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HUMAN RIGHTS IN HEALTHCARE: SOME REMARKS ON THE LIMITS OF THE RIGHT TO HEALTHCARE

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Abstract. *Notwithstanding the expectations related to the ‘invasion’ of human rights into the field of healthcare, the complexity of this field raises some problematic questions about the applicability of such a legal instrument. The present paper analyses the possible limits to the content of the core right to healthcare. These limits are discussed through the examination of two normative pillars of health law: the right to individual self-determination (or the principle of individual autonomy) and the right to healthcare itself. The authors conclude that in the context of the scarcity of resources the effectiveness of the guarantees of the right to healthcare will depend on the narrowing of the concept of the right by choosing the biomedical definition of health as the basis.*

Keywords: *human rights, right to health, right to healthcare, Biomedicine Convention, equitable access, definition of health.*

Introduction

Health is one of the most important factors enabling people to live a dignified life. Not long time ago, healthcare was generally regulated exclusively by the professional regulatory system known as medical ethics. Medical ethics has played its disciplinary and normative roles through traditional professional oaths, codes prepared by medical associations as well as guidelines applied by clinical and research ethics committees. Today medical ethics is conceptually enriched by influential texts and academic articles summarizing and categorizing its core professional virtues and principles.

Contemporary healthcare regulation is very complex: on one hand, its sources are multiple and heterogeneous, on the other hand, the regulatory mechanism is complex, i.e. including national, regional, municipal institutions.¹ At the national level, there are medical practice laws which regulate healthcare activities, patient rights laws which regulate some of the interactions between patients and healthcare practitioners, laws regulating specific medical activities, e.g. organ transplantation, artificial reproduction techniques (ART), sex assignment, etc.

However, the field of healthcare lacks international-level regulation. International regulation of healthcare has exclusively its ‘anchor’ in human rights law;² however, at the universal level, there are few general principles included in the main international human rights treaties such as Article 12 of the International Covenant on Economic, Social and Cultural Rights (1966) which recognizes ‘the right of everyone to the enjoyment of the highest attainable standard of physical and mental health’ or the International Covenant on Civil and Political Rights (1966) and the European Convention on Human Rights (1950) which assert such rights relevant to that field as the rights to life, to physical integrity and privacy as well as establish the prohibition of inhuman or degrading treatment and of any form of discrimination. The European Convention on Human Rights and Biomedicine of 1997 (the Biomedicine Convention) is currently the best and yet the only example of how to promote the protection of human rights in the biomedical field at the international level. The importance of this instrument lies in the fact that for the first time the human rights principles were comprehensively developed and assembled in one single multilateral legally binding instrument devoted entirely to biomedical issues.

Notwithstanding the expectations related to the ‘invasion’ of human rights into the field of healthcare, the complexity of this field raises some problematic questions about the applicability of such a legal instrument. The present paper will examine the possible limits to the content of the core right to healthcare.

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- 1 Juškevičius, J. *Asmens sveikatos priežiūros teisinio reguliavimo raidos bruožai* [Features of the Development of the Legal Regulation of Healthcare]. *Regnum est. 1990 m. Kovo 11-osios nepriklausomybės Aktui - 20. Liber Amicorum Vytautui Landsbergiui*. Vilnius: Mykolo Romerio universitetas, 2010, p. 627–645.
 - 2 Maljean-Dubois, S. *Bioéthique et droit international*. *Annuaire française de droit international*. 2000, 46: 85–97.

1. Principles Governing Healthcare and Human Rights

Moral and legal problems in medicine have led to the identification of a new academic field as health and human rights.³ According to this approach, the moral defects of medical practice and human life in general are to be rectified through the promotion of human rights.⁴ According to Annas⁵, human rights language seems to be more powerful than the primarily individual-based language of bioethics. Despite the mainstream agreement that the language of human rights is best suited for healthcare regulation, there are divergent views on normative pillars.

One of the positions is that healthcare is governed by the broad concept of ‘the right to health’. Its wider recognition in the legal doctrine started from 2001 when the United Nations Human Rights Commission called for international recognition of an obligation ‘with regard to the promotion of the right to health, including: the promotion of research; ensuring access to affordable essential drugs; the adoption of specific measures in relation to HIV/AIDS; and the promotion of international cooperation to implement the right to health...’⁶. In his 2003 report, the newly appointed Special Rapporteur for the right to health⁷ P. Hunt declared such goals as (1) to promote and encourage others to promote health as a human right; (2) to clarify the contours and content of this right; and (3) to identify best practices for winning support and recognition for it.⁸ Of special interest is the second goal; there the Special Rapporteur described the right to health as ‘an inclusive right, extending not only to timely and appropriate health care, but also to the underlying determinants of health’⁹. The said right contains both freedoms and entitlements, but at the same time it is ‘a broad concept that can be broken down into more specific entitlements’¹⁰.

Another moderated and significantly narrowed position strongly advocated by many European health lawyers is that healthcare could be governed by two normative pillars: the right to individual self-determination (or the principle of individual autonomy) and the right to healthcare.¹¹ The first principle expresses the right to govern one’s life in accordance with one’s own views. Actually, this principle is of an intrinsically

3 Tarantola, D.; Gruskin, S. Health and Human Rights. In Gruskin, S., *et al. Perspectives on Health and Human Rights*. New York: Routledge, 2005, p. 3–58; Idem. Health and Human Rights Education in Academic Settings. *Health and Human Rights*. 2006, 9: 297–300.

4 Benatar, D. Bioethics and health and human rights: a critical view. *Journal of Medical Ethics*. 2006, 32: 17–20, at 18.

5 Annas, G. Bioethics and Human Rights. *The Hastings Center Report*. 2003, 33: 3.

6 UN Human Rights Commission. *The Impact of the Agreement on Trade-Related Aspects of Intellectual Property Rights on Human Rights*. Report of the High Commissioner (E/CN.4/Sub.2/2001/13), 18, para. 59

7 The complete official title is the Special Rapporteur on the the right of everyone to the enjoyment of the highest attainable standard of physical and mental health.

8 Hunt, P. *Report to the UN Commission on Human Rights* (E/CN.4/2003/58), paras. 10–36.

9 *Ibid.*, para. 23.

10 *Ibid.*, para. 25.

11 Dute, J. The leading principles of the Convention on Human Rights and Biomedicine. In Gevers, J. K. M., *et al.* (eds.) *Health Law, Human Rights and the Biomedicine Convention*. Leiden/Boston: Martinus Nijhoff Publishers, 2005, p. 3–12.

subjective nature. The second pillar embodies the right of access to proper healthcare facilities. This is a social right. Therefore, according to this view, health law as a separate branch of law should be looked upon as the elaboration and realization of both principles: patient rights give expression to the principle of self-determination, the legal rules concerning the provision of healthcare give shape to the right to health care. Individual and social principles and rights differ by nature but are complementary to each other. In fact, they reflect both sides of one indivisible reality.

Other authors, for instance, put forward the view that the right to healthcare should be seen as the ultimate foundation of health law.¹² The priority of the principle of self-determination advocated by the majority of health lawyers is doubtful, since there are numerous legal areas of healthcare in which it virtually plays no role. Another part of the legal doctrine points to the Biomedicine Convention and to the core principle of human dignity contained in it.¹³ From the Biomedicine Convention it can be concluded that the protection of human dignity and the identity of a human being should be considered as the first and the most prominent normative pillar of the Biomedicine Convention and thus of the health law, and as the ultimate criterion for the justification of medical interventions (under no circumstances can infringements on human dignity be justified). However, the principle of human dignity is blamed for its vagueness¹⁴ or for its excessive inclusiveness¹⁵. In the Explanatory Report of the Biomedicine Convention, nothing is said to clarify the concept of human dignity. Probably, this is the main reason why in practice there are little possibilities for this principle to become a sufficient common denominator between the Member States.

However, rights-based approaches could be contested by the ‘traditional’ lawyers. According to some authors, healthcare regulation has no principles of its own. Health law is nothing more than a set of the rules of civil, criminal and administrative law having only one common denominator, namely, problems of healthcare. They only recognize the principles underlying civil, criminal and administrative law such as the freedom of contract and the principle of legality, and in their views, these principles should not play a pivotal role in the administration of justice—they should be applied only as the last resort.¹⁶

12 See, for example, Buijsen, M. The Concept of Health Law. In den Exter, A.; Sandor, J. (eds.) *Frontiers of European Health Law, Yearbook 2002*. Rotterdam: Erasmus University Press, 2003, p. 4–9.

13 See, for example, Andorno, R. The Oviedo Convention: a European legal framework at the intersection of human rights and health law. *Journal of International Biotechnology Law*. 2005, 2(I): 133–143; Caulfield, T.; Brownsword, R. Human dignity: a guide to policy making in the biotechnology era. *Nature Reviews – Genetics*. 2006, 7: 72–76.

14 Maklin, R. Dignity is a useless concept. *British Medical Journal*. 2003, 27: 1419–1420. See several replies to this paper in subsequent issues of the same journal. For a contrary view see Andorno, R. La notion de dignité humaine: est-elle superflue en bioéthique? *Revue Générale de Droit Médical*. 2005, 16: 95–102.

15 Moutouh, H. La dignité de l’homme en droit. *Revue de droit public*. 1999, 1: 159–196; Jorion, B. La dignité de la personne humaine ou la difficile insertion d’une règle morale dans le droit positif. *Revue de droit public*. 1999, 1: 197–233.

16 Dute, J., *supra* note 11.

2. The Principle of Individual Autonomy

First of all, one should pay attention to different perspectives that have shaped the American and European medical ethics and health law. This can be traced to their respective philosophical roots—that is, individual freedom and self-determination versus the role of a person within a larger social context. The connection between the legal principles of self-determination and the moral principle of autonomy in Anglo-Saxon countries is clear, and it stems from the liberal tradition starting with the famous J. S. Mill's distinction between self-regarding and other-regarding behaviour,¹⁷ and illustrated latterly in the Hart-Devlin debate on state interference in private morality¹⁸.

The European legal doctrine is less concerned with self-determination. From the inception of bioethics in Europe, dignity, not autonomy, has been the prevailing value. Most European state laws in the area of healthcare are instituted to protect and preserve human dignity. The same could be said about international human rights law. Despite the fact that the mainstream human rights doctrine presumes the principle of individual self-determination as the core of human rights, none of the basic United Nations (UN) and regional human rights treaties explicitly mentions the principle of autonomy. The UN Covenants of 1966 and the regional human rights instruments protect a certain number of civil and political rights rather than subsume to general protection of the principle of personal autonomy or self-determination. However, even given strong European traditional commitment to dignity over autonomy, it seems a certain shift is underway. The changing context could be explained both intrinsically and extrinsically.

Intrinsically, the entrenchment of the principle of personal autonomy could be explained by the definition of 'health'. The problem arises due to the lack of agreement on what is to be understood by it. However, the best-known concept established in the legal text is that of the World Health Organization: '[h]ealth is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'¹⁹. This extremely broad definition generates great expectations in the general population and makes it difficult to define in more precise terms the content not only of the right to health or to healthcare but also of other rights which necessarily deal with human health: the right to life, the right to physical and psychological integrity, etc. Individually defined, the concept of health includes personal expectations, demands or wishes which could be easily identified to the pursuit for happiness. This is a radical change, since historically the category of health was exclusively interpreted by physicians. They decided who was healthy and who needed their professional care, and their duties involved curing illnesses rather than satisfying individuals, as the outcome of medical activity was never wholly predictable. Physicians could undertake to carry out certain activities but not to guarantee a certain result that did not entirely depend on their will and skills.

17 Mill, J. S. *Apie laisvę* [On Liberty]. Vilnius: Pradai, 1995.

18 Devlin, P. *The Enforcement of Morals*. Oxford: Oxford University Press, 1965; Hart, H. L. A. *Law, Liberty and Morality*. Oxford: Oxford University Press, 1963.

19 World Health Organization. Preamble to the WHO Constitution. *Basic Documents*, 45th ed., Supplement, October 2006, 1–18.

However, rapid development of biomedical sciences and its achievements induce the establishment of contracts to guarantee a given result.²⁰ In this perspective, autonomy is an essential ethical and legal principle governing the physician–patient relationship which turns into a contract in which certain services (and sometimes even results) are exchanged. The patient, on the basis of information provided by the physician or other sources, is supposed to have a clear idea of his or her health, and the physician’s duty is to perform his job in terms of the patient’s directions.

Extrinsically, due to pressure from patients’ associations, the legal context is changing towards a greater autonomy and self-determination encompassed by the term of ‘private life’ beginning from the 1990s. Underlying the moral claim of specific rights in healthcare, the concept of autonomy has a crucial role in extending patient rights into a broader context of fundamental rights that create obligations.²¹ National patient rights laws introduced the principle of patients’ personal autonomy in the relationship between patients and physicians by stipulating, for example, the right of patients to be fully informed about all treatment methods and procedures, the right to refuse treatment, the right to confidentiality, etc.²²

The expansion of the principle of personal autonomy at the European level is stimulated by the case-law of the European Court of Human Rights (the Court). The Court for a long time had abstained from interpreting that a principle/right to personal autonomy or self-determination is contained in the European Convention on Human Rights. Starting from 2002, in the *Pretty v. the United Kingdom* case, the Court stated that the ‘notion of personal autonomy’ is an important ‘principle’ underlying the interpretation of the guarantees contained in Article 8 of the European Convention on Human Rights.²³ In the subsequent case-law, the Court shifted the concept of autonomy from a ‘notion’ to a ‘right’. It is not entirely clear though what was the doctrinal changing point, as it was never expressly stressed by the Court itself.²⁴ The first judgment in which the Court itself used the wording ‘a right to personal autonomy’ was the judgement in the *Evans v. the United Kingdom case*, where it was ruled that ‘private life is a broad term encompassing inter alia... the right to personal autonomy...’²⁵. This phrase was reiterated in the *Tysiāc*

20 Kass, L. R. *Towards a More Natural Science*. New York: The Free Press. 1985, p. 10–17.

21 D’Oronzio, J. C. A Human right to healthcare access: returning to the origins of the patient’s rights’ movement. *Cambridge Quarterly of Healthcare Ethics*. 2001, 10: 285–298.

22 See, for example, the Law on the Rights of Patients and Compensation of the Damage to their Health of the Republic of Lithuania. *Official Gazette*. 1996, No. 102-2317.

23 *Pretty v. the United Kingdom*, No. 2346/02, para. 61, ECHR 2002-III: ‘though no case has established as such any right to self-determination as being contained in Article 8 of the Convention, the Court considers that the notion of personal autonomy is an important principle underlying the interpretation of the Convention’. In the subsequent case-law, the Court has frequently reiterated this phrase from the *Pretty* judgement.

24 Judges Wildhaber, Bratza, Bonello, Loucaides, Cabral Barreto, Tulkens and Pellonää in their dissenting opinion (para. 11) to the case of *Odievre v. France*, No.42326/98, ECHR 2003-III, already spoke: ‘[t]hus, certain aspects of the right to private life are peripheral to that right, whereas others form part of its inner core. We are firmly of the opinion that the right to an identity, which is an essential condition of the right to autonomy... and development..., is within the inner core of the right to respect for one’s private life’.

25 *Evans v. the United Kingdom*, No. 6339/05, para. 57, ECHR 2007-IV.

v. *Poland* case.²⁶ In the latter case, the Court seemed to take the narrow approach of personal autonomy in the sense of physical integrity at least if the health of a mother-to-be is in danger. It could be concluded that the Court so far has not discussed the principle of personal autonomy in the broader context of healthcare, except for the little instructive references to it made in a limited number of extreme cases related to the so-called ‘tragic choices’ such as assisted suicide, embryo *in vitro* destruction or abortion.

According to some authors, the principle of individual self-determination is presumed to be a normative pillar of the Biomedicine Convention.²⁷ Closely connected to the principle of respect for everyone’s physical and moral integrity, it could be considered as a central element of human dignity. However, the said assertion is contentious, as neither the Convention itself nor its Explanatory Report has any explicit reference to the principle of individual self-determination. By same token it should be admitted that the intuitive principle of individual self-determination cannot serve as a justification or explanation for all of the Convention’s provisions.

The individual autonomy shapes the ‘post-modern’ view of rights which is prevalent today. It implicitly rejects the view that human beings are naturally situated within relationships of dependence, and that rights imply correlative duties incumbent on the rights-bearer.²⁸ Rights in the current understanding are simple entitlements possessed by individuals who are burdened by no obligations to others. Although the concept of responsibility remains as such, it falls mainly upon others in the form of the so-called ‘positive obligations’²⁹, i.e. the obligation of governments to secure the enjoyment of fundamental rights and to provide the welfare of autonomous, independent, and entitled individuals.

3. The Right to Health or the Right to Healthcare?

Health issues turn upon the distinction between individual and social rights, or, in the words of Isaiah Berlin, negative and positive rights.³⁰ Negative rights are said to be individual rights that inhibited state action: the individual had a right to be ‘let alone’ by others. Negative rights create duties of non-interference which are called negative because of their passive nature. On the other hand, positive rights are those rights that required active state intervention in order to be fulfilled such as the large body of economic, social and cultural rights.³¹ For example, the language of the European

26 *Tysic v. Poland*, No. 5410/03, para. 107, ECHR 2007-IV.

27 Dute, J, *supra* note 11.

28 Goodman, T. Is there a right to health? *Journal of Medicine and Philosophy*. 2005, 30: 643–662, at 646–47.

29 Mowbray, A. *The Development of Positive Obligations Under the European Convention on Human Rights by the European Court of Human Rights*. Oxford: Hart Publishing, 2004.

30 Berlin, I. *Two Concepts of Liberty, An Inaugural Lecture Delivered Before the University of Oxford on 31 October 1958*. Oxford: Clarendon Press, 1958.

31 This characterization led some authors and politicians to argue that only negative rights are real rights and, consequently, positive rights are nothing more than mere objectives to be attained. It was particularly characteristic of the Reagan administration’s engagement with international human rights; Kirkpatrick, J. J.

Convention on Human Rights certainly points to an almost exclusive concern with the former (with the exception of Article 2 ('Right to Education') of the First Protocol). The justification for the claim of positive rights is that negative rights (liberties) on their own are of no use for those who lack indispensable basic economic, social and cultural conditions necessary to exercise them. What is the point of the right to life in the negative sense (non-interference) for someone who will die in a couple of days due to the lack of medical treatment?³² In other words, no legal system can consistently claim to respect human rights without recognizing a positive right to health (healthcare). The state has a threefold obligation to protect and promote that right as a social right. Firstly, the obligation to respect, i.e. not to violate the right directly by its action; secondly, the obligation to protect, i.e. prevent its violation by third parties; and finally, an obligation to fulfil the need for the state to act in order to ensure that the right can be enjoyed. However, there still remains the complex task of defining the extent and content of the right to health (or healthcare).

The first difficulty arising in the human rights doctrine is the definition of the subject-matter of the social fundamental right—health or healthcare. International treaties are rather confusing in this respect. For example, the 'right to health' was first formulated in the WHO Constitution, in the Preamble of which it is declared: '[t]he enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition'³³. Article 25(1) of the Universal Declaration of Human Rights (1948) formulates this right in broader terms: '[e]veryone 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'³⁴. Since the Constitution of WHO is not a human rights treaty itself, and the Universal Declaration of Human Rights formally is not a legally binding document, it was for the International Covenant on Economic, Social and Cultural Rights (the Covenant) (1966) to put such a right into the legal circulation. The Covenant uses a more cautious wording in Article 12: '[t]he State Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'³⁵. Pertaining to the category of social human

The Reagan Phenomenon and Other Speeches on Foreign Policy. Washington, D.C.: American Enterprise Institute for Public Policy Research, 1983, quoted in Toope, S. J. Cultural diversity and human rights. *McGill Law Journal*. 1997, 42: 169–185, at 178.

- 32 Bellver Capella, V. *Il diritto alla vita e il diritto all'assistenza sanitaria: significati e limiti. Qualità della vita ed etica della salute*. Atti della XI Assemblea Generale della Pontificia Accademia pro Vita (Città del Vaticano, 21-23 Febbraio 2005). Vatican City: Libreria Editrice Vaticana, 2006.
- 33 The Constitution of the World Health Organization was adopted at the International Health Conference held in New York, which lasted from 19 June to 22 July, and signed on 22 July 1946 by the representatives of 61 states.
- 34 GA Res. 217 (III), UN GAOR, 3d Sess., Supp. No. 13, UN Doc. A/810 (1948) 71.
- 35 International Covenant on Economic, Social and Cultural Rights, 1966, 993 UNTS 3.

rights, this right require the states to ‘take steps’ in order to ‘progressively’ achieve the realization of such a social good ‘to the maximum of [their] available resources’³⁶.

Strict understanding of a ‘right to health’ or a ‘right to highest attainable standard of health’ implies, rather absurdly, that everyone has the guarantee of perfect health, which cannot be formulated objectively. At the most basic level, it is literally impossible for the society to guarantee good health to its members. Disease, physical deterioration and death remain intrinsic to the human condition, and there is a small prospect of a dramatic near-term change in that direction.³⁷ Additionally, any particular individual’s health, at least partially, depends on his or her behaviour and lifestyle, which are beyond state control. Hardly can one expect the legislator to criminalize smoking, excessive consumption of alcohol or junk-food, etc. For this reason, a part of the human rights doctrine considers that the right to health includes two main and at the same time interdependent components: a right to preventive and curative health care and a right to healthy conditions, i.e. the creation of conditions that promote health—a healthy living environment, safe drinking water and safe food, favourable social conditions, for example, housing and recreation.³⁸ This doctrinal approach fits the UN Human Rights Council (former Commission on Human Rights) policy to promote the right to health as ‘an inclusive right, extending not only to timely and appropriate health care, but also to the underlying determinants of health’, ‘a broad concept that can be broken down into more specific entitlements’³⁹.

For example, UN human rights bodies listed up to 14 human rights as integral components of the right to health: the rights to food, housing, work, education, human dignity, life, non-discrimination, equality, the prohibition against torture, privacy, access to information and the freedoms of association, assembly and movement. In other words, these related rights define, to a large extent, the determinants of health.⁴⁰

However, there remain some doubts regarding this approach. Firstly, we encounter with the endless multiplication of specific entitlements. The entitlements are closely linked to legal responsibility, as they simply denote rights granted and claimed by individuals and groups. Secondly, it is difficult to connect any aspect of social life or environmental condition with the right to health in practical terms. For example, what are national or international obligations stemming from a presumed violation of the right to health caused by the global climate change?⁴¹

In view of these difficulties, it is reasonable to assume that when some authors assert a ‘right to health’, they really mean a ‘right to healthcare’. The more recent international law-making seems to adopt the latter approach. This is obvious especially at the

36 International Covenant on Economic, Social and Cultural Rights, 1966, 993 UNTS 3.

37 Goodman, T., *supra* note 28, p. 644.

38 Toebe, B. *The Right to Health as a Human Right in International Law*. Antwerp/Groeningen/Oxford: Intersentia-Hart, 1999, p. 17–19.

39 Hunt, P., *supra* note 8.

40 Committee on Economic, Social and Cultural Rights. *General Comment 14: The right to the highest attainable standard of health*, E/C.12/2000/4, 4 July 2000, paras. 3, 34–37.

41 See Rathbeger, T. *Climate Change Violates Human Rights*. Berlin: Heinrich Böll Stiftung, 2009.

European level. For example, Article 3 of the Biomedicine Convention seems to have a primary task to strike a balance between health needs and available resources and to ensure ‘equitable access’⁴² to healthcare: ‘[p]arties, 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’⁴³. The Biomedicine Convention Explanatory Report makes clear that ‘the purpose of this provision is not to create an individual right on which each person may rely in legal proceedings against the State, but rather to prompt the latter to adopt the requisite measures as part of its social policy in order to ensure equitable access to health care’⁴⁴. Subsequently, the Charter of Fundamental Rights of the European Union (2000) follows the path adopted by the Biomedicine Convention although employing the language of individual rights: ‘[e]veryone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices’⁴⁵. It is clear that financial feasibility is both a precondition for giving effect to the fundamental right to healthcare and a limitation of that right: the fundamental right stops where the state runs out of financial means.⁴⁶

Keeping in mind that the subject-matter ‘healthcare’ suits for the fundamental right better, there is a sound reason to narrow the concept of the right to healthcare due to uncertainty of the definition of ‘health’. In the Preamble to the WHO Constitution, health is defined as: ‘a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity’⁴⁷. Widening physical health to the psychological and the social dimensions was conceptually important; however, it has no direct operational value. As it was observed, ‘it is at the conceptual level that the definition runs into the most serious problems, which impair its guiding role when the conflict between health needs and resources has become of paramount concern, nationally and internationally’, and a state of complete physical, mental, and social well-being corresponds much more closely to happiness than to health.⁴⁸ Unclear distinction between health and happiness threatens to the practical implementation of the right to healthcare. Firstly, any, even minimal, disturbance to happiness may come to be seen as a health problem. Secondly, because the quest for happiness is essentially boundless, the quest for health also becomes boundless. This legitimizes an unlimited demand for health services. Thirdly, the

42 “‘Equitable’ means, first and foremost, the absence of unjustified discrimination. Although not synonymous with absolute equality, equitable access implies effectively obtaining a satisfactory degree of care’ (Council of Europe. *Explanatory Report to 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*. 1997, para. 25).

43 *Ibid.*

44 *Ibid.*, para. 24.

45 Charter of Fundamental Rights of the European Union, 2000, O.J. (C 364)

46 De Groot, R. Right to Health Care and Scarcity of Resources. In Gevers, J. K. M., *et al.* (eds.) *Health Law, Human Rights and the Biomedicine Convention*. Leiden/Boston: Martinus Nijhoff Publishers, 2005, p. 52.

47 World Health Organization, *supra* note 19.

48 Saracci R. The World Health Organization needs to reconsider its definition of health. *British Medical Journal*. 1997, 314: 1409–1410.

distinction between health and happiness is crucially relevant in terms of rights requiring societal actions to ensure that they effectively and fully materialize. It seems impossible to construct an argument that happiness is a subject-matter of social right simply because the prescriptive view of happiness cannot be introduced in the democratic society. Finally, trying to guarantee the unattainable happiness for every citizen will inevitably subtract resources and jeopardize the chances of guaranteeing the gradually attainable justice and equity in health.

On the other hand, such a concept of health embraces virtually all aspects of human life and, at the same time, health also becomes a subjective category, an aspiration which is construed by the individuals themselves. If health is considered an objective reality, i.e. a natural norm governing the lives of all human beings, the right to healthcare will normally include an obligation on the part of a state to guarantee more or less satisfactory healthcare to all citizens to enable them to develop their personal and social life. In contrast, if health is identified with individual desire, the content of the right to health will be limited considerably because of the scarcity of financial resources. It could only guarantee an individual's freedom to choose his or her preferred healthcare, and the state would merely be responsible for the qualifications of service providers and for the safety and efficacy of such services.⁴⁹ The subjectivist concept of health also influences health policy at the international level. The emphasis will not be put on investing resources to fight the most serious health problems in poor countries, rather it will be used to develop luxury medicine in the richer ones.

Probably, due to the mentioned problems, the Biomedicine Convention carefully avoids the employment of the WHO definition of health in its text. The Biomedicine Convention makes no reference to any WHO document, and its Explanatory Report provides a rather narrow definition of the concept of health indirectly attributing only the biomedical meaning to it. This could be deduced from the definition of 'healthcare': 'the services offering diagnostic, preventive, therapeutic and rehabilitative interventions, designed to maintain or improve a person's state of health or alleviate a person's suffering. This care must be of a fitting standard in the light of scientific progress and be subject to a continuous quality assessment'⁵⁰.

4. The Right to Healthcare and Scarcity of Resources

Some of the statements made by the UN Committee on Economic, Social and Cultural Rights in the General Comment No. 14 might lead one to believe that a state has compelling legal obligations to provide sufficient resources to ensure adequate health for all. It is said, for example, that 'health facilities, goods and services must be affordable for all. Payment for health care services, as well as services related to the underlying determinants of health, have to be based on the principle of equity, ensuring that these services, whether privately or publicly provided, are affordable for all, including socially

49 Bellver Capella, V., *supra* note 32.

50 Council of Europe, *supra* note 42, para. 24.

disadvantaged groups. Equity demands that poorer households should not be disproportionately burdened with health expenses as compared to richer households⁵¹. However, there is one important qualification to this claim—‘the precise nature of the facilities, goods and services’ depending ‘on numerous factors, including the State party’s developmental level’⁵².

The Biomedicine Convention avoids including a non-exhaustive wish-list based on the ‘underlying determinants of health’ into the notion of the right to healthcare. The notion of healthcare is stripped from social aspects and limited to ‘diagnostic, preventive, therapeutic and rehabilitative interventions’ whereas interventions are understood as ‘all medical acts, in particular interventions performed for the purpose of preventive care, diagnosis, treatment or rehabilitation’.⁵³ All these objective limitations are directed to the sole purpose—to strike a balance between health needs and available resources and to ensure ‘equitable access’. Only economic accessibility in healthcare is of undisputed social importance—it supports social cohesion. Usually the European countries have statutory health insurance schemes in the form of social benefits or publicly funded healthcare enabling people to overcome financial barriers that otherwise exist. In this context, ‘equitable’ means, first and foremost, the prohibition of unjustified discrimination. The prohibition of discrimination is an important tool for protecting individual patients in a market-driven healthcare field. Equitable access also implies effectively obtaining a satisfactory degree of care and, at the same time, incites governments towards a policy of distributive justice in healthcare when faced with the dilemma of fair and equal allocation of scarce resources.

A national healthcare system may not be able to provide for objective health needs in every respect due to limited availability of financial resources. So what can be said about the enforceability of the right to healthcare? Is there a principled way of adjudicating between the two competing claims: on one hand, those of the group denied health care access claiming that its health rights are violated and, on the other hand, those of state claiming that its resources can be utilized better elsewhere? The provisions of treaties which affirm the right to health or healthcare do not generally provide with legal instruments to proceed against the state. Having a well functioning example of the European Court of Human Rights, one could expect broader judicial intervention in the protection of human rights, including the right to healthcare, under the Biomedicine Convention. However, the European countries showed reluctance in conferring the judicial competence to European Court of Human Rights, thus leaving the protection under this Convention to domestic courts.⁵⁴ Social fundamental rights are mainly relied by courts when all other, ‘better’ arguments have been exhausted.⁵⁵ Because of its general

51 Committee on Economic, Social and Cultural Rights, *supra* note 40, para. 12 (b).

52 *Ibid.*, para. 12 (a).

53 Council of Europe, *supra* note 42, para. 29.

54 Juškevičius, J.; Balsienė, J. Bioethics and Human Rights: Towards a Possible Universal Bioethics. *Člověk a jeho práva. Kapitoly z multikulturní tolerance*. 2006, 4: 100–116, at 114–115.

55 De Groot, R., *supra* note 46, p. 49.

and abstract formulation, it is not an appropriate instrument with which to resolve specific disputes regarding the access to care.

The access to healthcare cannot be enforceable, since there is no shared understanding of what constitutes good healthcare. Because of resource scarcity, the access to healthcare in practice depends largely not on legal provisions, but on social security or government budget decisions and, at the private level, on the clinical judgments of health professionals and the incomes of individual patients. These and similar variables would make it virtually impossible for a state to anticipate and fund the costs involved in recognizing an individual right to healthcare.⁵⁶ Securing welfare rights by judicial decree rather than by the normal process of legislative give-and-take can serve to delegitimize the result, prolong and even intensify social conflict and ultimately devalue democratic institutions. Because it does not require the adducing of reasons, the assertion of individual welfare rights discourages the process of rational argument, deliberation and justification that a healthy democracy requires.⁵⁷

Conclusions

Rather contrary to the official UN human rights approach in the field of healthcare, it seems that the subject-matter ‘healthcare’ is best suited for a social fundamental right for the following reasons:

- at the most basic level, it is literally impossible for the society to guarantee good health to its members, as it remains intrinsic to the human condition and at least partially depends one’s behaviour and lifestyle, which are beyond state control;
- the definition of health coined by the WHO permits boundless multiplication of specific entitlements based on the underlying determinants of health. Consequently, such a multiplication will reduce the possibilities to manage effective protection of the right.

The WHO definition of health as a state of complete physical, mental, and social well-being corresponds to happiness rather than to health. Such a subjective category may legitimize an unlimited demand for health services. These are compelling reasons to call for narrowing the concept of the right to healthcare by choosing the biomedical definition of health as a basis. Therefore, the core purpose of the social right to healthcare is to strike a balance between health needs and available resources and to ensure ‘equitable access’.

⁵⁶ Goodman, T., *supra* note 28, p. 649.

⁵⁷ Glendon, M. A. *Rights Talk: The Impoverishment of Political Discourse*. New York: The Free Press, 1991, 191.

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ŽMOGAUS TEISĖS SVEIKATOS PRIEŽIŪROJE: KAI KURIOS PASTABOS DĖL TEISĖS Į SVEIKATOS PRIEŽIŪRĄ RIBŲ

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Santrauka. Sveikatos priežiūros srities reguliavimas yra sudėtingas dėl įvairių šaltinių gausos ir jų nevienodos prigimties. Tarptautiniu mastu sveikatos priežiūros sritis kol kas yra reguliuojama žmogaus teisių instrumentais. Nepaisant pamatuotų bei ne visai pamatuotų lūkesčių, liečiančių žmogaus teisių ekspansiją į šią sritį, dėl paties sveikatos priežiūros kompleksškumo kyla ir kai kurių probleminių klausimų, susijusių su žmogaus teisių instrumentų praktiniu taikymu, bei galimų to pasekmių. Straipsnyje nagrinėjamos tiesiogiai su šia sritimi susijusios socialinės teisės – teisės į sveikatos priežiūrą turinio galimos ribos. Šios ribos yra aptariamoms remiantis dviem kertinėmis sveikatos teisės sąvokomis: autonomijos arba apsisprendimo principu bei pačia teise į sveikatos priežiūrą.

Kalbant apie teisę į sveikatos priežiūrą, doktrinoje nesutariama, kas yra šios teisės objektas – sveikata ar sveikatos priežiūra. Pirmąjį požįūrį palaiko Jungtinių Tautų Žmogaus teisių tarybos formuojama doktrina. Sveikatos turinys, remiantis Pasaulio sveikatos organizacijos pateiktu sveikatos apibrėžimu, tampa labai platus. Šiuo atveju visuomenė negali užtikrinti savo nariui geros sveikatos, nes ji vis dar priklauso nuo konkretaus asmens prigimties ir glaudžiai susijusi su jo elgesiu arba pasirinktu gyvenimo būdu. Kitas neigiamas aspektas yra susijęs su faktu, kad platus sveikatos apibrėžimas lemia neribotą specifinių išvestinių teisių atsiradimą, kurių gausa stabdo veiksmingą teisės apsaugą. Šios ir kitos nepaminėtos priežastys leidžia atskiriems akademinės doktrinos atstovams skeptiškai vertinti teisės į sveikatą pagrįstumą, pasisakant už ribotą teisės į sveikatos priežiūrą formuluoatę.

Nors teisės į sveikatos priežiūrą objektas ir turinys yra siauresnis, tačiau šios teisės veiksmingą įgyvendinimą gali riboti minėto sveikatos apibrėžimo platumas. Dabartiniu metu doktrinoje reiškiamas susirūpinimas, kad sveikatos kaip visapūsės fizinės, dvasinės ir socialinės gerovės apibrėžimas labiau susijęs su subjektyvia laimės sąvoka negu su objektyviais sveikatos parametrais. Ši subjektyvi kategorija gali grėsti neribojamų sveikatos priežiūros poreikių įteisinimu. Atsižvelgiant į tai, jog esami sveikatos priežiūrai skirti ištekliai yra riboti bei kad teisės į sveikatos priežiūrą praktinis įgyvendinimas turi būti veiksmingas, straipsnio autoriai linkę manyti, kad nustatant šios teisės turinį reikėtų remtis biomedicininio sveikatos apibrėžimu, t. y. ligos arba negalios nebuvimu.

Reikšminiai žodžiai: *žmogaus teisės, teisė į sveikatą, teisė į sveikatos priežiūrą, Biomedicinos konvencija, lygiateisiškas prieinamumas, sveikatos apibrėžimas.*

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