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COUNCIL OF EUROPE AND THE RIGHT TO HEALTHCARE- IS THE EUROPEAN CONVENTION ON HUMAN RIGHTS APPROPRIATE INSTRUMENT FOR PROTECTING THE RIGHT TO HEALTHCARE?

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VIJEĆE EUROPE I PRAVO NA ZDRAVSTVENU ZAŠTITU – DA LI JE EUROPSKA KONVENCIJA ZA ZAŠTITU LJUDSKIH PRAVA ODGOVARAJUĆI INSTRUMENT ZA ZAŠTITU PRAVA NA ZDRAVSTVENU ZAŠTITU?

Sažetak

Europska konvencija za zaštitu ljudskih prava kao temeljni instrument Vijeća Europe za zaštitu građanskih i političkih prava ne jamči pravo na zdravstvenu zaštitu. Međutim, Europski sud za ljudska prava široko tumači Konvencijska prava, te je unutar konteksta članaka 2., 3. i 8. Konvencije dao određene naznake da bi se mogao početi baviti i pitanjem zdravstvene zaštite. U ovom radu bit će analizirani predmeti u kojima se Sud bavio pitanjem prava na zdravstvenu zaštitu kao i stajalište Suda u takvim predmetima. Za razliku od Konvencije, Europska socijalna povelja jamči pravo na zdravstvenu zaštitu u članku 11., te ga vrlo iscrpno i detaljno uređuje. Nakon prikaza prava na zdravstvenu zaštitu kako je zajamčeno i Konvencijom i Europskom socijalnom poveljom, u radu zaključujem kako se pitanje prava na zdravstvenu zaštitu treba prepustiti Europskom odboru za socijalna prava.

Ključne riječi: članci 2., 3. i 8. Europske konvencije za zaštitu ljudskih prava; pravo na zdravstvenu zaštitu; članak 11. Europske socijalne povelje.

1. INTRODUCTION

There is no universal definition on the right to health (or on the right to healthcare) and there has been significant disputation on the international and regional level regarding the concept of the right to health.¹ Article 25(1) of the Universal Declaration of Human Rights described the right to health in the following words:

“1. 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.”

The preamble of the 1946 World Health Organization (WHO) Constitution defined health broadly as a “state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”² It also enumerated some principles of this right as healthy child development; equitable dissemination of medical knowledge and its benefits; and government-provided social measures to ensure adequate health.

Later on, in its General Comment No. 14 the UN Committee on Economic, Social and Cultural Rights (CESCR) gave even broader definition of health:

“Health is a fundamental human right indispensable for the exercise of other human rights. Every human being is entitled to the enjoyment of the highest attainable standard of health conducive to living a life in dignity. The realization of the right to health may be pursued through numerous, complementary approaches, 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. Moreover, the right to health includes certain components which are legally enforceable.”

“The notion of the ‘highest attainable standard of health’ in Article 12.1 of the ICESCR takes into account both the individual’s biological and socio-economic preconditions and a State’s available resources. There are a number of aspects which

1 On the universal level, the right to health is protected in Universal Declaration of Human Rights 1948 (Article 25); International Covenant on Economic, Social and Cultural Rights 1966 (Article 12); Convention on the Rights of Child 1989 (Article 24); Convention on the Elimination of All Forms of Racial Discrimination 1965 (Article 5); Convention on the Elimination of All Forms of Discrimination Against Women 1979 (Articles 12 and 14); and Convention on the Rights of Persons with Disabilities 2007 (Article 25). Besides in the European Social Charter that will be discussed later in the paper, the right to health is also recognized in several other regional instruments, such as the African Charter on Human and Peoples’ Rights 1981 (Article 16), and the Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights 1999, known as the Protocol of San Salvador (Article 10).

2 The Constitution was adopted by the International Health Conference held in New York from 19 June to 22 July 1946, signed on 22 July 1946 by the representatives of 61 States (*Off. Rec. Wld Hlth Org.*, 2, 100), and entered into force on 7 April 1948.

cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health. Thus genetic factors, individual susceptibility to ill health and the adoption of unhealthy or risky lifestyles may play an important role with respect to an individual's health. Consequently, the right to health must be understood as a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health."³

Generally, the right to health is a traditional socio-economic right and it has been accorded the status of an aspirational right with the main problematic issue being its non-justiciable character. The European Convention on Human Rights (the Convention, ECHR), a Council of Europe (CoE) main human rights instrument on civil and political rights, contains no references to healthcare rights. However, the issue of providing healthcare in general has been raised before the European Court of Human Rights (the Court), mainly in relation to Articles 2 (right to life) and 8 (right to respect for private and family life). Nowadays, the Court is often using an 'integrated approach'⁴ when interpreting the Convention rights. This approach is predicated on the indivisibility of all human rights and "recognizes that, on the one hand, the enjoyment of civil and political rights requires respect for and promotion of social rights and, on the other hand, that social rights are not second best to civil and political rights."⁵ On that, one might say that the integrated approach has the advantage of opening the door to creative possibilities for litigation of social rights and re-conceptualizing of the contours of civil and political rights.⁶

The integrated approach to the protection of the right to health through traditional civil and political right to life is mostly visible in the jurisprudence of the Indian Supreme Court. The Indian Constitution was promulgated in 1947 and on its face does not provide legal protection of the right to health since the right to health is considered to be a directive principle of State policy.⁷ However, the Indian Supreme Court has provided the same level of protection to civil and political and economic and social rights, particularly the right to health, through the application of an expansive definition of the right to life. Already in the 1983 judgment,

3 CESCR, General Comment No. 14 (2000) E/C.12/2000/4 [1] and [9].

4 Robin C.A. White and Clare Ovey, *The European Convention on Human Rights* (5th ed OUP 2010) 75.

5 Ibid.

6 Alicia Ely Yamin, 'The Future in the Mirror: Incorporating Strategies for the Defense and Promotion of Economic, Social and Cultural Rights into the Mainstream Human Rights Agenda' (2005) 27 HUM. RTS. Q. 1200, 1219 (analysing strategies for the realization of economic, social, and cultural rights based on the indivisibility of all human rights).

7 Article 47 of the Indian Constitution contains the guarantee of the right to health, however, the right to health (as well as other economic and social rights) is consigned to the Directive Principles of State Policy section (Part IV). According to the Constitution the Directive Principles of State Policy "shall not be enforceable by any court, but the principles therein laid down are nevertheless fundamental in the governance of the country and it shall be the duty of the state to apply these principles in making laws." (Article 37).

Bandhua Mukti Morcha v Union of India and Others,⁸ the Supreme Court addressed the types of conditions necessary for enjoyment of health and held that right to live with human dignity involves the protection of the right to health. Later on, in a landmark case in this area, *Consumer Education and Research Centre v Union of India and Others* concerning the occupational health hazards faced by the workers in asbestos industry, the Supreme Court held that “the right to health and medical care is a fundamental right under Article 21 read with Articles 39(c), 41 and 43 of the Constitution and make the life of the workman meaningful and purposeful with dignity of person.”⁹ Another prominent decision with regard to health was *Paschim Banag Khet Samity v State of West Bengal*¹⁰ where the Supreme Court used the right to life to secure the right to emergency medical care. The facts that led to the case were that a train accident victim was turned away from a number of government-run hospitals in Calcutta, on the ground that they did not have adequate facilities to treat him. The said accident victim was ultimately treated in a private hospital but the delay in treatment had aggravated his injuries. The Supreme Court concluded that such an essential obligation could not be avoided by invoking financial problems and that the right to emergency medical care formed a core component of the right to health which in turn forms an integral part of the right to life.

As to the national systems that have provided constitutional recognition of the right to health and other economic, social and cultural rights the best example is the South African system. The specific provision protecting the right to health is Article 27 of the South African Constitution,¹¹ and health rights (together with housing rights) have provided the most significant cases concerning economic, social and cultural rights considered by the South African courts, particularly by the Constitutional Court.¹²

Returning to the European Court of Human Rights, what might be said, and is also in a way expected, is that the Court’s use of integrated approach and dynamic interpretation will include the right to healthcare in general, at least to some degree, in the Convention, particularly after the Court has gone in its dynamic interpretation of the right to satisfactory detention conditions and healthcare in prisons and the right to a healthy environment.¹³ However, it looks as though regarding the right to

8 *Bandhua Mukti Morcha v Union of India and Others* (1984) SCR (2) 67.

9 *Consumer Education and Research Centre v Union of India and Others* (1995) 3 SCC 42 [26].

10 *Paschim Banag Khet Samity v State of West Bengal* (1996) 4 SCC 37.

11 South African Constitution No. 128 of 1996, Article 27 (1) Everyone has the right to have access to (a) health care services, including reproductive health care; (b) sufficient food and water; and (c) social security, including, if they are unable to support themselves and their dependants, appropriate social assistance. (2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights. (3) No one may be refused emergency medical treatment.

12 For example, see cases *Soobramoney v Minister of Health KwaZulu Natal* 1997 (12) BCLR 1696; and *Minister of Health v Treatment Action Campaign (TAC)* (2002) 5 SA 721 (CC).

13 For example, on the right to have satisfactory detention conditions and healthcare in prisons in relation to Article 3 see cases: *Dolenec v Croatia* App no 25282/06 (ECtHR 26 November

healthcare the Court decided to make a distinction between the civil and political and social and economic rights. One of the reasons for doing so might be, although we have seen examples of successful judicial protection of the right to health on the national level, the Court's fear of entering States socio-economic sphere. The Court must be differentiated from national courts since all States are under the Court's jurisdiction willingly and are also free to withdraw from the Convention system at any time. There is a possibility that if the Court starts imposing new, socio-economic rights under the Convention that can be counter-productive. Not only can the States start withdrawing from the Convention system (which is the worst, but not impossible scenario)¹⁴ but it can also deteriorate the good situation there is at the moment regarding the States' compliance with the judgments and create uncertainty among States regarding their obligations under the Convention. Nevertheless, during the last few years the Court started giving indications it might, at least to some degree, include the right to healthcare into the Convention.

In this paper the Court's approach towards the right to healthcare will be analysed, together with the author's opinion on why the Court has not gone further and why that is a good thing. Jurisprudence on Article 2, in relation to healthcare rights, will be discussed. Later on, jurisprudence of the Convention's organs on Article 8 regarding the right to healthcare will be presented followed by the deportation cases where the applicants invoked violation of Article 3 because of the lack of satisfactory (or any) healthcare in the countries where they were supposed to be deported. Finally, the right to health as protected under the European Social

2009); *Dougoz v Greece* (2002) 34 E.H.R.R. 61; *Kalshnikov v Russia* (2003) 36 E.H.R.R. 34; *Melnik v Ukraine* App no 72286/01 (ECtHR, 28 March 2006); *Nevmerzhiitsky v Ukraine* (2006) 43 E.H.R.R. 32; *Peers v Greece* (2001) 33 E.H.R.R. 51; *Poltoratskiy v Ukraine* (2004) 39 E.H.R.R. 43; *Testa v Croatia* (2008) 47 E.H.R.R. 29; and on the right to a healthy environment as developed under Article 2 and 8, see: *Budayeva and others v Russia* App nos 15339/02, 21166/02, 20058/02, 11673/02 and 15343/02 (ECtHR, 20 March 2008); *Guerra and Others v Italy* (1998) 26 E.H.R.R. 357; *Hatton and Others v United Kingdom* (2003) 37 E.H.R.R. 28 (GC judgment); *Lopez Ostra v Spain* (1995) 20 E.H.R.R. 513; *Moreno Gomez v Spain* (2005) 41 E.H.R.R. 40; *Onerylidiz v Turkey* (2005) 41 E.H.R.R. 20.

14 The UK has already raised an issue of withdrawing from the Convention because they considered that the Court is interfering with their national decisions beyond its jurisdiction. See an article published online in the Daily Telegraph (7th February 2011) 'UK should withdraw from European Court of Human Rights' as a response to *Hirst (No.2) v UK* where Lord Hoffmann was quoted: "International institutions which are set up by everyone become in practice answerable to no one, and courts have an age-old tendency to try to enlarge their jurisdictions,"... "And so the Strasbourg court had taken upon itself an extraordinary power to micromanage the legal systems of the Member States of the Council of Europe (or at any rate those which pay attention to its decisions) culminating, for the moment, in its decision that the UK is not entitled to have a law that convicted prisoners lose, among other freedoms, the right to vote." <<http://www.telegraph.co.uk/news/worldnews/europe/8307782/UK-should-withdraw-from-European-Court-of-Human-Rights.html>> accessed 11 July 2013; or even more recent article from the Telegraph (29 September 2013) 'Britain might need to withdraw from the European Convention on Human Rights, says Cameron' <<http://www.telegraph.co.uk/news/politics/conservative/10342403/Britain-may-need-to-withdraw-from-European-Convention-on-Human-Rights-says-Cameron.html>>, accessed 7 November 2013.

Charter (the ESC, Charter) will be analysed. The collective complaints and the reports on ESC Article 11 will be discussed. In the author's opinion, the ESC is a better instrument for healthcare issues, and the reasons for that line of thinking will be presented.

2. THE ECHR AND THE RIGHT TO HEALTHCARE

There have been several cases where the Court explored the possibility of protecting the right to health or/and the right to healthcare. Here, the issue is not the right to healthcare in detention but in society in general, since the situation is rather different with the detention cases, where the applicants are under the full authority of the State. When it comes to the healthcare in detention the development of the Court's jurisprudence regarding the right to have satisfactory detention conditions and the right to healthcare of the persons deprived of their liberty under Article 3 is ongoing. On the other hand, most of the 'healthcare cases' have not even passed through the admissibility stage. However, in April 2013 the Court, for the first time, found a violation of the Convention's Article 2 in a case where the State's failure to provide emergency medical care resulted in death.

2.1. POSITIVE OBLIGATIONS UNDER ARTICLE 2 OF THE CONVENTION

The issue of providing healthcare has mainly been raised before the Court in relation to Article 2. Article 2 of the Convention is formed as a negative right, i.e. it is cast as a negative obligation.¹⁵ However, as with numerous Convention provisions, through the Court's jurisprudence Article 2 started imposing positive obligations on the States. In the first case before the Court involving Article 2, *McCann and Others v the United Kingdom*,¹⁶ the applicants contended that first paragraph of Article 2 imposed positive duty on States to protect life. However, the Court decided to examine this case under the notion of proportionality of Article 2(2), examining whether the control and organisation of that anti-terrorist operation complied with Article 2(2).¹⁷

Nevertheless, later in its jurisprudence the Court held that Article 2 contains positive obligations, such as the obligation to investigate unexplained deaths

15 Article 2(1): Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law.

16 *McCann and Others v United Kingdom* (1996) 21 E.H.R.R. 97.

17 *Ibid.* The Court found that although there was no premeditated plan to kill the suspects, there had been a breach of Article 2 of the Convention as the authorities had shown a lack of appropriate care and control in carrying out the operation by instructing their soldiers to act on their intelligence assessments which failed to account for a possible margin of error and which were, in the event, erroneous.

of those in the custody of State officials,¹⁸ to take action to prevent persons from being killed by private individuals,¹⁹ and the obligation to take appropriate steps to safeguard the lives of those within their jurisdiction.²⁰ As will be discussed now, these positive obligations have been to some extent extended into the sphere of healthcare.

2.2. ARTICLE 2 AND THE RIGHT TO HEALTHCARE IN GENERAL

There is a developing jurisprudence of the Court where it considers Article 2 as being capable of encompassing obligations on States to provide medical facilities and services.²¹ However, the Court has shown great reluctance in dealing with the right to healthcare in general.

The possibility of a duty to provide medical services was first explored by the Court in *L.C.B. v United Kingdom*. Here, the Court did not find it established that, given the information available to the State at the relevant time concerning the likelihood of the applicant's father having been exposed to dangerous levels of radiation and of this having created a risk to her health, it could have been expected for the State to act of its own motion to notify her parents of these matters or to take any other special action in relation to her. It followed that there has been no violation of Article 2. However, the Court stressed that obligations under Article 2 require from the State not only to refrain from the intentional or unlawful taking of life, but also to take all the appropriate steps to safeguard lives of those within their jurisdiction.²²

The next case where health-related issues were raised was *Erikson v Italy*²³ which concerned alleged medical malpractice. The applicant complained that his mother's right to life was violated on account of the failure of the Italian authorities to exercise their best efforts to identify those responsible for her death and invoked Article 2. The Court in its assessment of the case pointed out that:

18 For example in already mentioned case *McCann and Others v United Kingdom* (n 16) but also in numerous other cases like *Ergi v Turkey* (2001) 32 E.H.R.R. 18; *Ilhan v Turkey* (2002) 34 E.H.R.R. 36; *Akkoc v Turkey* (2002) 34 E.H.R.R. 51; and *Paul and Audrey Edwards v United Kingdom* (2002) 35 E.H.R.R. 19.

19 *Osman v United Kingdom* (2000) 29 E.H.R.R. 245.

20 *Budayeva and Others v Russia* (n 13).

21 Alastair Mowbray, *The Development of Positive Obligations under the European Convention on Human Rights by the European Court of Human Rights* (Hart Publishing 2004), 22.

22 *L.C.B. v United Kingdom* (1999) 27 EHRR 212 [36]. See also *Roche v United Kingdom* (2006) 42 E.H.R.R. 30 where the applicant was suffering from health problems as a result of his exposure to toxic chemicals carried out on him while he was serving in the British army. He complained that he had been denied proper access to his service medical records in breach of Articles 6, 8 and Article 1 of Protocol No.1. As to Article 8, the Court found that Article 8 had been breached as there had been a failure to provide an effective and accessible procedure that would have allowed the applicant to access relevant and appropriate information so that he could then assess the risk caused by the exposure.

23 *Erikson v Italy* (2000) 29 E.H.R.R. CD152.

“In particular, the positive obligations a State has to protect life under Article 2 of the Convention include the requirement for hospitals to have regulations for the protection of their patients’ lives and also the obligation to establish an effective judicial system for establishing the cause of a death which occurs in hospital and any liability on the part of the medical practitioners concerned.”²⁴

Nevertheless, the Court found this case manifestly ill-founded and therefore inadmissible since it did not disclose any failure by the respondent State to comply with the positive obligations imposed by Article 2 of the Convention.

In another related case, *Calvelli and Ciglio v Italy*, the applicants alleged a violation of Articles 2 and 6(1) on the ground that owing to procedural delays a time-bar had arisen making it impossible to prosecute the doctor responsible for the delivery of their child, who had died shortly after birth.²⁵ The Court found Article 2 applicable and repeated Article’s 2 principle which puts an obligation on the State to take appropriate steps to safeguard lives. Furthermore it, just like in *Eriskon*, stated the requirements and principles that apply in public sphere, namely in hospitals.²⁶ Nevertheless, the Court found no violation of Article 2.

Therefore, States are under an obligation to have regulations under which measures for the protection of patients’ lives will be adopted. However, in neither of these cases was the issue of providing healthcare in general mentioned by the Court.

Later on, in *Nitecki v Poland*²⁷ the applicant complained under Article 2 that the refusal to refund the full price of a life-saving drug violated his right to life. In that connection, he submitted that he had been making social security contributions for over thirty-seven years. The applicant could not afford to pay 30% of the price of the required drug and therefore could not follow the prescribed pharmaceutical treatment. Consequently, his medical condition deteriorated and his invalidity was assessed at the highest degree. Although he was one of only two amyotrophic lateral sclerosis (ALS) sufferers in Poland who had survived longer than four years, the fact was that inability to follow the prescribed pharmaceutical treatment would result in his untimely death. The Court referred to the aforementioned statements about the obligations of States parties with regard to healthcare measures.²⁸ Although the Court did find this application manifestly ill-founded the important thing to mention here is that it attached importance to the fact that Poland did in fact refund 70% of the cost of the drug and concluded:

“Bearing in mind the medical treatment and facilities provided to the applicant, including a refund of the greater part of the cost of the required drug, the Court considers that the respondent State cannot be said, in the special circumstances of the present case, to have failed to discharge its obligations under Article 2 by not paying the remaining 30% of the drug price.”²⁹

24 Ibid.

25 *Calvelli and Ciglio v Italy* App no 32967/96 (ECtHR, 17 January 2002).

26 Ibid [49].

27 *Nitecki v Poland* App no 65653/01 (ECtHR Decision, 21 March 2002).

28 See *Erikson v Italy* (2000) 29 E.H.R.R. CD152.

29 Ibid.

Since the Court stressed special circumstances of the case, it could have taken into account that for the applicant the amount the State refunded did not make a difference since he could not afford even 30% and because of that he has been denied the right to healthcare which caused deterioration of his health. However, as it did not do so we can only speculate the Court's judgment and reasoning if the State had not refunded 70 % of the drug price.

Similar circumstances occurred in *Pentiacova and Others v Moldova*³⁰ where almost all of the 49 applicants were suffering from chronic renal failure and consequently they needed haemodialysis. They were all disabled on account of their disease and receiving State disability allowances. The applicants submitted that before 1997 the expense of their haemodialysis was covered entirely by the hospital. Between 1997 and 2004 the hospital's budget was reduced and only strictly necessary procedures and medication were provided free to them. From January 2004 the situation became more or less identical to that existing before 1997, with the exception of the frequency of haemodialysis session. In their application, they complained about the failure of the State to provide all the medication necessary for haemodialysis at public expense and about the poor State financing of the haemodialysis section of the Spitalul Clinic Republican. They also alleged that on account of the insufficient financing some of them were forced to have two instead of three haemodialysis sessions per week. Accordingly, the applicants argued that their right to life under Article 2 had been breached.

The Court first examined this issue under Article 8 and found it manifestly ill-founded. As to the alleged violation of Article 2 it repeated the above expressed principles on the State's duty to take appropriate steps to safeguard lives. The Court furthermore noted that the applicants had failed to adduce any evidence that their lives had been put at risk. It pointed out that chronic renal failure is a very serious progressive disease with a high rate of mortality, not only in Moldova but throughout the world. The fact that a person had died of this disease was not, therefore, in itself proof that the death was caused by shortcomings in the medical care system. The Court therefore found that the complaint under Article 2 was also manifestly ill-founded. However, it did not reject the idea that the State may be under an obligation to provide healthcare measures but emphasised that there needs to be a direct causal link between the applicants' deaths and the shortcomings in the medical care system in order for a State to be under obligation.

Another important statement was made by the Court in this case, as well as in the above discussed *Nitecki* case and in one of the rare inter-State cases, *Cyprus v Turkey*. The Court emphasized that:

"Moreover, an issue may arise under Article 2 where it is shown that the authorities of a Contracting State put an individual's life at risk through the denial of health care which they have undertaken to make available to the population generally."³¹

30 *Pentiacova and 48 Others v Moldova* (2005) 40 E.H.R.R. SE23.

31 *Pentiacova and 48 others v Moldova* (n 30); *Nitecki v Poland* (n 27); and *Cyprus v Turkey* (2002) 35 E.H.R.R. 30 [219].

The facts of *Cyprus v Turkey* are complex and concern numerous claims of violations, but regarding healthcare issues it is important to note that the applicant Government claimed that the Greek-Cypriots living in the northern part of Cyprus were denied the right to avail themselves of medical services in the southern part of Cyprus and that the facilities in the north were inadequate. In relation to those allegations the Court took note of the fact:

“(T)hat the Commission was unable to establish on the evidence that the “TRNC” authorities deliberately withheld medical treatment from the population concerned or adopted a practice of delaying the processing of requests of patients to receive medical treatment in the south. It observes that during the period under consideration medical visits were indeed hampered on account of restrictions imposed by the “TRNC” authorities on the movement of the populations concerned and that in certain cases delays did occur. However, it has not been established that the lives of any patients were put in danger on account of delay in individual cases. It is also to be observed that neither the Greek-Cypriot nor Maronite populations were prevented from availing themselves of medical services including hospitals in the north. The applicant Government is critical of the level of health care available in the north. However, the Court does not consider it necessary to examine in this case the extent to which Article 2 of the Convention may impose an obligation on a Contracting State to make available a certain standard of health care”³²

A similar statement was made by the Commission in an admissibility decision from 1998, *Scialacqua v Italy*, where the applicant requested a refund from Italian health service for his treatment at the herbalist which was helpful for his liver. It stated:

“However, even assuming that Article 2 (Art. 2) of the Convention can be interpreted as imposing on States the obligation to cover the costs of certain medical treatments or medicines that are essential in order to save lives, the Commission considers that this provision cannot be interpreted as requiring States to provide financial covering for medicines which are not listed as officially recognised medicines.”³³

Up until 2013 there have not been complaints before the Court where the applicants raised the issue of basic medical care or of emergency healthcare. For that reason both the Court and the former European Commission on Human Rights (the Commission) left the question about the minimum level of healthcare needed under the Convention opened and they did not want to be drawn into making a framework or creating standards about a possible minimal level of healthcare. The Court strictly emphasized that it does not consider it necessary to examine the extent to which Article 2 of the Convention may impose an obligation on States to make available a certain standard of healthcare.

However, in April 2013 the Court for the first time found a violation of the Convention where there has been a failure to provide basic medical care which

32 *Cyprus v Turkey* (n 31), [219].

33 *Scialacqua v Italy* (1998) 26 E.H.R.R. CD164 (ECtHR Decision).

led to death.³⁴ The case concerned the death of a pregnant woman (Mrs Sentürk) following a series of misjudgements by medical staff at different hospitals and the subsequent failure to provide her with emergency medical treatment even when her condition was known to be critical. The doctors found her child was dead and after notifying Mrs Sentürk they also told her that she would have to be operated on to remove the child. However, in order to get operated she was asked to pay a deposit to cover the costs of her hospital admission and the surgery. As she and her husband did not have the sum required, they were sent to another hospital and while being transferred in the hospital ambulance Mrs Sentürk died without receiving any medical assistance. Following these events and after exhausting domestic remedies, Mr Sentürk and his son lodged an application to the Court claiming violations of Articles 2, 3, 6 and 13 of The Convention. Regarding Article 2, the Court held that the deceased had been the victim of blatant shortcomings on the part of the hospital authorities and had been denied the possibility of access to appropriate emergency treatment. It reiterated that failure by a State to comply with its duty to protect a person's physical well-being amounted to a breach of the substantive aspect of Article 2 of the Convention. Therefore, the Court found a State to be in a violation of Article 2 for not providing emergency medical treatment to a patient which eventually led to death.

From the above survey of the case-law, there are some suggestions that the issue of providing healthcare may be of relevance, for example, in certain cases in which a State may/will be under an obligation to provide healthcare to preserve life under the Convention's Article 2. However, beyond this core obligation there is no clear evidence or a judgment which might allow us to say whether the Court is willing to protect the right to a healthcare in general under the aegis of Article 2 of the Convention. What can be said is that the Court is rather hesitant about reading into Convention's Article 2 a positive obligation to provide healthcare.³⁵

2.3. ARTICLE 8 AND THE RIGHT TO HEALTHCARE

There is jurisprudence from the Convention's organs on Article 8 regarding the right to healthcare. Article 8 places the obligations on States to respect a wide range of personal interests. Generally, there are four main interests protected: private life, family life, home and correspondence and all of those interests have 'autonomous'

34 *Mehmet Sentürk and Bekir Sentürk v Turkey* App No 13423/09 (ECtHR, 09 April 2013).

35 The HRC also emphasized the need for positive measures from States. It has pointed out much more clearly socio-economic aspect of the right to life than the Court did. "Moreover, the Committee has noted that the right to life has been too often narrowly interpreted. The expression "inherent right to life" cannot properly be understood in a restrictive manner, and the protection of this right requires that States adopt positive measures. In this connection, the Committee considers that it would be desirable for States parties to take all possible measures to reduce infant mortality and to increase life expectancy, especially in adopting measures to eliminate malnutrition and epidemics." HRC, General Comment No. 6 Article 6 (Right to life), Sixteenth session, 1982. U.N. Doc. HRI/GEN/1/Rev.1 at 6 (1994) [5].

meaning. In its application of Article 8, the Court has taken a flexible approach to the definition of the individual interests protected, with the result that the provision continues to broaden in scope. When it comes to deciding the healthcare issues under Article 8 the Convention organs have kept the same restraint as they have under Article 2, until 2011. However, in 2011 the Court delivered a judgment, *Georgel and Georgeta Stoicescu v Romania*³⁶ in which it, rather surprisingly, found a State to be in violation of Article 8 for not introducing general and preventive measures for protecting the applicant's health. Besides this judgment there are two decisions, one adopted by the Court and another by the Commission, which are relevant for this paper.

The first one is an admissibility decision made by the Commission, *Passannate v Italy*.³⁷ Here, the applicant complained that she had to wait about five months in order merely to book a specialist's visit in an Italian public hospital while she would have been able to see the same specialist in the same hospital within only four days if she had been able to pay 150,000 Italian lire. The Commission stated:

"The Commission notes the Italian public health service is based on compulsory contributions which entitle those who pay them to certain services, among which medical examinations within public hospitals.

Therefore, the Commission considers that, in such circumstances where the State has an obligation to provide medical care, an excessive delay of the public health service in providing a medical service to which the patient is entitled and the fact that such delay has, or is likely to have, a serious impact on the patient's health could raise an issue under Article 8 para. 1 (Art. 8-1) of the Convention."³⁸

However, in this case the applicant did not prove nor even allege that the above delay had a serious impact on her physical or psychological conditions and the Commission found the application manifestly ill-founded. Again, like as the Article 2 case *Pentiacova and 48 Others v Moldova*, the lack of causal link was the reason for dismissing the case.

In a later case, *Sentges v Netherlands*,³⁹ the Court decided that positive duties under Article 8 did not extend to the State's obligation to provide a severely disabled person with a robotic arm. The applicant, who was represented by his mother, suffered from Duchenne Muscular Dystrophy (DMD), a disease characterised by progressive muscle degeneration, loss of the ability to walk and often the loss of lung or cardiac functions. There is currently no known cure for DMD and most affected people survive into their twenties. The applicant was unable to stand, walk or lift his arms, and his manual and digital functions were virtually absent. He had to use an electric wheelchair to move about, both outside the home and at school. On 20 July 1999 the applicant's parents requested their health insurance fund to provide him with a "MANUS Manipulator", a robotic arm specifically designed to

36 *Georgel and Georgeta Stoicescu v Romania* App no 9718/03 (ECtHR, 26 July 2011).

37 *Passannate v Italy* (1998) 26 E.H.R.R. CD153.

38 Ibid.

39 *Sentges v Netherlands* (2004) 7 C.C.L. Rep. 400.

be mounted on electric wheelchairs in order to give disabled people more autonomy in handling objects in their environment. It was predicted that after being provided with the robotic arm, the applicant's dependence on the constant presence of carers would be reduced by at least one to three hours a day. The health insurance fund rejected the request for the reason that the provision of a robotic arm was not covered by any social insurance scheme. The parents' various appeals against this decision all failed. The applicant submitted that refusal of his request to be provided with a robotic arm infringed his right to respect for his private life, as guaranteed by Article 8. The Court rejected his complaint as manifestly ill-founded. It stated that:

“Even assuming that in the present case such a special link indeed exists – as was accepted by the Central Appeals Tribunal –, regard must be had to the fair balance that has to be struck between the competing interests of the individual and of the community as a whole and to the wide margin of appreciation enjoyed by States in this respect in determining the steps to be taken to ensure compliance with the Convention (see *Zehnalová and Zehnal*, cited above).

This margin of appreciation is even wider when, as in the present case, the issues involve an assessment of the priorities in the context of the allocation of limited State resources (see, *mutatis mutandis*, *Osman v. the United Kingdom*, judgment of 28 October 1998, *Reports* 1998-VIII, p. 3159, § 116, *O'Reilly and Others v. Ireland* (dec.), no. 54725/00, 28 February 2002, unreported). In view of their familiarity with the demands made on the health care system as well as with the funds available to meet those demands, the national authorities are in a better position to carry out this assessment than an international court. In addition, the Court should also be mindful of the fact that, while it will apply the Convention to the concrete facts of this particular case in accordance with Article 34, a decision issued in an individual case will nevertheless at least to some extent establish a precedent (see *Pretty*, cited above, § 75), valid for all Contracting States.”⁴⁰

Here, unlike in *Passannate* the Court recognised the existence of a causal link, however it invoked the State's margin of appreciation. The Court emphasized that the applicant had access to the primary, basic healthcare and every aspect of healthcare that goes beyond that basic standard was within the State's margin of appreciation. It is also interesting to mention that the Court invoked the possibility of this case establishing a precedent which would, had the Court found a violation, extend the scope of Article 8 into healthcare rights. Again, limited State resources were, unlike in the detention conditions cases, of importance when deciding whether a violation occurred.

Therefore, when it comes to Article 8 and the right to healthcare the Court largely relied on the State's margin of appreciation when it came to every issue beyond the basic healthcare leaving to States to arrange their healthcare system in accordance with the available resources. We can assume that it was exactly because of the scarcity of State resources.

40 Ibid.

However, in the *Georgel and Georgeta Stoicescu v Romania* case the Court narrowed the State's margin of appreciation when it comes to preventive healthcare measures and invoked the doctrine of effectiveness. This case is conceptually different from the *Passannate* and *Sentges* cases since those two cases were concerned with the provision of healthcare, whereas in *Stoicescu*, the thrust of the complaint is that the State was the cause of the applicant's medical condition. The case concerned the Bucharest authorities' failure to protect a 71-year-old woman, who was left disabled after being attacked by a pack of stray dogs. At the relevant time, the large numbers of stray dogs in Romanian cities was already a public health and safety issue. Relying in particular on Article 8, Mrs Stoicescu (who later during the proceedings died so her husband continued with the application) complained that she had been attacked by a pack of stray dogs because the local authorities had failed to take adequate measures to control stray dogs in Bucharest.

The Court, in its assessment first invoked positive obligations inherent in Article 8.⁴¹ It went on by emphasizing that positive obligations to adopt appropriate measures must be interpreted in a way that does not impose an impossible or disproportionate burden on the authorities. However, it stressed that the authorities had broad and detailed information on the large number of stray dogs in the city of Bucharest and the danger they represented to the physical integrity and health of the population. The Court agreed with the Romanian Government that responsibility for the general situation of stray dogs in Romania also lies with civil society and it was not for the Court to determine the best policy for dealing with such public safety problems. Nevertheless, the Court found that the lack of sufficient measures taken by the authorities in addressing the issue of stray dogs in the particular circumstances of the case, combined with their failure to provide appropriate redress to the applicant as a result of the injuries sustained, amounted to a breach of the State's positive obligations under Article 8 to secure respect for the applicant's private life. Therefore, there has been a violation of Article 8.

This judgment was reached with only one dissenting opinion. Judge López Guerra emphasized one very important point:

“In the present case it is obvious that the authorities had no knowledge of the existence of a real and immediate, individual risk to the applicant, but were aware of a general situation of risk that might affect citizens in general, rather than only (and specifically) this individual applicant. According to the Court's case-law, it is certainly justified to require the member State authorities to take action to prevent probable and immediate risks with respect to rights guaranteed under the Convention that affect specific and identified persons. But I do not deem warranted the present extension of this principle to demand that authorities adopt all necessary measures to protect all people from all forms of danger in general. The public powers are required to meet practically unlimited needs with inevitably limited means. They must provide vital services such as clean water, sewer systems, waste

41 *Georgel and Georgeta Stoicescu v Romania* (n 36) [48]-[50].

disposal, health care, traffic safety and public safety, among many others. And the number of victims of the faulty delivery of those services may be considerable. But it is the competent authorities of each country and not this Court who must establish priorities and determine preferences when allocating efforts and resources.⁴²

The author agrees with this viewpoint. This case is about the State's obligation to take general and preventive measures that concern not only this applicant but the population in general. It concerns the issue of the protection of health since the Court found that the failure of the authorities to adopt general preventive measures concerning stray dogs violated the applicant's right under Article 8. The Court entered into clearly economic issues, stating where the national authorities should allocate their resources. Furthermore, even though this judgment concerns one individual, from the judgment is visible that it also concerns the population in general since there was a lack of general, preventive State measures that led to finding a violation. Also, in 2000 some 22,000 persons had received medical care following attacks by stray dogs and from the beginning of 2001 more than 6,000 persons had been bitten by stray dogs.⁴³ It is clear that this judgment has numerous socio-economic elements on the State. The Committee of Ministers (CoM) is currently waiting an action plan from Romanian authorities regarding the execution of judgment.

As we can see, the Court has up until 2011 refrained from entering the healthcare sphere since it concerns allocation of national resources and left these with this issues wide margin of appreciation to States. However, with the *Georgel and Georgeta Stoicescu* it went one step further, finding a State to be in violation of an individual right by not introducing preventive, general measures that include allocating national, already scarce, resources.

2.4. ARTICLE 3 DEPORTATION CASES IN THE HEALTHCARE CONTEXT

The deportation cases where the applicants invoked violation of Article 3 because of the lack of satisfactory (or any) healthcare in the countries where they were supposed to be deported are connected with the right to healthcare. What is interesting is that one of the first deportation cases regarding healthcare related issues suggested that the Court would be willing to deal with the health and healthcare rights.⁴⁴ Although in this case the circumstances were special and dealt with the concept of inhuman and degrading treatment, this case is worth mentioning since it gave interesting indicators to the interpreters of the Convention. However, those indicators were later rejected by the Court. Moreover, following this judgment, a number of decisions of the Court sought to distinguish this case.

42 Ibid, partly dissenting opinion of Judge López Guerra.

43 Ibid [34].

44 *D. v United Kingdom* (1997) 24 E.H.R.R. 423.

The facts of *D. v United Kingdom* are as follows. D., a national of St Kitts, was found in possession of a substantial amount of cocaine upon his arrival in the UK and was convicted of illegally importing a controlled drug and sentenced to six years' imprisonment. By the time he was released, D. was in the advanced stages of AIDS and was provided with accommodation and care by a UK charity, as well as receiving medical treatment for his condition. The immigration authorities ordered D.'s removal to St Kitts and his application for judicial review of that decision and subsequent appeal were dismissed. D. applied to the Court, contending that his removal would breach Article 3, as he would not receive adequate medical treatment and had no family in St Kitts who could care for him. The Court in its assessment of the situation concluded:

“Aside from these situations and given the fundamental importance of Article 3 in the Convention system, the Court must reserve to itself sufficient flexibility to address the application of that Article in other contexts which might arise. It is not therefore prevented from scrutinising an applicant's claim under Article 3 where the source of the risk of proscribed treatment in the receiving country stems from factors which cannot engage either directly or indirectly the responsibility of the public authorities of that country, or which, taken alone, do not in themselves infringe the standards of that Article. To limit the application of Article 3 in this manner would be to undermine the absolute character of its protection.”⁴⁵

“Against this background the Court emphasises that aliens who have served their prison sentences and are subject to expulsion cannot in principle claim any entitlement to remain in the territory of a Contracting State in order to continue to benefit from medical, social or other forms of assistance provided by the expelling State during their stay in prison.

However, in the very exceptional circumstances of this case and given the compelling humanitarian considerations at stake, it must be concluded that the implementation of the decision to remove the applicant would be a violation of Article 3.”⁴⁶

Although the Court stressed that the notion of inhuman treatment had a specific meaning due to the very exceptional circumstances of the case and that entitlement to care and treatment could not in principle be invoked, to many future applicants (and interpreters of the Convention) this judgment looked as if it opened a space for invoking a right to a healthcare treatment under the Convention.⁴⁷ However, in none

45 Ibid [49].

46 Ibid [54].

47 *Bensaid v United Kingdom* (2001) 33 E.H.R.R. 10 (expulsion of schizophrenic to Algeria); *Arcila Henao v Netherlands* App no 13669/03 (ECtHR Decision, 24 June 2003) (expulsion to Columbia of an HIV-positive drug offender); *Karagoz v France* App no 47531/99 (ECtHR Decision, 15 November 2001) (deportation to Turkey, where the applicant, undergoing continuous medical treatment, claims his life will be at risk due to the absence of the necessary medicines); *Ndangoya v Sweden* App no 17868/03 (ECtHR Decision, 22 June 2004) (Expulsion to Tanzania, where applicant alleges he would be prevented from receiving treatment for HIV); *Salkić and Others v Sweden* App no

of the later cases did the Court find the circumstances were so exceptional that the decision to remove the applicant would be a violation of Article 3. It is clear that the *D.* judgment has not established Article 3 as promoting a general right to medical care for individuals facing expulsion from the State. What *D. v UK* represents is a single case and it did not establish a minimum core right to treatment of dying patients without anyone to take care of them, or even less a precedent,⁴⁸ as one might have expected.

For example, in a later case *N. v the United Kingdom*⁴⁹ the applicant (N.), a HIV positive Ugandan national, complained, in particular, that if she were returned to Uganda she would not have access to the medical treatment she required. In this case N., following her entry into the UK, had been diagnosed as HIV positive. She had developed AIDS defining illnesses. Her condition stabilised upon receipt of medication and access to medical facilities in the UK. The secretary of State, after rejecting N.'s asylum claim, dismissed her claim under Article 3 on the basis that all major anti-viral drugs were available in Uganda at highly subsidised prices and that the treatment of AIDS in Uganda was comparable to any other African country. N. argued that, given her illness and the lack of freely available medical treatment, social support or nursing care in Uganda, her removal there would cause acute physical and mental suffering, followed by an early death, in breach of Article 3. As we can see, the facts are quite similar to *D. v UK*. However, the Court said:

“The Court does not exclude that there may be other very exceptional cases where the humanitarian considerations are equally compelling. However, it considers that it should maintain the high threshold set in *D. v United Kingdom* and applied in its subsequent case law, which it regards as correct in principle, given that in such cases the alleged future harm would emanate not from the intentional acts or omissions of public authorities or non-state bodies, but instead from a naturally occurring illness and the lack of sufficient resources to deal with it in the receiving country.”⁵⁰

If the above statement is the principle, then even D. would not have succeeded. D. alleged the same harm as N. which would arise out of the lack of medical services in case of deportation to a home country. However, D. succeeded in his application, despite the principle proclaimed by the Court in *N. v UK* where it found no violation of Article 3. Another interesting issue was pointed out by the Court in this case:

7702/04 (ECtHR Decision, 29 June 2004) (expulsion to Bosnia of a family suffering from post-traumatic stress syndrome).

48 In *Cossey v United Kingdom* (1991) 13 E.H.R.R. 622, the Plenary Court stated that ‘it is not bound by its previous judgments’ but that it ‘usually follows and applies its precedents, such a course being in the interests of legal certainty and the orderly development of the Convention case-law.’ However, the Court continued, it is free to depart from an earlier judgment if there are ‘cogent reasons’ for doing so, which might include the need to ‘ensure that the interpretation of the Convention reflects societal changes and remains in line with present day conditions.’” David Harris, Michael O’Boyle and Colin Warbrick, *Law of the European Convention on Human Rights* (2nd ed, OUP 2009), 18.

49 *N. v United Kingdom* (2008) 47 E.H.R.R. 39.

50 *Ibid* [43].

“Although many of the rights it contains have implications of a social or economic nature, the Convention is essentially directed at the protection of civil and political rights. Furthermore, inherent in the whole of the Convention is a search for a fair balance between the demands of the general interest of the community and the requirements of the protection of the individual’s fundamental rights. Advances in medical science, together with social and economic differences between countries, entail that the level of treatment available in the contracting state and the country of origin may vary considerably. While it is necessary, given the fundamental importance of Art.3 in the Convention system, for the Court to retain a degree of flexibility to prevent expulsion in very exceptional cases, Art.3 does not place an obligation on the contracting state to alleviate such disparities through the provision of free and unlimited health care to all aliens without a right to stay within its jurisdiction. A finding to the contrary would place too great a burden on the contracting states.”

The Court stressed that there are significant social and economic differences between countries and that even though Article 3 is of fundamental importance, putting an obligation to the State to provide free and unlimited healthcare to all aliens would place too great burden on the States. The Court’s concern regarding the financial burden that will be placed on States is clearly expressed. This wording is coming from the same Court that considered detention conditions and Article 3, stating:

“...when considering the material conditions in which the applicant was detained and the activities offered to him, that Ukraine encountered serious socio-economic problems in the course of its systemic transition and that prior to the summer of 1998 the prison authorities were both struggling under difficult economic conditions and occupied with the implementation of new national legislation and related regulations. However, the Court observes that lack of resources cannot in principle justify prison conditions which are so poor as to reach the threshold of treatment contrary to Article 3 of the Convention. Moreover, the economic problems faced by Ukraine cannot in any event explain or excuse the particular conditions of detention which it has found in paragraph 145 to be unacceptable in the present case.”⁵¹

Both of the two quoted cases have strong economic and social elements and if the Court finds a violation of Article 3 it places a strong financial burden on the State. Even more, one might expect that there are and will be fewer aliens looking for protection of their health from the State than detainees requiring detention conditions and healthcare in prisons of a certain standard. So, why did the Court decide to continue in its findings of violation of Article 3 based on poor detention conditions but when it came to the right to healthcare of aliens it decided to stop after one judgment? One can only speculate. Maybe, with the right to healthcare for aliens the Court became worried about the consequences of those judgments

⁵¹ *Poltoratskiy v Ukraine* (n 13) [148].

in terms of heightening expectations to provide the right to a healthcare in general, i.e. to the population in general. Maybe the fact that the victims in these cases are foreigners and not citizens of the respondent State also had influence on the Court. Also, with the detention conditions the Court was and still is very much influenced by the work of the European Committee for the Prevention of Torture, Inhuman and Degrading Treatment (the CPT) and the CPT findings are of great help to the Court when deciding whether a violation occurred. In the deportation cases there is also a difficulty in assessing standards of healthcare in non-European States which might be another reason for the Court's reluctance. As said, one can only speculate.

But, what we might conclude is that the doctrine of the indivisibility of civil and political and economic and social rights has been used by the Court on a somewhat discretionary basis. The Court has in the cases concerning detention conditions and healthcare in prisons as well decided to very much rely on the living instrument and the dynamic interpretation doctrines, while in the issue of healthcare in general it has been much more cautious and allowed to States a wide margin of appreciation which, together with the need to ration scarce resources, has been used as an explanation for its reluctance.

Before turning to the right to protection of health under the European Social Charter (ESC, the Charter) the short overview of the practice of the Court where it invoked the Convention on Human Rights and Biomedicine will be presented.

2.5. EUROPEAN COURT OF HUMAN RIGHTS AND THE CONVENTION ON HUMAN RIGHTS AND BIOMEDICINE

The Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine (Convention on Human Rights and Biomedicine)⁵² was signed in Oviedo on 4 April 1997 and it entered into force on 1 December 1999. Up until October 2013 twenty nine Member States of the Council of Europe have ratified it. The Convention on Human Rights and Biomedicine in its Article 3 guarantees the equitable access to healthcare and states "Parties, taking into account health needs and available resources, shall take appropriate measures with a view to providing, within their jurisdiction, equitable access to health care of appropriate quality." Although the Court has through its jurisprudence, particularly on Articles 2 and 8, often invoked the Convention on Human Rights and Biomedicine,⁵³ it never invoked the right to equitable access to

52 The Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, CETS No.: 164.

53 See, for example cases *S.H. and Others v Austria*, App no 57813/00 (ECtHR, 3 November 2011); *Vo v France* (2005) 40 EHRR 259; *Evans v United Kingdom* (2008) 46 EHRR 728; *V.C. v Slovakia* App no 18968/07 (ECtHR 8 November 2011); *Costa and Pavan v Italy* App no 54270/10 (ECtHR 28 August 2012); *Glass v United Kingdom* (2004) 39 EHRR 341; *Demir and Baykara v Turkey* (2009) 48 EHRR 1272; and *R.R. v Poland* App no 27617/04 (ECtHR 26 May 2011).

healthcare. Therefore, for the moment we may only speculate on the influence the Convention on Biomedicine will or might have on the Court's inclusion of the right to healthcare under the Convention.

Now, the right to protection of health as interpreted by the European Committee on Social Rights (the ESCR) will be discussed. This is to show that despite the notion of indivisibility which is strongly supported in theory, the practice shows us that the protection of economic and social rights is still better and suitable when left to the ESC organs then to the ECHR ones.

3. EUROPEAN SOCIAL CHARTER AND THE RIGHT TO THE PROTECTION OF HEALTH

Within the CoE a deliberate decision was made to have two different human rights instruments, one on civil and political rights and the other one on economic and social rights. The Convention came into force in 1953 and eight years later, the ESC was adopted.

The ESC sets out economic and social rights and freedoms and establishes a supervisory mechanism guaranteeing their respect by the States parties. Following its revision, the 1996 Revised ESC, which came into force in 1999, is gradually replacing the initial 1961 treaty. By the end of 2012, all the CoE States had signed either the Revised ESC or the 1961 ESC, while 43 States had ratified one or both versions of the ESC.⁵⁴

Article 11 of the Revised ESC, which is a main provision that deals with the healthcare issues, states:

With a view to ensuring the effective exercise of the right to protection of health, the Parties undertake, either directly or in cooperation with public or private organisations, to take appropriate measures designed *inter alia*:

1. to remove as far as possible the causes of ill-health;
2. to provide advisory and educational facilities for the promotion of health and the encouragement of individual responsibility in matters of health;
3. to prevent as far as possible epidemic, endemic and other diseases, as well as accidents.⁵⁵

Information document prepared by the secretariat of the ESC in March 2009 on the right to health and the ESC contains numerous recommendations and expectations relating to public health as protected under Article 11, such as food safety, vaccination programmes and alcoholism. Also, it makes reference to the other ESC articles related to the right to health, namely, Article 3 which concerns

54 Out of 43 States that have ratified the ESC, 10 have ratified only the Original ESC while 33 have ratified the Revised ESC. European Social Charter, <http://www.coe.int/t/dghl/monitoring/socialcharter/Presentation/Overview_en.asp> accessed 18 October 2013.

55 In the Original ESC there is no mention of accidents.

health and safety at work; Articles 7 and 17 which concern the health and wellbeing of children and young persons; Articles 8 and 17 which concern the health of pregnant women and Article 23 which deals with the health of elderly persons.⁵⁶

As to the healthcare issues the Information document states:

“The system of health care must be accessible to the entire population. To that end, states should take as their main criterion for judging the success of health system reforms effective access to health care for all, without discrimination, as a basic human right.

The right to access to health care implies:

- that the cost of health care should be borne, at least in part, by the community as a whole;

- that health costs should not place an excessive financial burden on individuals. Steps must therefore be taken to reduce the financial burden on patients from the most disadvantaged sections of the population;

- that arrangements for such access must not lead to unnecessary delays in its provision. Access to treatment should notably be based on transparent criteria, agreed at national level, that address the risk of deterioration both in clinical and quality of life terms;

– the number of health care professionals and equipment must be adequate (the criterion is 3 beds per thousand population).⁵⁷

The document itself is intended to be used as guidance for State parties as it points out what is expected from States under the Charter provisions that deal with the right to healthcare. The Information document is based on the conclusions adopted by the ECSR through its Reporting system over the years and it might be said to represent a summary of the ECSR conclusions in the healthcare issues.

The ECSR interpreted and made observations regarding Article 11 not only in its conclusions but also through its decisions in the Collective Complaints procedure.⁵⁸ Both the ECSR conclusions and decisions concerning the right to health will now be discussed.

3.1. THE REPORTING PROCEDURE AND ARTICLE 11 OF THE ESC

Under the Reporting procedure every year States parties submit a report indicating how they implement the ESC in law and in practice. Each report concerns some of the accepted provisions of the ESC. The provisions are divided into four

⁵⁶ The right to health and the European Social Charter, Information document prepared by the secretariat of the ESC (March 2009).

⁵⁷ Ibid, 10-11.

⁵⁸ There are two forms of machinery seeking to ensure that parties comply with obligations under the ESC. The first is the system of Reporting which has been in existence since 1961 and is obligatory for all the State parties to the ESC. As to the second mechanism, the system of Collective Complaints, it was introduced in 1995 and has been in force since 1998. So far only 15 Member States have ratified it.

thematic groups and each provision of the ESC is reported on once every four years. As to the Article 11 of the ESC it is a 'non-core' right, but all the States that have accepted it are under the ECSR authority regarding obligations as set out under Article 11. Some conclusions adopted by the ECSR regarding the right to health will now be presented.

In the introduction to its Conclusions XVII- 2 from 2005 (Volume 1) the ECSR made the following general observation regarding Article 11 of the (Original) Charter:

"The Committee notes that the right to protection of health guaranteed in Article 11 of the Charter complements Articles 2 and 3 of the European Convention on Human Rights - as interpreted by the European Court of Human Rights - by imposing a range of positive obligations designed to secure its effective exercise. This normative partnership between the two instruments is underscored by the Committee's emphasis on human dignity. In Collective Complaint FIDH v. France (No. 14/2003) it stated that "human dignity is the fundamental value and indeed the core of positive European human rights law – whether under the European Social Charter or under the European Convention of Human Rights and [that] health care is a prerequisite for the preservation of human dignity.

In assessing whether the right to protection of health can be effectively exercised, the Committee pays particular attention to the situation of disadvantaged and vulnerable groups. Hence, it considers that any restrictions on this right must not be interpreted in such a way as to impede the effective exercise by these groups of the right to protection of health.

...

The Committee notes that this approach calls for an exacting interpretation of the way the personal scope of the Charter is applied in conjunction with Article 11 on the right to protection of health, particularly with its first paragraph on access to health care. In this respect, it recalls that it clarified the application of the Charter's personal scope in its general introduction to Conclusions XVII-1 and 2004 (pp. 9-10; see also the general introduction to Conclusions XVI-1 and 2002).

...

Finally, the management of waiting lists and waiting times in health care, which the Committee examines by paying particular attention to the issues of discrimination and emergency situations and in the light of the Council of Europe Committee of Ministers Recommendation No. R (99) 21 on criteria for the management for waiting lists and waiting times in health care, and health education in schools are crucial for assessing the conformity of national situations with Articles 11§1 and 11§2 respectively."⁵⁹

As we have seen, the Court similarly made statements on the necessity of having a healthcare system available to everyone without discrimination; however, the ECSR expressed this obligation with additional explanations and more clarity.

59 ESC, ECSR Conclusions XVII- 2, Volume 1 (Austria, Belgium, Czech Republic, Denmark, Finland, Germany, Greece, Hungary, Iceland) (CoE Publishing 2005), 10-11.

In assessing the State's compliance with Article 11(1) in Conclusions from 2009 concerning Articles 3 and 11 of the Revised Charter in respect of Albania, the ECSR found Albania to be in non-conformity. The ECSR pointed out regarding general indicators of the state of health of the population: "To comply with Article 11(1), the main indicators of a country's state of health must reflect an improvement and not be too significantly below the average for all European countries."⁶⁰ It also paid close attention to life expectancy and the principal causes of death, infant and maternal mortality and the healthcare system (access to healthcare, healthcare professionals and facilities).⁶¹

Regarding Article 11(2) the same ECSR Conclusions will be looked at, but on Belgium.⁶² The ECSR examined various spheres of Article 11(2) on advisory and educational facilities, such as encouraging individual responsibility through public information and awareness-raising, health education in schools; counselling and screening to the population in general and then specifically pregnant women, children and young people. On Belgium the ECSR decided to defer its conclusion until receiving the information requested on the above mentioned issues.

We can look at two more conclusions on Hungary and Iceland. Conclusions XIX-2 on Article 11(1) concerning the situation in Hungary are on the right to protection of health on the removal of the causes of ill-health. On the issue of life expectancy and principal causes of death the ECSR considered it has not been established that measures taken to reduce the mortality rate are adequate. Therefore it did not find the situation in Hungary in conformity with Article 11(1) of the Charter. On the issues of infant and maternal mortality as well as access to healthcare Hungary is placed among the average for European countries. Finally, on healthcare professional and facilities the ECSR concluded that the situation in Hungary is not in conformity with Article 11(1) of the Charter because there is nothing in the report to show that sufficient measures have been taken to reduce the mortality rate.⁶³ On the same issues and in the same Conclusions, Iceland was found to be in conformity with Article 11(1) since the life expectancy is above the European average,⁶⁴ infant mortality dropped and maternal mortality was zero during the reference period. As for the issue of access to healthcare and healthcare professional and facilities the ECSR also found Iceland to be in conformity with the Charter.⁶⁵

60 ECSR Conclusions 2009 - Volume I (Albania, Andorra, Armenia, Azerbaijan, Belgium, Bulgaria, Cyprus, Estonia, Finland, France, Georgia, Ireland, Italy) (CoE Publishing 2010), 27.

61 Ibid, 27-30.

62 Ibid, 123-125.

63 ESC, ECSR Conclusions XIX-2 (2009) (Austria, Croatia, Czech Republic, Denmark, Germany, Greece, Hungary, Iceland, Latvia, Luxembourg, Poland, Slovakia, Spain, "the Former Yugoslav Republic of Macedonia", United Kingdom) (CoE Publishing 2010), 247-249.

64 In 2006 it was 79 years for males and 83 years for females compared to an EU average (2004) of 75.2 years for males and 81.5 years for females.

65 ECSR Conclusions XIX-2 (2009) (n 63), 272-273.

Therefore, the ECSR has developed a general approach in assessing the compliance of States with the right to health as well as the particular interpretation of each paragraph of Article 11. It started its interpretation in its first cycle of conclusions on Article 11 and up to July 2012 the ECSR has assessed numerous national reports and set out standards in providing the right to health as required under Article 11 of the Charter. In its 2009 Conclusions on Article 11(1) and 11(2) of the Revised Charter, the ECSR found ten out of twenty three States that have accepted Article 11(1) to be in conformity with it, while regarding Article 11(2) it found eleven out of twenty three States that have accepted it to be in conformity.⁶⁶ In the 2009 Conclusions but on the Original Charter the ECSR found nine out of fifteen States that have accepted Article 11(1) to be in conformity with it, while regarding Article 11(2) it found eight out of fifteen States to be in conformity.⁶⁷ Generally, the conclusions are very detailed and the ECSR analyses every aspect of the right to health in accordance with its interpretation of every paragraph.

One of the problems in the Reporting system is the amount of information the ECSR requires from States in order for it to reach a conclusion whether the State is in conformity or in non-conformity with Article 11(1) and Article 11(2) requirements. For that reasons, it on several occasions decided to defer its conclusion, for example in 2009 Conclusions on the Revised Charter it decided to defer its conclusions on Article 11(1) regarding three States while on Article 11(2) regarding six States.⁶⁸ As to the Original Charter's Articles 11(1) in 2009 it deferred its conclusions on Greece, Poland and Spain, while regarding Article 11(2) it did so on Croatia, Greece, Hungary, Spain and "The former Yugoslav Republic of Macedonia".⁶⁹ Again it is evident that the more information the ECSR requires State parties to provide for it to be able to make a judgment about their compliance, the more difficult it becomes for it to make a definite judgment about compliance.

Unfortunately, the biggest defect within the Reporting system is the CoM follow up procedure, or the lack thereof. Despite very detailed ECSR conclusions on the healthcare rights, the CoM has to date only issued two recommendations,

66 States that are found to be in conformity with Article 11(1) of the Revised ESC are: Belgium, Estonia, Finland, France, Ireland, Netherlands, Norway, Portugal, Slovenia and Sweden. States that are found to be in conformity with the Article 11(2) of the Revised ESC are: Andorra, Bulgaria, Cyprus, Finland, France, Ireland, Italy, Netherlands, Norway, Slovenia and Sweden. See ECSR Conclusions 2009- Volume I (n 60), 16.

67 States that are found to be in conformity with Article 11(1) of the Original ESC are: Austria, Croatia, Czech Republic, Denmark, Germany, Iceland, Luxemburg, The Former Yugoslavian Republic of Macedonia and United Kingdom. States that are found to be in conformity with Article 11(2) of the Original ESC are: Austria, Czech Republic, Denmark, Germany, Iceland, Luxemburg, Poland and United Kingdom. See ECSR Conclusions XIX-2 (2009) (n 63), 16.

68 The ECSR decided to defer its conclusions on Article 11(1) of the Revised ESC on: Andorra, Cyprus and Ukraine while regarding Article 11(2) of the Revised ESC it decided to defer its conclusions on: Azerbaijan, Belgium, Estonia, Lithuania, Portugal and Ukraine. See ECSR Conclusions 2009- Volume I (n 60), 16.

69 ESC, ECSR Conclusions XIX- 2 (2009) (United Kingdom), Articles 3, 11, 12, 13 and 14 of the Charter (CoE Publishing 2010), 16.

both concerning Turkey.⁷⁰ Not only does the CoM rarely issue recommendations, but even the adopted recommendations are very mild and brief. It only stated that it recommends that the Government of Turkey takes account, in an appropriate manner, of the negative conclusions and requested information from Turkey in its next report on the measures it has taken to this effect.⁷¹

3.2. COLLECTIVE COMPLAINTS ON THE RIGHT TO HEALTHCARE

The ECSR has up to June 2013 dealt with nine collective complaints and delivered six decisions on the merits.⁷² Giving an in-depth analysis of all collective complaints on the right to health is not relevant for this paper, since the main point, to show how the ECSR operates and deals with the claims of violation, can be shown without discussing all the complaints. The complaint discussed here will be *ERRC v Bulgaria*⁷³ as it consists of the best and most comprehensive presentation of the ECSR approach towards the right to health. But first two other cases will be discussed briefly.

In the *International Centre for the Legal Protection of Human Rights (INTERIGHTS) v Croatia*⁷⁴ INTERIGHTS alleged that Croatia is not in conformity with Articles 11(2), and 16 taken alone and in the light of the non-discrimination clause in the Preamble; nor with Article 17 of the ESC, because Croatian schools do not provide comprehensive or adequate sexual and reproductive health education for children and young people. Since education materials used in Croatian school contained some discriminatory statements the ECSR held that such statements contained in educational material used in the ordinary curriculum constitutes a violation of Article 11(2) in light of the non-discrimination clause.⁷⁵

70 Recommendation no. R ChS (98) 4 on the application of the European Social Charter by Turkey during the period 1993-1994 (13th supervision cycle, part IV) on Turkey; and Recommendation no. R ChS (2002) 1 on the application of the European Social Charter by Turkey during the year 1995-1998 (15th supervision cycle, part II) on Article 11-1 of the Original ESC.

71 Ibid.

72 *Confédération générale du travail (CGT) v France* (22/2003), (decision on the merits of 7 December 2004); *Marangopoulos Foundation for Human Rights (MFHR) v Greece* (30/2005), (2007) 45 E.H.R.R. SE11; *International Centre for the Legal Protection of Human Rights (INTERIGHTS) v Croatia* (45/2007), (2009) 49 E.H.R.R. SE13; *ERRC v Bulgaria* (46/2007), (2009) 49 E.H.R.R. SE2; *Defence for Children International (DCI) v the Netherlands* (47/2008), (2010) 51 E.H.R.R. SE14; *Medecins du Monde- International v France* (67/2011), (decision on the merits 11 September 2012); *Defence for Children International (DCI) v Belgium* (69/2011), (decision on the merits of 23 October 2012); *International Federation of Human Rights (FIDH) v Greece* (72/2011), (decision on the merits of 23 January 2013); *International Planned Parenthood Federation- European Network (IPPF EN) v Italy* (87/2011) (decision on admissibility of 22 October 2012) .

73 *ERRC v Bulgaria* (n 72).

74 *INTERIGHTS v Croatia* (n 72).

75 Ibid [43]-[66].

As to the complaint brought to the ECSR by the *Confédération Générale du Travail (CGT) v France*,⁷⁶ the CGT asked the ECSR to rule that the provisions of Act No. 2003-47 of 17 January 2003 on wages, working time and employment development, referred to as “Fillon II”, and specifically those of Article 2 A, II, III and VIII and of Article 3, fail to comply with Articles 2(1) and (5), 3(1) and 11(1) and (3) of the Revised Charter. However, the ECSR in this case did not pay particular attention to Article 11 of the Charter since the CGT did not claim a sole violation of Article 11 but only in conjunction with Article 2(1) and (5). The ECSR in its conclusions only found violation of Article 2(1).

The *ERRC v Bulgaria* case concerns the rights of Roma to healthcare, health insurance, exemption of payment of healthcare contributions for persons receiving social assistance, the living environment of Roma, access of Roma to healthcare services and measures to address health problems of Roma in Bulgaria. In this case, the ERRC claimed violations of Article 11, Article 13 and of Article E on non-discrimination, while the Government considered that the relevant legislation guaranteed equal access to health insurance for all citizens and that it had taken sufficient positive measures for the improvement of the health status of the Roma.

The right to healthcare in Bulgaria is based on a system of compulsory health insurance through the collection of healthcare contributions. Persons who perform their obligations related to the payment of health contributions have access to medical care and a whole range of medical services. There is, however, a patient participation fee for each visit to a physician or each day of hospital treatment. Coverage under the contributory healthcare scheme is possible on a “non-contributory” basis for certain categories of socially vulnerable persons, namely persons entitled to social assistance, targeted assistance for heating or unemployment benefits, who are exempted from paying healthcare contributions, and can also obtain an exemption or reduction of the patient participation fee. Finally, there is a health scheme funded by taxes which provides benefits in kind, other than those provided by the contributions funded scheme, to all residents irrespective of their health insurance status. This ensures medical aid in emergency cases and another range of minimum medical services.⁷⁷

In its assessment of the parties’ submissions regarding the alleged legal restrictions on access to health insurance and medical assistance for socially vulnerable individuals, the alleged systemic barriers for the effective exercise of the right to health protection and the alleged discrimination against Roma in the provision of medical services, the ECSR concluded as follows. In respect of ERRC’s complaint that healthcare legislation excludes Roma from access to healthcare, the ECSR considered that none of the relevant statutory provisions examined can be deemed to be discriminatory on the grounds of ethnicity. The ECSR considered that a health insurance system based on the collection of healthcare contributions, as is the case in Bulgaria, met the requirements of the Revised Charter, given that there

⁷⁶ *CGT v France* (n 72).

⁷⁷ *ERRC v Bulgaria* (n 72) [18].

also existed a subsidiary “non-contributory” system, open to persons who did not benefit from the contributory system and which ensured them sufficient coverage, not only in situations of emergency or a threat to life.⁷⁸ Furthermore, the ECSR observed that exemption from paying healthcare contributions for persons receiving social assistance, targeted assistance for heating or unemployment benefits – who are entitled to state-subsidised health insurance - ensured that some of the most disadvantaged sections of the community had access to healthcare.⁷⁹ However, regarding the situation of persons who did not qualify for social assistance or who had temporarily lost the right to social assistance, the ECSR noted that such persons were left without health coverage during the period that social assistance was interrupted, given that the Health Insurance Act links eligibility for “non-contributory” State health coverage to being a recipient of social assistance benefits.

The main issue was for the ECSR to assess what medical services were available to persons who had lost social insurance and who required medical care, namely the access of Roma to healthcare services.⁸⁰

The ECSR concluded:

“The Committee recalls that Article 11 of the Charter imposes a range of positive obligations to ensure an effective exercise of the right to health, and the Committee assesses compliance with this provision paying particular attention to the situation of disadvantaged and vulnerable groups (Conclusions XVII-2 – General Introduction).

...

The Committee considers there is sufficient evidence which shows that Roma communities do not live in healthy environments. This situation can in part be attributed to the failure of prevention policies by the State, for instance the lack of protective measures to guarantee clean water in Romani neighbourhoods, as well as the inadequacy of measures to ensure public health standards in housing in such neighbourhoods (see *European Roma Rights Centre v. Bulgaria*, Complaint No. 31/2005, decision on the merits of 18 October 2006)... In connection with the measures taken by the authorities as regards health education, health counselling and screening for the Roma population, the Committee notes that some programmes recently put in place – such as the establishment of health mediators - may have a positive impact on improving Roma access to health care. However, it considers that there has been a lack of systematic, long-term government measures to promote health awareness.

The Committee also notes from various studies referred to by the ERRC in the complaint that the health status of Roma is inferior to that of the general population. The Government acknowledges in its submissions that the health condition of Roma is poor, and refers to the adoption of a “Health Strategy Concerning People in Disadvantaged Position Belonging to Ethnic Minorities” with a view to improving

78 Ibid [40] and [41].

79 Ibid [42].

80 Ibid [43].

their health condition. The Committee nevertheless considers that the State has failed to meet its positive obligations to ensure that Roma enjoy an adequate access to health care, in particular by failing to take reasonable steps to address the specific problems faced by Roma communities stemming from their often unhealthy living conditions and difficult access to health services.

...

The Committee therefore holds that the failure of the authorities to take appropriate measures to address the exclusion, marginalisation and environmental hazards which Romani communities are exposed to in Bulgaria, as well as the problems encountered by many Roma in accessing health care services, constitute a breach of Article 11§ 1, 2 and 3 of the Revised Charter in conjunction with Article E.”⁸¹

As we can see, the ECSR found a violation of all Article 11 paragraphs together with Article E of the ESC. It emphasized that Article 11 imposes a range of positive obligations and that regarding the Roma community in Bulgaria the national authorities had not complied with the requirements set out in Articles 11 and E of the ESC. The ECSR analysed the situation in detail together with all the particularities concerning the Roma population in comparison to the population in general.

Following the ECSR’s decision, the CoM adopted a Resolution in which it, on the basis of information provided by the Permanent Representative of Bulgaria, it welcomed the measures already taken by the Bulgarian authorities to bring the situation into conformity with the standards of the Charter regarding the provision of healthcare to all persons who might need it, irrespective of their origin or social condition, and stated that it looks forward to Bulgaria reporting that, at the time of the submission of the next report concerning the relevant provisions of the ESC, the situation has been brought into full conformity.⁸²

Therefore, the situation in Bulgaria has improved from December 2008, when the decision on the merits was adopted, to March 2010 when the CoM adopted its Resolution. If we compare this with the time it takes for the Court’s judgments to be executed it does not seem as if the ESC is a less effective mechanism for human rights protection than the ECHR.

The author is not trying here to reach a final conclusion based on one single collective complaint; however, through the years of the Reporting system and after looking at the Convention system in healthcare issues, it looks as if within the CoE healthcare issues should be left to the ESC mechanism and bodies to deal with, especially nowadays when the Collective Complaint system is gaining in importance and the number of collective complaints is increasing.

81 Ibid [45]-[51].

82 Resolution CM/ResChS(2010)1 on the Collective complaint No. 46/2007 by the European Roma Rights Centre (ERRC) against Bulgaria, Adopted by the Committee of Ministers on 31 March 2010 at the 1081st meeting of the Ministers’ Deputies.

Again, the CoM is rather bland in its Resolution and it took almost two years for it to adopt a Resolution. Unfortunately, the pressure it puts on States through the Convention system is also mild and with the same time distance. Therefore, the fact that the Court delivered a judgment will not make a difference in terms of the CoM political pressure on States.

4. CONCLUSION

The reason for giving an in-depth analysis of the *ERRC v Bulgaria* is that it provided us with the claims of violations of all aspects of the right to health as guaranteed under Article 11. By looking at this decision on the merits we can see the ECSR working methods when deciding whether a violation of Article 11 occurred within the Collective Complaints system. The way the ECSR deals with the healthcare complaints is, in my opinion, another argument against the Court's involvement in protection of economic and social rights, that is, in rights with significant socio-economic elements. Even more importantly, the execution of the ECSR decisions and of the Court judgments dealing with the rights with significant socio-economic elements is quite similar. Although the Court has not dealt with the right to health, at least not as much as with the right to a healthy environment and with the right to healthcare in detention, it gave indications it might start doing so in the future. But, what the author has also tried to show is that although the Collective Complaints system is relatively new (especially in comparison to the Court's judgment system) it is making important progress and the awareness of possible claimants of protection provided by the ESC system is rising. The standards of healthcare required under Article 11 have been set by the ECSR under the Reporting procedure and now, with the Collective Complaints procedure, those standards have reached a more obligatory level, despite the non-binding character of the ECSR decisions. Also, the Court has shown inconsistency in deciding cases concerning the right to health in all its aspects with no clear guidelines and standards. On the other hand, the ECSR has made clear its expectations and State obligations regarding the right to health in its conclusions and is also stressing them through its collective complaints decisions.

The biggest deficiencies of the ESC system in general are the small number of States that have ratified the Collective Complaints Protocol and the lack of the CoM follow-up where it should address appropriate recommendations to States found by the ECSR to be in non-compliance. One must not ignore those problematic issues. However, instead of looking for a solution for those problems within the ECHR system, the CoE bodies should focus into improving the ESC system and urge States to ratify the Collective Complaints Protocol as well as pressure the CoM to issue proper and concrete recommendations. Therefore, the right to health and healthcare issues should be left for the ESC mechanisms of protection to deal with.

Summary

COUNCIL OF EUROPE AND THE RIGHT TO HEALTHCARE - IS THE EUROPEAN CONVENTION ON HUMAN RIGHTS APPROPRIATE INSTRUMENT FOR PROTECTING THE RIGHT TO HEALTHCARE?

The European Convention on Human Rights (the Convention, ECHR), a Council of Europe main human rights instrument, contains no references to healthcare rights. Despite that, the issue of providing healthcare in general has been raised before the European Court of Human Rights (the Court), mainly in relation to Articles 2 (right to life) and 8 (right to respect for private and family life). Also, the deportation cases where the applicants invoked violation of Article 3 because of the lack of satisfactory (or any) healthcare in the countries where they were supposed to be deported are connected with the right to healthcare. This paper will look at the Court's approach towards guaranteeing the right to healthcare under the Convention. Since the Court is nowadays often using an integrated approach and dynamic interpretation of the Convention provisions one might have expected that it will include the right to healthcare, at least to some degree, in the Convention. However, despite this Court's use of integrated approach, when it comes to the right to healthcare the Court on most occasions decided that the right to healthcare is not appropriate for the protection under the Convention. In this paper the Court's approach towards the right to healthcare will be analysed, together with the author's opinion on why the Court has not gone further in guaranteeing the right to healthcare and why that is a good thing. Also, the right to health as protected under the European Social Charter (the ESC), the Convention's counterpart on economic and social rights, will be analysed. Despite the fact that the ESC system, particularly the Collective Complaints procedure, is accepted by considerably fewer states than the Convention, the right to healthcare is not an area where the Court should enter, since the European Committee on Social Rights (the ESCR) has so far proven to be successful in formulating clear standards regarding states' obligations regarding healthcare rights. In the author's opinion, the ESC is a better instrument for healthcare issues, and the reasons for that line of thinking will be presented.

Key words: *European Convention on Human Rights; Articles 2, 3 and 8 of the Convention; the right to healthcare; European Social Charter; Article 11 of the Charter.*

Zusammenfassung

DER EUROPARAT UND DAS RECHT AUF GESUNDHEITSSCHUTZ – IST DIE EUROPÄISCHE MENSCHENRECHTSKONVENTION DAS RICHTIGE INSTRUMENT FÜR DEN SCHUTZ DES RECHTES AUF GESUNDHEITSSCHUTZ

Die Europäische Konvention zum Schutz der Menschenrechte und Grundfreiheiten als das grundlegende Instrument des Europarats zum Schutz der bürgerlichen und politischen Rechte gewährleistet kein Recht auf Gesundheitsschutz. Der Europäische Gerichtshof für Menschenrechte bietet aber eine breite Auslegung der Konventionsrechte und weist im Kontext von Artikeln 2, 3 und 8 der Konvention darauf hin, dass er sich auch mit der Frage des Gesundheitsschutzes auseinandersetzen könnte. In dieser Arbeit werden Rechtssachen analysiert, in welchen sich der Gerichtshof mit Fragen des Rechtes auf Gesundheitsschutz beschäftigte, sowie die Stellungnahme des Gerichtshofs in solchen Sachen. Im Gegensatz zur Konvention gewährleistet die Europäische Sozialcharta das Recht auf Gesundheitsschutz im Artikel 11 und sie reguliert es sehr ausführlich und detailliert. Nach der Darstellung des durch die Konvention und die Europäische Sozialcharta gewährleisteten Rechtes auf Gesundheitsschutz wird in der Arbeit der Schluss gezogen, dass die Frage des Rechtes auf Gesundheitsschutz dem Europäischen Ausschuss für soziale Rechte überlassen werden sollte.

Schlüsselwörter: Artikel 2, 3 und 8 der Europäischen Konvention zum Schutz der Menschenrechte und Grundfreiheiten, Recht.

Riassunto

**IL CONSIGLIO D'EUROPA ED IL DIRITTO ALLA
PROTEZIONE DELLA SALUTE – SI PUÒ RITENERE LA
CONVENZIONE EUROPEA PER LA SALVAGUARDIA DEI
DIRITTI DELL'UOMO E DELLE LIBERTÀ FONDAMENTALI
STRUMENTO IDONEO A GARANTIRE IL DIRITTO ALLA
PROTEZIONE DELLA SALUTE?**

La Convenzione europea per la salvaguardia dei diritti dell'uomo e delle libertà fondamentali, quale strumento di base del Consiglio d'Europa per la tutela dei diritti civili e politici, non garantisce il diritto alla protezione della salute. Nondimeno, la Corte europea per i diritti dell'uomo dà un'ampia interpretazione dei diritti sanciti dalla Convenzione, offrendo nell'ambito degli articoli 2, 3 e 8 della Convenzione diversi segnali circa la sua intenzione di iniziare ad occuparsi del diritto alla protezione della salute. Nel presente lavoro si prenderà in esame la giurisprudenza della Corte che si riferisce al diritto alla protezione della salute, come pure la posizione adottata dalla Corte in detti casi. A differenza della Convenzione, la Carta sociale europea garantisce il diritto alla protezione della salute nell'articolo 11, il quale offre una disciplina dettagliata ed esaustiva. Una volta portata a termine l'indagine circa il diritto alla protezione della salute tanto nella Convenzione, quanto nella Carta sociale europea, si perviene alla conclusione che la questione del diritto alla protezione della salute debba essere posta al vaglio del Comitato europeo dei diritti sociali.

Parole chiave: *articoli 2, 3 e 8 della Convenzione europea per la salvaguardia dei diritti dell'uomo e delle libertà fondamentali; diritto alla protezione della salute; articolo 11 della Carta sociale europea.*