Chapter 3

For the definitive version please consult Toebes et al, Health and Human Rights in Europe, Intersentia 2012

The right to health, and the other health-related rights

Brigit Toebes

1. Introduction

In the previous chapters attention was paid to how the European institutions engage with health and human rights. Building on these chapters, this chapter will analyse the normative framework of the health-related rights. As mentioned in the introduction, a wide range of human rights is in one way or another connected to health. Box 1 gives an overview of the most important health-related rights.¹

Box 1 - rights and principles relevant for the protection and promotion of health

<table>
<thead>
<tr>
<th>Right/principle</th>
<th>UN provisions</th>
<th>European provisions</th>
<th>Health topics involved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dignity</td>
<td>1 UDHR</td>
<td>1 Biomedicine Convention Section 1 (Art 1) ECFR</td>
<td>‘Core notion’ and inter alia, protection of persons with disabilities Dying with dignity</td>
</tr>
<tr>
<td></td>
<td>10 ICCPR</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3 CRPD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Life</td>
<td>3 UDHR</td>
<td>2 ECHR</td>
<td>Abortion, maternal mortality, protection of the foetus Euthanasia, positive obligations to protect health</td>
</tr>
<tr>
<td></td>
<td>6 ICCPR</td>
<td>2 ECHR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>6 CRC</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>9 MWC</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>10 CRPD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Autonomy,</td>
<td>1, 3 UDHR</td>
<td>8 and 5 ECHR</td>
<td>Abortion, forced sterilisation, female genital mutilation Confinement of persons with mental disabilities Legal capacity (re disability)</td>
</tr>
<tr>
<td>Liberty and</td>
<td>9 ICCPR</td>
<td>1 and 7 Biomedicine Convention Rec (2004) 10 CoE 3 and 6 ECFR</td>
<td></td>
</tr>
<tr>
<td>security of the</td>
<td>5(b) CERD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>person</td>
<td>37(b)-(d) CRC</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Integrity</td>
<td>12, 14, 17 CRPD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prohibition of</td>
<td>5 UDHR</td>
<td>3 ECHR</td>
<td>Confinement of persons with mental disabilities Access to health care for prisoners Rape, sexual abuse</td>
</tr>
<tr>
<td>torture and</td>
<td>CAT</td>
<td>7 ECHR</td>
<td></td>
</tr>
<tr>
<td>inhuman and</td>
<td>7 ICCPR</td>
<td>4 ECFR</td>
<td></td>
</tr>
<tr>
<td>degrading</td>
<td>15, 16 CRPD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Privacy and</td>
<td>12 UDHR</td>
<td>8 ECHR</td>
<td>Physical and psychological integrity, including personal autonomy in the context of medical interventions Protection of personal data Involuntary placement in an institution Prohibition of compulsory use of contraceptives, non-voluntary sterilisation or abortion</td>
</tr>
<tr>
<td>family life</td>
<td>17 ICCPR</td>
<td>7, 10 Biomedicine Convention 7-8 ECFR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>10 ICESCR</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>16 CEDAW</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>16 CRC</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>22, 23 CRPD</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marry and found</td>
<td>16 UDHR</td>
<td>12 ECHR</td>
<td>Prohibition of compulsory use of contraceptives, non-voluntary sterilisation or abortion</td>
</tr>
<tr>
<td>a family</td>
<td>23 ICCPR</td>
<td>9 ECFR</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5(d)(iv) CERD</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>16 CEDAW</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>8, 9 CRC</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

At the core of our health and human rights’ analysis lies the international ‘right to health’. As the right to health is so important for our analysis, in this chapter we will start with an elaborate explanation of the meaning and implications of this human right. Subsequently a shorter overview is provided of the scope of the other most
important health-related rights. It should be born in mind that while the right to health is the core or key right in this debate, it should not be seen as an umbrella right that covers the normative framework of the other health-related rights. While such an approach would make the right to health immensely broad and intangible, it would also deny the specific meaning of the other health-related rights.

2.1 The right to health

2.1.1 Introduction

A right to health, or a right to health care, suggests that States bear a certain responsibility for the health of their inhabitants. A sense of State responsibility or at least community responsibility for the health of the public has existed since ancient civilisations. The public health concerns during the earlier centuries were, however, mainly utilitarian in character. It was recognised that without government interference serious public health problems, including the spread of infectious diseases, were likely to arise. Gradually, the concerns became more sensed towards individual wellbeing, which eventually led to the recognition of health as a right in the various human rights instruments adopted after World War II. ²

Currently it is generally recognised that government interference in the maintenance and promotion of public health is required to prevent health disparities and other threats to people’s health. There is a general acceptance that the provision of health cannot be left solely to private parties. Although private health care providers may be very capable of providing good-quality health-related services, they do not have an interest in improving the health of the population as a whole, nor of certain marginalised population groups. It is therefore accepted that government interference is required to prevent selection of customers on the basis of, for example, health criteria, income or geographic conditions.³

Government intervention is also necessary because individuals themselves are not always capable of caring for their own health completely, due to such factors as financial resources, lack of information and impaired decision-making capacities. They may carry a certain personal responsibility for their own health, but governments have to provide for a health infrastructure and create conditions under which the availability, accessibility and quality of health services are guaranteed.⁴

It is one step to recognise governmental responsibility over the health of the population. However, to recognise a right of the individual to health services goes yet one step further. Health may be an important social good, but the recognition of health as a human right creates problems regarding the distribution of health services. As such, the ‘right to health’ is a controversial right that has led to much confusion and debate. It is difficult to define ‘health’ and it is challenging to indicate the boundaries of entitlements to health-related services. As a result, the ‘right to health’ is difficult to delineate while it is problematic to enforce such a right before a court of law.⁵

---

⁵ Toebes, 2009, p. 366.
However, over the past fifteen years much progress has been made as regards the definition of the right to health.

The most important provision on the right to health at the European level is Article 11 of the (Revised) European Social Charter (ESC). While this provision contains a right to protection of health, several other provisions in the ESC also contain health-related claims. Before discussing these provisions more elaborately, we need to look at global definitions of the right to health, as such provisions have set the stage for the adoption of the European ones.

2.1.2 The right to health at the UN level

The first instrument to lay down a right to health was the Constitution of the World Health Organization, adopted in 1946.⁶ The preamble to the Constitution, which defines ‘health’ and recognises health as a right was a breakthrough in the field of international health and human rights law. It created an important point of departure for the further elaboration of a right to health in human rights documents. It is also interesting that this text defines both ‘health’ and ‘health as a right’, a distinction that was also made in the introduction of this book. The text of the preamble defines ‘health’ as ‘a state of complete physical, mental and social well-being and not merely the absence of disease’. It is striking that this provision contains an absolute and broad definition of health, which not only embraces physical but also mental and social wellbeing. Furthermore, as mentioned, the preamble recognises health as an individual human right. In connection to this, the text refers to the relation between health problems and unequal development in different countries, to the importance of the healthy development of the child, and to the importance of the informed opinion and active co-operation on the part of the public. This approach did not get the approval of everyone; for example the American Medical Association stressed that the provision of health care services should be considered a concern of the individual nation rather than of an international health organization.⁷

In spite of such objections, the text was adopted and has clearly inspired the right to health provisions that were drafted at a later stage, in particular Article 12 of the UN International Covenant on Economic, Social and Cultural Rights (ICESCR). Article 12 ICESCR contains a provision along the lines of the WHO Constitution. This provision is broader than the previously adopted Article 25 of the Universal Declaration of Human Rights, which embeds a right to health in a broader provision on a right to an adequate standard of living.⁸

An issue that was heavily debated during the drafting process of Article 12 ICESCR was the question of whether the provision should contain a definition of health. Several drafters objected to the insertion of a definition of health on the basis of the argument that such a definition is not appropriate in a legal instrument. The final text

---

⁸ Toebes, 1999, p. 43.
of 12 ICESCR therefore, does not contain a definition of health. What has not been deserted is the broad approach to health, the notion that health is not merely the ‘absence of disease’. Although the concept of ‘social well-being’ has been deleted, the steps mentioned in the article reflect the interpretation of health as a broad concept, in referring also to environmental hygiene, preventive health care, and occupational diseases.

The provisions that followed were Article 12 of the Convention on the Elimination of all forms of Discrimination Against Women (CEDAW, 1979) and Article 24 of the Convention of the Rights of the Child (CRC, 1989). While 12 CEDAW focuses primarily on access to health care for women, Article 24 CRC covers the broader right to health of children, in referring not only to health care facilities, but also to adequate food, drinking water, and prohibition of harmful traditional practices. As a result, whereas Article 12 CEDAW is aimed at providing women with additional protection where this is needed, Article 24 purports to restate the principles of the WHO Constitution and of Article 12 ICESCR with respect to children.

In addition to the above-mentioned provisions a number of other UN treaties and declarations exist that refer to a right to health. Some of these provision focus on equal access to medical services. For example, the Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (MWC, 1990), puts emphasis on equal access to medical care for migrant workers. Article 5(e)(iv) of the Convention on the Elimination of All Forms of Racial Discrimination (CERD, 1965) is slightly more elaborate, in that it provides in general terms that States Parties are to prohibit and eliminate racial discrimination in the enjoyment of public health, medical care, social security and social services. Also worth mentioning are Rules 22 to 26 of the Standard Minimum Rules for the Treatment of Prisoners (1957), which lay down a number of principles for the treatment of sick prisoners. Finally, the Conventions of the ILO contain numerous references to a specific area of health, namely occupational health. Different in character is Article 25 of ILO Convention No. 169 (1989), which explicitly recognises a right to health of indigenous and tribal peoples. Lastly, worth mentioning is the Convention on the Rights of Persons with Disabilities (CRPD, 2006), which contains several references to the health of disabled persons, including Article 25 on the right to health of disabled persons (see also chapter 9).

2.1.3 The right to health at the European level

In addition to such global provisions, the right to health is set forth in a number of regional human rights instruments. Given the scope of this book we will focus on the relevant European provisions. The European Social Charter, adopted in 1965,
contains a ‘right to protection of health’ in Article 11. An initial draft, which had several similarities with Article 12 ICESCR, was eventually narrowed after objections made by several States against such a far-going text. The final text of Article 11 ESC defines three general state undertakings, which will be more elaborately discussed below. It tries to bring the responsibility of governments into perspective by referring to the individual responsibility in matters of health and to co-operation with public and private organisations. The text does not refer to child health and environmental health, yet these matters are raised within the framework of the reporting procedure. In 1996, a revised text of the ESC was adopted by the Committee of Ministers (the ‘Revised ESC’). Apart from a reference to the prevention of accidents in paragraph 3, Article 11 ESC was left unchanged. The (Revised) ESC recognises several other health-related rights, the most important of which are Article 3 (safety at work); 12 (social security); 13 (social and medical assistance); 7 and 17 (protection of mothers and children); 19 (protection and assistance to migrant works and their families); and 23 (social protection of the elderly).

As was also mentioned in chapter 1, the European Committee on Social Rights monitors compliance with the European Social Charter. Organisations entitled to submit a so-called ‘collective complaint’ regarding the alleged violations of the rights in the Charter may lodge their complaint with the Committee. So far the Committee has handed down more than 40 decisions. As at September 2011, three of these decisions had led to the conclusion that there was a breach of the right to protection of health under Article 11 of the Charter. Interestingly these three decisions each concern a different aspect of the right to protection of health. The first decision concerned the right to a healthy living environment and healthy working conditions (Marangopoulos), the second concerned the access to healthcare services of the Roma population in Bulgaria (ECR v. Bulgaria). The third decision concerned the right to access to sexual and reproductive health education in schools in Croatia (INTERIGHTS v. Croatia).

The Convention on Human Rights and Biomedicine (Biomedicine Convention) formulates a duty on the part of Member States to provide ‘equitable access to health care of appropriate quality’. The terms ‘equitable access’ and ‘appropriate quality’

---

14 It should be noted here that not all Contracting States have ratified the Revised Charter: to them the (old) text of the ESC applies.
are comparable to the principles formulated under the ‘AAAQ’ in General Comment 14 (see below). Given the scope of the treaty, i.e. areas concerning the application of biology and medicine, this provision focuses on the narrower area of healthcare, and not on the underlying determinants for health.

The Charter of Fundamental Rights of the European Union (ECFR, 2000) contains in article 35 a provision on health care. Contrary to the Biomedicine Convention, the first sentence of this provision recognises an individual right to preventive as well as curative health care, albeit under the conditions established by national laws and practices. The second sentence expresses a “mainstreaming” state obligation of health protection by providing that a high level of human health protection has to be ensured in the definition and implementation of all Union policies and activities (see also chapters 2 and 9).

2.1.4 Constitutional provisions

The right to health is also firmly embedded in national constitutional law. According to the former UN Special Rapporteur on the Right to Health, Paul Hunt, over 100 national constitutional provisions now include the right to health, the right to health care, or health-related rights such as a right to a healthy environment. A distinction can be made between common law and civil law countries. Common law countries generally do not have an explicit right to health in their constitution. The Constitution of the Republic of Ireland, for example, contains no reference to health. Many civil law countries, on the other hand, have an explicit or implicit right to health in their constitution. The Constitution of the Netherland for example, does not contain an individual right to health but defines the duty of the Dutch Government to take steps to promote the health of the population. More explicit recognitions of a right to health can be found in the Constitutions of the former Socialist Republics. The Charter of fundamental rights and basic freedoms of the Czech Republic, for example, contains the following provision in Article 31:

‘Everyone has the right to the protection of his health. Citizens shall have the right, on the basis of public insurance, to free medical care and to medical aids under conditions provided for by law.’

This provision contains an explicit right to protection of health which is made subject to public insurance and national legal conditions.

---

19 Yet, a reference to health is sometimes made in the preamble to the constitution or couched in terms of a state policy. An example is India, where a State duty to improve health is stipulated as one of the ‘Directive Principles of State Policy’. Interestingly, this provision has been used by the Indian Supreme Court to broaden the scope of the right to life in the Indian Constitution so as to give it a health dimension. See also Toebes, 1999, pp. 79-84.
20 Article 22-1 of the Constitution of the Netherlands.
2.1.5 The scope of the right to health

The right to protection of health in Article 11 ESC is a broad right covering both healthcare and the underlying conditions for health. This broad approach to the definition of health as a right has been influenced by the approach taken at the UN level. An important landmark concerned the adoption of General Comment No. 14 on the ‘right to the highest attainable standard of health’ in Article 12 ICESCR, adopted in 2000 (General Comment 14), after consultation with NGOs and WHO. General Comment is a document drawn up by a UN treat-monitoring body that explains the meaning and implications of a certain aspect of the treaty concerned and that seeks to assist States parties to fulfil their reporting obligations. While General Comments are strictly speaking not legally binding (‘soft law instruments’), General Comments are increasingly being referred to in legal scholarship and practice. As such they can be considered as influential and authoritative documents which can supersede the status of mere soft law.

General Comment 14 reflects the debate about the right to health that took place in the years leading up to the adoption of this text. It is an influential document that gives an authoritative explanation of the meaning and implications of the right to health. General Comment 14 recognises the somewhat absolute wording of the term ‘right to health’ by stating that the right to health is not a right to be healthy. As such, it confirms the notion expressed by Leary, that the right to health is to be used as a ‘shorthand expression’, which refers to the more elaborate treaty texts. At the international level therefore, the term ‘right to health’ is used, instead of the narrower term ‘right to healthcare’. The term ‘right to healthcare’ is however suitable and more specific where it concerns discussions regarding access to healthcare services.

Furthermore, it is important to note that General Comment 14 takes a broad approach to the definition of health as a human right. It recognizes that the right to health in 12 ICESCR is not confined to the right to health care, but extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment. This reinforces the notion that underlying determinants for health are at least as important for people’s health as access to health care services. There is a growing amount of research indicating that the circumstances under which people live and work are decisive for their health and well-being. It is increasingly argued that the growing health inequalities (that exist also in Europe) should be addressed by trying to improve people’s living conditions and their lifestyles (see also Chapter 7 of this book).

---

23 General Comment 14, paragraph 8.
25 General Comment 14, paragraph 4.
27 For example, World Health Organization/Commission on the Social Determinants of Health, Closing the gap in a generation, 2008.
2.1.7 Elements of the right to health

As was mentioned, the right to health covers access to healthcare services as well as a number of determinants to health. Access to such services are formulated as State duties or undertakings. The second paragraph of Article 12 ICESCR mentions the following State undertakings:

- the provision for the reduction of the stillbirth-rate and of infant mortality and for the healthy development of the child;
- the improvement of all aspects of environmental and industrial hygiene;
- the prevention, treatment and control of epidemic, endemic, occupational and other diseases;
- the creation of conditions which would assure to all medical service and medical attention in the event of sickness.

Along similar lines, Article 11 (Revised) ESC contains the following State undertakings:

- to remove as far as possible the causes of ill-health;
- to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
- to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.

Although both provisions focus on different health-related issues, it is clear that the range of State undertakings goes further than providing mere healthcare services. In a comprehensive report, the secretariat of the ESC explains that Article 11 covers numerous issues relating to public health, such as food safety, protection of the environment, vaccination programmes and alcoholism.28 Within the framework of its reporting procedure, this European Committee of Social Rights pays attention to a wide range of health-related issues that go beyond the mere ‘provision of healthcare services’. Attention is paid, *inter alia*, to the reduction of environmental risks, food safety, health education in schools, measures to combat smoking, tobacco control, and accidents.29 And as was illustrated in Chapter 1, the case law of the Economic Committee of Social Rights has addressed not only access to health care but also access to sexual health education and environmental health under the umbrella of the right to protection of health in Article 11 (Revised) ESC.

2.1.8 Guiding principles for the right to health

General Comment 14 mentions a set of principles that is widely used for the definition of the general framework of the right to health (paragraph 12). Similar principles can be found in the General Comments on the right to food, housing, and education. This set of principles relates not merely to healthcare services but to the broad range of

---


‘functioning public health and healthcare facilities, goods and services’. This set of principles can be useful for assessing health-related rights in a policy framework, for example. For example, it can be a helpful tool when analysing the impact of planned healthcare commercialisation trends. Countries could be asked to use this framework for so-called ‘human rights impact assessments’ of planned healthcare reforms.

This set of principles, also addressed as the ‘AAAQ’ reads as follows:

- **Availability** of health-related services does not refer so much to the distribution of health services, but rather to the general availability of health services. It requires that ‘functioning public health and health-care facilities, goods and services, as well as programmes, are available in sufficient quantity within the State party’.

- **Accessibility** implies that ‘health facilities, goods and services have to be accessible to everyone without discrimination, within the jurisdiction of the State party’. According to the General Comment, accessibility has four overlapping dimensions:
  1) **non-discrimination**: ‘health facilities, goods and services must be accessible to all, especially the most vulnerable or marginalized sections of the population, in law and in fact, without discrimination on any of the prohibited grounds’;
  2) **physical accessibility**: ‘health facilities, goods and services must be within safe physical reach for all sections of the population, especially vulnerable or marginalized groups, such as ethnic minorities and indigenous populations, women, children, adolescents, older persons, persons with disabilities and persons with HIV/AIDS’;
  3) **economic accessibility** (affordability): ‘health facilities, goods and services must be affordable for all. Payment for health-care services, as well as services related to the underlying determinants of health, 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’; and
  4) **information accessibility**: ‘the right to seek, receive and impart information and ideas concerning health issues’. As also mentioned by Mette Hartlev in chapter 4, this undertaking embraces the duty to provide information about community health problems (eg epidemics).

- **Acceptability** requires that ‘all health facilities, goods and services are 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’.

- **Quality** implies that ‘health facilities, goods and services are scientifically and medically appropriate and of good quality’. This requires, *inter alia*, ‘skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation’.

---

30 General Comment 14, paragraph 12.
Two principles are increasingly being referred to in a right to health context: accountability and participation (and as such we can refer to a broader set of principles which can be abbreviated to ‘AAAQ-AP’):

- **Accountability**\(^{32}\) has been described by Potts as a broad process which requires governments to show, explain and justify how they have discharged their obligations regarding the right to health. An effective accountability process comprises the following essential elements according to Potts: monitoring, accountability mechanisms, remedies, and participation.\(^{33}\) Monitoring is aimed at providing governments the information that they need to create transparent health policies, as well as providing rights-holders with essential health-related information.\(^{34}\) ‘Accountability mechanisms’ can be judicial or quasi-judicial (for example a health ombudsman or other independent complaint mechanism), as well as administrative, political or social in character.\(^{35}\) States should establish supervisory bodies which monitor the actions and decisions of actors in the health sector on actors in the health sector, be they public or private actors, ranging from hospitals to health equipment providers and where necessary impose sanctions upon them.

- **Participation**\(^{36}\) requires that the public has a say in important decisions concerning the health sector, for example, the decision to privatise or decentralise (parts of) the health sector. States should ensure political participation in the decision-making on the organisation of the health sector. Political participation is not only realised through a democratic system of elections, but also by providing for public enquiries regarding planned health sector reform. When it comes to the health budget, it has been pointed out that the public and/or civil society can be actively included in all stages of the budget cycle for the health sector. Public budget hearings can be held at the local level to involve citizens in the way public services are delivered.\(^{37}\)

2.1.9 **Vulnerable groups**

Another important notion underlying the right to health concerns the emphasis on ‘vulnerable groups’ when it comes to accessing health services (see chapters 7-10). UN General Comment 14 pays attention to the position of vulnerable groups. It stipulates in paragraph 19 that States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and health-care facilities, and to prevent any discrimination on internationally prohibited grounds in the provision of health care and health services. Singled out as vulnerable groups are women, children and adolescents, older persons, persons with disabilities, and indigenous peoples. In addition, several UN treaties guarantee the health rights of a

---


\(^{33}\)Potts, pp. 13-17.

\(^{34}\)Potts, pp. 13-17.

\(^{35}\)Potts, pp. 17-27.


specific vulnerable group, including the Women’s Convention (CEDAW), the Children’s Convention (CRC) and the Convention on the Rights of Persons with Disabilities (CRPD).

The (Revised) ESC contains several rights that focus on a vulnerable group: Articles 17 (protection of mothers and children); 19 (protection and assistance to migrant works and their families); and 23 (social protection of the elderly). As was discussed in chapter 1, the case law of the European Committee on Social Rights has *inter alia* addressed the position of the Roma and of undocumented migrants.

2.1.10 Legal obligations

*Respect, protect, fulfil*

As a legal human right, the right to health imposes binding obligations on States that have ratified the treaties in which the right to health is set forth. The question arises, what do these legal obligations look like? An important concept that is elaborated in General Comment 14 concerns the distinction between three types of State obligations. The General Comment explains that the right to health, like all human rights, imposes three types or levels of obligations on States parties: the obligations ‘to respect’, ‘to protect’ and ‘to fulfil’.

The obligation to *respect* is a negative State obligation and requires States to refrain from interfering directly or indirectly with the enjoyment of the right to health. Examples of violations of these obligations are, according to General Comment 14: denying or limiting equal access to health services; enforcing discriminatory practices as a State policy; unlawfully polluting air, water and soil, e.g. through industrial waste from State-owned facilities, or through using or testing nuclear, biological or chemical weapons if such testing results in the release of substances harmful to human health.

The obligations to *protect* and to *fulfil* are positive State obligations, requiring States to take measures that prevent third parties from interfering with article 12 guarantees (protect); and to adopt appropriate legislative, administrative, budgetary, judicial, promotional and other measures towards the full realisation of the right to health (fulfil). Violations of the obligation to protect may occur for example when States decline to adopt legislation or to take other measures ensuring equal access to health care and health-related services provided by third parties; or when States decline to ensure that harmful social or traditional practices do not interfere with access to pre- and post-natal care and family-planning.

With regard to the obligation to fulfil, a distinction is made between obligations to facilitate (taking positive measures to enable and assist individuals and communities to enjoy the right to health), to provide (when individuals or a group are unable, for

---

38 It should be noted here that not all Contracting States have ratified the Revised Charter: to them the (old) text of the ESC applies, which contains similar guarantees. See [http://www.coe.int/t/dghl/monitoring/socialcharter/Presentation/TreatiesIndex_en.asp](http://www.coe.int/t/dghl/monitoring/socialcharter/Presentation/TreatiesIndex_en.asp) accessed March 2011.
39 *Inter alia*, ECCR v Bulgaria (46/2007) and DCI v the Netherlands (47/2008). See also chapter 1.
40 General Comment 14, paragraph 34.
41 General Comment 14, paragraph 35.
reasons beyond their control, to realise that right themselves (by the means at their disposal), and the obligation to promote (undertaking actions that create, maintain and restore the health of the population). Violations of the obligation to fulfil may, according to General Comment 14, occur when insufficient recognition is given to the right to health in the national political and legal systems; when States decline to adopt a national health policy with a detailed plan for realising the right to health; or decline to ensure provision of health care, including immunisation programmes against the major infectious diseases, and ensure equal access for all to the underlying determinants of health, such as nutritiously safe food and potable drinking water, basic sanitation and adequate housing and living conditions.

As is also explained by Sinding Aasen in chapter 10, this so-called ‘tri-partite typology of State obligations’ was first introduced into the human rights debate by Asbjørn Eide in 1981, and later refined by several other scholars and subsequently introduced into the UN human rights regime. It is generally considered to be a useful tool for analysing positive as well as negative obligations inherent in all rights, and as such for underlining the equality and interdependence of all human rights. However, the usefulness of this tool has also been put to question. Koch for example argues that the distinction between the three categories is blurred and that it is very difficult to fit a certain obligatory measure into the tripartite typology. She argues that ‘confronted with the complexities of real life the various obligations are hard to distinguish from one another’. And ‘(…) the adequate metaphor would rather be a slope, not divided into levels (…)’. Koch also notices that the case law of the ECtHR does not apply the tri-partite typology. According to Koch ‘The Court is not preoccupied with the issue of fitting a certain obligation into a certain category (…)’. While we should not overstate the usefulness of this typology, it can be a helpful tool when it comes to the identification of the legal obligations resulting from economic, social and cultural rights, including the right to health.

**International obligations**

Furthermore, General Comment 14 mentions the international obligations of States with regard to the right to health, which are also stipulated in Article 2(1) of the ICESCR. States are to respect the right to health in other countries, and to prevent third parties from violating the right in other countries. For example, this obligation is of importance with regard to the tension between patent protection and the accessibility of drugs in developing countries.

42 General Comment 14, paragraph 37.
43 General Comment 14, paragraph 36.
47 See also Chapter 2.
obligation contains a reference to providing development aid where necessary. The General Comment refers to the obligation to facilitate access to essential health facilities, goods and services in other countries, wherever possible and to provide the necessary aid when required.48

**Core obligations**

Finally, General Comment 14 refers in paragraphs 43-44 to the definition of core obligations, which implies that States parties have certain minimum obligations to ensure under all circumstances the satisfaction of minimum essential levels of, in this case, essential health services. For the further definition of these core obligations the General Comment draws from the Programme of Action of the International Conference on Population and Development (UNDP, Cairo 1994), and the Primary Health Care Strategy as set forth in the Alma-Ata Declaration (WHO, 1978). As such, the core obligations include among other things the obligation to provide access to health facilities on a non-discriminatory basis, in particular reproductive, maternal and child health care, immunisation against the major infectious diseases, prevention, treatment and control epidemic and endemic diseases, education and access to information concerning the main health problems in the community, and appropriate training for health personnel, including education on health and human rights. It should be noted that national courts have so far rejected the existence of an immediately enforceable core content in the right to health.49 We can also doubt whether the definition of core obligations is useful in a European context where generally accessible health care packages go beyond the core obligations mentioned above. The notion of a ‘core’ could possibly be of some use in the debate over which healthcare services should be available to deprived or uninsured persons or population groups, including undocumented migrants.

2.1.11 The right to health: responsible actors

It is increasingly argued that other actors besides States have obligations under human rights law. International (human rights) law provides several bases for this assumption.50 For example, the preamble to the Universal Declaration of Human Rights recognises the human rights responsibilities of ‘all organs of society’. And important for our purposes, Article 11 (Revised) ESC refers to the collaboration between the State and public and private organisation towards the realisation of the right to protection of health. Already at the time of the drafting of this provision, there was awareness of the role that private organisations play in the provision of medical care.51 Nonetheless, recognition of the human rights obligations of other actors

48 General Comment 14, paragraph 39.
49 For example, in the decision in Minister of Health and Others v. Treatment Action Campaign and Others (2005), the South-African Constitutional Court argued that ‘all that can be expected from the state is that it act reasonably to provide access to the socio-economic rights (…) on a progressive basis’ (paragraph 35). On the reasonableness approach, see also Koch, 2005, p. 287.
50 In this regard, reference is often made to the body of International Humanitarian Law and to the Genocide Convention, which both contain references to the human rights responsibilities of non-state actors. For this debate see, *inter alia*, Nicola Jägers, *Corporate responsibility for human rights violations*, Antwerp/ Oxford: Intersentia/HART, 2000.
besides States should never undermine the primary responsibility of States under international law.

One could argue that non-state actors have a so-called derived or indirect responsibility to realise those elements of human rights that lie in their scope of influence. This means, for example, that corporations have obligations to safeguard the health of their employees, and that factories need to ensure the environmental health of the area in which they are based. Hospitals need to respect the privacy of their patients, and doctors need to respect the patients’ ‘informed consent’.52

As health service provision is increasingly privatised and put into the hands of private providers, it is important to consider the (human rights) responsibilities of all the actors in the health sector. While governments remain ultimately responsible for human rights violations, it is important to develop the tools to address private actors directly. Furthermore, health sectors are very complex in character due to the fact that many actors engage with each other in multiple relationships. This makes health sectors extremely vulnerable to abuse and corruption, hence the importance of addressing abuse and corruption by all the actors in the health sector.53

It would be desirable to define the human rights responsibilities of all the actors in the health sector, varying from health ministries, social security organisations, public and private insurers, hospitals, doctors, pharmacists, to pharmaceutical companies, producers of medical equipment, and patients. For example, the perceived responsibility of the pharmaceutical industry to produce and provide affordable and good quality drugs geared towards the health needs of the population at large has been the subject of intense debate. But also the role of healthcare providers, hospitals, medical research and patients can potentially be addressed under international human rights law.

2.1.10 The right to health and public health

A distinction can be drawn between ‘medicine’ and public health’. While medicine is more concerned with the health and rights of the individual (eg creating conditions enabling a particular individual access to care), public health is more aimed at the protection of collective health interests.54 Since the right to health represents individual claims to health towards governments, it clearly represents the concept of ‘medicine’. The question arises whether and if so, to what extent, the right to health also contains claims to ‘public health’. Meier and Mori argue that the concept of a ‘right to health’ insufficiently reflects this perspective. They point at the escalation of endemic diseases and the rapid proliferation of infectious and chronic diseases, and to the uneven distribution of wealth and increases in poverty. They claim that the current

definition of a right to health is no longer applicable to a globalising world, which requires a renewed focus on the societal factors that facilitate the spread of disease.\textsuperscript{55}

According to Gruskin and Tarantola, both ‘medicine’ and ‘public health’ ideally seek to ensure every person’s right to achieve the right to the highest attainable standard of health, and both have a strong focus on the individual. As such, the right to health would both contain a ‘medicine’ component, in the sense that it is aimed at protecting the individual’s right to medical care, as well as a ‘public health component’ in the sense that it obliges governments to effectuate a national health policy and to enhance the health of the public.\textsuperscript{56}

There can be a certain tension between public health component of the right to health and the civil and political rights of individuals, including the rights to physical integrity and privacy.\textsuperscript{57} For example, while the public at large has an interest in being protected against the spread of infectious diseases, individuals have a right to be protected against unnecessary interference in their private sphere. Clearly, caution should be observed if the right to health is used to justify certain types of governmental health measures. Although, as mentioned above, the state has an obligation to protect ‘the right to health, it cannot take such measures to the extent that they violate the rights of others. According to WHO, restrictions to rights are only allowed as a last resort and should meet the so-called ‘Siracusa Principles’, a set of UN principles on the limitations of human rights (see also chapter 4).\textsuperscript{58}

2.1.12 Justiciability of the right to health

Justiciability refers to the enforceability of a norm before a judicial or quasi-judicial body. The justiciability of the right to health and of other economic, social and cultural rights has been the subject of much debate.\textsuperscript{59} There is generally great reluctance on the part of the judiciary to assess cases on the basis of economic, social and cultural rights. Not only because the wording of these rights is often general and open-ended, but also because the judiciary does not want to interfere too much with the margin of appreciation of the legislator. To find evidence of the justiciability of economic and social rights, scholars have gone in search of examples of cases in


\textsuperscript{56} Gruskin and Tarantola, 2000, p. 16.

\textsuperscript{57} See also Article 8(2) ECHR, which stipulates under which conditions an interference with the right to private and family life is allowed; it includes restrictions ‘for the protection of health and morals’.


which such rights were deemed justiciable. In fact, international and domestic courts have increasingly enforced access to health-related services.\textsuperscript{60}

However, most of the examples of enforceability of the right to health have materialised in lower and middle income countries where more dramatic cases have been addressed before the courts.\textsuperscript{61} Due to absence of the minimum social service flours in many countries, the violations of the rights are clear and persistent. In the developed world, where the debate is much more about the sufficiency of the benefit level, there is more reluctance towards the enforceability or so-called ‘justiciability’ of economic and social rights, including the rights to health, education, and employment. When it comes to Europe, some of the most illustrative decisions have been produced by the European Committee of Social Rights, which were discussed in Chapter 1. While such cases address a wide range of health-related topics, a recurrent theme concerns the socio-economic protection of vulnerable groups, including the Roma and undocumented migrants. It seems that in situations where the generally available services are not available or are denied to a certain population group, the Court is willing to assess compliance with the rights set forth in the (Revised) ESC.

3. Other health-related rights

3.1 Introduction

As mentioned above the right to health does not stand alone, but is reinforced and supported by several other rights. General Comment 14 affirms that:

‘the right to health is closely related to and dependent upon the realisation of other human rights, as contained in the International Bill of Rights, including the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information, and the freedoms of association, assembly and movement.’\textsuperscript{62}

It goes well beyond the scope of this chapter to discuss all the rights elaborately. However, in order to draw the scope of the area of ‘health and human rights’ some of the rights will be discussed more briefly below. Where relevant, references will be made to other chapters in this book.

3.1 The right to life

The right to life is sometimes called the most important of all human rights. But there is also a danger in calling it the ‘supreme’ right, or to place it on top of a hierarchy. This could imply that the right to life should always prevail, while there may be occasions where a right to life is to be balanced against other rights or interests. An


\textsuperscript{61} A well-known example concerns the decision of the South African Constitutional Court in \textit{Minister of Health and Others v. Treatment Action Campaign and Others}, CCT 8/02 (decision July 5, 2002), on the general availability of the drug nevirapine, which is used to prevent the spread of HIV from mother to child.

\textsuperscript{62} General Comment 14, paragraph 3.
example concerns situations where the right to life of a foetus is recognised, conflicting with the rights to health and privacy of the woman.\(^{63}\)

A core aspect of right to life is the deprivation of life, including the issue of the death penalty.\(^{64}\) However, the scope of the right to life has expanded gradually and is now embracing a broader set of issues, several of which have clear connections to health, and the sphere of medical care. Altogether, we can roughly identify three dimensions in the right to life: issues covering the mentioned deprivation of life, the parameters of life, and the protection of life.\(^{65}\) It is especially these two last dimensions that are relevant for the protection of health.

With the parameters of life we refer to decisions surrounding the beginning and the end of life. The beginning of life touches upon the issue of abortion – and whether the unborn has a right to life, as opposed to the concurring rights of the pregnant woman. Starting at the UN level, where this question remains largely unresolved, a development in this debate can be observed in the decision of \textit{KL v. Peru}. In this decision Human Rights Committee (HRC), the treaty-monitoring body of the ICCPR, upheld that the refusal of the medical authorities to carry out a therapeutic abortion constituted a violation of Article 2 (life) in conjunction with Article 7, 17 (privacy) and 24 of the ICCPR of the woman.\(^{66}\) Furthermore, at the regional level, some differences can be observed when it comes to the status of the foetus: the American Convention on Human Rights (ACHR) protects the right to life ‘from the moment of conception’ (although the scope of this provision has been expanded in case law).\(^{67}\) Contrary to the ACHR, the ECHR does not recognise the right to life from the moment of conception, but allows Contract States to do so. As is more elaborately discussed in Chapters 1 and 5, the ECtHR leaves Contracting States with a wide margin of appreciation, while abortions are under circumstances considered to be in conformity with the ECHR.\(^{68}\) Lastly, in the African context, a clear provision is contained by the ‘Protocol to the African Charter on Human and Peoples’ Rights on the Rights of Women in Africa’, better known as the ‘Maputo Protocol’. Article 14 (2) (c) of this Protocol urges States parties to authorise medical abortion ‘in cases of sexual assault, rape, incest, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the foetus’.\(^{69}\)

\(64\) See Articles 2 ECHR and 6 ICCPR.
\(68\) See also more elaborately chapters 1 and 5.
Issues surrounding the end of life have also been addressed in the framework of the right to life. In chapters 1 and 6 the well-known Pretty judgment is discussed, and the question of whether the right to life embraces a ‘right to die’.\(^7^0\) While the ECtHR has rejected this assumption, it seems that other rights, including the prohibition of torture and the right to private and family life may play a more significant role when it comes to respecting or fulfilling a person’s wish to die.\(^7^1\)

Thirdly, the right to life embraces positive obligations to take measures to protect life. This means inter alia that States must adopt criminal legislation to punish individuals who deprive others of their right to life, and establish a police force and take other measures to maintain law and order.\(^7^2\) But it may also embrace positive measures to offer protection against serious health and environmental problems and to offer essential health services. The Human Rights Committee (HRC) gives a broad interpretation of the right to life, by claiming that it ‘cannot properly be interpreted in a restrictive manner, and the protection of this right requires that States adopt positive measures’.\(^7^3\) With respect to such positive measures, the HRC refers to measures to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics.\(^7^4\)

The ECtHR takes an approach comparable to the HRC. In the decision of *Cyprus v. Turkey*, the ECtHR recognised that ‘an issue may arise under Article 2 of the Convention where it is shown that the authorities put an individual’s life at risk through the denial of healthcare which they have made available to the population generally’.\(^7^5\) As was also discussed in chapter 1, the ‘protection of life’ also embraces the questions surrounding hunger strike, and the duty to investigate deaths. Furthermore, the protection of life may entail protection against environmental health threats, such as in the case of *Öneryildiz v. Turkey*, where a methane explosion at a rubbish tip caused the death of thirty-nine slum dwellers.\(^7^6\) Altogether, when it comes to the duty to protect life under the right to life, the right to life clearly has a health-related dimension and in this regard it connects and overlaps with the scope of the right to health.

### 3.2 The right to liberty and security of the person

The right to liberty and security of the person is set forth in, *inter alia*, Article 5 ECHR. This provision primarily stipulates the right to (physical) liberty, subject only to lawful arrest or detention under certain other circumstances, such as arrest on suspicion of a crime or imprisonment in fulfilment of a sentence. But as discussed in

---

\(^7^0\) ECtHR 29 April 2002, *Pretty v. the UK*, no. 2346/02.

\(^7^1\) See notably ECtHR 20 January 2011, *Haas v. Switzerland*, no. 31322/07.

\(^7^2\) ECtHR 10 October 2000, *Akkoc v. Turkey*, Nos. n 22947 & 8/93, (in which the Court held that the right to life had been violated by the respondent State as it had not taken sufficient steps to protect the applicant’s (Kurdish) husband from being murdered).

\(^7^3\) HRC General Comment No. 06: The right to life, 30/04/1982 (sixteenth session, 1982), available at [www.unhchr.ch](http://www.unhchr.ch).

\(^7^4\) HRC, General Comment 6, paragraph 5.

\(^7^5\) ECtHR 10 May 2001, *Cyprus v Turkey*, , no. 25781/94, paragraph 219.

\(^7^6\) ECtHR 30 November 2004, *Öneryildiz v. Turkey* (GC), no. 48939/99.
Chapters 1, 4 and 5, there are several ECtHR judgments concerning the deprivation of liberty of persons with a mental disability.\(^\text{77}\)

In addition, the right to liberty and security of persons can be relevant in relation to matters relating to reproductive health, including regarding the wish to have an abortion, and the issues of forced sterilisation and female genital mutilation.\(^\text{78}\) For example, the right to liberty may imply a right on the part of the woman to choose an abortion and as such it may support the right to privacy. While the ECtHR has not addressed the right to liberty and security in such a way, some domestic courts have based access to an abortion on the basis of this right.\(^\text{79}\)

3.3 The right to privacy and family life

Article 8 ECHR combines the right to respect for privacy with the right to family life. This provision has several health-related dimensions, which are discussed more elaborately in chapters 1, 4, 5, and 6. It emerges that the rights to privacy and family life are connected to issues of personal autonomy, including access to medical data, the disclosure of confidential information, abortion, trans-sexualism, and end-of-life decisions.

Another dimension of the right to respect for privacy and family life concerns the protection against health risks and environmental harm in particular. In several decisions, the ECtHR has established a link between such health risks and the enjoyment of the right to privacy and family life.\(^\text{80}\)

3.4 Freedom of expression and the right to information

Article 10 ECHR contains the freedom to receive and impart information. The ECtHR does not construe this provision as imposing on a State a positive obligation to disseminate information or to disclose information to the public.\(^\text{81}\) As was discussed elaborately by Aart Hendriks in chapter 1, this right contains a negative obligation to refrain from interfering with the right to freely disseminate information, for example about the availability of abortion services.\(^\text{82}\) While the ECtHR does not recognise a positive obligation on the part of governments to disseminate information on the basis of Article 10 ECHR, Article 8 ECHR offers some solace: the ECtHR has recognised that Article 8 ECHR embraces a duty of healthcare providers to inform patients prior to treatment as part of the informed consent principle, reflecting the patient’s right to personal autonomy. Another dimension of Article 8 ECHR concerns the

\(^{\text{77}}\) Inter alia, ECtHR 24 October 1979, Winterwerp v. the Netherlands, no. 6301/73, paragraph 39.

\(^{\text{78}}\) See also Cook and Fathalla, 1996, p. 118.


confidentiality of medical files, and the physician’s duty not to disclose medical data to others without the patient’s consent (see chapter 1). Mette Hartlev concludes that the guidance provided by the case law is rather general and that in order to acquire a more detailed picture of the scope of a right to information, it is necessary to look into patients’ rights legislation (see more elaborately chapter 4).

The issue of access to information has also come up in a few cases concerning (environmental) health risks. In relation to the provision of environmental information, the Court has stated that the freedom to receive and impart information cannot be ‘construed as imposing on a State, (…) positive obligations to collect and disseminate information of its own motion’. Such an obligation was nonetheless – again - based on Article 8 ECHR. And in a more recent decision against the Czech Republic the Court has slightly expanded the scope of Article 10 ECHR. It recognised that the refusal of the Czech authorities to grant access to administrative documents regarding plans for a new nuclear power station is to be considered as an interference with the right to receive information as granted under Article 10 ECHR. This did however not lead to a violation of Article 10 ECHR because according to the Court the Czech authorities had reasoned in a pertinent and sufficient manner the refusal to grant access to the requested documents. Yet the implication of this decision is that restrictions of access to administrative documents now have to be assessed in light of the limitations clause in Article 10, paragraph 2 ECHR. According to Voorhoof, this decisions ‘opens new perspectives for citizens, journalists and NGOs for accessing administrative documents in matters of public interest’. 85

3.5 The right to marry and found a family

The general approach of the ECtHR is that the right to found a family does not embrace a positive right to increase the family. In a decision of 2003 the Court found that ‘the right to have grandchildren or the right to procreation is not covered by Article 12 or any other Article of the Convention.’ Yet the right to found a family may offer (additional) protection in situations where States are putting obstacles in the way of couples who wish to exercise their ability to procreate (see also chapter 5). An example concerns situations where the authorities seek to submit women to forced sterilisation or abortion. For example, in the case of the ECtHR in V.C. v. Slovakia, the complainant argued inter alia that her right to found a family had been breached on account of her sterilisation without her full and informed consent. Furthermore, the right to found a family could potentially embrace a positive obligation to provide relevant information and services on family

---

83 ECtHR 19 February 1998, Anna Guerra et al v. Italy, no. 14967/89 (where the Court decided that there was a violation of 8 ECHR). For other recent environmental cases see inter alia ECtHR 30 November 2004, Önerylidiz v. Turkey (GC), no. 48939/99 (violation of Article 2 ECHR) and ECtHR 19 October 2005, Roche v. UK (GC), no. 32555/96 (violation of Article 8 ECHR).
84 ECtHR 10 July 2006, Sdružení Jihočeské Matky v. The Czech Republic (admiss. dec.), no. 19101/03.
85 See Voorhoof above.
87 Margarita Šijakova e.a. v. Macedonië (admissibility dec.), 6 March 2003, no. 67914/01
89 ECtHR, V.C. v. Slovakia, case no. 18968/07 (admissibility decision of 16 June 2009).
planning and fertility; for example, to prevent a frequently occurring curable infection.  

3.6 The rights to benefit from scientific progress

Contrary to the American and African frameworks, the ECHR does not contain a right to enjoy the benefits of scientific progress. Nonetheless, several UN treaties contain this right, as well as the Declaration of Helsinki of the World Medical Association (see Box 1), and as such this norm influences the European (domestic) legal orders. The right to enjoy the benefits of scientific progress could require European governments and European institutions to give a high priority to medical research into the needs of vulnerable population groups, including women, children, and ethnic minorities.

3.7 Economic, social and cultural rights, and the protection of health

Other economic, social and cultural rights include the rights to housing, education, food and work. As will be addressed more elaborately in Chapter 7, there is growing awareness that the way in which people are raised, educated, live and work are decisive for people’s health, or the so-called ‘social determinants of health’. The other economic, social and cultural rights have the potential to enhance the improvement of people’s social determinants to health.

The right to education is of particular importance for the promotion and protection of health. Article 13(1) ICESCR affirms that education shall ‘enable all persons to participate effectively in society’. Research has consistently shown that people’s health is determined to an important extent by their general educational levels. Women’s education more particularly strongly influences improved reproductive health, including infant survival and healthy growth of children.

4. Conclusions

A wide range of rights was presented in this chapter which have the potential to protect and to promote health and which are relevant in a healthcare setting. Based on the internationally guaranteed right to health, there is a legally binding right to healthcare services and a right ensuring the necessary conditions for health, including access to health-related information, access to safe drinking water, occupational health, and the protection of environmental health. It remains unclear which services are granted exactly on the basis of the right to health, and the question arises whether it can be a useful tool for priority setting in healthcare. For these reasons, courts are reluctant to adjudicate cases on the basis of this right. Nonetheless, in combination with the principle of non-discrimination, the right to health proves an effective tool to

---

90 Cook and Fathalla give the example of tract infection, which is a serious cause of infertility in some parts of Africa. Cook and Fathalla, 1996, p. 119.

91 WMA Declaration of Helsinki, Ethical Principles for Medical Research Involving Human Subjects, Adopted by the 18th WMA General Assembly, Helsinki, Finland, June 1964 (last amended in 2008).

protect the health needs of vulnerable population groups, including women, children, and (undocumented) migrants.

Several other health-related human rights were mentioned in this chapter. On some occasions, such rights reinforce the right to health, for example when it comes to the principle of non-discrimination, and in situations where the right to life protects health. On other occasions such rights have a distinct meaning for the protection of health, for example where the right to privacy enables women the freedom to choose to have an abortion. Lastly, some rights have a specific meaning in healthcare settings, for example the right to liberty and security which sets limits to the involuntary placement in institutions of persons with mental disabilities.