore, some guidelines for the implementation of the human right to health have been set up, at both the international and the regional levels.

1. The Implementation of the Right to Health at the International Level

Guidelines for the implementation of the human right to health have been provided in several documents at the international level. For instance, article 24 of the Convention on the Rights of the Child lays out some measures that states should take in order to achieve the full implementation of the right to health. These measures include reducing infant and child mortality; ensuring the provision of essential medical care to all children; fighting sickness and malnutrition; ensuring pre- and post-natal medical care for mothers; guaranteeing access to information and education to everyone in society, especially to children and parents; and developing preventive healthcare[96].

However, the most accurate and comprehensive documents at the international level laying out some guidelines concerning the implementation of the human right to health are the International Covenant on Economic, Social and Cultural Rights, together with its General Comment 14, and the Fact Sheet No. 31.

1.1 The International Covenant on Economic, Social and Cultural Rights and its General Comment No. 14

In article 12 of the International Covenant on Economic, Social and Cultural Rights, the

[96] UN General Assembly, Convention on the Rights of the Child, *op. cit.*, art. 24.2.

States Parties recognize "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health"[97], and then lay out four fundamental steps that have to be taken in order to achieve the full implementation of the human right to health. Therefore, in order to accomplish the complete realization of the human right to health, States have to reduce the rate of stillbirth and infant mortality, adopt provisions concerning the betterment of the healthy development of the child, improve environmental and industrial hygiene, prevent, treat and control various disease, especially the epidemic, endemic, and occupational ones, and create the conditions which would guarantee to everyone the health services necessary in the event of illness[98].

More detailed indications concerning the implementation of the human right to health can be found in General Comment 14, which provides an authoritative guidance on how States Parties are expected to implement the obligations arising from article 12 of the International Covenant on Economic, Social, and Cultural Right. According to General Comment 14, States Parties have four kind of obligations: general legal obligations, specific legal obligations, international obligations, and core obligations. The general legal obligations are those of immediate effect. Among them, there are the obligation to ensure the exercise of the right to health without any form of discrimination, and the obligation to take action in order to move towards the full implementation of the right to health[99]. The general obligations related to the human right to health are of three types: the obligation to respect, the obligation to protect, and the obligation to fulfil. According to these three types of obligation, states have to avoid interfering with the enjoyment of the right to health (respect), to prevent any form of interference with the right to health from third parties (protect), and to adopt adequate measures towards the full implementation of the right to health (fulfil)[100].

General Comment 14 also imposes some specific legal obligations on States Parties. These specific legal obligations are based on the three types of obligation discussed above, i.e. the obligation to respect, the obligation to protect, and the obligation to fulfil.

States have to "respect the right to health by (…) refraining from denying or limiting equal access for all persons (…) to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy; abstaining from imposing discriminatory practices relating to women's health status and needs". States also have "to

97 UN General Assembly, International Covenant on Economic, Social and Cultural Rights, *op. cit*.

98 *Ivi*, art. 12.2.

99 UN Committee on Economic, Social and Cultural Rights (CESCR), General Comment No. 14: The Right to the Highest Attainable Standard of Health (Art. 12 of the Covenant), *op. cit.*, par. 30.

100 *Ivi*, par. 33.

refrain from prohibiting or impeding traditional preventive care, healing practices and medicines, from marketing unsafe drugs and from applying coercive medical treatments, (…) from limiting access to contraceptives and other means of maintaining sexual and reproductive health, from censoring, withholding or intentionally misrepresenting health-related information, (…) as well as from preventing people's participation in health-related matters. States should also refrain from unlawfully polluting air, water and soil, (…) from using or testing nuclear, biological or chemical weapons if such testing results in the release of substances harmful to human health, and from limiting access to health services as a punitive measure"[101].

States also have an obligation to protect the right to health, and therefore they have obligations "to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties; to ensure that privatization of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services; to control the marketing of medical equipment and medicines by third parties; and to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct. States are also obliged to ensure that harmful social or traditional practices do not interfere with access to pre- and post-natal care and family planning; to prevent third parties from coercing women to undergo traditional practices, (…); and to take measures to protect all vulnerable or marginalized groups of society (…) States should also ensure that third parties do not limit people's access to health-related information and services"[102].

Finally, States have an obligation to fulfil the right to health, and they are therefore required "to give sufficient recognition to the right to health in the national political and legal systems (…) and to adopt a national health policy with a detailed plan for realizing the right to health". They are also required to "ensure provision of health care (…) and ensure equal access for all to the underlying determinants of health", as well as "to ensure the appropriate training of doctors and other medical personnel, the provision of a sufficient number of hospitals, clinics and other health-related facilities, and the promotion and support of the establishment of institutions providing counselling and mental health services, with due regard to equitable distribution throughout the country. Further obligations include the provision of a public, private or mixed health insurance system which is affordable for all, the promotion of medical research and health education, as well as information campaigns (…) States are also required

[101] *Ivi*, par. 34.
[102] *Ivi*, par. 35.

to adopt measures against environmental and occupational health hazards and against any other threat" by formulating and implementing "national policies aimed at reducing and eliminating pollution of air, water and soil (…) Furthermore, States parties are required to formulate, implement and periodically review a coherent national policy to minimize the risk of occupational accidents and diseases, as well as to provide a coherent national policy on occupational safety and health services"[103].

In General Comment 14, the United Nations Committee on Economic, Social and Cultural Rights also presents a series of international obligations of States Parties concerning the right to health. It is here underlined that, in order to achieve full realization of the right to health, states have to acknowledge the fundamental role of international cooperation and assistance, and therefore they have to take both individual and joint action[104]. Furthermore, states "have to respect the enjoyment of the right to health in other countries, and to prevent third parties from violating the right in other countries"[105]. They also have to "facilitate access to essential health facilities, goods and services in other countries, (…) and provide the necessary aid when required"[106]. Moreover, States have an obligation to "ensure that the right to health is given due attention in international agreements and (…) that their actions as members of international organizations take due account of the right to health"[107]. In particular, "States parties which are members of international financial institutions (…) should pay greater attention to the protection of the right to health in influencing the lending policies, credit agreements and international measures of these institutions"[108]. States have a duty to provide help in times of emergency, and this includes also providing medical aid and supplies[109]. They also have to refrain from imposing measures that could restrict the supply of medicines and medical equipment to another State[110].

The last type of obligations of States Parties concerning the right to health dealt with in General Comment 14 by the United Nations Committee on Economic, Social and Cultural Rights are core obligations. Under these core obligations, States parties have "(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups; (b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to

[103] *Ivi*, par. 36.
[104] *Ivi*, par. 38.
[105] *Ivi*, par. 39.
[106] *Ibidem*.
[107] *Ibidem*.
[108] *Ibidem*.
[109] *Ivi*, par. 40.
[110] *Ivi*, par. 41.

everyone; (c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water; (d) To provide essential drugs (…) (e) To ensure equitable distribution of all health facilities, goods and services; (f) To adopt and implement a national public health strategy and plan of action (…) addressing the health concerns of the whole population"[111]. Moreover, States also have "(a) To ensure reproductive, maternal (prenatal as well as post-natal) and child health care; (b) To provide immunization against the major infectious diseases (…) (c) To take measures to prevent, treat and control epidemic and endemic diseases; (d) To provide education and access to information concerning the main health problems in the community (…) (e) To provide appropriate training for health personnel"[112].

General Comment 14 also deals with the obligations of actors other than States parties, underlining the important role of various United Nations agencies and programmes. In particular, it underlines the relevant function of the World Health Organization in providing assistance to States parties in the process of implementing of the right to health, and of the United Nations Children's Fund (UNICEF) in protecting the right to health of children.

1.2 The Fact Sheet No. 31

The other document at the international level laying out some guidelines concerning the implementation of the human right to health is Fact Sheet No. 31 of 2008, issued by the World Health Organization together with the United Nations Office of the High Commissioner for Human Rights. In its third section, Fact Sheet No. 31 specifically deals with the obligations of states and the responsibilities of others towards the right to health.

According to Fact Sheet No. 31, States have some general obligations towards the human right to health, namely progressive realization, taking steps towards the realization of the right to health, and some core minimum obligations[113].

According to the obligation to progressive realization, once States parties have ratified a human rights treaty, they have to make these rights effective within their jurisdiction. This obligation takes into account that States might have resource constraints and that therefore the full implementation of these rights might take some time, and thus has to take place

[111] *Ivi*, par. 43.
[112] *Ivi*, par. 44.
[113] UN Office of the High Commissioner for Human Rights (OHCHR), Fact Sheet No. 31, The Right to Health, *op. cit.* 3 (A).

progressively. However, States immediately have to ensure that the rights, including the right to health, are enjoyed on a non-discriminatory base[114].

The second general obligations of States is the obligation to take steps to realize the right to health. This process of taking steps implies the adoption of some measures, which, however, are not specified in international law, since the best measures to realize the right to health are peculiar to every State[115].

The third general obligation is the core minimum obligation, and it requires States to guarantee the satisfaction of minimum essential levels of the right to health, such as "access to health facilities, goods and services on a non-discriminatory basis (…); access to the minimum essential food which is nutritionally adequate and safe; access to shelter, housing and sanitation and an adequate supply of safe drinking water; the provision of essential drugs; [and] equitable distribution of all health facilities, goods and services"[116].

Fact Sheet No. 31 presents the obligations of States as divided in three categories: the obligation to respect, the obligation to protect, and the obligation to fulfil[117].

According to the obligation to respect, States have to avoid any interference with the right to health. Indeed, they should never deny or limit access to medical services, censor or withhold medical information, or commerce unsafe medicines. Moreover, States parties also have the obligation to respect the exercise of the right to health in other countries[118].

The second category of obligations is the the obligation to protect. This obligation requires States to avoid any interference made by third parties with the right to health. Therefore, States have to make sure that private actors respect the human right to health and act in conformity with human rights standards, as well as to make sure that "the availability, accessibility, acceptability and quality of health-care facilities, goods and services" are not endangered by privatization. Furthermore, States have to ensure that individuals are not harmed by third parties in their right to health, and that the provision of health related information and services is not limited or denied by third parties[119].

The third and final category of obligations of States towards the right to health is the obligation to fulfil, which requires States to take the necessary steps towards the full implementation of the right to health. These steps can consist in various measures of a "legislative, administrative, budgetary, judicial, promotional" nature. Among these measures,

[114] *Ibidem*.
[115] *Ibidem*.
[116] *Ibidem*.
[117] *Ivi*, 3 (B).
[118] *Ibidem*.
[119] *Ibidem*.

there are the adoption of appropriate health policies or plans at the national level, the provision of health and health related services and care, the ensuring equal access to the underlying determinants of health to everyone, and the provision of information and suggestions on health-related issues[120].

Fact Sheet No. 31 also deals with the responsibilities of other actors towards the human right to health. These actors are "individuals, intergovernmental and non-governmental organizations (NGOs), health professionals, and business"[121]. Fact Sheet No. 31 especially highlights the greatly important role of some United Nations bodies and specialized agencies, such as the United Nations Children's Fund (UNICEF), and of some international financial institutions, such as the World Bank and the International Monetary Fund, in cooperating efficaciously with States parties on the national implementation of the human right to health. Moreover, also the private sector can have an important role in the implementation of the right to health. For instance, pharmaceutical companies can influence the exercise of the right to health by making medicines affordable or not affordable[122].

2. The Implementation of the Right to Health at the European Level

The human right to health at the European level is dealt with in article 35 of the Charter of Fundamental Rights of the European Union, which affirms that "everyone has the right to access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices"[123], and in the European Social Charter, which claims that "everyone has the right to benefit from any measures enabling him to enjoy the highest possible standard of health attainable"[124]. Article 11 of the European Social Charter specifies in general terms which measures States parties have to undertake in order to implement the right to health. These measures concern the elimination of the causes of ill-health, the prevention of diseases and accidents, and the ensuring of the provision of facilities focused on the promotion of good health[125].

[120] *Ibidem*.
[121] *Ivi*, 3 (C).
[122] *Ibidem*.
[123] European Union, Charter of Fundamental Rights of the European Union, *op. cit*.
[124] Council of Europe, European Social Charter, *op. cit*.
[125] *Ivi*, art. 11.

Notwithstanding the importance of the Charter of Fundamental Rights of the European Union and the European Social Charter, at the European level there is still no document that lays out in an appropriate and sufficient way how States can implement the human right to health. The implementation of this right is therefore mainly based on guidelines at the international level.

3. Discrepancy between theory and practice

Although the right to health is internationally recognised as a human right, nowadays this right is no more than words. Indeed, data show that today health, and therefore also healthcare, are still a privilege rather than a right.

The World Health Organization has estimated that more than 400 million people worldwide lack access to at least one essential health service[126], and it has presented some data concerning several thematic areas, such as reproductive, maternal, newborn and child health; infections diseases; non-communicable diseases; environmental risks; and universal health coverage and health systems[127].

Concerning reproductive, maternal, newborn and child health, the World Health Organization has estimated that in 2015 about 830 women globally died daily due to complications in pregnancy or childbirth, and that in 2016 about 22% of births took place without the assistance of a skilled birth attendant. Moreover, in 2015 the under-five mortality rate was 43 per 1000 live births and the neonatal mortality rate was 19 per 1000 live birth worldwide. The World Health Organization has also estimated that in 2016 in the world 155 million children younger than five years old were stunted, i.e. too short, 52 million were wasted, i.e. too light, and 41 million were overweight, i.e. too heavy[128].

For what concerns infectious disease, the World Health Organization presents data for HIV, malaria, tuberculosis, hepatitis, and neglected tropical diseases. It has been estimated that in 2015 there have been 1.1 million deaths due to HIV-related illnesses, that at the end of that year there were about 36.7 million people living with HIV, at that 2.1 million people became newly infected with HIV. Moreover, in 2015 there have been 429.000 deaths caused by malaria worldwide, and about 212 million malaria cases, with an incidence rate of 94 per

[126] WORLD HEALTH ORGANIZATION, *Universal Health Coverage (UHC), Key Facts*, available online.
[127] WORLD HEALTH ORGANIZATION, *World health statistics 2017: monitoring health for the SDGs, sustainable development goals*, 2017, 29.
[128] *Ivi*, 29-30.

1000 persons at risk. The World Health Organization has also estimated that in 2015 tuberculosis caused 1.4 million deaths, plus 0.4 million deaths among people living with HIV, and that there were about 10.4 million new cases. Concerning hepatitis, in 2015 it caused about 1.3 million deaths, and in the same year an estimated 257 million people were living with hepatitis B and 71 million with hepatitis C[129].

Concerning non-communicable diseases, the World Health Organization has estimated that in 2015 they caused about 40 million deaths. In particular, 17.7 million deaths were due to cardiovascular disease, 8.8 million to cancer, 3.9 million to chronic respiratory disease, and 1.6 million to diabetes[130].

The World Health Organization presents some data concerning also environmental risks. It has been estimated that in 2012 about 6.5 million deaths were caused by indoor and outdoor air pollution. Moreover, in the same year about 871.000 people died due to unsafe water, unsafe sanitation and lack of hygiene. Finally, in 2015 an estimated 108.000 people died due to unintentional poisonings[131].

Data are presented also in relation to universal health coverage and systems. The World Health Organization calculated that in 2014 the average national percentage of total government spending dedicated to health was 11.7%, ranging from a minimum of 8.8% in the Eastern Mediterranean Region to a maximum of 13.6% in the Region of the Americas[132]. Indeed, about 32% of each country's health expenditure comes from out-of-pocket payments[133].

The World Health Organization has also estimated that every year 150 people face extreme financial hardship and 100 million people are pushed into poverty because of out-of-pocket expenditure on health services[134]. In some countries, every year extreme financial hardship due to health services costs affects up to 11% of the population and pushes into poverty up to 5% of it[135].

From the data presented, it is clear that nowadays health is recognised as a right, but in practice it is still a privilege rather than a right. The international system has acknowledged this discrepancy between theory and practice concerning the human right to health, and it is therefore trying to change this situation in order to make the right to heath and healthcare a

[129] *Ivi*, 30.
[130] *Ivi*, 31.
[131] *Ivi*, 33.
[132] *Ivi*, 32.
[133] WORLD HEALTH ORGANIZATION, *Universal Health Coverage (UHC), Key Facts*, available online.
[134] WORLD HEALTH ORGANIZATION, *The World Health Report 2010: Health System Financing. The Path to Universal Coverage, Executive Summary*, 2010, 8.
[135] *Ibidem*.

reality, an actual right rather than a theoretical right but an actual privilege. A way in which this situation might change and the human right to health can be better implemented is through Universal Health Coverage.

Chapter 3 –Universal Health Coverage

1. Definition

Universal Health Coverage is defined by the World Health Organization as
"ensuring that all people have access to needed promotive, preventive, curative and rehabilitative health services, of sufficient quality to be effective, while also ensuring that people do not suffer financial hardship when paying for these services"[136], and regardless of their personal characteristics, such as gender, age, ethnicity, race, religion, social status and sexual orientation.
Universal Health Coverage refers to coverage for three dimensions, namely health services, finance and population[137]. Its goals are "defined by [these] three dimensions: the population that is covered (…); the proportion of direct health costs covered (…); and the health services covered"[138]. Therefore, Universal Health Coverage has three fundamental components: population (universal), health services (health), and financial coverage (coverage). The first element, population, concerns who has access; the second element, health services, refers to which services are provided; and the third and last element, financial coverage, concerns what proportion of the cost is covered[139].

1.1 A Problematic Definition of Universal Health Coverage

Even though Universal Health Coverage has been internationally recognised as a fundamental step towards the realisation of the human right to health, there still is no consensus on how to interpret its key components, especially on how to interpret the population-universal one. Indeed, "the term universal has been defined as a legal obligation of the state to provide health care to all its citizens"[140]. This definition limits the extent of coverage to the citizens of a State, therefore making "legal nationality (…) [a] prerequisite for accessing medical

[136] WORLD HEALTH ORGANIZATION, *Universal Health Coverage*, available online.
[137] WORLD HEALTH ORGANIZATION, *Tracking universal health coverage: first global monitoring report*, 2015.
[138] REICH, M. R., HARRIS, J., IKEGAMI, N., MAEDA, A., CASHIN, C., ARAUJO, E. C., TAKEMI, K, & EVANS, T. G., *Moving towards universal health coverage: lessons from 11 country studies*, in *The Lancet*, 2016, 387(10020), 811.
[139] JAIN, V., & ALAM, A., *Redefining universal health coverage in the age of global health security*, in *BMJ global health*, 2017, 2(2), e000255.
[140] O'CONNELL, T., RASANATHAN, K., & CHOPRA, M., *What does universal health coverage mean?*, in *The Lancet*, 2014, 383(9913), 277.

citizenship and the human right to health"[141]. As a consequence, the 11 to 12 million[142] "stateless people, such as refugees, undocumented migrants, nomadic people, or those denied birth registration, are often seen by authorities as without legal entitlement to any rights to health care"[143], and therefore they "often face an inability to access the most basic of healthcare"[144]. However, consensus is lacking also concerning the interpretation of the other two key elements, i.e. health and coverage. Indeed, there is conflict between the definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"[145], which would require a broad provision of services, and the definition of Universal Health Coverage as coverage for essential health services[146]. It is important to remember that these essential health services ensured under Universal Health Coverage encompass not only medical treatments, but also rehabilitation, palliative care, and health initiatives focused on the promotion of better health, as well as on the prevention of illness.

2. Universal Health Coverage in the Sustainable Development Goals

Through universal access to health services – including treatment, palliative care, and rehabilitation of sufficient quality, access to essential medicines and vaccines, and health initiatives focused on the promotion of better health and the prevention of illness – it is possible to ensure a healthier, and therefore more productive, population[147], and through protection from financial hardship it is possible to prevent people from facing financial hardship and ending up in poverty[148]. Therefore, Universal Health Coverage is an extremely important step towards development, and this is why it is included in the Sustainable Development Goals.

The Sustainable Development Goals are a set of 17 goals, with a total of 169 targets, aimed at

[141] KINGSTON, L. N., COHEN, E. F., & MORLEY, C. P., *Debate: Limitations on universality: the" right to health" and the necessity of legal nationality*, in *BMC international health and human rights*, 2010, 10(1), 11, 22.
[142] *Ibidem*.
[143] O'CONNELL, T., RASANATHAN, K., & CHOPRA, M., *op. cit.*
[144] KINGSTON, L. N., COHEN, E. F., & MORLEY, C. P., *op. cit.*
[145] Preamble to the Constitution of WHO, *op. cit*.
[146] WORLD HEALTH ORGANIZATION, *Universal Health Coverage (UHC), What is UHC?*, available online.
[147] BRADY, A. H., *Universal Health Coverage*, in *Global Journal of Medicine and Public Health*, 2017, vol. 6, issue 3.
[148] JAIN, V., & ALAM, A., *op. cit.*

ending poverty, fighting inequalities, protecting the planet, and ensuring prosperity for all[149]. They are part of the 2030 Agenda for Sustainable Development, which was agreed upon and adopted by all UN Member States at the UN Sustainable Development Summit September 25–27, 2015 in New York. The Sustainable Development Goals cover a wide set of sustainable development issues: poverty, hunger, health, education, gender equality, economic growth, peace and justice, climate change, desertification, and still others[150]. Although the Sustainable Development Goals are not legally binding, national government are still expected to actually take action in order to move towards their achievement.

One of the issues covered by the Sustainable Development Goals is good health and well-being, which is the topic of the 3rd SDG, "Ensure healthy lives and promote well-being for all at all ages"[151]. This goal has several targets, such as reducing maternal and neonatal mortality, ending preventable deaths of newborns and children, ending or at least reducing epidemics, combating communicable diseases, strengthening the prevention and treatment of substance abuse, reducing the number of deaths and injuries from road traffic accidents, ensuring universal access to sexual and reproductive health-care services, providing access to affordable essential medicines and vaccines, and still others[152]. The target dealing with Universal Health Coverage is Target 3.8, "Achieve Universal Health Coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all"[153]. This target has two indicators. The first indicator is coverage of essential health services, defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population. The second indicator is the number of people covered by health insurance or a public health system per 1,000 population[154].

[149] UNITED NATIONS, *Sustainable Development Goals*, available online.
[150] *Ibidem*.
[151] UNITED NATIONS, *Sustainable Development Goals, Goal 3: Ensure healthy lives and promote well-being for all at all ages*, available online.
[152] *Ibidem*.
[153] UNITED NATIONS DEPARTMENT OF ECONOMIC AND SOCIAL AFFAIRS, *Sustainable Development Goal 3, Targets and Indicators*, in *Sustainable Development Knowledge Platform*, available online.
[154] *Ibidem*.

3. Measuring and Monitoring Universal Health Coverage

Steps towards the enforcement of Universal Health Coverage have already been taken in several countries. Whether a country is making progress towards Universal Health Coverage depends on the proportion of the population that can access medicines and health services, and the proportion of the amount of out-of-pocket expenditure on healthcare in the population[155]. Universal Health Coverage is made up of two dimensions which have to be taken into account in the measuring and the monitoring processes: access to health services and protection from financial difficulties. Therefore, frameworks to measure and monitor the progress towards Universal Health Coverage based on these dimensions have been developed by the World Health Organization, in collaboration with the World Bank. In these frameworks, Universal Health Coverage is usually measured with two indicators: a health service coverage index, and indicators of financial protection.

The health service coverage index is made up of four categories, each composed by four essential services, "as indicators of the level and equity of coverage in countries:

- Reproductive, maternal, newborn and child health:
  - family planning
  - antenatal and delivery care
  - full child immunization
  - health-seeking behavior for child illness.
- Infectious diseases:
  - tuberculosis treatment
  - HIV antiretroviral treatment
  - coverage of insecticide-treated bed nets for malaria prevention
  - adequate sanitation.
- Noncommunicable diseases:
  - prevention and treatment of raised blood pressure
  - prevention and treatment of raised blood glucose
  - cervical cancer screening
  - tobacco (non-)use.

[155] WORLD HEALTH ORGANIZATION, *Universal Health Coverage (UHC), Can UHC Be Measured?*, available online.

- Service capacity and access:
  - basic hospital access
  - health worker density
  - access to essential medicines
  - health security: compliance with the International Health Regulations"[156].

The indicators of financial protection used in monitoring and measuring progress towards Universal Health Coverage are the incidence of 'catastrophic' health expenditure and the incidence of impoverishment due to out-of-pocket health payments. The incidence of "catastrophic" health expenditure indicates the amount of people of all income levels that face health payments that are higher than their resources. The incidence of impoverishment due to out-of-pocket health payments indicates the degree to which health expenditure causes extreme financial hardship, and pushes people below the poverty line157.

4. Implementing and Financing Universal Health Coverage

The path towards the establishment of Universal Health Coverage is quite complex and long and it requires some time, as well as many efforts. This path differs from country to country, depending on several factors, such as where and how they start[158]. However, it involves three fundamental steps common to all states. These steps are raising sufficient funds for health, reducing financial risks and barriers to access, and promoting efficiency and eliminating waste[159].

In order to raise sufficient funds, states have three main ways to do it. First of all, states can increase the efficiency of revenue collection, which in turn will increase the amount of resources that can be used to finance the provision of health services and the health system as a whole. The second way in which states can raise sufficient funds is by re-prioritizing government budgets, giving health a relatively high priority. Finally, state can also raise more

[156] *Ibidem*.
[157] BOERMA, T., EOZENOU, P., EVANS, D., EVANS, T., KIENY, M. P., & WAGSTAFF, A., *Monitoring progress towards universal health coverage at country and global levels*, in *PLoS medicine*, 2014, 11(9), e1001731, 4.
[158] WORLD HEALTH ORGANIZATION, *The World Health Report 2010: Health System Financing. The Path to Universal Coverage, Executive Summary*, 2010, 14.
[159] WORLD HEALTH ORGANIZATION, *The World Health Report 2010: Health System Financing. The Path to Universal Coverage*, 2010.

funds through innovative financing mechanisms. However, some low- and middle-income countries do not have much chance of generating more funds from domestic sources. Therefore, a fourth possible option for raising sufficient resources for health consists in increasing development aid and assistance for health[160].

The second fundamental step towards the implementation of Universal Health Coverage consists in reducing financial risks and barriers to access, and it mainly consists in reducing the reliance on direct payments to finance health services. The way to do so is for government to advance the risk-pooling, prepayment approach. It is important that contributions be compulsory[161].

The third and last fundamental step that states need to take consists in promoting efficiency and eliminating waste. Indeed, in order to successfully achieve Universal Health Coverage it is not enough to have enough resources and remove financial barriers. It has been estimated that about 20-40% of resources spent on health are wasted, and therefore the final necessary step consists in using the resources efficiently[162].

4.1 Financing Universal Health Coverage

The financing of health systems is at the core of a successful implementation of Universal Health Coverage. Indeed, the way in which a health system is financed greatly affects the population's ability to receive needed medical care without facing financial catastrophe[163].

A major problem concerning the financing of health systems concerns out-of-pocket payments for health services. Indeed out-of-pocket payments often prevent people from seeking or continuing care, make them face financial difficulties, and sometimes even push them into poverty[164]. Out-of-pocket payments mainly consist in fees for services, direct payment for treatment and medicines, or co-payments where insurances covers only partially the cost of care. An important and fundamental step towards an effective and successful implementation of Universal Health Coverage therefore consists in moving from out-of-pocket payments to some form of prepayment as a mean of financing health systems.

Prepayment systems can be either tax-based or social health insurance-based[165]. These

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[160] WORLD HEALTH ORGANIZATION, *The World Health Report 2010: Health System Financing. The Path to Universal Coverage, Executive Summary*, 2010, 10-11.

[161] *Ivi*, 12-14.

[162] *Ivi*, 14-16.

[163] CARRIN, G., EVANS, D., & XU, K., *Designing health financing policy towards universal coverage*, in *Bulletin of the World Health Organization*, 2007, 85(9), 652-652.

[164] *Ibidem*.

[165] CARRIN, G., JAMES, C., & EVANS, D., *Achieving Universal Coverage: Developing The Health Financing System*, 2005.

systems differ on various levels, but they both involve the pooling of contributions and the provision of health services on the basis of need, and in both systems the health services are usually purchased or provided from a mix of public and private providers[166].

Although there are many ways in which a health system can be financed, such as through public payments (such as taxation), private payments, social insurance and community insurance schemes, a public financing system has been agreed upon as the best and most reliable financing system on the path towards Universal Health Coverage[167]. As stated by Rob Yates, Senior Fellow at the international affairs think-tank Chatham House, "the countries should publicly finance their health systems if they want to achieve Universal Health Coverage"[168]. That Universal Health Coverage can be achieved only through public financing has been stressed several times also by the World Bank's President Jim Yong Kim and the World Health Organization's previous Director-General Margaret Chan[169].

5. Priority Setting and Universal Health Coverage

The aim of every government moving towards the implementation of Universal Health Coverage is to be able to ensure access to all the essential health services to the whole population, while also providing financial coverage in order to prevent people from facing financial hardship and ending up in poverty. However, almost every country in the world is characterized by the existence of a gap between what its population needs concerning health and healthcare, and what the country's government is economically able to provide[170]. It is therefore necessary to proceed towards Universal Health Coverage step-by-step, according to the actual resources available. This step-by-step path towards Universal Health Coverage has to be guided by fairness, meaning that unmet health needs have to be addressed in a fair order[171]. Priority setting should be guided by three principles: coverage should be based on need, giving extra weight to the needs of underprivileged people; the main goal should be to create the greatest total improvement in health; and contributions should be on the basis of

166 *Ibidem*.
167 BRADY, A. H., *op. cit.*
168 NHS MANIFESTO, *Universal Health Coverage – Looking to the Future*, in *The Lancet*, 2016, 388(10062), 2837.
169 *Ibidem*.
170 NORHEIM, O. F., *Ethical priority setting for universal health coverage: challenges in deciding upon fair distribution of health services*, in *BMC medicine*, 2016, 14(1), 75.
171 *Ibidem*.

personal resources, on the ability to pay, and not on the basis of need[172]. Some generally accepted criteria for a fair priority setting are cost-effectiveness, priority to the worse-off, and financial risk protection[173]. According to these criteria, a fair health system should move towards Universal Health Coverage starting with the expansion of coverage for cost-effective health services, especially for those benefiting the worse-off, and at the same time it should provide financial risk protection[174].

It is important to underline that priority setting should be impartial and treat everyone in the same way. It is indeed unacceptable to treat people in different ways based on their gender, religion, social status, ethnicity, sexual orientation, or political affiliation[175].

However, it is no easy job to establish a fair priority setting. There are many cases in which the path towards Universal Health Coverage is characterized by unfair decisions. Such decisions can be seen as trade-offs between competing goals. Norheim has identified five of such unacceptable trade-offs[176]. The first unacceptable trade-off is when coverage for low- or medium-priority health services is expanded before there is universal coverage for high-priority health services. The second unacceptable trade-off is when universal coverage is expanded only to those people who are able to pay (such as people already covered by a partial insurance scheme), and not to everyone, especially not to poor and disadvantaged groups of people. The third unacceptable trade-off is when high-cost services are given priority even if the health benefits gained from it are smaller than those gained from alternative and cheaper services. The fourth unacceptable trade-off is when coverage is expanded for well-off groups before than for worse-off groups, and there is no much difference between the costs and benefits. The last and fifth unacceptable trade-off is when the shift from out-of-pocket payments towards mandatory prepayments makes the financing system less progressive. Indeed, out-of-pocket payments tend to be regressive with respect to income, meaning that the poor pay proportionately more than the rich.

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[172] RUMBOLD, B., BAKER, R., FERRAZ, O., HAWKES, S., KRUBINER, C., LITTLEJOHNS, P., NORHEIM, O.F., PEGRAM,T., RID, A., VENKATAPURAM, S., VOORHOEVE, A., WANG, D., WEALE, A., WILSON, J., YAMIN, A.E., & HUNT, P., *Universal health coverage, priority setting, and the human right to health*, in *The Lancet*, 2017, 390(10095), 712-714.

[173] NORHEIM, O. F., *op. cit.*

[174] *Ibidem*.

[175] *Ibidem*.

[176] NORHEIM, O. F., *Ethical perspective: five unacceptable trade-offs on the path to universal health coverage*, in *International journal of health policy and management*, 2015, 4(11), 711.

6. Universal Health Coverage as a Better Way to Implement the Human Right to Health

Universal Health Coverage has been defined the World Health Organization as "a practical expression of the concern for health equity and the right to health"[177], by the newly-elected World Health Organization's Director-General Dr. Tedros Adhanom Ghebreyesus as a human right[178], and by the World Health Organization's previous Director-General Margaret Chan as "the single most powerful concept that public health has to offer"[179] and as "the ultimate expression of fairness"[180]. The Deputy Secretary-General (Corporate) at the Commonwealth Secretariat Gary Dunn has underlined the important connection between Universal Health Coverage and the human right to health, affirming that "the right to health cannot be fully realised without the availability of health care for everyone" and that "the right to health can, and should, inform, shape and strengthen efforts to develop and deliver Universal Health Coverage policies and programmes"[181]. The Vice-President for External Affairs of the International Federation of Medial Students' Association Marie Hauerslev has underlined that Universal Health Coverage "is about taking social responsibility, about the right the health"[182]. Moreover, the World Health Assembly resolution 58.33 of 2005 affirms that everyone should be able to access health services without having to face financial hardship[183], and underlines the importance of moving towards Universal Health Coverage as a way to meet the needs of people, to improve the quality of health care, and to reduce poverty[184].

It is therefore clear that Universal Health Coverage is recognised as way to implement the human right to health, and also as an extremely appropriate and good way to do so. Indeed, Universal Health Coverage can contribute greatly to the realisation of the human right to health, particularly through the promotion of comprehensive health-care services, the adoption of the principles of progressive realisation and of cost-effectiveness prioritization, and the effort to end any form of discrimination based on financial grounds.

Therefore, succeeding in the achievement of Universal Health Coverage can be, and it

[177] WORLD HEALTH ORGANIZATION, *Positioning health in the post-2015 development agenda*, 2012.
[178] TEDROS, A. G., *All Roads Lead to Universal Health Coverage*, 2017, available online.
[179] CHAN, M., *Ministerial Meeting on Universal Health Coverage*, 2013, available online.
[180] CHAN, M., & BRUNDTLAND, G. M., *Universal Health Coverage: an Affordable Goal for All*, 2016, available online.
[181] THE COMMONWEALTH, *Putting Human Rights at the Centre of Universal Health Coverage*, 2015, available online.
[182] UHC2030, *World Leaders for Universal Health Coverage: Achieving the SDGs through Health for All*, 2017, available online.
[183] WORLD HEALTH ORGANIZATION, *The World Health Report 2010: Health System Financing. The Path to Universal Coverage, Executive Summary*, 2010, p. 8.
[184] Art. 4, Resolution 58.33 of the World Health Assembly, 2005.

actually is, an extremely important step towards the advancement of health and towards the full realisation of the human right to health.

Bibliography

- AIFA , *International Treaties and the Right to Health*, 2016, available online.
- A. DEL VECCHIO, *La protezione dei diritti umani nelle diverse aree geografiche mondiali*, in *Studi in onore di Claudio Zanghì. Diritti umani. Volume II* (a cura di L. Panella, E. Spatafora), Torino, 2011, pp. 233-253.
- A. G. TEDROS, *All Roads Lead to Universal Health Coverage*, 2017, available online.
- A. H. BRADY, *Universal Health Coverage*, in *Global Journal of Medicine and Public Health*, 2017, vol. 6, issue 3.
- A. SINGH, M. CHOKSHIL, *Realizing the Right to Health through Universal Health Coverage*, 2013.
- A. R. CHAMPMAN, *The Contributions of Human Rights to Universal Health Coverage*, in *Health and Human Rights*, 2016.
- B. M. MEIER, *Advancing health rights in a globalized world: responding to globalization through a collective human right to public health*, 2007.
- B. M. MEIER, *The highest attainable standard: The World Health Organization, global health governance, and the contentious politics of human rights*, 2009.
- B. RUMBOLD, R. BAKER, O. FERRAZ, S. HAWKES, C. KRUBINER, P. LITTLEJOHNS, O. F. NORHEIM, T. PEGRAM, A. RID, S. VENKATAPURAM, A. VOORHOEVE, D. WANG, A. WEALE, J. WILSON, A. E. YAMIN, & P. HUNT, *Universal health coverage, priority setting, and the human right to health*, in *The Lancet*, 2017, 390(10095), 712-714.
- B. TOEBES, *The right to health as a human right in international law*, in *Refugee Survey Quarterly*, 2001, *20*(3).
- D. CHISHOLM, & D. B. EVANS, *Improving health system efficiency as a means of moving towards universal coverage*, in *World health report*, 2010.
- D. SRIDHAR, M. MCKEE, G. OOMS, C. BEIERSMANN, E. FRIEDMAN, H. GOUDA, P. HILL, & A. JAHN, *Universal health coverage and the right to health: from legal principle to post-2015 indicators*, in *International journal of health services*, 2015, *45*(3), 495-506.
- E. A. FRIEDMAN, A. JAHN, G. OOMS, D. SRIDHAR, A. WARIS, D. AKAKIMPA, C. BEIERSMANN, C. BROLAN, S. DURRANI, J. EDGE, A. EIDE, W. FLORES, L. FORMAN, T. GEBAUER, L. O. GOSTIN, R. HAMMONDS, P. S. HILL, S. HUSSAIN, L. ABDUL, M. MCKEE, O. MULLER, M. MULUMBA, J. NANTABA, & A. L. RUANO, *Realizing the right to health for everyone: the health goal for humanity*, 2013.

- E. D. KINNEY, & B. A. CLARK, *Provisions for health and health care in the constitutions of the countries of the world,* in *Cornell International Law Journal*, 2004, *37*, 285.
- G. BACKMAN, P. HUNT, R. KHOSLA, C. JARAMILLO-STROUSS, B. M. FIKRE, C. RUMBLE, D. PEVALIN, D. A. PÁEZ, M. A. PINEDA, A. FRISANCHO, D. TARCO, M. MOTLAGH, D. FARCASANU, & C. VLADESCU, *Health systems and the right to health: an assessment of 194 countries*, in *The Lancet*, 2008, *372*(9655), 2047-2085.
- G. CARRIN, D. EVANS, & K. XU, *Designing health financing policy towards universal coverage*, in *Bulletin of the World Health Organization*, 2007, 85(9), 652-652.
- G. CARRIN, I. MATHAUER, K. XU, & D. B. EVANS, *Universal coverage of health services: tailoring its implementation*, in *Bulletin of the World Health Organization*, 2008, *86*(11), 857-863.
- G. CARRIN, C. JAMES, & D. EVANS, *Achieving Universal Coverage: Developing The Health Financing System*, 2005.
- G. CARRIN, R. ZERAMDINI, P. MUSGROVE, J. P. POULLIER, N. VALENTINE, & K. XU, *The impact of the degree of risk-sharing in health financing on health system attainment,* in *Working Group*, 2001, (Vol. 3).
- H. POTTS, & P. H. HUNT, *Accountability and the right to the highest attainable standard of health*, 2008.
- H. SCHMIDT, L. O. GOSTIN, & E. J. EMANUEL, *Public health, universal health coverage, and Sustainable Development Goals: can they coexist?*, 2015.
- INTERNATIONAL LABOUR ORGANIZATION, *Addressing the Global Health Crisis: Universal Health Protection Policies,* 2014.
- INTERNATIONAL LABOUR ORGANIZATION, *Global health protection crisis leaves almost 40% of the world's population without any coverage*, accessible online.
- J. D. SACHS, *Macroeconomics and health: investing in health for economic development*, in *Revista Panamericana de Salud Pública*, 2002, *12*(2), 143-144.
- J. KLABBERS, *International Law,* 2013.
- J. MCHALE, *Fundamental rights and health care*, 2010.
- J. M. ZUNIGA, S. P. MARKS, & L.O. GOSTIN, *Advancing the human right to health*, 2013.
- J. P. KOPLAN, T. C. BOND, M. H. MERSON, K. S. REDDY, M. H. RODRIGUEZ, N. K. SEWANKAMBO, & J. N. WASSWERHEIT, *Towards a common definition of global health*, in *The Lancet*, 2009, *373*(9679), 1993-1995.
- J. TOBIN, *The right to health in international law*, 2012.

- J. VAGEESH, & A. ALAM, *Redefining universal health coverage in the age of global health security*, in *BMJ global health*, 2017, *2*(2), e000255.
- L. FORMAN, C. BEIERSMANN, C. E. BROLAN, M. MCKEE, R. HAMMNONDS, & G. OOMS, *What Do Core Obligations under the Right to Health Bring to Universal Health Coverage?*, in *Health and Human Rights*, 2016, *18*(2), 23.
- L. N. KINGSTON, E.F. COHEN, & C. P. MORLEY, *Debate: Limitations on universality: the" right to health" and the necessity of legal nationality*, in *BMC international health and human rights*, 2010, 10(1), 11.
- M. CHAN, *Ministerial Meeting on Universal Health Coverage*, 2013, available online.
- M. CHAN, & G. M. BRUNDTLAND, *Universal Health Coverage: an Affordable Goal for All*, 2016, available online.
- M. H. MERSON, R. E. BLACK, & A. MILLS, *International public health: diseases, programs, systems and policies*, 2006.
- M. R, REICH, J. HARRIS, N. IKEGAMI, A. MAEDA, C. CASHIN, E. C. ARAUJO, K. TAKEMI, & T. G. EVANS, *Moving towards universal health coverage: lessons from 11 country studies*, in *The Lancet*, 2016, 387(10020), 811.
- N. DANIELS, *Just health: meeting health needs fairly*, 2007.
- N. RONZITTI, *Introduzione al diritto internazionale*, Torino, 2016.
- NHS MANIFESTO, *Universal Health Coverage – Looking to the Future*, in *The Lancet*, 2016, 388(10062), 2837.
- G. OOMS, C. BROLAN, N. EGGERMONT, A. EIDE, W. FLORES, L. FORMAN, E. A. FRIEDMAN, T. GEBAUER, L. O. GOSTIN, P. S. HILL, S. HUSSAIN, M. MCKEE, M. MULUMBA, F. SIDDIQUI, D. SRIDHAR, L. VAN LEEMPUT, A. WARIS, & A. JAHN, *Universal health coverage anchored in the right to health*, in *Bulletin of the World Health Organization*, 2013, *91*(1), 2-2a.
- G. OOMS, L. A. LATIF, A. WARIS, C. E. BROLAN, R. HAMMONDS, E. A. FRIEDMAN, M. MULUMBA, & L. FORMAN, *Is universal health coverage the practical expression of the right to health care?*, in *BMC International Health and Human Rights*, 2014, *14*(1), 3.
- O. F. NORHEIM, *Ethical perspective: five unacceptable trade-offs on the path to universal health coverage*, in *International journal of health policy and management*, 2015, 4(11), 711.
- O. F. NORHEIM, *Ethical priority setting for universal health coverage: challenges in deciding upon fair distribution of health services*, in *BMC medicine*, 2016, 14(1), 75.
- P. HUNT, *Interpreting the international right to health in a human rights-based approach to health*, in *Health and Human Rights*, 2016 *18*(2), 109.

- P. HUNT, *The human right to the highest attainable standard of health: new opportunities and challenges,* in *Transactions of the Royal Society of Tropical Medicine and Hygiene*, 2006, *100*(7), 603-607.
- P. PUSTORINO, *La responsabilità delle organizzazioni internazionali*, Cap. IX, in A. Del Vecchio (a cura di), *Diritto delle organizzazioni internazionali*, Napoli, 2012, p. 315 ss.
- P. PUSTORINO, *La tutela dei diritti dell'uomo nell'ordinamento comunitario: dalla Carta dei diritti fondamentali al progetto di Costituzione europea*, in S. Maffettone, G. Pellegrino (a cura di), *Etica delle relazioni internazionali*, 2004, p. 289 ss.
- R. DITTRICH, L. CUBILLOS, L. GOSTIN, K. CHALKIDOU, & R. LI, *The international right to health: what does it mean in legal practice and how can it affect priority setting for universal health coverage?,* in *Health Systems & Reform*, 2016, *2*(1), 23-31.
- S. K. PEREHUDOFF, *Health, human rights & national constitutions*, 2008.
- THE COMMONWEALTH, *Putting Human Rights at the Centre of Universal Health Coverage*, 2015, available online.
- T. BOERMA, P. EOZENOU, D. EVANS, T. EVANS, M. P. KIENY, & A. WAGSTAFF, *Monitoring progress towards universal health coverage at country and global levels*, in *PLoS medicine*, 2014, 11(9), e1001731, 4.
- T. O'CONNELL, K. RASANATHAN, & M. CHOPRA, *What does universal health coverage mean?,* in *The Lancet*, 2014, 383(9913), 277.
- UHC2030, *World Leaders for Universal Health Coverage: Achieving the SDGs through Health for All*, 2017, available online.
- U. LEANZA, & I. CARACCIOLO, *Il diritto internazionale. Diritto per gli stati e diritto per gli individui. Parte Generale*, 2012.
- UNITED NATIONS DEPARTMENT OF ECONOMIC AND SOCIAL AFFAIRS, *Sustainable Development Goal 3, Targets and Indicators*, in *Sustainable Development Knowledge Platform*, available online.
- UNITED NATIONS, *Human Rights*, available online.
- UNITED NATIONS, *Sustainable Development Goals*, available online.
- UNITED NATIONS, *Sustainable Development Goals, Goal 3: Ensure healthy lives and promote well-being for all at all ages*, available online.
- V. A. LEARY, T*he right to health in international human rights law,* in *Health and human rights*, 1994 24-56.
- V. JAIN, & A. ALAM, *Redefining universal health coverage in the age of global health*

security, in *BMJ global health*, 2017, 2(2), e000255.

- WORLD HEALTH ORGANIZATION, *Advancing the right to health: the vital role of law*, 2016.
- WORLD HEALTH ORGANIZATION, *Ancoring universal health coverage in the right to health: What difference would it make? Policy Brief,* 2015.
- WORLD HEALTH ORGANIZATION, *Arguing for Universal Health Coverage,* 2013.
- WORLD HEALTH ORGANIZATION, *Everybody's business – strengthening health systems to improve health outcomes: WHO's framework for action,* 2007.
- WORLD HEALTH ORGANIZATION, *Making fair choices on the path to universal health coverage: Final report of the WHO Consultative Group on Equity and Universal Health* Coverage, 2014.
- WORLD HEALTH ORGANIZATION, *Positioning health in the post-2015 development agenda*, 2012.
- WORLD HEALTH ORGANIZATION, *The World Health Report 2010: Health System Financing. The Path to Universal Coverage, Executive Summary*, 2010.
- WORLD HEALTH ORGANIZATION, *The World Health Report 2010: Health System Financing. The Path to Universal Coverage*, 2010.
- WORLD HEALTH ORGANIZATION, *Tracking universal health coverage: first global monitoring report*, 2015.
- WORLD HEALTH ORGANIZATION, *Universal Health Coverage*, available online.
- WORLD HEALTH ORGANIZATION, *Universal Health Coverage (UHC)*, available online.
- WORLD HEALTH ORGANIZATION, *World health statistics 2017: monitoring health for the SDGs, sustainable development goals*, 2017.

Riassunto in Lingua Italiana

I diritti umani sono diritti fondamentali ed inalienabili, propri di tutti gli esseri umani, che ne devono godere senza distinzione di sesso, razza, religione, opinione politica, o condizione economica e sociale; sono codificati nella Dichiarazione Universale dei Diritti dell'Uomo adottata dalle Nazioni Unite nel 1948, e comprendono vari diritti di natura politica, sociale, civile, culturale ed economica.

Tra i diritti umani, vi è anche il diritto alla salute. La salute è stata definita dall'Organizzazione Mondiale della Sanità come uno stato di completo benessere fisico, mentale e sociale. Pertanto, il diritto alla salute consiste nel diritto di ciascun essere umano a godere delle migliori condizioni di salute fisica e mentale che sia in grado di conseguire.

Il diritto alla salute è ufficialmente riconosciuto e protetto a livello internazionale, regionale e talvolta anche nazionale.

A livello internazionale, è presente in varie dichiarazioni e convenzioni. Alcune di esse sono di applicazione generale, e trattano del diritto alla salute in relazione a tutti gli esseri umani, mentre altre sono di applicazione specifica, e quindi trattano del diritto alla salute in riferimento ad un particolare gruppo di persone, come ad esempio le donne, i bambini, le persone affette da disabilità, o i migranti. L'articolazione più completa e soddisfacente del diritto alla salute a livello internazionale si trova nel Patto Internazionale Relativo ai Diritti Economici, Sociali e Culturali, il cui articolo 12 riconosce il diritto di ogni individuo a godere delle migliori condizioni di salute fisica e mentale che sia in grado di conseguire. Il Commento Generale N. 14 fornisce una guida autorevole su come gli stati debbano implementare gli obblighi derivanti dall'articolo 12 del Patto. In questo commento, il diritto alla salute è definito come fondamentale per l'esercizio di altri diritti umani, ed anche strettamente dipendente dalla loro realizzazione. Viene anche sottolineata l'importanza di una definizione adeguata e comprensiva del termine salute, che deve infatti essere inteso come uno stato di completo benessere fisico, mentale e sociale, e non come la mera assenza di malattia o infermità. Tale definizione deve inoltre includere tutti quei fattori socio-economici che promuovono le condizioni in cui le persone possono condurre una vita sana. Il Commento Generale N. 14 definisce ulteriormente il diritto alla salute come un diritto inclusivo, che non si limita strettamente all'assistenza sanitaria tempestiva e adeguata, ne presenta gli elementi fondamentali, quali disponibilità, accessibilità, accettabilità, e qualità. Pertanto i servizi sanitari devono essere presenti in quantità sufficiente (disponibilità), essere accessibili da un

punto di vista fisico, economico e di informazione, a tutti e senza alcuna forma di discriminazione (accessibilità), devono rispettare l'etica medica ed essere appropriati da un punto di vista medico, scientifico e culturale (accettabilità), e devono essere di buona qualità. Sempre a livello internazionale, il diritto alla salute è riconosciuto anche nella Costituzione dell'Organizzazione Mondiale della Sanità, il cui preambolo afferma che la salute consiste in uno stato di completo benessere fisico, mentale e sociale, e non solo in assenza di malattia o d'infermità, e che il possesso del migliore stato di salute possibile costituisce un diritto fondamentale di ogni essere umano, senza distinzione di sesso, razza, religione, opinioni politiche, o condizione economica e sociale. Inoltre, la salute è riconosciuta come condizione fondamentale per la pace e la sicurezza del mondo, e come dipendente dalla cooperazione tra i singoli e tra gli Stati, e l'obiettivo principale dell'Organizzazione Mondiale della Sanità consiste infatti nel portare tutti i popoli al più alto grado di salute possibile. L'Organizzazione Mondiale della Sanità ha dedicato grande attenzione al diritto umano alla salute, trattandone anche in alcune schede informative, tra cui il Fact Sheet N. 31, che definisce questo diritto come un diritto inclusivo. Infatti, questa scheda informativa sottolinea che il diritto alla salute non include solo l'accesso ai servizi sanitari, ma anche una serie di fattori che promuovono le condizioni in cui le persone possono condurre una vita sana, e sottolinea anche che l'accesso ai servizi sanitari deve essere garantito a tutti senza discriminazione di alcun tipo. Così come il Commento Generale N. 14, anche il Fact Sheet N. 31 evidenzia che i servizi sanitari devono essere caratterizzati da disponibilità, accessibilità. accettabilità, e qualità. La scheda informativa ulteriormente specifica che il diritto alla salute non coincide con il diritto ad essere sani, e che i diritti umani sono interdipendenti, indivisibili ed interrelati, rendendo quindi il diritto alla salute dipendente dalla realizzazione di molti altri diritti umani, ma anche suo prerequisito. Il Fact Sheet N. 31 tratta anche del diritto umano alla salute in relazione ad alcuni gruppi specifici, come donne, bambini, persone affette da disabilità, migranti, e persone affette da HIV/AIDS. Infatti, questi gruppi sono spesso soggetti a discriminazioni che possono impedire l'accesso ai servizi sanitari e ai farmaci, ed è di conseguenza necessario prestare loro particolare attenzione, ed assicurarsi che godano pienamente di tale diritto.

Il diritto alla salute è riconosciuto e protetto anche a livello regionale, ad esempio nella Carta Africana dei Diritti dell'Uomo e dei Popoli o nel Protocollo Addizionale alla Convenzione Americana sui diritti umani in materia di diritti economici, sociali e culturali. A livello europeo, è riconosciuto come uno dei diritti fondamentali dell'Unione Europea, e come tale è incluso nella Carta dei Diritti Fondamentali dell'Unione Europea, il cui articolo 35 afferma il diritto di ogni individuo di accedere alla prevenzione sanitaria e di ottenere le cure mediche

necessarie. Il diritto alla salute a livello europeo è trattato anche nella Carta Sociale Europea, che sottolinea il diritto di ogni persona ad usufruire di tutte le misure che le consentano di godere del miglior stato di salute ottenibile.

Il diritto alla salute è talvolta riconosciuto e protetto anche a livello nazionale. Infatti, di 186 costituzioni accessibili, il 73% include alcune disposizioni sanitarie, il 51% garantisce il diritto a strutture, beni e servizi sanitari, e il 2% include i medicinali essenziali come parte dei diritti sanitari.

Che il diritto alla salute sia riconosciuto e protetto in molti documenti a livello nazionale, regionale ed internazionale risulta ormai evidente. Tuttavia, ciò non è sufficiente. È infatti necessario implementare questo diritto, oltre che riconoscerlo a livello teorico e giuridico. Pertanto, alcune linee guida concernenti l'implementazione del diritto alla salute sono state prodotte, sia a livello internazionale che a livello regionale.

A livello internazionale, linee guida sono state fornite in numerosi documenti, sia di applicazione generale che di applicazione specifica. I documenti che presentano le linee guida più comprensive e accurate sono il Patto Internazionale Relativo ai Diritti Economici, Sociali e Culturali con il relativo Commento Generale N. 14, e il Fact Sheet N. 31. Nell'articolo 12 del Patto Internazionale Relativo ai Diritti Economici, Sociali e Culturali vengono elencate le misure fondamentali che gli stati devono prendere per assicurare la piena attuazione del diritto alla salute. Queste misure hanno come obiettivo la diminuzione del numero dei nati-morti e della mortalità infantile, nonché il sano sviluppo dei fanciulli; il miglioramento dell'igiene ambientale e industriale; la profilassi, la cura e il controllo delle malattie epidemiche, endemiche, professionali e d'altro genere; e la creazione di condizioni che assicurino a tutti servizi medici e assistenza medica in caso di malattia. Indicazioni più specifiche e dettagliate riguardo all'implementazione del diritto alla salute si possono trovare nel Commento Generale N. 14, che identifica quattro categorie di obblighi degli stati: obblighi generali, obblighi specifici, obblighi internazionali, e obblighi fondamentali. Gli obblighi degli stati sono inoltre di tre tipi. Rispetto al diritto alla salute gli stati hanno l'obbligo di rispettare, di proteggere e di adempiere, pertanto gli stati devono evitare di interferire con il godimento del diritto alla salute (rispettare), devono impedire qualsiasi forma di interferenza al diritto alla salute da parte di terzi (proteggere), e devono adottare misure adeguate per la piena attuazione del diritto alla salute (adempiere). Inoltre, gli stati devono riconoscere la fondamentale importanza della cooperazione e dell'assistenza internazionali, e devono pertanto agire sia individualmente che in collaborazione. Secondo il Commento Generale N. 14, gli obblighi fondamentali degli stati nei confronti del diritto alla salute sono garantire l'accesso a strutture,

beni e servizi medici senza discriminazione; assicurare l'accesso al cibo minimo essenziale e nutrizionale adeguato e sicuro, per garantire la libertà dalla fame a tutti; garantire l'accesso a riparo, alloggio e igiene di base e ad un'adeguata fornitura di acqua sicura e potabile; fornire i farmaci essenziali; garantire una distribuzione equa di tutti i beni, le strutture ed i servizi sanitari; adottare e attuare una strategia nazionale di sanità pubblica e un piano d'azione affrontando le preoccupazioni della salute di tutta la popolazione. Il Commento Generale N. 14 sottolinea anche gli obblighi di altri attori a livello internazionale, evidenziando in particolare il ruolo fondamentale di varie agenzie e vari programmi delle Nazioni Unite.

L'altro documento a livello internazionale che presenta linee guida sull'implementazione del diritto alla salute è il Fact Sheet N. 31. Secondo questa scheda informativa, gli stati hanno tre obblighi generali riguardo al diritto alla salute, ossia la realizzazione progressiva, l'adozione di misure adeguate per la realizzazione del diritto alla salute, e alcuni obblighi minimi fondamentali, che richiedono agli stati di garantire la soddisfazione dei livelli minimi essenziali del diritto alla salute. Così come per il Commento Generale N. 14, anche per il Fact Sheet N. 31 gli obblighi degli stati nei confronti del diritto alla salute sono rispettare, proteggere ed adempiere. Inoltre, anche questa scheda informativa riconosce le responsabilità di attori oltre che gli stati, ovvero di individui, di organizzazioni intergovernative e non governative, di professionisti della salute e di aziende private.

Linee guida sull'implementazione del diritto alla salute a livello europeo si possono trovare nell'articolo 11 della Carta Sociale Europea, che presenta in termini generali quali misure devono essere prese. Tali misure riguardano l'eliminazione delle cause di una salute deficitaria; la prevenzione delle malattie epidemiche, endemiche e di altra natura, nonché degli infortuni; e il garantire la presenza di consultori e servizi d’istruzione riguardo al miglioramento della salute ed allo sviluppo del senso di responsabilità individuale in materia di salute.

Nonostante il diritto alla salute sia riconosciuto e protetto, troppo spesso si rivela essere un mero diritto teorico, piuttosto che un diritto reale. Infatti, in molti paesi e per molte persone nel mondo la salute è ancora un privilegio piuttosto che un diritto. Questa affermazione è sostenuta da numerosi dati, tra cui il fatto che globalmente più di 400 milioni di persone non hanno accesso ad uno o più servizi sanitari essenziali.

Il sistema internazionale ha riconosciuto l'esistenza della discrepanza che esiste tra teoria e pratica per quanto riguarda il diritto alla salute, e di conseguenza sta cercando delle soluzioni alternative per implementare questo diritto in maniera più efficace.

Uno dei possibili modi per ottenere una migliore implementazione del diritto umano alla

salute è attraverso la copertura sanitaria universale.

La copertura sanitaria universale consiste nel garantire che tutti abbiano accesso ai servizi sanitari necessari senza dover subire difficoltà finanziarie. La copertura sanitaria universale è composta da tre dimensioni: popolazione, servizi sanitari, e copertura finanziaria. Tuttavia, non vi è ancora consenso sull'interpretazione di queste dimensioni, in particolare per quanto riguarda la dimensione "popolazione". Infatti, il termine "universale" è stato spesso interpretato come un obbligo legale degli stati a fornire assistenza sanitaria ai propri cittadini. Il problema è che questa definizione limita la portata della copertura a persone con cittadinanza, pertanto escludendo tutte le persone apolidi, che di conseguenza spesso si ritrovano a non poter accedere ai servizi sanitari essenziali. La copertura sanitaria universale è parte degli Obiettivi per lo Sviluppo Sostenibile da raggiungere entro il 2030, obiettivi incentrati sull'eliminazione della povertà, sulla lotta alle inuguaglianze, sulla protezione del pianeta, e sul garantire la prosperità a tutti gli esseri umani. Tra i 17 obiettivi, ve ne è anche uno dedicato alla salute, ovvero il terzo. Tale obiettivo consiste nell'assicurare la salute e il benessere a tutti e per tutte le età. Tra i vari traguardi inclusi in questo obiettivo, vi è anche il conseguimento della copertura sanitaria universale.

Passi verso l'attuazione della copertura sanitaria universale sono già stati fatti in numerosi paesi. Per misurare e monitorare il progresso nel processo di implementazione della copertura sanitaria universale bisogna tener conto di due dimensioni fondamentali: accesso ai servizi sanitari e protezione da difficoltà finanziarie. Per quanto riguarda la prima dimensione, vengono prese in considerazione quattro categorie di servizi: salute riproduttiva, materna, neonatale e infantile; malattie infettive; malattie non trasmissibili; accesso ai servizi sanitari. Per quanto invece riguarda la protezione da difficoltà finanziarie, bisogna analizzare l'incidenza di spese mediche catastrofiche e l'incidenza di impoverimento dovuto a spese sanitarie out-of-pocket. Il processo di implementazione della copertura sanitaria universale è peculiare di ogni paese, ma include tre passaggi fondamentali: raccogliere fondi sufficienti; ridurre i rischi finanziari e le barriere d'accesso; promuovere l'efficienza ed eliminare lo spreco. Il finanziamento del sistema sanitario è di fondamentale importanza per una realizzazione della copertura sanitaria universale di successo. Infatti, il modo in cui un sistema sanitario è finanziato influenza notevolmente la capacità della popolazione di ricevere le cure mediche necessarie senza incorrere in difficoltà finanziarie. Un grande problema riguardante il finanziamento di un sistema sanitario riguarda i pagamenti out-of-pocket per i servizi sanitari. Infatti, a cause di tali pagamenti, le persone spesso rinunciano alle cure mediche se impossibilitati a pagare, e quando in grado di affrontarle economicamente rischiano di

incorrere in difficoltà finanziarie estreme.

Un passaggio fondamentale verso una realizzazione effettiva e di successo della copertura sanitaria universale consiste proprio nel modificare il metodo di finanziamento del sistema sanitario, sostituendo i pagamenti out-of-pocket con una qualche forma di pagamento anticipato, che può essere basato sulle tasse o sull'assicurazione sanitaria sociale. In entrambi i casi, i contributi finanziari si basano sulle risorse economiche individuali, vengono raccolti in modo cumulativo, e vengono poi utilizzati per finanziare i servizi sanitari, la cui fornitura è sulla base della necessità. Nonostante vi siano svariati modi di finanziarie un sistema sanitario, un sistema di finanziamento pubblico è stato più volte riconosciuto come il modo migliore nel percorso vero la copertura sanitaria universale.

Lo scopo della copertura sanitaria universale è assicurare a tutta la popolazione l'accesso ai servizi sanitari essenziali e fornire una copertura finanziaria per prevenire il rischio di difficoltà finanziarie. Tuttavia, è comune trovare un divario tra quello di cui la popolazione ha bisogno circa la salute e la sanità, e quello che il governo è in grado di fornire. Pertanto, è necessario procedere passo dopo passo con un processo che deve essere guidato dal principio di equità. L'impostazione delle priorità deve essere guidata da tre principi: la copertura deve essere fornita sulla base della necessità, tenendo in particolar conto i bisogni delle persone svantaggiate; l'obiettivo principale deve essere la creazione del maggior miglioramento totale possibile nella salute; le contribuzioni economiche devono essere sulla base delle risorse personali e non sulla base della necessità. Criteri generalmente accettati per un'equa decisione delle priorità sono: efficacia dei costi, priorità per il più svantaggiato, e protezione dal rischio finanziario.

La copertura sanitaria universale è riconosciuta come una delle modalità più efficaci per implementare il diritto umano alla salute. Infatti, la copertura sanitaria universale può contribuire in grande misura alla realizzazione di questo diritto, in particolare attraverso la promozione di servizi sanitari globali, l'adozione dei principi di realizzazione progressiva e dell'efficacia dei costi, e lo sforzo ad eliminare ogni forma di discriminazione su basi finanziarie. Infatti, attraverso la copertura sanitaria universale sarà possibile garantire a tutte le persone l'accesso ai servizi sanitari essenziali e necessari senza che ci sia il rischio di incorrere in estreme difficoltà finanziare o addirittura di ridursi in povertà.

Pertanto, la realizzazione della copertura sanitaria universale può costituire un importante passaggio nel processo di miglioramento dello stato di salute a livello globale e di una piena realizzazione del diritto umano alla salute.