The Right to Health of Irregular Migrants: An Exploration of Enabling and Constraining Factors in International and European Human Rights Law

A thesis submitted by

Stefano Angeleri

in partial fulfilment

of the requirements for the degree of

PhD in Law

Supervised by

Dr Ciara M. Smyth

Irish Centre for Human Rights

School of Law

National University of Ireland Galway

April 2019

Summary of Contents

This doctoral thesis asks whether international and European human rights law are substantially and structurally equipped to enhance the right to health of irregular migrants. These legal frameworks encounter structural and conceptual hurdles where the social rights of irregular migrants are concerned. One such challenge is the tension that exists between sovereign immigration enforcement and 'universal' human rights law, which results in limitations on the personal and material scope of the latter. Another crucial issue is the uneven approach to socio-economic rights vis-à-vis civil rights in human rights law and practice, which reduces the normative force of the international right to the highest attainable standard of physical and mental health. These factors have led the European Courts of Human Rights, the most authoritative European human rights adjudicator, to conceptualise the right to health of irregular migrants in terms of urgent and exceptional medical measures only. This trend is inconsistent with the principle of the indivisibility of human rights and with the jurisprudence of several United Nations Human Rights bodies. Indeed, among them, the Committee on Economic Social and Cultural Rights (influenced by the approach of the World Health Organization) insists that essential primary health care, core obligations, and the determinants of health should apply to everyone and should target vulnerable people in particular. The European Committee of Social Rights locates itself half-way between these positions and, while struggling with a limited competence *ratione personae,* has engaged with an extensive interpretation of rights. The case study of Italy demonstrates that a right to essential health care for irregular migrants – the enjoyment of which is guaranteed by a separation (called 'firewalls') between immigration law enforcement and public service providers – is addressed in the legal system and administrative practice, although it does not receive full constitutional protection, and international and European law have made only limited contributions to shaping it.

Declaration of Originality

I, Stefano Angeleri, do hereby declare that the work submitted for examination is my own and that due credit has been given to all sources of information contained herein. With this declaration, I certify that I have not obtained a degree at the National University of Ireland, Galway, or elsewhere, based on this work. I acknowledge that I have read and understood the Code of Practice for dealing with Plagiarism and the University Code of Conduct of the National University of Ireland, Galway and that I am bound by them.

Stefano Angeleri

Galway, 1st April 2019

Acknowledgments

This thesis could not have come to fruition without the moral and professional support of several people. A very special thank-you goes to my PhD supervisor, Dr Ciara Smyth who has encouragingly pushed me to improve my findings throughout the process. I look up to you a lot, both professionally and as a kind human being. Many thanks to my first supervisor, Professor Michael O'Flaherty, now Director of the Fundamental Rights Agency of the European Union, who believed in my potential and accepted me into this PhD programme. I am very grateful to the academic and administrative staff of the Irish Centre for Human Rights and my fellow PhD candidates. I have always felt a sense of community and belonging. A special mention goes to my friend Dr Anita Ferrara with whom I share an unconditional love for the Irish weather. Thank you, Jia and Noemi for your format- and IT-related tips, and thank you Sarah, Peter, and Rebecca for your kind proof-reading on this and other pieces of research. I would also like to thank my colleagues and friends at the Department of Law at the University of Verona, where I spent 3 months on a research visit in 2018, and especially Professor Giovanni Guiglia.

An endless thank-you goes to my parents, Patrizia and Loris, and my broader family, including my aunties Laura and Silvia and my cousin Alessandra, who love me so much and have unconditionally supported my choices, even when they entailed living 2,000 km from home. Many thanks to my close friends in Milano, Cologne, Galicia, Lleida, Messina, Toronto, Dublin, and Verona. I always feel at home with you around, and I can't wait to meet you again soon! Thank you, Corinna and Chris of La Collina Restaurant in Salthill, for giving me a job (and several plates of pasta and pizza) during the first unfunded months of my postgraduate studies. I am thankful for all the new friends that I have met in Galway, Tatel, Sara, Inma, Elena, Javier, Nacho, Silvia, Mario, Peter, Sarah, Eric, Olive, Catherine, Mara, Alex and Jia to name just a few. Thanks also to my partner, Edgar. You have been so patient and loving during the final stages of this research.

Thank you, Galway! I am sure this is not 'goodbye'.

Table of Contents

List of Common Abbreviations

AAAQ	Availability, Accessibility, Acceptability and Good Quality
CCPR	Human Rights Committee
CESCR	Committee on Economic Social and Cultural Rights
CIA	(Italian) Consolidated Immigration Act
CMW	International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families
COs	Concluding Observations
CRPD	Convention on the Rights of Persons with Disabilities
CUP	Cambridge University Press
ECHR	European Convention on Human Rights
ECSR	European Committee of Social Rights
ECtHR	European Court of Human Rights
ESC	European Social Charter
EU	European Union
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic Social and Cultural Rights
LEA	(Italian) Levels of Essential Assistance Act
OUP	Oxford University Press
PHC	Primary Health Care
SDH	Social Determinants of Health
SR	Special Rapporteur
SSN	Servizio Sanitario Nazionale (Italian National Health Care System)
UDH	Underlying Determinants of Health
UDHR	Universal Declaration of Human Rights
UHC	Universal Health Coverage
UN	United Nations
UNGA	General Assembly of the United Nations
WHO	World Health Organization

Introduction

1. Context

Irregular migrants and the right to health have been struggling to receive consistent recognition in the human rights project over the last 70 years. Therefore, this dissertation explores the factors that can enable and constrain the full realisation of the right to health of irregular migrants in international and European human rights law and practice.

The human rights revolution, during this period of time, has generated a new body of international law revolving around the interrelated concepts of human dignity for every person and the universality of rights. The Universal Declaration of Human Rights (UDHR) and the other instruments of the UN human rights system have contributed to the development of international, regional, and domestic cultural and legal environments that are increasingly rights-supportive.[1] Despite this, and regardless of their proclaimed equal importance (or 'indivisibility') in international law, socio-economic rights were widely neglected for most of the 20th century because they were not regarded as enforceable legal human rights. Furthermore, migration became a topical issue at both domestic and international levels in the 1970s and remains one of the most politicised topics of national and international affairs, with serious repercussions for the human rights of migrants, especially irregular migrants.

Focusing on Europe, battles for citizens' welfare rights were far more prevalent at the domestic level than on regional agenda during the 1960s and '70s, although the negotiation in the 1950s of the European Social Charter (ESC) demonstrated a cultural and institutional climate that was supportive of 'social progress', and social rights as either entitlements or non-binding principles of social policy.[2] As for migration, over the last 20 years and

[1] Universal Declaration of Human Rights (adopted 10 December 1948) UNGA Res 217 A(III) (UDHR). For the other UN human rights treaties, see infra at n 14.
[2] For example, Committee of Ministers of the Council of Europe, 13th Session (12 September 1953) CM (53) 99, Consultative Assembly of the Council of Europe, 5th Ordinary Session -

especially today, we can observe that immigration rates have increased, public security is perceived as a top agenda issue, domestic and European Union (EU) measures have cracked down on irregular migration without opening up avenues for regular migration, and the continent is still beset by various armed conflicts and widespread socio-economic deprivation.[3] Moreover, the financial and economic crisis of the last 10 years has been used as justification for the adoption of conservative and regressive measures that have cut social expenditure in domestic budgets, the latter being critical for implementing social rights for vulnerable people, including the right to health. All of this considered, it appears more topical today than ever to reaffirm meaningful standards and state obligations in the area of health for migrants, in particular those who are undocumented or irregular, so as not to betray the promise of universality and indivisibility of human rights by adopting selective 'sovereigntist' approaches.

2. Motivation

The motivation for this research came from my collaboration with the Italian NGO 'Naga Onlus'. This NGO was established in the 1980s as a medical clinic run by volunteers who provide free medical and social care to irregular migrants and Romani communities in the Milan area. I strongly believe that health is a public good and a human right, that the enjoyment of good health is crucial for us to flourish as human beings,[4] and that fair and equal access to services should be available to meet basic health needs and ensure equality of opportunity to function in society.[5] During the 1990s, irregular migrants had very few health care rights in Italy. In the 2000s, after the enactment of

Common Policy of Member States in Social Matters - Official Report of the Debate on the Report of the Committee on Social Questions (23 September 1953) Doc no 188. In 'Collected "Travaux préparatoires" of the ESC, Vol. I, 11, 14 < https://www.coe.int/en/web/european-social-charter/preparatory-work> accessed 20 March 2019.

[3] For further details, see EU policy on (irregular) migration <https://ec.europa.eu/home-affairs/what-we-do/policies/irregular-migration-return-policy_en> accessed 1 March 2019.

[4] Amartya Sen, 'Elements of a Theory of Human Rights' (2004) *Philosophy and Public Affairs* 32(4) 315, 332; Martha Nussbaum, *Creating Capabilities: The Human Development Approach* (Belknap Press 2011) 20-26.

[5] Norman Daniels, *Just Health: Meeting Health Needs Fairly* (CUP 2007) 20-21.

the 1998 Immigration Act and a series of related administrative measures, migrants became entitled by law to 'urgent and essential health care'.[6] However, this right was extremely difficult to enjoy in practice, and many irregular migrants were turned away by hospital staff before administrative measures were implemented to allow hospitals to recoup the costs of medical treatment of irregular migrants and thus protect their anonymity. As discussed in Chapter 5 of this thesis, the current Italian legal framework is generally protective in this regard. However, new legislative initiatives of the current anti-immigrant government and, potentially, of future governments could remove 'essential health care' from domestic rights protection. For this reason, I turned my attention to international and European human rights law in search of legal principles and norms that could bind Italy (and other countries) to a standard of health for irregular migrants that is not limited to 'life-saving-treatment'. I was guided by the naïve hypothesis that international human rights law, which is supposed to be aimed at human rights protection and promotion, is more human-centred than domestic law.

I was not entirely correct.

3. Research Question and Aims

The central research question addressed in this thesis is whether international and European human rights law can offer consistent and comprehensive solutions for enhancing the right to health of irregular migrants. In other words, are they substantially and structurally equipped to do so? To answer this question, this dissertation is composed of five substantive chapters, each of which answers a particular sub-question. Chapter 1 addresses the question of how the clash between the principle of state sovereignty in the area of immigration and the development of universal human rights shapes the conceptualisation of the rights of irregular migrants and the case law in this area. Chapter 2 asks how the health-related interests are protected by various

[6] Legislative Decree no 286 of 25 July 1998, published in the Official Gazette no 191 of 18 August 1998 (Consolidated Immigration Act) Article 35.

human rights treaties and their monitoring bodies. Understanding this is crucial as the next two chapters ask how 'thick' the protection of the right to health of irregular migrants is in European and international law and jurisprudence. Chapter 3 addresses the accessible levels of health care and Chapter 4 addresses the standards governing the determinants of health. Finally, Chapter 5 asks how the right to health of irregular migrants is protected at domestic level in Italy and what role international and European human rights law can play in enhancing domestic standards when they are jeopardised by regressive state measures.

The aim of my research is to systematise and analyse norms regarding the right to health of irregular migrants in international and European human rights law, which oscillate between 'emergency medical measures' and 'primary health care'. My analysis is aimed at exposing the confusion that exists with respect to the scope and the conceptualisation of the right to health in these legal frameworks, and therefore at proposing clarifications. The conceptual confusion that exists concerning the right to health of irregular migrants prevents international and European human rights law from efficiently and meaningfully guiding national standard-setting in this area, when states are reluctant to introduce progressive standards in the fields of health and irregular migration.[7]

Even though I strongly believe in the potential of international and European human rights law as a transformative and reinforcing process for domestic law and practice, the structural and material limitations of these legal frameworks need to be acknowledged. Therefore, the purpose of this analysis is to scrutinise, select and recommend the use of those legal standards and arguments that are consistent with the idea that genuine human rights obligations require states to promote and protect the health – and not only the life – of vulnerable people. This would make it possible to reduce the gap

[7] Fundamental Rights Agency of the European Union, *Migrants in an Irregular Situation: Access to Healthcare in 10 European Union Member States – Comparative Report* (FRA Publishing 2011); Sarah Spencer & Vanessa Hughes 'Outside and In: Legal Entitlements to Health Care and Education for Migrants with Irregular Status in Europe' (2015) *Oxford COMPAS Report* <https://www.compas.ox.ac.uk/2015/outside-and-in/> accessed 1 March 2019.

between the health-related entitlements of irregular migrants and those of the registered population. As 'health' is not a legal concept, if this purpose is to be achieved, it is important to consistently enhance the links between legal means and the technical or meta-legal content of norms.

4. Methodology and Research Limits

This doctoral thesis employs a 'qualified doctrinal approach' inspired by a belief in the significance of 'methodological pluralism'.[8]

It incorporates a close doctrinal analysis of the scope and content of the right to health for irregular migrants in international and European human rights law, including the root causes of inequality, together with an analysis of policy and practice in Italy regarding the use of firewall mechanisms and procedures. Moreover, it draws on certain items of 'public health' literature to complement the definition of 'health', which entails regarding (human rights) 'law as a means to an end', that end being the realisation of 'highest attainable standards of health' for everyone.[9]

This approach means integrating legal doctrinal analysis, including its goal of interpreting and systematising sources of law and legal arguments,[10] with analyses of policy reports, medical and public health guidelines, and other practice documents on how to facilitate access to health care for irregular migrants. It also involves considering commentary and analysis from civil society, NGOs, United Nations (UN) bodies, and non-legal academic literature.

Although I believe that adopting a doctrinal approach to law is methodologically sound,[11] a 'qualified approach' mitigates against the

[8] Christopher McCrudden 'Legal Research and Social Science' (2006) *Law Quarterly Review* 122 632, 642.
[9] Brian Tamanaha, *Law as a Means to an End* (CUP 2006); Dabney Evans & Megan Price 'Measure for Measure: Utilizing Legal Norms and Health Data in Measuring the Right to Health', in Fons Coomans, Fred Grünfeld & Menno T. Kamminga (eds) *Methods of Human Rights Research* (Intersentia 2009) 111.
[10] Richard A. Posner 'Legal Scholarship Today' (2002) *Harvard Law Review* 115 1314, 1316.
[11] Jan M. Smits, 'Redefining Normative Legal Science: Towards an Argumentative Discipline', in Coomans et al (n 9) 45.

criticism that a purely doctrinal approach considers law to operate within a 'socio, political, and economic vacuum'.[12]

Even though, this research does not include interactive data collection (e.g., interviews or questionnaires) and it is not purely multidisciplinary, nor does it adopt an exclusive 'internal legal approach'. Irregular migration is scrutinised as a 'practice' and a 'legal phenomenon', and health is analysed as a 'status' and an 'entitlement', keeping in mind the rules of international human rights law and 'striking a balance between foolish utopianism and grim realism'.[13]

For this 'qualified doctrinal analysis' to be rigorous it is important to set clear research boundaries, and the following points help to position my research in relation to the existing literature.

First, in consideration of my research question, the legal analysis in Chapters 1 to 4 focuses on international and European human rights law. In Chapter 5, the assessment extends to the Italian constitutional and statutory law. Regarding international human rights law, although human rights law originates from the 'constitutional' traditions of the states belonging to the international community, it has, since the late 1940s, become a subject of study with its own conceptual autonomy, even within the broader field of international law. For the purposes of this research, 'international human rights law' refers to the UN machinery of human rights, particularly the nine UN human rights treaties and the special procedures of the Human Rights Council,[14] and 'European human rights law' refers to the instruments adopted

[12] David Ibbetson, 'Historical Research in Law', in Mark Tushnet and Peter Cane (eds) *Oxford Handbook of Legal Studies* (OUP 2003) 863, 864.

[13] David J. Bederman, 'Appraising a Century of Scholarship in the American Journal of International Law' (2006) *American Journal of International Law* 100 20, 22.

[14] International Convention on the Elimination of All Forms of Racial Discrimination (adopted 21 December 1965 entry into force 4 January 1969) (ICERD) UNGA Res 2106 (XX); International Covenant on Civil and Political Rights (adopted 16 December 1966 entry into force 23 March 1976) (ICCPR) UNGA Res 2200A (XXI); International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966 entry into force 3 January 1976) (ICESCR) UNGA Res 2200A (XXI); Convention on the Elimination of All Forms of Discrimination against Women (adopted 18 December 1979 entry into force 3 September 1981) (CEDAW) UNGA Res 34/180; Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (adopted 10 December 1984 entry into force 26 June 1987) (CAT) UNGA Res 49/46; Convention on the Rights of the Child (adopted 20 November 1989 entry into force 2 September 1990) (CRC) UNGA Res 44/25; International

in the context of the Council of Europe but excludes the legal standards and case law that have developed in EU law.[15] The exclusion of EU law can be explained by the fact that although irregular migration is a shared competence of the EU and member states, health remains an exclusive competence of member states, albeit one that is supported and complemented by various provisions of the Treaty on the Functioning of the EU. The right to health is stated in the Charter of Fundamental Rights of the EU but applies only within the scope of EU law. The net effect is that the Court of Justice of the EU has pronounced on the right to health of an irregular migrant only once, in the context of deportation-related inhuman or degrading treatment.[16] Accordingly, there is very little to be gleaned from EU law about the right to health of irregular migrants.

Second, the doctrinal analysis is both 'expository' and 'evaluative', which means that the legal standards considered are presented and assessed within the legal frames of reference and in the light of relevant legal principles, norms, case law, jurisprudence, meta-legal arguments, and scholarly analyses.[17]

Third, the geographical scope of the research is potentially global, even though the comparison between universal/international and European standards makes the research particularly interesting to European law and policymakers. Italy is the geographical focus of Chapter 5. Regarding the

---

Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (adopted 18 December 1990 entry into force 1 July 2003) (CMW) UNGA Res 45/158; International Convention for the Protection of All Persons from Enforced Disappearance (adopted 20 December 2006 entry into force 23 December 2010) (ICPED) UNGA Res 61/177; Convention on the Rights of Persons with Disabilities (adopted 13 December 2006 entry into force 3 May 2008) (CRPD) UNGA Res 61/106. For further details, including on the UN human rights bodies and their procedures, see <https://www.ohchr.org/EN/pages/home.aspx> accessed 1 March 2019.

[15] These include the Convention for the Protection of Human Rights and Fundamental Freedoms (adopted 4 November 1950 entry into force 3 September 1953) ETS 5 (ECHR); European Social Charter (adopted 18 October 1961 entry into force 26 February 1965), ETS 35; Revised European Social Charter (adopted 3 May 1996 entry into force 1 July 1999) ETS 163 (ESC).

[16] European Parliament and Council Directive 2008/115/EC of 16 December 2008 laying down common standards and procedures in Member States for returning illegally staying third-country nationals [2008] OJ L348/98; Case C-562/13 *Centre public d'action sociale d'Ottignies-Louvain-la-Neuve v Moussa Abdida* [2014] paras 62-64.

[17] Robert Cryer et al., *Research Methodologies in EU and International Law* (Hart Publishing 2011) 9.

regional legal frameworks examined in this research, the choice to exclude from the analysis the instruments of the Organisation of American States and the African Union was made in the interest of avoiding excessively general statements and conclusions on migration and health situations in Africa and the Americas. Migration and health in the American regional systems, which is briefly referred to in Chapter 1 and in the concluding chapter, may be the subject of further future research.

Fourth, the personal/group targets of the research are irregular migrants (or undocumented people) as human rights holders.[18]

Fifth, the main jurisprudential approach is legal positivism, qualified by a human and social-centred approach to law. Therefore, I argue that legally valid law is that created and laid down by human beings through agreed decision-making procedures and does not gain its authority from the metaphysical concepts of reason, nature or god. International and European human rights laws are created by states and decision-making bodies and are spelled out by courts, quasi-judicial bodies, or other human rights procedures that receive authority from internationally elected decision-making bodies. This approach is complemented by the belief that state law, as much as protecting freedom, should serve the fundamental human interest of enjoying decent conditions of living that permit real freedom of choice in life for 'everyone'.

Sixth, the main theories on which the arguments are built are those of 'vulnerability' and 'non-discrimination' as components of the theory of 'core obligations' in relation to health, and in interaction with the concept of 'primary health care'.

Seventh, the research extends the analysis to encompass certain extra-legal and meta-legal standards, namely, the concepts of 'primary health care', 'universal health coverage', and the 'social determinants of health', as interpreted by the World Health Organization.

Finally, it should be acknowledged that while international human rights courts and bodies have contributed to the development of international

[18] Section 5 *infra* at 'preliminary definitions'.

and European human rights laws concerning irregular migrants and while many institutional follow-up measures have been implemented, the enforcement of these laws is heavily reliant on the political willingness of state powers to adjust their domestic legal systems to such internationally recognised norms.

5. Preliminary Definitions

In terms of personal scope, this study focuses on 'undocumented or irregular migrants'. In terms of material scope, the focus is on 'health and the right to health'. It is important to be clear on the meaning of these terms of art.

This research refers interchangeably to 'irregular' and 'undocumented' migrants or people to refer to those foreign nationals who do not comply with immigration law requirements for entry and/or stay in a country and are, therefore, susceptible to deportation.[19] This is in line with the recommendations of various international bodies and the practice of specialised NGOs, although there is no consensus on the correct term to use.[20]

In 1975, the General Assembly of the UN passed a resolution that required the 'United Nations organs and specialised agencies concerned to use in all official documents the term "non-documented or irregular migrant workers" to define those workers that illegally and/or surreptitiously enter another country to obtain work'.[21] The UN Committee on Migrant Workers recently declared that 'the use of the term "illegal" to describe migrant workers in an irregular situation is inappropriate and should be avoided as it tends to stigmatise them by associating them with criminality'.[22] The UN

[19] Elspeth Guild, 'Who is an Irregular Migrant?', in Barbara Bogusz et al. (eds) *Irregular Migration and Human Rights: Theoretical, European and International Perspectives (Immigration and Asylum Law and Policy in Europe)* (Martinus Nijhoff Publishers 2004) 3.
[20] Magdalena Perkowska, 'Illegal, Legal, Irregular or Regular – Who is the Incoming Foreigner?' (2016) *Studies in Logic, Grammar and Rhetoric* 45(58) 187. The Platform for International Cooperation on Undocumented Migrants (PICUM), <https://picum.org/> and Migrant Rights Centre Ireland (MCRI) <https://www.mrci.ie/> (accessed 1 March 2019) mainly employ 'undocumented migrants'.
[21] UNGA Res 3449 'Measures to Ensure the Human Rights and Dignity of All Migrant Workers' (9 December 1975).
[22] Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families (CMW Committee), 'General Comment No. 2: The rights of migrant workers in an

Committee on Economic, Social and Cultural Rights has recently demonstrated a preference for the term 'undocumented migrants', whereas the International Organization for Migration prefers to employ the term 'irregular migration'.[23]

In the European context, the Parliamentary Assembly of the Council of Europe has expressed a preference 'irregular migrant' over 'illegal migrant' or 'migrant without papers', and other monitoring bodies employ similar terminology.[24]

In relation to 'health', the Constitution of the World Health Organization (WHO) defines the concept as a 'state of complete physical, mental and social well-being and not merely the absence of disease or infirmity'.[25] International human rights law has reduced the corresponding legal standard to the 'right to the highest attainable standard of physical and mental health' because it was seen as impossible to conceive of imposing on the state a duty to guarantee a 'state of complete […] health' for everyone.[26]

The highest attainable standard of health must be realised through intersectoral measures concerning both health care or medical care and the socio-economic determinants of health that address prevention, promotion, and treatment.[27] In 1978, discussions between health experts and world leaders led to the adoption of the Declaration of Alma Ata on 'primary health care'.[28] This milestone document on 'public health' has influenced the way

---

irregular situation and members of their families' (23 August 2013) UN Doc CMW/C/GC/2, para 4. Similarly, UNHRC, Statement of the Special Rapporteur on the Human Rights of Migrants 'Mainstreaming a Human Rights-Based Approach to Migration within the High-Level Dialogue' UNGA Plenary Session – Criminalization of Migrants (2 October 2013).

[23] IOM Key Migration Terms <https://www.iom.int/key-migration-terms> accessed 1 March 2019.

[24] CoE PACE Res 1509 'Human Rights of Irregular Migrants' (2006); CoE ECRI, 'General Policy Recommendation No.16: Safeguarding Irregularly Present Migrants from Discrimination' (16 March 2016).

[25] Constitution of the World Health Organization (Adopted 22 July 1946 entry into force 7 April 1948) Off. Rec. WHO 2, 100, Preamble.

[26] ICESCR (n 14) Article 12. For further details, see Chapter 2.

[27] Committee on Economic Social and Cultural Rights (CESCR) 'General Comment No. 14: The Right to the Highest Attainable Standard of Health (article 12 of the International Covenant on Economic, Social and Cultural Rights)' (11 August 2000) UN Doc E/C.12/2000/4, paras 4, 11.

[28] Declaration of Alma-Ata - Health for All, International Conference on Primary Health Care (6-12 September 1978). For further details, see Chapter 2.

in which the Committee on Economic, Social and Cultural Rights – the monitoring body of the UN International Covenant on Economic, Social and Cultural Rights – has framed the normative content of the right to health and its correlative general and core obligations.[29] Therefore, in the field of health, states are obliged to 'addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services' through the implementation of medical and socio-intersectoral measures.[30] As 'primary health care is essential health care', it is difficult to accept that the right to health is protected, respected, and fulfilled solely by the provision of life-saving, emergency-oriented medical treatment, which is often the case where undocumented or irregular migrants are concerned.[31]

6. Structure

In addition to this introduction, this study is composed of five substantive chapters, and a concluding chapter. The first two chapters address the root causes of the inability of international law to generate a sufficiently clear and universal right to health for irregular migrants. Chapters 3 and 4 describe and critically analyse international and European human rights standards where 'health care' and the 'social or underlying determinants of health' of irregular migrants are concerned, respectively. Chapter 5 explores how the human rights-sovereignty clash in this area is resolved in Italy and demonstrates the significance of enforcing consistent international social rights standards for vulnerable people at the domestic level.

More specifically, Chapter 1, entitled *'Sovereignty and the Human Rights of Irregular Migrants'*, situates the human rights of irregular migrants within the legal frames of reference chosen for this study. This chapter aims at contrasting the principle of sovereignty in international law with the principle of the universality of human rights. The tension between the two foundational principles is a major root cause for the oscillation of

[29] CESCR, GC14 (n 27) para 43.
[30] Declaration of Alma-Ata (n 28) para VII,2-4). Emphasis added.
[31] ibid, VI. For a discussion of the emergency approach, see Chapters 3 and 4.

international and European case law on the rights of irregular migrants between 'sovereigntist' and human-centred tendencies. The trend is also visible in relation to migrants' entitlement and enjoyment of health services and healthy living conditions.

Chapter 2, entitled '*The Normative Contours of the Right to Health*', provides an overview of the conceptualisation of the right to health and its correlative obligations in international and regional human rights law. It demonstrates a certain engagement by international bodies with the protection of 'health' while arguing that a structural and conceptual bias against socio-economic rights poses a risk for the universal protection and accountability of the right to health of vulnerable people, a category to which irregular migrants belong. The development of the international and European jurisprudence on health reveals a disjunct between 'ensuring survival or avoiding degrading treatment' and guaranteeing 'primary health care'.

Chapter 3, entitled '*The Right to Health Care of Irregular Migrants in European and International Human Rights Law*', builds on the structural and conceptual challenges outlined in the preceding chapters to describe, compare, and analyse the international and European jurisprudence on the right to 'health care' or 'medical care' of undocumented people. The assessment uncovers several inconsistencies. While international human rights law elaborates on the concepts of 'primary health care' and non-discrimination of vulnerable people, European human rights law entitles irregular migrants to a level of health protection that equates to 'urgent' or 'life-saving' treatments. Although the international standards are relatively in line with the technical concept of health, the chapter recommends a more substantive-oriented approach and consistent use of vocabulary related to health care by international bodies with an alignment of the accessible universal level of health care with the WHO recommendations on 'primary health care'.

Chapter 4 is entitled '*The Determinants of the Health of Irregular Migrants in European and International Human Rights Law'* This chapter aims at exploring whether international and European human rights laws

provide for the determinants of health of irregular migrants. The determinants of health, together with health care, are part of the scope of the right to health and constitute a very important field within the study of public health. Indeed, the enjoyment of social rights that support the determinants of health is in keeping with the concepts of power, indivisibility, interrelatedness and vulnerability that ground human rights law. However, an examination of the applicable human rights jurisprudence reveals that, where irregular migrants are concerned, these narratives often dissipate in the face of the imperative, as states see it, to control immigration, with the result that the social rights of irregular migrants are guaranteed at only 'basic' or 'survival' level.

Chapter 5 is a case study entitled '*The Right to Health of Irregular Migrants in Italy*'. This chapter presents the arguments of Italian constitutional, national, and regional law relating to the right to health of irregular migrants, together with the administrative solutions that Italy has developed to address this right. The aim is to evaluate the role that the international theories and practices discussed in the preceding chapters play at the domestic level. Today, the national standards in Italy on health care for irregular migrants are more closely aligned with the standards of international human rights law than with the applicable regional human rights law. However, with regard to the social rights that support the determinants of health of irregular migrants, the domestic system appears to respond with 'emergency measures' or to remains silent. This chapter also explores the clash between the various levels of central and regional government and law in relation to the realisation of social benefits and rights for the undocumented and the impact of international and European law in the shaping and evolution of domestic social rights.

The concluding chapter synthesises and analyses each chapter's findings, makes recommendations for the progressive development of the law and highlights areas worthy of further research. Overall, it reaffirms that technical standards and legal arguments do exist but that greater internal and relational consistency in international and European legal practice is crucial

to enhance their beneficial normative effect on the right to health of irregular migrants as human beings.

Chapter 1
Sovereignty and the Human Rights of Irregular Migrants

This chapter presents a first set of arguments that explains why irregular migrants are often prevented from enjoying health-related rights on an equal basis with others with reference to international law-making and adjudication. Neither the form of international law nor the developing content and redress mechanisms of international human rights law facilitate the enjoyment of human rights by irregular migrants. This results in an expansion of domestic law and state discretion where the rights of irregular migrants are concerned. This analysis begins by providing an overview of two interacting normative elements of international law that are crucial in this regard, namely state sovereignty and human rights. They are often presented as contrasting concepts, and the clash is particularly acute in relation to irregular migrants. Thus, over the last 130 years, a significant amount of domestic and international case law has referred to immigration control as the executive power to exclude undesired aliens that are not refugees – with the establishment of domestic laws regulating the legal entry, stay and return of aliens – as a corollary of state sovereignty.[1] By contrast, international human rights standards are aimed at limiting arbitrary treatment of persons in the light of a common belonging to the human family.[2] The tensions between state self-determination and universal principles and between human rights and a subset of rights for irregular migrants lie at the heart of the philosophy and organisation of liberal democracy, which 'draws boundaries and creates closures'.[3] Thus, the unequal treatment of irregular migrants in both law and

[1] James A.R. Nafziger, 'The General Admission of Aliens under International Law' (1983) *The American Journal of International Law* 77(4) 804, 822.
[2] UDHR (n 1, Introduction) Preamble: 'Whereas recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom justice and peace in the world'.
[3] Marie-Bénédicte Dembour and Tobias Kelly (eds) *Are Human Rights for Migrants? Critical Reflections on the Status of Irregular Migrants in Europe and the United States* (Routledge

practice puts to test the coherence of international and European human rights law and personhood as a source of human rights.[4] This chapter conducts such a test by providing examples of the most acute violations of human rights that irregular migrants have experienced in the context of border control. The intention is to give a flavour of the fragility – reflected in European and International case law – of the human rights of irregular migrants when they are subject to administrative detention, when they are deported, and when they attempt to enjoy their right to family life. Furthermore, the unequal and somewhat inconsistent recognition of their right to health in the European Social Charter (ESC) and the UN Convention on Migrant Workers (CMW) – partially remedied by the interpretative activities of their monitoring bodies – is revealed to demonstrate the dramatic extent to which sovereign state interests shape international human rights law-making with regard to these migrants. A brief reference to the jurisprudence of the Inter-American system of human rights demonstrates that the 'sovereignty-human rights' relationship can also be shaped by a *pro-homine* approach and that there is nothing 'natural' in considering 'sovereignty' the starting point from which to grapple with immigrant-related cases.[5] However, the recent intergovernmental negotiations on the Global Compact for Migration confirm the reliance on the 'guiding principles' of both national sovereignty and human rights in dealing with the challenges of international migration.

1. Sovereignty and Human Rights Obligations

1.1. State sovereignty in international law

2011) 8; Seyla Benhabib, *The Rights of Others: Aliens, Residents and Citizens* (CUP 2004) 2.

[4] Sylvie Da Lomba, 'Immigration Status and Basic Social Human Rights – A Comparative Study of Irregular Migrants' Right to Health Care in France, The UK and Canada' (2010) *The Netherlands Quarterly of Human Rights* 28(1) 6, 7.

[5] Marie-Bénédicte Dembour, *When Humans Become Migrants. Study of the European Court of Human Rights with an Inter-American Counterpoint* (OUP 2015) 6-7.

Public international law,[6] here commonly referred to as international law, is that body of laws that, since the 16th century, has traditionally regulated the relationships between independent and sovereign nation states.[7] Its first interpreters founded international law and its principles on the universal law of nature, to be discovered using reason and to be binding on all states.[8] By contrast, from the 19th century on, the dominant positivist doctrine has grounded international law in the 'theory of consent', that is, that states could only be bound by those rules to which they had first agreed to be bound.[9] Until the 20th century, the rules of this legal framework were – and still largely are – concerned with inter-state relations. However, in relation to the role of people in international law, legal theories have reached different conclusions. For instance, in the 19th century, Hegel thought that individuals were subordinate to the state because the latter enshrined the 'wills' of all citizens and had evolved into a higher will.[10] According to this orthodox, state-centred approach, from an international perspective, the state was sovereign and supreme, and people were merely objects of international law. Lauterpacht, an influential 20th-century internationalist who witnessed the birth of the new post-World War II international community, considered the achievement of peoples' well-being as the primary function of all laws and advocated that international law based on human rights was the best way to achieve this purpose.[11] As acknowledged in the following pages, contemporary international law recognises individuals as subjects of international law: whereas states are primary subjects of international law, individuals are – for

[6] Public international law differs from private international law, which is that body of domestic law that comes into play when a controversy contains a foreign element. In that case, the conflict of laws is resolved by this body of domestic law which identifies the law and jurisdiction applicable to the case. See Paul Torremans et al. (eds), *Cheshire, North and Fawcett: Private International Law* (OUP 2017).
[7] Antonio Cassese, *International Law* (2nd edn, OUP 2003) 3; Patrick Dailler and Alain Pellet *Droit International Public* (7th edn, LGDJ 2002) 35.
[8] Francisco de Vitoria and Hugo Grotius belonged to the school of natural law, see Malcolm N. Shaw, *International Law* (7th edn, OUP 2014)16-18; Daillier and Pellet (n 7) 4-57.
[9] Daillier and Pellet (n 7) 59, 98-100.
[10] Shaw (n 8) 21.
[11] Hersch Lauterpacht, *International Law and Human Rights* (Stevens & Sons 1950).

the purposes of this discussion – rights holders in international (and European) human rights law.[12]

As for the principle of 'sovereignty', common language understands sovereignty as 'supremacy in respect of power, domination, or rank; supreme dominion, authority, or rule'.[13] Although sovereignty has existed since ancient times in different fashions within and between different polities, the conceptual elaboration of modern sovereignty[14] as an institutional attribute is owed to the French jurist and philosopher Jean Bodin, who elaborated it as the absolute and perpetual power of the *République*.[15] His views, together with those of Hugo Grotius,[16] contributed significantly to the appearance of state sovereignty as a key principle of the international legal order since the adoption of the 17th-century Treaties of Westphalia.[17] The essence of this double-sided concept is clearly captured by the influential *Palmas Islands Case* award of the Permanent Court of Arbitration:

> Sovereignty in the relations between states signifies independence. Independence in regard to a portion of the globe is the right to exercise therein, to the exclusion of any other state, the functions of a state. The development of the national organization of states during the last few centuries and, as a corollary, the development of international law, have established this principle of the exclusive competence of the state in regard to

[12] Cassese (n 7) 142-150; Shaw (n 8) 188-189.
[13] Oxford English Dictionary, 'Sovereignty' <http://www.oed.com/view/Entry/185343?redirectedFrom=sovereignty#eid> accessed 1 March 2019.
[14] For an overview on the nature, subject, and source of sovereignty, see Samantha Besson, 'Sovereignty' (2011) the Max Planck Encyclopaedia of Public International Law <http://opil.ouplaw.com/home/EPIL> accessed 1 March 2019.
[15] Jean Bodin, *Les Six Livres de la République* (First published 1579, Alden Press 1955) ch VII.
[16] Hugo Grotius, *De Jure Belli ac Pacis* (Buon 1625) Book I.3.8.1.
[17] The peace process of Westphalia is associated with the birth of modern international law, which is a feature of sovereign and equal states. For an overview, see Rainer Grote, 'The Westphalian System' (2006), the Max Planck Encyclopaedia of Public International Law <http://opil.ouplaw.com/home/EPIL> accessed 1 March 2019.

> its own territory in such a way as to make it the point of departure in settling most questions that concern international relations.[18]

Sovereignty means both 'independence' from interference of other states and 'supreme authority' within a territory and over the population located therein.[19] In international law, the former – which is related to power and authority 'between' states – is referred to as 'external sovereignty', and the latter – which concerns the power and authority 'of/within' the state – is the 'internal' component of sovereignty. International law is engaged with both aspects of the 'content' of sovereignty and, from 1945 onwards, it has increasingly imposed obligations concerning how states behave in their jurisdictions and how they exercise their public power in relation to people and markets.

As described above, sovereignty is a 'structural' principle of the international legal order, which locates the state at the centre of the stage of international relations, indeed as the 'primary subject'.[20] Nevertheless, given that international law in the era of the UN has rapidly switched from being the law of 'coexistence' to the law of 'cooperation', with many inroads into matters traditionally considered to be of a domestic nature, some scholars have begun to question the view that state sovereignty is the central feature of international society.[21] These debates focus on whether, and to what extent, the participation of new subjects in international law-making marks a paradigm shift in the structural order of international law.[22] Nevertheless, the dominant doctrine still considers (state) sovereignty to be a fundamental

---

[18] *Island of Palmas Case* (*the Netherlands v USA)* (Merits) [1928] 2 UN Reports of International Arbitral Awards 829, para 8.
[19] *Customs Régime between Germany and Austria* (Advisory Opinion) [1931] PCIJ Series A/B No 41 [Individual Opinion of M. Anzilotti] 57, emphasis added.
[20] Cassese (n 7) 71.
[21] See reference made by José E. Alvarez, 'State Sovereignty in Not Withering Away: A Few Lessons from the Future' in Antonio Cassese (ed) *Realizing Utopia* (OUP 2012) 26, 29.
[22] McCorquodale claims a 'participatory approach to sovereignty' and describes it as a relational concept shared by all subjects that engage in the international community. See chapters 'International Community and State Sovereignty: An Uneasy Symbiotic Relationship' and 'An Inclusive International Legal System', in Robert McCorquodale, *International Law beyond the State: Essays on Sovereignty, Non-State Actors and Human Rights* (CMP 2011) 401, 427.

principle governing international relations or an organising principle of international law.[23]

Regardless of this, there is substantial agreement on the point that the 'exclusive' sovereignty of the *Palmas Islands Case* is not a synonym for 'unlimited' sovereignty.[24] The limit, as far as international law is concerned, is represented by state duties to comply with customary international law and treaty law,[25] including in the field of human rights. Before looking at the rather tense 'sovereignty – human rights' relationship, the next section briefly introduces human rights law as a branch of international law.

1.2. Human rights law

International human rights law as a comprehensive legal framework was born in the aftermath of World War II. The horrors of the Holocaust had shocked the world and the international community mobilised around the idea that the treatment of people within states borders could not be left to the exclusive 'domestic domain' of states.[26] The idea behind the modern theory of human rights is rooted in several 17th- and 18th- century theories of natural law and rights, according to which – very briefly – there existed a reason-based moral framework with which positive man-made laws had to comply, and men were endowed with some innate tendencies and freedoms – natural rights – that were cognisable though the use of reason.[27] In the mid-20th century, these theories led to the conceptualisation of universal human rights according to which 'all human beings are born free and equal in dignity and rights',[28] and the notion that every state must exercise its powers in a way compatible with

[23] See, Cassese (n 7) 46.
[24] Besson (n 14) para 75, and Christopher Greenwood 'Sovereignty: A View from the International Bench' in Richard Rawlings, Peter Leyland and Alison Young (eds) *Sovereignty and the Law* (OUP 2013) 251, 254.
[25] Vienna Convention on the Law of Treaties (adopted 23 May 1969 entry into force 27 January 1980) 1155 UNTS 331 (VCLT) Article 27: 'a party may not invoke the provisions of its internal law as justification for its failure to perform a treaty'.
[26] Johannes Morsink, *The Universal Declaration of Human Rights: Origins, Drafting, and Intent* (University of Pennsylvania Press 1999) 36-51.
[27] For example, see John Finnis, *Natural Law and Natural Rights* (OUP 1980).
[28] UDHR (n 1, Introduction) Article 1.

them. The Charter of the United Nations, the document that set out a new international order based on the prohibition of the use of force in international relations, declared the 'promotion' of human rights to be one of the of the purposes of the organisation and a value to be reaffirmed.[29] This statement represented the first encroachment of the naturalist logic in the revisited post-war international law. Human rights gained their first recognition in an international legal document, and, since then, this bond has been secured with the adoption of the morally authoritative Universal Declaration of Human Rights (UDHR) – that contained civil, political, economic, social and cultural rights –,[30] through binding human rights treaties,[31] and with the recognition of some rights as customary international law and *jus cogens*.[32] International law became progressively more engaged with the protection of human rights, and this has had an impact on the legitimate exercise of jurisdictional functions by states. However, it is worth noting that the UN Charter had not empowered the UN with any direct competence for the protection of human rights. Rather, states 'delegated' to the organisation the 'promotion' of the law and of 'cooperation' in the area. Accordingly, these loose state obligations allowed Article 2(7) of the UN Charter to protect state sovereignty in the area of human rights as a matter 'essentially within the domestic jurisdiction of any State'. It took more than 20 years for the General Assembly of the United Nations to recognise that the protection of human rights was a predominantly international issue, and that happened only a few years before the UN became more engaged with the rights of migrants.[33] The negotiation

[29] Charter of the United Nations (Adopted 26 June 1945 entry into force 24 October 1945) 892 UNTS 119, Preamble, Articles 1(3) and 55(c).
[30] UDHR (n 1, Introduction) Preamble: '[…] the General Assembly proclaims this Universal Declaration of Human Right as a *common standard of achievement* for all people and all nations […]'. Italics added.
[31] For example, see n 14, 15, Introduction.
[32] *Jus cogens* is synonym of 'peremptory norms', VCLT (n 25) Article 53. Some human rights norms, such as the prohibition of genocide and freedom from torture are considered non-derogable under any circumstance. See Erika de Wet, '*Jus Cogens* and Obligations *Erga Omnes',* in Dinah Shelton (ed) *The Oxford Handbook of International Human Rights Law* (OUP 2013) 541.
[33] The UNGA Res 3219 (XXIX)/1974 on Chile was 'the real watershed in UN practice in this area'. See Israel de Jesús Butler, *Unravelling Sovereignty. Human Rights Actors and the Structure of International Law* (Intersentia 2007) 34-44; Stefanie Grant, 'The Recognition of

of binding treaties in international and regional *fora* had, since the late 1940s, given legal recognition to the idea of the 'international protection' of human rights. These human rights regimes have developed through the creation of monitoring bodies, some of which allow individuals to bring claims against states for human rights violations. This revolutionary development attributed elements of international legal personality to individuals, which empowered them to claim their rights and hold states as international duty bearers to account.[34] All that being said, while international and regional human rights law as a set of substantive rules might be considered internationally led, the enforcement of such rules and the establishment of associated redress systems primarily take place at the domestic level. As such, the legal system is built around the principle of 'subsidiarity'.[35] And this cannot be underestimated as far as the relationship between human rights and sovereignty is concerned.

1.3. The mutual impact of sovereignty and human rights

State sovereignty and human rights are often presented as opposing principles. The former is state-centred, and the latter is person-focused. They are synonyms of power and the limitation of power, respectively. To assess their relationship, it seems appropriate to distinguish between sovereignty as 'content' and sovereignty as 'structure' and, in relation to the former, between 'authority' and 'independence'. Finally, it will be shown that sovereignty is embedded in international human rights law, with the consequence of confirming sovereignty as a structural principle of international law to which human rights belong.

Sovereignty as 'independence' from external intervention, based on Articles 2(1) and 2(4) of the UN Charter, has been besieged by the doctrines of 'humanitarian intervention' and 'responsibility to protect', two contested

Migrants' Rights within the UN Human Rights System: The First 60 Years', in Dembour and Kelly (n 3) 33.

[34] Irene Khan, *The Unheard Truth: Poverty and Human Rights* (W.W. Norton & Company 2009).

[35] See Section 1.3.

concepts which qualify 'sovereignty as responsibility' albeit to different extents. These doctrines hold that every state is internationally responsible for the treatment of people within its jurisdiction while also justifying the collective use of force in response to severe human rights violations within a state. However, these clashes of norms and goals in international law fall beyond the scope of this study.[36]

Sovereignty as state 'authority' to enact laws, adjudicate, draw up policies and enforce laws within the domestic jurisdiction is a central feature of international human rights law. The evolution of human rights as a branch of international law over the last 70 years has aimed to prevent the arbitrary treatment of people by establishing a 'minimum' content for state obligations in this regard. Accordingly, although logic may lead one to conclude that there is an inherent clash between this aspect of sovereignty and human rights, the 'legal' understanding of these concepts points to a softer confrontation, at least in theory. Indeed, on the one hand, looking at the broader picture of international law, it must be acknowledged that the international legal concept of sovereignty is not intended as unrestricted power and that international law works by imposing legal obligations regarding state behaviours by 'validating some claims of sovereign powers and refusing to validate others'.[37] On the other hand, most human rights as legal rights have not been conceptualised as 'absolute' vis-à-vis other public interests. Human rights treaties and protocols allow, or at least do not prohibit, reservations[38] and many rights contain limitation clauses which allow for the rights to be balanced against other public interests.[39] Furthermore, the formal 'incorporation' of international human rights law into the domestic legal order, at least in dualist states,

[36] For an overview of this debate, see Ramesh Thakur, 'The Use of International Force to Prevent or Halt Atrocities: from Humanitarian Intervention to the Responsibility to Protect', in Shelton (n 32) 815 and Amitai Etzioni, 'Sovereignty as Responsibility' (2006) *Orbis* 50(1) 71-85.

[37] Patrick Macklem, *The Sovereignty of Human Rights* (OUP 2015) 29.

[38] For example, VCLT (n 25) Articles 2(d), 19-23 (n. 25); ECHR (n 15, Introduction), Article 57. See Ineke Boerefijn, 'Impact on the Law on Treaty Reservations', in Menno T. Kamminga and Martin Scheinin (eds) *The Impact of Human Rights Law on General International Law* (OUP 2009) 63.

[39] This broad wording means both 'derogations' in time of emergency, e.g., Article 15 ECHR (n 15, Introduction), Article 4 ICCPR (n 14, Introduction), or common 'limitations' or 'restrictions' of rights, e.g. Articles 9, 12, 13, 18, 19, 21, 22 ICCPR, Articles 5, 8-11 ECHR.

appears key for its applicability.[40] In addition, international treaties on human rights require the state to establish domestic means of redress for cases of violation[41] and subject individual complaints before international bodies to admissibility criteria, such as the exhaustion of domestic remedies, which are often strict.[42] All of these structural, procedural and substantive features constitute an encroachment of state sovereignty into the legal sphere of human rights, which is grounded in the principle of 'subsidiarity'. Subsidiarity – a central feature of human rights law – means that, in systems of multi-level governance, the most local level of governance is considered best equipped to exercise sovereign regulatory functions.[43] Notwithstanding some erosion of the domestic domain as a result of international and regional human rights law in relation to the internal aspect of sovereignty, human rights seem to 'qualify, rather than displace, the sovereignty of states'.[44]

Finally, in relation to the impact of human rights on sovereignty as a 'structural' principle of international law, the conclusions are much the same. There are scholars who argue that the proliferation of international subjects or legal persons in the context of law-making and monitoring jeopardises the position of state sovereignty as a key organising principle of the international legal order.[45] The impact of civil society organisations, the delegation of power to international organisations, and the increasing role of individuals in the field of human rights law is undeniable. Nevertheless, due to the fact that

[40] The 'incorporation' or 'transposition' of international law into domestic legal order is necessary for the domestic applicability of treaties only when states are 'dualist'. Dualism, as opposed to monism, is a legal tradition according to which international law and domestic law are two separate spheres of law. Therefore, for the applicability of international treaties at domestic level, national acts incorporating international norms need to be enacted. See, Davíd Thór Björgvinsson, *The Intersection of International Law and Domestic Law, A Theoretical and Practical Analysis* (Elgar Publishing 2015).

[41] For example, ICCPR (n 14, Introduction) Article 2.3(a) and ECHR (n 15, Introduction) Article 13.

[42] For example, ECHR (ibid), Article 35 and Optional Protocol to the International Covenant on Economic, Social and Cultural Rights (adopted 10 December 2008, entered into force 5 May 2013) ('OP-ICESCR') UN Doc A/RES/63/117, Articles 2-5.

[43] For details Gerald L. Neuman, 'Subsidiarity', in Shelton (n 32) 360, and Isabel Feichtner 'Subsidiarity' (2007) in Max Planck Encyclopaedia of Public International Law <http://opil.ouplaw.com/> accessed 1 March 2019.

[44] James Crawford 'Sovereignty as a Legal Value', in James Crawford and Martti Koskenniemi (eds) *The Cambridge Companion to International Law* (CUP 2012) 122.

[45] *Inter alia*, De Jesús Butler (n 33), and McCorquodale (n 22).

the structure of international law is still state-oriented, states appear to retain key *de jure* and *de facto* powers in this field. For example, the implementation of human rights standards and the enforcement of monitoring bodies' decisions are mainly contingent on the willingness of states to comply. In relation to the latter, the findings of most international human rights monitoring and adjudication bodies have only moral authority, and even when they are legally binding, the execution of judgements is mediated through political bodies.[46] The concept of sovereignty is, therefore, built into human rights instruments. Since subsidiarity may be regarded as a structural principle of human rights law,[47] state sovereignty remains a valid lynchpin of international law. Overall, the relationship between human rights and general international law is characterised by a 'tension between substance and form'.[48] Human rights, by becoming international legal rights, have had to surrender to the structural logic of public international law.

The next sections discuss the above debates in the context of immigration in order to assess whether the delicate balance between sovereign interests and individual human rights works in both theory and practice when it comes to non-citizens. In particular, they examine whether migrants are legitimate human rights holders on an equal basis with others, what sovereignty means in relation to migration, and, finally, how human rights law treats irregular migrants.

2. Migrants: Between Sovereignty and Human rights

[46] For example, on the role of the intergovernmental body of the Council of Europe, the Committee of Ministers, on the execution of binding judgements and non-binding decisions on human rights. See ECHR (n 15, Introduction) Article 46, and the Additional Protocol to the European Social Charter Providing for a System of Collective Complaints, (adopted 9 November 1996) ETS. No. 158.

[47] Paolo G. Carozza 'Subsidiarity as a Structural Principle of International Human Rights Law' (2003) 97 *American Journal of International Law* 38.

[48] Frédéric Mégret, 'Nature of Obligations', in Daniel Moeckli, Sangeeta Shah and Sandesh Sivakumaran (eds) *International Human Rights Law* (OUP 2018) 86, 88.

The core aim of this section is to assess if, and to what extent, human rights have 'qualified' sovereignty in relation to the treatment of migrants or if the opposite is the case.

2.1. Migrants and sovereignty

The Westphalian system of states, even though it is qualified and limited in the exercise of both internal and external sovereign powers, is still the reference model of the international community.[49] Intimately linked to this is state-led immigration management,[50] which has been regarded as a defining aspect of state sovereignty since the end of the 19th century.[51] Indeed, 'sovereignty's inherent powers within the nation-state system' are considered to include the state's power to control and manage the entry, residence, and expulsion of aliens. [52] This is the result of a series of historical contingencies that occurred at the end of the 19th century, including political and economic tensions between states, which resulted in the spread of protectionism and nationalism[53] and in the 'appearance of non-European foreigners on the migratory landscape' after four centuries of European international emigration. When these new migrants, mostly Asians, were drawn by the colonial interest in recruiting labour on a temporary basis,[54] governing elites in both Australia and the US proved reluctant to grant them entry. One of the outcomes was the development of a common law jurisprudence that interpreted international legal theories as condoning the 'absolute' state

[49] Alvarez (n 21) 26.
[50] In general, the last 40 years of the European history have seen a gradual narrowing of the legal possibilities for aliens to immigrate and settle in European countries. See Boeles et al. (n 16, Introduction) 25. For example, in the post-WWII era and during the 70s, French policy on immigration was not aimed at combating irregular immigration but rather was informally but deliberately focused on tolerating it. See Godfried Engbersen and Dennis Broeders, 'The State versus the Alien: Immigration Control and Strategies of Irregular Immigrants' (2009) *West European Politics* 32 867, 874.
[51] Catherine Dauvergne, 'Sovereignty, Migration and the Rule of Law in Global Times' (2004) *The Modern Law Review* 67(4) 588, 590; Eve Lester, *Making Migration Law. The Foreigner, Sovereignty and the Case of Australia* (CUP 2018) 81-111.
[52] Nafziger (n 1) 822.
[53] ibid 816.
[54] Lester (n 51) 82, 84.

power to regulate immigration.[55] The texts of Emer De Vattel, authoritative internationalist, were misinterpreted and bent to the political-judicial intent to regulate race and labour.[56] Indeed, in his *The Law of Nations*, Vattel set forth that:

> The lord of the territory may, whenever he thinks proper, forbid its being entered […] he has, no doubt, a power to annex what conditions he pleases to the permission to enter. This, as we have already said, it is a consequence of the right to domain.[57]

However, he identified several qualifiers to this power in the law of nations, including the stipulation that 'every nation has the right to refuse to admit a foreigner into the country, when he cannot enter without putting the nation in evident danger, or doing it a manifest injury'.[58] Vattel added that the sovereign's 'duty towards all mankind obliges him on other occasions to allow free passage through, and residence in, his state'.[59] These rights of passage and residence could not be refused without 'particular and important reasons' and were extended to the case of 'a foreigner who comes into the country with the hope of recovering his health, or for the sake of acquiring instruction in the schools and academies'.[60] As for the right of establishment of foreigners, sovereign discretion would take precedence and establishment could be refused if it represented 'too great an inconvenience or danger'.[61] Vattel even mentioned that in Europe, unlike in Japan and China, the general rule was 'open frontiers', except in relation to 'enemies of the state'. State power to exclude was not absolute in Vattel's writings but was framed and limited by the above situations.[62] However, since the late 19th century, for the reasons discussed below, Vattel has often been associated with a maxim of

[55] *Nishimura Ekiu v United States* [1892] 142 US 651 (US Supreme Court); *Fong Yue Ting v United States* [1893] 149 US 698 (US Supreme Court); *Musgrove v Chun Teong Toy* [1891] AC 272 (Privy Council of the United Kingdom). For details and other jurisprudential references see Lester (n 51) 94-107.
[56] Lester (n 51) 99-100; Nafziger (n 1) 813-814.
[57] Emer de Vattel, *The Law of Nations* (first published 1787, Liberty Fund 2009) Book II, ch VIII, para 100.
[58] ibid, Book I, para 230.
[59] ibid, Book II, ch VIII, para100.
[60] ibid, Book II, ch X, para 135.
[61] ibid, Book II, ch X, para 136, emphasis added.
[62] ibid, Book II, ch IX, para 119-125; Nafziger (n 1) 810-815.

international law that expressed preference for absolute state power to regulate the entry of non-nationals who are not asylum seekers or refugees.

This exclusionary approach has survived until the present time, and the case law of the European Court of Human Rights (ECtHR) has, since the landmark *Abdulaziz Case*,[63] made wide use of the 'long-established maxim of international law' according to which immigration control and the right to exclude are prerogatives of sovereign states. The constant repetition of this 'maxim' encapsulates the idea of 'fixed and exclusive territoriality that is associated with the rise of the modern nation-state' and sovereignty.[64] This suggests a 'natural' state of the world divided into territories, whereby people are associated inextricably with their state of origin. However, this idea of the foreigner as 'outsider' without the right to enter countries that are not her own was the result of historical contingencies and was deeply linked to political-economic interests, the rise of non-European immigration, and nativism.[65]

The doctrine of the 'integrity of national borders' and the exercise of sovereign power to determine who is entitled to enter and stay in a given state territory gave rise to different categories of people: nationals and non-nationals, and, in relation to the latter, authorised immigrants and irregular or undocumented migrants. Concerning the latter – the target group of this research – their very presence within a state jurisdiction is perceived as a *de facto* erosion of the state's territorial sovereignty and a violation of the state's power to determine the composition of its *demos* or national community.[66] The state's right 'to exclude' through refusal of admission or deportation is characterised by extensive executive discretion, but it is not unrestricted: slim but significant limitations are stipulated in refugee law and in certain provisions of human rights law. For this reason, the next section elucidates

[63] *Abdulaziz, Cabales and Balkandali v the United Kigndom* App nos 9214/81, 9474/81 (ECHR 1985) para 67; New York Declaration for Refugees and Migrants (16 September 2016) UNGA Res 71.1, A/RES/71/1, para 24.
[64] Dora Kostakopoulou, 'Irregular Migration and Migration Theory: Making State Authorisation Less Relevant', in Bogusz et al. (n 19, Introduction) 45.
[65] Lester (n 51) 77-86; Nafziger (n 1) 816.
[66] Linda S. Bosniak, 'Human Rights, State Sovereignty and the Protection of Undocumented Migrants Under the International Migrant Workers Convention', in Barbara Bogusz et al. (n 19, Introduction) 311, 329; Dembour and Kelly (n 3) 6-10.

on whether migrants and irregular migrants enjoy the protection of human rights law, and to what extent this tool manages to counterbalance the sovereignty-related right to exclude.

2.2. Migrant rights or human rights?

2.2.1. International law and the standards of civilisation

The treatment of foreigners was a topic of international law long before human rights law was officially recognised within that legal framework. It originated at the beginning of the 16th century with a series of intellectual and legal arguments that were designed to protect Western nationals while they were conducting business and expanding their interests in the non-European world during the colonial era. Fathers of international law such as Francisco de Vitoria and Hugo Grotius dealt with 'civilised' Christian European foreigners by resorting to theories of natural law to articulate the 'rights of aliens to trade and preach' in the New World.[67] Francisco de Vitoria, in justifying the Spanish expansion in the Indies, defended the 'humane and dutiful' obligation to welcome strangers:[68] the stranger's (that is, the European coloniser's) right to hospitality, to trade, to travel and to reside were central to his thinking.[69]

A century after Vitoria's speculations, Hugo Grotius also defended the mobility of European traders in Europe and outside the continent as the natural order of things by asserting the rights to trade and hospitality.[70] Although the starting point was the right to free movement, the rights of foreigners could be restricted when their intentions were not 'benign'.[71]

---

[67] Tony Anghie and Wayne McCormack, 'The Rights of Aliens: Legal Regimes and Historical Perspectives', in Thomas N. Maloney and Kim Korinek (eds) *Migration in the 21st Century: Rights, Outcomes and Policy* (Routledge 2010) 23, 30.
[68] Francisco de Vitoria, 'On the American Indians', in Anthony Pagden and Jeremy Lawrance (eds) *Vitoria: Political Writings* (CUP 1991) 250, 278-282.
[69] ibid; Lester (n 51) 54-60.
[70] Hugo Grotius, *De Jure Praedae Commentarius* (first published 1604, Clarendon Press 1950) 218-220.
[71] Hugo Grotius, *De Jure Belli ac Pacis Libri Tres* (first published 1646, Clarendon Press 1925) Book II ch II 192, 198, 201-202.

Finally, it is interesting to note that Grotius went as far as recognising the (limitable) right of foreigners to enjoy 'basic necessities'.[72] Although he is commonly regarded as a theorist who excluded foreigners' rights from international law, his arguments are similar to those put forward by Vattel.[73]

Furthermore, by the end of the 19th century, international law had developed the doctrine of 'state responsibility for injuries to aliens'. This meant that the treatment of a non-national below (un)certain minimum 'standards of civilisation'[74] constituted a wrongful act towards the state of nationality of that person, which gave rise to inter-state responsibility. The state of nationality, at its own discretion,[75] could exercise diplomatic protection in favour of its national. These relations constituted an exercise of state sovereignty and were the result of a traditional paradigm of international law whereby individuals were mere 'objects' of inter-state relationships and not active 'subjects'.[76] Therefore, during the pre-human-rights era, an individual classed as an alien often enjoyed greater protection under international law than as a national in his home country, since the latter was the exclusive domain of national law. For these reasons, the law of diplomatic protection has been defined as the forerunner of human rights in international law.[77] This conclusion is a simplification, considering that the 'standard of civilisation' doctrine and the practice of 'capitulation agreements'[78] were

[72] ibid 192-195, 201.
[73] See *supra* at Section 2.1.
[74] Debates about 'civilisation' are very controversial, interdisciplinary and beyond the scope of this study. As per Westlake, the 'test of civilisation' could consist in the capacity of the government to guarantee both the life and security of aliens and the security and well-being of locals. According to many 'colonial' doctrines, when a 'country' was not considered civilized, it lacked sovereignty and therefore was suitable for conquest as *terra nullius*. See Anthony Anghie, 'The Evolution of International Law: Colonial and Postcolonial Realities' (2007) *Third World Quarterly* 27(5) 739, 745.
[75] *Barcelona Traction case (Belgium v. Spain*) [1970] ICJ, para 79, ICJ stated that 'the State must be viewed as the sole judge to decide whether its protection will be granted, to what extent it is granted, and when it will cease'.
[76] On diplomatic protection and minimum standards of treatment for aliens, see Vincent Chetail, 'The Human Rights of Migrants in General International Law: From Minimum Standards to Fundamental Rights' (2014) *Georgetown Immigration Law Journal* 28 225, 231 and Annemarieke Vermeer-Kunzli, 'Diplomatic Protection as a Source of Human Rights', in Shelton (n 32) 250, 251.
[77] ibid (Vermeer-Kunzli) 262.
[78] Capitulations were bilateral agreements whose purpose was essentially to insulate European expatriates or colonisers from the domestic jurisdiction of the forum state. For

legal constructs of the colonial period aimed at protecting citizens of European countries as they went about their expansionist business in the 'uncivilised' colonies. It is interesting to note that when human mobility started to flow significantly in the opposite direction, contemporary international law shifted to play a marginal normative role with regard to migration.[79]

2.2.2. Human rights for migrants

In the contemporary legal world, the 'standard of civilisation' has been replaced by international human rights law.[80] However, during the first decades post-UDHR, international human rights were purely formal in relation to migrants and were meant to empower citizens vis-à-vis their state of nationality and residence. At the universal level, the human rights framework was still non-binding, and, furthermore, developing countries identified the rights of aliens with colonialism.[81] The change began in the 1970s when the mass expulsion of Asians from Uganda operated as a catalyst for greater involvement of the UN in the protection of the rights of non-nationals.[82] Since then, debates within the UN General Assembly and ancillary bodies brought about, *inter alia*, the adoption of the Declaration on the Human Rights of Individuals who are not Citizens of the Country in which they Live,[83] the Convention on the Rights of Migrant Workers,[84] the Durban

---

further details, see Christine Bell, 'Capitulations' (2009), in Max Planck Encyclopaedia of Public International Law <://opil.ouplaw.com> accessed 1 March 2019; Cassese (n 7) 26-28.

[79] E. Achiume Tendayi, 'Reimagining International Law for Global Migration: Migration as Decolonization?' (2017) *American Journal of International Law* 111 142-146.

[80] See the ICJ acknowledgment in *Ahmadou Sadio Diallo (Guinea v Dem. Rep. Congo),* (Preliminary Objections) [2007] 599 para 39.

[81] Article 2(3) ICESCR (n 14, Introduction), which allows developing countries to restrict the enjoyment of socio-economic rights for non-nationals, is a result of this approach. Chetail (n 76) 235, 248-249.

[82] Grant (n 33).

[83] UNGA Res 40/144, 13 December 1985.

[84] CMW (n 14, Introduction).

Declaration and Programme of Action,[85] and, recently, the New York Declaration for Refugees and Migrants and the Global Compacts.[86]

Apart from these migrant-specific initiatives, the wording of the general human rights treaties embraces every human being as a human rights holder by virtue of her common humanity,[87] irrespective of her migration status. They apply *ratione personae* to 'everyone'[88] or 'all individuals'[89] in a state territory or jurisdiction,[90] and this includes 'non-citizens' and, among them, 'irregular migrants'. While this is the general rule, some treaty provisions and their interpretations allow for differential treatment on the grounds of nationality and immigration status. The Human Rights Committee (originally HRC, now institutionally referred to as CCPR), which is the monitoring body of the International Covenant on Civil and Political Rights (ICCPR), made clear, in its General Comment No. 15, that non-citizens must enjoy without discrimination all human rights set forth in the covenant, with the exclusion of the right to vote established in Article 25.[91]. In addition to the above, the right to freedom of movement and freedom to choose a residence within the territory (Article 12 ICCPR) and the guarantees of due process in relation to expulsion from the territory (Article 13 ICCPR) were

[85] This declaration reiterated that state sovereignty should be consistent with the human rights of all migrants, regardless of their legal status. See UN Doc A/CONF 189/12 (2001) paras 26 and 39.
[86] New York Declaration (n 63); Global Compact for Safe, Orderly and Regular Migration (19 December 2018) UNGA Res 73/195; Global Compact on Refugees (17 December 2018) UNGA Res 73/151.
[87] UDHR (n 1, Introduction) Article 2 stipulates that 'everyone is entitled to all the rights and freedoms set forth in this Declaration, without distinction of any kind'. See also ICCPR (n 14 Introduction) Article 2(1); CRC (n 14 Introduction) Article 2(1); CMW (n 14 Introduction) Article 7; American Convention on Human Rights (adopted 22 November 1969 entry into force 18 July 1978) (ACHR) Article 1(1); African Charter on Human and Peoples' Rights (adopted 27 June 1981 entry into force 21 October 1986) (ACHPR) OAU Doc. CAB/LEG/67/3 rev. 5, Article 2.
[88] ECHR (n 15, Introduction), Article 1.
[89] ICCPR (n 14, Introduction).
[90] For example, the ECtHR acknowledges the existence of the application of the ECHR *ratione loci* when a violation of human rights takes place in a state party's territory and exceptionally when, extraterritorially, the state exercises control and authority over an individual. See *Hirsi Jamaa and Others v Italy* App no 27765/09 (ECHR 2012) paras 70-82.
[91] Human Rights Committee (CCPR) 'General Comment No. 15: The Position of Aliens under the Covenant' (11 April 1986), para 2.

intended to apply only to 'lawfully residing aliens'.[92] In all other areas, the interpretation of the principle of non-discrimination on the grounds of nationality and legal status is central for the actual enjoyment of human rights law. Discrimination is defined as 'any distinction, exclusion, restriction or preference or other differential treatment' taking place in comparable situations 'that is directly or indirectly based on the prohibited grounds, with the intention or effect of nullifying or impairing the recognition, enjoyment or exercise, on an equal footing, of […] rights'.[93] While the prohibited grounds for discrimination do not explicitly include nationality or the legal status of people, the normative interpretation by international bodies has covered this gap.[94] Therefore, *prima facie,* all migrants enjoy a broad catalogue of human rights on a non-discriminatory basis. The concept of equality/non-discrimination is deeply influenced by the Aristotelian maxim that 'things that are alike should be treated alike'.[95] Applying this to people, modern scholars have criticised this concept as being entirely 'circular', because it does not clarify what is meant by 'like people', which generates confusion regarding what defines comparable situations.[96] Accordingly, differential treatment may be justified because the comparators – irregular/regular migrants or migrants/citizens – are not deemed sufficiently similar to warrant similar treatment in various legal frameworks. Moreover, differential treatment in the enjoyment of rights can be considered permissible because immigration control and deportation of undocumented people may

[92] ibid, paras 8, 9, 10. Similarly, the ECtHR, in *Maaouia v France* App no 39652/98 (ECHR 2000), held that the right to fair trial in Article 6 ECHR does not apply to immigration proceedings.

[93] CESCR, 'General Comment No. 20: Non-discrimination on Economic, Social and Cultural Rights' (2 July 2009) UN Doc E/C.12/GC/20, para 7. The reference herein is not to a self-standing right to non-discrimination, but Article 2(2) ICESCR (n 14, Introduction) protects against prohibited differential treatments in relation to the enjoyment of other human rights. See also Article 2(1) ICCPR and Article 14 ECHR.

[94] CCPR, GC15 (n 91); CESCR, GC20 (n 93) para 30. Nationality and legal status, as prohibited grounds of discrimination, are covered by the phrase 'other status' in Articles 2(1) ICCPR and 2(2) ICESCR. See *Ibrahima Gueye et al. v France* Com no 196/1985 (CCPR 1989).

[95] David Ross, *The Nicomachean Ethics / Aristotle* John Loyd Ackrill and James Opie Urmson (eds) (OUP 1980) 112-117.

[96] Peter Westen, 'The Empty Idea of Equality' (1980) *Harvard Law Review* 95(3) 537; Christopher J. Peters, 'Equality Revisited' (1997) *Harvard Law Review* 110 1211.

be considered a legitimate public interest that counter-balances migrants' individual rights. Differentiations may be acceptable when restrictive state measures have a domestic legal basis, pursue a legitimate aim, and are reasonable and proportionate.[97] In the concrete assessment, the proportionality test between means and aim usually plays a crucial role.[98]

The prohibition of discrimination is also of pivotal relevance for socio-economic rights, since, in relation to societal inequalities and concrete situations of vulnerability, it requires states to take appropriate measures to achieve both formal and substantial equality.[99] On the one hand, the UN Committee on Economic, Social and Cultural Rights (CESCR), which is the monitoring body of the International Covenant on Economic, Social and Cultural Rights (ICESCR), clearly states that socio-economic rights apply to 'everyone including non-nationals, such as refugees, asylum seekers, stateless persons, migrant workers and victims of international trafficking, regardless of legal status and documentation',[100] and that very limited circumstances allow restrictions of those rights.[101] On the other hand, at domestic level, socio-economic rights are often restricted for irregular migrants, which underscores the state belief that limitation of these subsistence rights reduces the 'pull factor' of immigration and deters people from infringing immigration law.[102] Furthermore, as is explained in Chapters 2 and 3, these

[97] *Gaygusuz v Austria* App no 17371/90 (ECHR1996) para 42; *Case 'Relating to Certain Aspects of the Laws on the Use of Languages in Education in Belgium' v Belgium* App nos 1474/62, 1677/62, 1691/62, 1769/63, 1994/63, 2126/64 (ECHR 1968) para 10. See also CCPR, 'General Comment No. 18: Non-discrimination' (1989) para 13; CESCR, GC20 (n 93) para 13. Manfred Nowak, *UN Covenant on Civil and Political Rights – Commentary* (2nd edn, NP Engel Publishing 2005) 31-51; Ciara Smyth, 'Why is it so Difficult to Promote Human Rights-Based Approach to Immigration', in Donncha O'Connell (ed) *The Irish Human Rights Law Review 2010* (Clarus Press 2010) 83, 89.

[98] See examples provided in Section 3 *infra.*

[99] The former means equality of everyone before the law, without consideration of individual or group-related disadvantaged situations. The latter means that the state – to avoid *de facto* discrimination – should abandon the neutrality of a non-discrimination approach to law and actively adopt all necessary measures to equalize people's starting points and opportunities to attain real equality.

[100] CESCR, GC20 (n 93) para 30; CERD Committee, 'General Recommendation No. XXX: Discrimination Against Non-Citizens' (2005).

[101] ICESCR (n 14, Introduction) Article 4. See also Section 3.1, Chapter 3. See also Office of the High Commissioner for Human Rights, *The Economic, Social and Cultural Rights of Migrants in an Irregular Situation* (UN Publications 2014) 31-32.

[102] Bosniak (n 66) 324.

rights have always been regarded as resource-demanding, and, as such, states have tended to limit their enjoyment by community outsiders such as (irregular) immigrants.

Even where irregular migrants are entitled to their human rights, the actual enjoyment of those rights can prove problematic because of their irregular immigration status. For such migrants – perceived as people that have infringed a state's territorial sovereignty – universal human rights risk becoming just illusionary rhetoric, since activating domestic and international complaint mechanisms, according to the principle of subsidiarity, normally 'presupposes that migrants entertain contacts with the hosting state organs'.[103]

To conclude, on the one hand, the principle of state sovereignty is not unrestricted, one of the limitations being international human rights law. On the other hand, most human rights are structured as non-absolute rights, one of the limitations being competing sovereign public interests, including immigration management. Against this background, as exemplified below, irregular migrants are *sui generis* subjects of human rights law because, on the one hand, some international treaties plainly limit their human rights, on the other hand, the interpretation of universal treaty obligations may permit a limitation of their rights. Furthermore, their 'irregular status' is a structural barrier that makes them particularly vulnerable because of 'their inability to call upon the basic protective functions of the state in which they reside for fear of deportation'.[104]

Human rights law, then, is framed in a way that oscillates between statements of universalism and 'the attraction of particularism or closure' whereby 'only those who are recognised as belonging to the polity' seem to have full enjoyment of human rights.[105] Having clarified the undertones of the 'human rights – sovereignty' tension in the context of immigration and the incomplete extension of universal human rights frameworks to include irregular migrants, the next sections demonstrates how the clash plays out,

[103] Gregor Noll, 'Why Human Rights Fail to Protect Undocumented Migrants' (2010) *European Journal of Migration and Law* 12 241, 243.
[104] Jaya Ramji-Nogales, '"The Right to Have Rights": Undocumented Migrants and State Protection' (2015) *Kansas Law Review* 63 1045.
[105] Dembour (n 5) 251; See also Dembour and Kelly (n 3) 6-11.

often at the expenses of these migrants, in international (and European) human rights litigation and in some human rights treaties.

3. Examples of the European and International Jurisprudential Trends on the Human Rights of Irregular Migrants

This section aims to give a flavour of European and international human rights case law regarding the rights of migrants who have either irregular or precarious status. The case law, for the reasons discussed above, oscillates between exclusionary and protective tendencies, often in unpredictable ways. The section analyses the case law of the ECtHR, followed by the case-based jurisprudence of the UN human rights treaty bodies. The focus is on rights *other than* the right to health (and the rights associated with the right to health), although health-related issues are touched on tangentially. This helps to set the stage for later chapters which extensively detail the right to health (and associated rights) in international and European human rights law.

3.1. Instances of immigration cases before the ECtHR

The ECHR is a multilateral human rights treaty between 47 countries across Europe and western Asia, signed in the context of the Council of Europe in 1950. It is probably the most visible and celebrated human rights instrument, partly because its monitoring body, the ECtHR, is empowered to receive individual applications claiming violations of the provisions of the ECHR and to deliver binding international judgements for the member states of the Council of Europe.[106] Like many other general human rights instruments of the same period, the original purpose of the ECHR was to protect citizens against arbitrary state treatment. This is clear from the drafting history: The Convention's personal scope was universally extended as a result of the

[106] ECHR (n 15, Introduction) Articles 32, 46.

Italian delegation's dissatisfaction with a proposal to link the rights in the Convention to people's residence in a member state.[107]

Although the ECHR has been a treaty of universal personal application since its adoption, the case law of the Strasbourg Court concerning the rights of migrants has mainly developed over the last 30 years, and more intensively in the last decade.[108] Furthermore, some provisions of the ECHR and the case law of the ECtHR provide for a certain asymmetric implementation of rights where migrants are concerned. For example, Article 5.1(f) and 16 of ECHR (dealing with the right to liberty and restrictions on the political activities of aliens, respectively) explicitly authorise limitations of the rights of migrants, and, in the *Maaouia* case, the Court established that the fair trial guarantees of Article 6 ECHR do not apply to immigration procedures.[109]

The clash between human rights and sovereignty for irregular migrants is explored here by examining a small sample of the relevant ECtHR's case law in relation to the principle of *non-refoulement*, the freedom from arbitrary detention, living conditions in and outside detention, and the right to family life as it impacts on immigration decisions. Further examples of this European jurisprudence - more directly linked to the core subject of this research - will be cited and analysed in subsequent chapters. It is, however, beyond the scope of this chapter to provide a detailed analysis of the human rights jurisprudence in the field of immigration. The more modest aim pursued here is to present how, either directly or indirectly, state sovereignty impacts on the immigration case-law of the ECtHR, and to foreground some instances of *pro-homine* findings.

Prior to examining the Court's findings on the merits of the cases selected for review, it is worth mentioning the exceptional interim measures

[107] As explained by Dembour (n 5) 35-45, the Italian government was preoccupied with the rights of Italian citizens who were working abroad, in particular in Belgium, rather than with the right of non-European migrants.
[108] The case of *Abdulaziz* (n 63) in 1985 was the first case decided on the merits which concerned the rights of immigrants.
[109] *Maaouia v France* (n 92). Furthermore, in *Saadi v the United Kigndom* App no 13229/03 (ECHR 2008), analysed in the main body, the Court made clear that immigration detention is justified even when it is not the measure of last resort.

jurisdiction of the ECtHR (*per* rule 39 of the Rules of the Courts) in cases of deportation. This arises when an applicant would face a real risk of serious and irreversible harm involving violations of Articles 2 (life), 3 (torture or inhuman or degrading treatment or punishment) or 8 (right to private and family life) ECHR - if the deportation was not suspended while the Court was considering the merits of the case.[110] This trend, which concerns only a small number of (migrant-related) cases, demonstrates a certain *prima facie* commitment by the Court to the human rights of migrants with precarious status. Indeed, several well-known health-related cases, analysed in detail in Chapter 3, have been accompanied by the application of interim measures to protect migrants from irreparable harm to their freedom from inhuman or degrading treatment.[111]

Very recently, an interim measure was granted in the case of the search and rescue vessel, SeaWatch 3, which was prevented from harbouring in Sirausa (Italy) because 47 non-authorised migrants were on board and the Italian government did not want them to go ashore. This was pursuant to a new and particularly restrictive immigration policy in Italy. In light of the 'poor health' of the migrants on board, whose number included children, the Court requested Italy 'to take all necessary measures, as soon as possible, to provide all the applicants with adequate medical care, food, water and basic supplies as necessary' to avoid any irreparable harm to their human rights.[112] Although it is undeniable that this was a protective-oriented measure, it is interesting to note that the Court did not order Italy to allow the migrants to disembark, thus demonstrating a lack of willingness to directly challenge sovereign immigration policies.

[110] European Court of Human Rights – Press Unit, 'Interim measures – Factsheet' (January 2019) <https://www.echr.coe.int/Documents/FS_Interim_measures_ENG.pdf> accessed 26 March 2019.
[111] See *D. v UK* (n 114 *infra*); *N. v UK* App no 26565/05 (ECHR 2008), and *Paposhvili v Belgium* (n 36, Chapter 3 *infra*).
[112] Registrar of the European Court of Human Rights, 'ECHR Grants an Interim Measure in Case Concerning the SeaWatch 3 Vessel' Press release ECHR 043 (2019) <https://hudoc.echr.coe.int/eng-press#{%22itemid%22:[%22003-6315038-8248463%22]}> accessed 26 March 2019.

3.1.1. The prohibition of *refoulement* and collective expulsions

The principle of *non-refoulment* is ostensibly the strongest weapon against the sovereign right to control immigration and to deport non-nationals, in all human rights frameworks, including the ECHR. This principle, which is an essential component of contemporary human rights law and which originated in international refugee law,[113] prevents states from transferring people, either nationals or non-nationals, to a country where they face a real risk of irreparable harm or a serious violation of human rights.[114]

The ECtHR began to apply and develop this preventive and complementary protection in its case law on the prohibition of torture and inhuman or degrading treatment in Article 3 ECHR.[115] In *Soering*, the Court held, for the first time, that an extradition that resulted in exposure to a real risk of treatment prohibited by Article 3 would, 'while not explicitly referred to in the brief and general wording of Article 3, [...] plainly be contrary to the spirit and intendment of the Article'.[116] The right to life, fundamental aspects of the right to liberty and the right to fair trial were successively considered relevant human rights in this regard.[117] More recently, in *Hirsi*, a case relating to the 'push-back' of migrants to Libya by Italian Revenue Police and Coastguard ships in the High Seas, the ECtHR recalled the absolute character of *non-refoulment*, its applicability even in the maritime context when extra-territorial interceptions of migrants take place, and also when the return

[113] Convention Relating to the Status of Refugees (adopted 28 July 1951 entry into force 22 April 1954) 189 UNTS 137 (Refugee Convention) Article 33.
[114] Maarten Den Heijer 'Whose Rights and Which Rights? The Continuing Story of Non-Refoulement under the European Convention on Human Rights' (2008) *European Journal of Migration and Law* 10(3) 277; Guy Goodwin-Gill and Jane McAdam, *The Refugee in International Law* (OUP 2007) chapters 5 and 6.
[115] *Soering v the United Kingdom* App no 14038/88 (ECHR 1989) paras 85-91; *Chahal v United Kingdom* App no 22414/93 (ECHR 1996) paras 74, 83-107; *D. v the United Kingdom* App no 30240/96 (ECHR1997) para 49.
[116] *Soering* (ibid) para 88.
[117] For example, *Bader and Kanbor v Sweden* App no 13284/04 (ECHR 2005); *Othman (Abu Qatada) v the United Kingdom* App no 8139/09 (ECHR 2012).

operations are grounded in a bilateral agreement between two countries as a part of a state migration policy to combat irregular migration.[118]

M.S.S. is another seminal *non-refoulement* case that has impacted on states' interpretation and implementation of EU law in the area of immigration and asylum. Belgium had sent an asylum seeker back to Greece under the EU Dublin Regulation, which generally allocates responsibility for processing asylum claims to the first EU member state into which the asylum seeker enters.[119] Greece was held liable for violating the ECHR because reception conditions and procedures for processing asylum claims were largely dysfunctional and asylum seekers were either detained or left to fend for themselves on the street in dire socio-economic conditions. Furthermore, the applicant had no access to a serious examination of his asylum claim, with the risk of being denied international protection and thus potentially expelled to Afghanistan.[120] Against this background of violations of Articles 3, 5 and 13 (right to an effective remedy) ECHR by Greece, Belgium was also held accountable because its decision to return the applicant to Greece had exposed him to inhuman or degrading treatment in Greece, about which Belgium 'should have known'. Under such circumstances, instead of transferring the asylum seeker to the EU country of first entry, Belgium could have drawn on the 'sovereignty clause' in the Dublin Regulation to take responsibility for the case.[121] This judgment is certainly a significant - and even exceptional – example of how the Court can reach very migrant-oriented findings. It is also worth noting that in *M.S.S.* no mention is made of the 'well-established maxim' of the sovereign right to control immigration. Thus, the principle of *non-refoulement* may apply to and prevent cases of deportation that are likely

[118] *Hirsi* (n 90) paras 70-82. For a detailed analysis, see Maarten Den Heijer, 'Reflections on *Refoulement* and Collective Expulsion in the *Hirsi* Case' (2013) *International Journal of Refugee Law* 25(2) 265.
[119] European Parliament and of the Council Regulation (EU) No. 604/2013 of the of 26 June 2013 establishing the criteria and mechanisms for determining the Member State responsible for examining an application for international protection lodged in one of the Member States by a third-country national or a stateless person, OJ L 180.
[120] *M.S.S. v Belgium and Greece* App no 30696/09 (ECHR 2011) paras 207-234, 254, 300.
[121] Dublin Reg (n 119); Violeta Moreno-Lax, 'Dismantling the Dublin System: M.S.S. v Belgium and Greece' (2012) *European Journal of Migration and Law* 14 1, 29.

to expose people to degrading treatment (Article 3 ECHR) which consists of exceptionally poor and dire socio-economic material conditions.

In *Tarakhel*, a case involving a family of asylum seekers who were due to be transferred from Switzerland to Italy under the EU Dublin Regulation, the Court held, in the light of the vulnerability of asylum seekers – the children in particular - and the deficient reception conditions for families in Italy, that Article 3 ECHR required the returning country to obtain sufficient assurances that the actual accommodation facilities for the returnee family in Italy were human-rights compliant.[122]

Furthermore, the expulsion of 'non-nationals' may give rise to violations of human rights law when it is carried out in collective form without reasonable and objective examination of the case. Such cases are in potential violation of Article 4 of Protocol 4 to the ECHR, which prohibits collective expulsions. This procedural guarantee has been subject to oscillating interpretation. In the above-mentioned *Hirsi* case, reasonable and objective examination meant an assessment of 'the particular case of each individual alien of the group' whereby everyone is 'given the opportunity to put arguments against his expulsion to the competent authorities' with a suspensive effect on deportation enforcement.[123] In the more recent, and controversial, *Khlaifia case*,[124] which concerned the lawfulness of the removal of three migrants from the 'First Aid and Reception Centre' of Lampedusa to Tunisia via Palermo, it was significant how the Grand Chamber of the ECtHR reversed the arguments of the Chamber (and of *Hirsi*) on the requirements of 'collective expulsion'. Indeed, whereas the Chamber judgement had ascertained a violation of human rights law because the cases had not been examined individually, the 2016 Grand Chamber judgement, while confirming that other articles of the ECHR had been violated, held that the prohibition of the collective expulsion of aliens:

> Does not guarantee the right to an individual interview in all circumstances; the requirements of this provision may be satisfied

[122] *Tarakhel v Switzerland* App no 29217/12 (ECHR 2014).
[123] *Hirsi* (n 90) paras 184-185, 205-206.
[124] *Khlaifia and Others v Italy* App no 16483/12 (ECHR 2015) and [ECHR 2016).

> where each alien has a genuine and effective possibility of submitting arguments against his or her expulsion.[125]

This opinion was considered a retrograde step in human rights protection by the dissenting judge Serghides who, *inter alia*, held that the findings of the majority of the Grand Chamber might lead to:

> (i) Giving the authorities the choice of deciding to abstain from upholding the rule of law, i.e., from the fulfilment of their said procedural obligation, at the expense of satisfying the principles of effectiveness and legal certainty; (ii) making the Convention safeguards dependent merely on the discretion of the police or the immigration authorities […] thereby not only making the supervisory role of the Court difficult, but even undermining it and rendering it unnecessary.[126]

3.1.2. The right to personal liberty and to fair and decent conditions of detention and living

In *Khlaifia*, the Court declared other breaches of the ECHR, including the right to liberty and security of person in Article 5(1) because the detention of the applicants in a migrant 'reception' centre had no legal basis.[127] Generally, when a limitation of liberty is justified by a legal basis and a legitimate aim, the legality of detention is further scrutinised under the umbrella of the 'proportionality test', which means adopting the least restrictive alternative and ensuring that the detriment to the person is not excessive when compared with the benefits for the state. However, in immigration detention cases – which are explicitly foreseen in Article 5(1)f) – the case law of the ECtHR has evolved, since the *Saadi* case, so that it does not require a 'full' test of necessity and proportionality.[128] Accordingly, unlike all other types of

[125] ibid (*Khlaifia* 2016) para 248, emphasis added.
[126] ibid, Partly Dissenting Opinion of Judge Serghides, para 12(a).
[127] On the violation of Article 5.1(f) ECHR, ibid, paras 66-72.
[128] ECHR (n 15, Introduction) Article 5.1:'[…] No one shall be deprived of his liberty save in the following cases and in accordance with a procedure prescribed by law […] f) the lawful arrest or detention of a person to prevent his effecting an unauthorised entry into the country

detention listed in Articles 5(1)a) to 5(1)e) and regardless of a substantially similar wording, the detention of unauthorised migrants, which is a 'necessary adjunct' of the power to control entry and stay of aliens on a state's territory, is considered permissible without checking the 'necessity' of the measure, provided that it is 'closely connected' to the purpose of preventing unauthorised entry or deportation. This is a clear example of how the principle of Westphalian sovereignty and its immigration-related corollary frame the interpretation of human rights provisions in a way that is detrimental to migrants.[129] However, the Strasbourg Court has adopted a full test of proportionality to scrutinise the legality of immigration-related detention where minors are concerned. For instance, in *Rahimi*, the Court held that the placement of a minor in a detention centre with dire conditions had been arbitrary – and thus illegal – because the 'best interest of the child' and the extreme vulnerability of unaccompanied minors would have required a less restrictive measure.[130]

In *Rahimi*, the Court also held a violation of Article 3 ECHR on the accounts provided by a series of NGOs and the European Committee for the Prevention of Torture, which described the material conditions of the Pagani camp as 'abominable'.[131] Indeed, a post-entry or pre-deportation detention in unsuitable locations may lead to violations of Article 3 ECHR, a human rights provision that admits no derogation under any circumstance. In this respect, the ECHR case law shows that violations of the freedom from inhuman or degrading treatment require a minimum level of severity to be met and are more likely to be ascertained as a result of the cumulative effect of certain factors/concrete circumstances. These include the excessive length of detention, lack of privacy, overcrowding, lack of basic hygiene requirements, restricted access to the open air and the external world, lack of ventilation,

---

or of a person against whom action is being taken with a view to deportation or extradition'; *Saadi* (n 109) paras 72, 73.

[129] For further details Galina Cornelisse, 'A New Articulation of Human Rights, or Why the European Court of Human Rights Should Think Beyond Westphalian Sovereignty', in Dembour and Kelly (n 3) 99.

[130] *Rahimi v Greece* App no 8687/2008 (ECHR 2011) paras 108 – 111.

[131] ibid, paras 85, 95-96.

scarce means of subsistence, lack of access to social and legal assistance, and inadequate medicine or medical care.[132] Poor conditions of detention might amount to violations of minimum subsistence rights and serious violations of human dignity,[133] which may increase the vulnerability of individuals and groups already recognised as socially and legally vulnerable. According to the Court such groups include asylum seekers, children and elderly people.[134]

Finally, outside cases of migration detention, the Court has recently found that the neglect of an unaccompanied migrant child, who was not placed under state protection and care and left in a shanty town near Calais in France, constituted inhuman or degrading treatment contrary to Article 3 ECHR.[135] This judgement relied heavily on the findings of *Rahimi* to establish that France had failed to consider the extreme situation of vulnerability of the child (which would displace any considerations pertaining to irregularity of status) which would lower the threshold of severity that triggers Article 3 ECHR. In particular the state was found to have failed to fulfil an Article 3-related positive obligation by not enforcing and following up on a court order to provide protection and care to unaccompanied minors.

3.1.3. The protection of family life

Another highly controversial area where European human rights law has encroached, although only partially, upon the sovereign state power to regulate the entry and stay of non-nationals is the protection of 'family life' in Article 8 ECHR. This is a limitable right insofar as it is susceptible to any interference that is:

> In accordance with the law […] necessary in a democratic society in the interest of national security, public safety or the economic well-being of the country, for the prevention of disorder or crime,

[132] For example, *S.D. v Greece* App no 53541/07 (ECHR 2007) paras 52-53; *M.S.S.* (n 120) paras 223-234; *Khlaifia GC2016* (n 124) para 163-174.
[133] *M.S.S.* (n 120) para 233.
[134] *Khlaifia* GC2016 (n 124) para 194.
[135] *Khan v France* App no 12267/16 (ECHR 2019) paras 74, 81, 92.

> for the protection of health or morals, for the protection of the rights and freedom of others.[136]

The case law of the Court has elaborated extensively on what 'family life' means, including married couples that are presumed to be a family,[137] and those situations that demonstrate *de facto* family ties, like applicants living together, in a long-term relationship or having children.[138] The 'mutual enjoyment by parent and child of each other's company constitutes a fundamental element of family life'.[139] By contrast, the recent case of *Narjis* illustrates that, in the context of deportation, an unmarried and childless adult who 'has not demonstrated additional elements of dependence other than normal emotional ties towards his mother, sisters and brother (all of whom were adults)' does not fall within the ambit of family life.[140]

The immigration case law of the ECtHR actually began with a family-life case: the case of *Abdulaziz*, *Cabales and Balkandali*, which concerned the applications of three UK resident women of foreign origin to be reunited with their husbands, applications which were rejected by the UK's authorities. This case has become infamous for setting the precedent – and premise of most of the immigration cases pending in Strasbourg – that as a 'matter of well-established international law' immigration control is a sovereign state power that may counterbalance the enjoyment of human rights by migrants. Accordingly, while the Court recognised that Article 8 ECHR may give rise to 'positive obligations inherent in an effective "respect" for family life' and is *in abstracto* applicable to migrants:

> The duty imposed by Article 8 cannot be considered as extending to a *general* obligation on the […] state to respect the choice by

[136] ECHR (n 15, Introduction) Article 8(2).
[137] *Marcks v Belgium* App no 6833/74 (ECHR 1979).
[138] *Johnston and Others v Ireland* App 9697/82 (ECHR 1986) para 56; *X, Y and Z v the United Kingdom* App no 21830/93 (ECHR 1997) para 36.
[139] *B. v the United Kingdom* App 9840/82 (ECHR 1987). For further details, see Council of Europe, *Guide on Article 8 of the European Convention on Human Rights* (COE-ECHR 2018) 46.
[140] *Narjis v Italy* App 57433/15 (ECHR 2019) para 37.

> married couples of the country of their matrimonial residence and to accept the non-national spouse for settlement in that country.[141]

Finally, the ECtHR rejected the applicants' claims on the ground that they had not, *inter alia*, shown that 'there were obstacles to establishing family life in their own or their husbands' home countries'.[142]

Therefore, even though there is no general state duty to guarantee the right to enter or stay in a country to enjoy family life, under certain circumstances, 'the removal of a person from a country where close members of his family are living may amount to an infringement' of Article 8 ECHR.[143] In cases of alleged violation of Article 8 ECHR, the Court seeks to ascertain whether a 'fair balance' has been struck between the competing interests of protection of family life in paragraph 1 and any relevant state interest in paragraph 2, while affording states 'a certain margin of appreciation' in that regard. This entails that, case-by-case, the ECtHR undertakes a 'legitimacy' and 'proportionality test' concerning the acceptability and necessity of the deportation or refusal of entry of a family member in relation to the applicant's right to family life.

For example, the Court has found that immigration measures 'may be justified by the preservation of the country's economic well-being, by the need of regulating the labour market and by considerations of public order weighing in favour of exclusion.[144] However, the case-law of the ECtHR has indicated several factors that must be considered by the state in immigration cases. These factors include:

> The extent to which family life would effectively be ruptured, the extent of the ties in the Contracting State, whether there are insurmountable obstacles in the way of the family living in the country of origin of the alien concerned and whether there are factors of immigration control […], considerations of public order weighing in favour of exclusion [and] whether family life was

[141] *Abdulaziz* (n 63) 68. Emphasis added.
[142] ibid.
[143] *Al-Nashif v Bulgaria* App 50963/99 (ECHR 2002) para 114.
[144] *Berrehab v the Netherlands* App 10730/84 (ECHR 1988) para 26; *Rodrigues da Silva and Hoogkamer v the Netherlands* App 50435/99 (ECHR 2006) para 38.

> created at a time when the persons involved were aware that the immigration status of one of them was such that the persistence of that family life within the host State would from the outset be precarious […]. Where children are involved, their best interests must be taken into account.[145]

Although 'very weighty reasons' are necessary to justify the deportation of a settled migrant who, for example, has regularly spent most of her childhood or youth in the deporting state, or who is disabled, or where serious impediments prevent the establishment of family life in the country of deportation,[146] the assessment of proportionality in the area of immigration adds a wide degree of unpredictability to the findings of the Court.

This unpredictability of outcomes in cases of family life and immigration is evident in the comparison between the Chamber and the Grand Chamber's findings in the case of *Biao*. Denmark refused to grant a residence permit for family reunion to one of the applicants because her husband – a naturalised Danish citizen and co- applicant in the proceedings – had not demonstrated sufficient 'attachment' to Denmark, in that he did not meet the 28-year citizenship requirement to bring his spouse into the country without undertaking an 'attachment' test. The Court's Chamber judgement assessed the permissible interference with Article 8 ECHR by recalling the maxim of state sovereignty in immigration management and without attaching importance to the several years of Mr Biao's regular residence in Denmark. Furthermore, considering the alleged ties of the applicants to countries other than Denmark and the couple's awareness of the precarity of the status of one of them when the relationship started, the Court concluded that there were no insurmountable obstacles that prevented the family from moving to another country and thus considered the balance struck by the state as fair and compliant with Article 8 ECHR.[147] The Court also rejected the argument that

[145] *Jeunesse v The Netherlands* App no 12738/10 (ECHR 2014) paras 107-109.
[146] *Maslov v Austria* App no 1638/03 (ECHR 2008) para 75; *Nasri v France* App 19465/92 (ECHR 95).
[147] *Biao v Denmark* App 38590/10 (ECHR 2014) paras 52-60.

the 28-year citizenship pre-requisite for family reunification constituted indirect discrimination, on grounds of ethnic origin.

The Grand Chamber reversed the findings of the Chamber judgement and considered that Article 14 on non-discrimination and Article 8 ECHR were jointly violated. It held that Denmark had failed to show that there were:

> Compelling or very weighty reasons unrelated to ethnic origin to justify the indirect discriminatory effect of the 28-year rule. That rule favours Danish nationals of Danish ethnic origin, and places at a disadvantage, or has a disproportionately prejudicial effect on persons who acquired Danish nationality later in life and who were of ethnic origins other than Danish.[148]

3.1.4. Partial concluding remarks

This section, by presenting a sample of the immigration-related case-law of the ECtHR, has demonstrated that a precarious immigration status significantly exposes people to human rights violations that are difficult successfully adjudicate before the ECtHR. On the one hand, the Court has relied on Article 3 ECHR concerning the prohibition of degrading treatment to rule out situations of appalling migration detention, extreme poverty outside of the detention context and cases of *refoulement*, where a high threshold of severity of abuse is met. Violations of Article 3 have often been adjudicated before the Court in health-related cases, with either successful or unsuccessful outcomes, as discussed in Chapter 3. On the other hand, the Court has been more hesitant to challenge restrictive state practices that impinge on migrants' right to family life. Furthermore, settled case law excludes that migration-related detention needs to be assessed by reference to its 'necessity', as is the case with other types of detention. Finally, procedural guarantees against collective expulsions have been recently lowered and fair trial guarantees do not generally apply to immigration proceedings. Thus, the Court's case law has navigated between restrictive and progressive trends,

[148] *Biao v Denmark* App 38590/10 (ECHR 2016) para 138.

whereas, as will now be discussed, the jurisprudence of the UN treaty bodies shows more progressive tendencies.

3.2. The UN treaty bodies and migrants' human rights

The nine UN human rights treaties are monitored by corresponding treaty bodies with mandates that, to different extents, allow them to make recommendations by issuing authoritative statements (called 'General Comments' or 'General Recommendations'), observations on states' periodic reports (called 'Concluding Observations'), and 'views' on individual communications.[149] Several of these bodies have made clear their commitment to the rights of migrants with precarious or irregular status. Some examples of this general commitment are provided below while, as far as health issues are concerned, systematic analysis is provided in the following chapters.

3.2.1. Normative statements on the rights of migrants

One of the first applicable authoritative statements is General Comment No. 15 of the Human Rights Committee (CCPR), which considers that aliens and citizens should, in principle, enjoy equal human rights:

> […] The Covenant does not recognize the right of aliens to enter or reside in the territory of a State party. *It is in principle a matter for the State to decide who it will admit to its territory*. However, in certain circumstances an alien may enjoy the protection of the Covenant *even in relation to entry or residence*, for example, when considerations of non-discrimination, prohibition of inhuman treatment and respect for family life arise.[150]

[149] For an overview of the system, <https://www.ohchr.org/EN/HRBodies/Pages/Overview.aspx> accessed 10 January 2019.
[150] CCPR, CG15 (n 91) paras 1, 2, 4, 5, emphasis added.

This extract, particularly the text in italics, demonstrates an explicit approach that is overall less deferential to the idea of state sovereignty than that of the ECtHR.

General Recommendation No. XXX of the Committee on the Elimination of Racial Discrimination, for reasons of consistency with other UN human rights instruments, reinterpreted the personal scope of application of the Convention on the Elimination of Racial Discrimination (CERD) as extending to racial discrimination against non-citizens, regardless of their immigration status.[151] This conclusion reversed the previous approach according to which the Convention did not apply to state differentiations between citizens and aliens, which were *prima facie* permissible under the Convention.[152]

More recently, the CESCR issued a statement on the rights of migrants, which specifies that all migrants and refugees, and in particular undocumented migrants, are vulnerable people with regard to the enjoyment of socio-economic rights.[153] This statement significantly relies on the concept of 'core obligations' to recommend states to guarantee to everyone the enjoyment of minimum essential levels of rights. This document will receive specific attention in the following chapters.

Finally, the Committee on the Rights of the Child and the Committee on the Rights of All Migrant Workers and Members of Their Families recently issued two ground-breaking joint General Comments on general principles and state obligations in relation to migrant children.[154] These collaborative joint General Comments reiterate that children a rights holders

[151] CERD Committee, GRXXX (n 100) paras 2, 4, 7.
[152] CERD (n 14, Introduction) Article 1.2 and CERD Committee, General Recommendation No. XI: 'Non-Citizens' (1993) para 1.
[153] CESCR, 'Statement: The Duties of States towards Refugees and Migrants under the International Covenant on Economic, Social and Cultural Rights' (13 March 2017) UN Doc E/C.12/2017/1.
[154] Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families and Committee on the Rights of the Child, 'Joint General Comment No. 3/22 on the general principles regarding the human rights of children in the context of international migration' (16 November 2017) UN Doc CMW/C/GC/3-CRC/C/GC/22; 'Joint General Comment No. 4/23 on the state obligations regarding the human rights of children in the context of international migration in countries of origin, transit, destination and return' (16 November 2017) UN Doc CMW/C/GC/4-CRC/C/GC/23.

are children first and foremost, regardless of their or their parents' nationality or migration status. Among various advancements – some discussed in the chapters which follow – it is worth highlighting that the committees plainly prohibit the detention of migrant children and establish that the *ultima ratio* principle – which is currently employed by the ECtHR, for example – does not apply to migrant children.[155]

3.2.2. A flavour of the outcomes of the communication procedures

In their individual communication procedures concerning failed asylum seekers and non-authorised migrants, the UN treaty bodies have been particularly concerned by alleged violations of the right to freedom from torture or inhuman or degrading treatment and of the prohibition of *refoulment*.[156] As mentioned previously, this principle requires states to refrain from deporting an individual when there are substantial grounds for believing that the person concerned would be at 'foreseeable, personal, present and real' risk of torture in that country [157] or at real and personal risk of irreparable harm.[158]

While for the ECtHR and for the CCPR the identification of a real and personal risk of degrading or undignified treatment in the country of removal should, in principle, inhibit the enforcement of a return, the Committee of the Convention against Torture (CAT Committee) interprets the principle of *non-refoulment* as protecting the complainant against a risk of being subjected to 'torture' in the event of removal. Torture is defined in the Convention as the intentional infliction of severe pain or suffering, whether physical or mental,

[155] ibid (JGC 4/23) para 5. For further details, see Ciara M. Smyth, 'Towards a Complete Prohibition on the Immigration Detention of Children' (2019) *Human Rights Law Review* 19(1) 1.
[156] More than 50% of the communications filed before a human rights treaty bodies concerns the principle of non-refoulement <http://juris.ohchr.org/> accessed 10 December 2018.
[157] CAT Committee, 'General Comment No. 4 (2017): The Implementation of Article 3 of the Convention in the Context of Article 22' (4 September 2018) UN Doc CAT/C/GC/4, para 11.
[158] Human Rights Committee (CCPR), 'General Comment No. 31: The Nature of the General Legal Obligation Imposed on States Parties to the Covenant (26 May 2004) UN Doc CCPR/C/21/Rev.1/Add. 13.

by the state. This fact raises considerably the threshold of potential human rights abuse that may prevent a removal. In this assessment 'the existence of a consistent pattern of gross, flagrant or mass violations of human rights' in the country of deportation is considered, together with the complainant's personal risk of being tortured,[159] in the light of her vulnerabilities and medical record. In particular, a comparison of the findings in two recent 'Dublin' cases against Switzerland, *A.N.* and *J.B.*, demonstrates that being a victim of torture and suffering from serious mental health problems may play a central role in preventing a removal of a migrant to a country where such specialised care is not easily accessible to migrants. In *A.N.* the Committee found that the ill-treatment to which the complainant would be exposed upon return to Italy, where shelter, food and basic needs are not always guaranteed, would entail a risk of worsening his depression 'to the extent that he would be likely to commit suicide and that, in the circumstances of this case, this ill-treatment could reach a level comparable to torture'.[160] Furthermore, 'such a precarious situation endangering the life of the complainant would leave him no reasonable choice but to seek protection elsewhere, exposing him to a risk of chain refoulement to his home country'.[161] By contrast, in *J.B.*, the lack of sufficient medical proof of a situation of particular vulnerability, considered in the context of a return to Bulgaria, led the Committee to hold that there were not substantial grounds to believe that the complainant would be at risk of torture if retuned.[162]

The CCPR, in the context of deportation, has demonstrated particular sensitivity with regard to family and child-related situations. In *O.A.*, which concerned the removal of an unaccompanied minor from Denmark to Greece under the EU Dublin System, the CCPR held that the child would be exposed to a real (high) risk of irreparable harm because of the still-ongoing substandard state of the Greek reception system.[163] In particular, the

[159] For example, see *M.A.M.A. et al v Sweden* Com 391/2009 (CAT Committee 2012); Rouba *Alhaj Ali v Morocco* Com no 682/2015 (CAT Committee 2016).
[160] *A.N. v Switzerland* Com no 742/2016 (CAT Committee 2018) para 8.10.
[161] ibid, para 8.5.
[162] *J.B. v Switzerland* Com no 721/2015 (CAT Committee 2017).
[163] *O.A. v Denmark* Com no 2770/2016 (CCPR 2017) para 8.9.

Committee held that the state party failed to undertake an individualised assessment of the risk of being subjected to inhuman and degrading treatment that a vulnerable person, in this case a child, would face if deported.[164] In *Y.A.A. & F.H.M.*, the Committee reached similar conclusions in relation to the deportation of a family with four children to Italy, where they had previously encountered extreme hardship in securing basic social assistance, including shelter, work and health care. In this case, the state had failed to give enough weight to the situation of vulnerability of the authors of the complaint and their family, and 'to seek proper assurances from the Italian authorities that the authors and their four children would be assured of living conditions that are compatible with Article 7 (prohibition of torture and inhuman or degrading treatment) ICCPR'.[165] In the case of *Warda*, although similar circumstances of material deprivation in the 'first country of asylum' led the CCPR to hold a violation of Article 7 ICCPR, the concurring opinion of two judges clarified the very exceptional and particular factors that grounded that decision.[166] Similarly, in *I.A.M.*, the principles of precaution and the best interest of the child were employed by the Committee on the Rights of the Child (CRC Committee) to oppose the Danish decision to repatriate a Somali mother and her daughter to (an area of) their country of origin where female genital mutilation is widely practised.[167]

The protection of the family was also one of the main arguments in the *Mansour* case, which concerned the refusal to grant a visa because of insufficiently clarified 'compelling reasons of national security' to an Iranian father who had lived regularly for more than 16 years in Australia. The CCPR held that the state's procedure lacked due process of law and violated Articles 17 (private and family life) and 23 (protection of the family and rights associated with marriage) ICCPR because it failed to disclose the actual reasons for terminating the applicant's right to remain or, in the Committee's words, 'adequate and objective justification for the interference with his long-

[164] ibid, para 8.11.
[165] *Y.A.A. and F.H.M. v Denmark* Com no 2681/2015 (CCPR 2017) para 7.9.
[166] *Warda v Denmark* Com no 2360/2014 (CCPR 2015) Appendix II.
[167] *I.A.M. v Denmark* Com no 3/2016 (CRC Committee 2018); Similarly, *Kaba v Canada and Guinea* Com no 1465/2006 (CCPR 2010).

settled family life'.[168] In another case of expulsion from Australia, the same Committee clarified that the state interest in expelling a long-term settled person to his country of nationality, where he had no family bonds, might be considered – as in that case – a disproportionate interference with the right to family life as per Article 17 ICCPR.[169]

In relation to detention, unlike the ECtHR, the CCPR considers that the 'detention of unauthorised arrivals is not arbitrary per se *but* that remand in custody could be considered arbitrary if it is *not necessary* given all the circumstances of the case'.[170] Detention can give rise to a finding of violation of Article 10 ICCPR (right to liberty) if the conditions are not dignified or the type of detention is not based on 'a proper assessment of the circumstances of the case but is, as such, disproportionate'. This was found to be so in the case of a person with a deteriorated mental health situation, who was placed in a detention centre against the advice of various doctors and psychiatrists.[171]

The tension between sovereign immigration enforcement and human rights clearly underlies the recent *Toussaint* case. In this recent case, the CCPR grappled, for the first time, with an alleged violation of the ICCPR because of the lack of access to (emergency) health care of an irregular migrant. The applicant was denied health care because the state authorities claimed that the 'operative cause' of the risk to her life and health was her own decision to irregularly remain in the country. The domestic court had stated that:

> The exclusion of immigrants without legal status from access to health care is justifiable as a reasonable limit under section 1 of the Canadian Charter because appropriate weight should be given to the interests of the state in defending its immigration laws.[172]

However, the Committee concluded that, in consideration of the domestic courts' acknowledgement that the applicant's 'life and health were placed at significant risk by the State party's denial of access to health care', Article 6

[168] *Mansour Leghaei et al v Australia* Com no 1937/2010 (CCPR 2015) para 10.5.
[169] *Stefan Lars Nystrom v Australia* Com no 1557/2007 (CCPR 2011).
[170] *Madafferi v Australia* Com no 1011/2001 (CCPR 2004) para 9. Emphasis added.
[171] ibid, para 9.3.
[172] *Toussaint v Canada* Com no 2348/2014 (CCPR 2018) para 2.12.

ICCPR on the right to life had been breached. Furthermore, in relation to the issue of discrimination, the CCPR held the opinion that a differentiation based on her 'immigration status' that 'could result in the author's loss of life or in irreversible negative consequences for the author's health' was not based on reasonable and objective criteria and was therefore discriminatory:

> Aliens have an 'inherent right to life'. States therefore cannot make a distinction, for the purposes of respecting and protecting the right to life, between regular and irregular migrants.[173]

Overall, the treaty bodies communication procedures have been particularly protective where non-derogable rights and *non-refoulment* are concerned and in relation to migrant families and children.

3.3. Concluding remarks on trends in the international and European case law

Instances of deportation from a country and irregular stay are particularly delicate circumstances in which human rights abuses are likely to take place and executive powers of immigration control are strong vis-à-vis a situation of personal and legal vulnerability. Against this backdrop, the ECtHR has established certain procedural and substantial minimum standards that, to different extents, limit the sovereign power to exclude. However, state sovereignty considerations, reminders of our Westphalian system of international law, are subsumed in the ECHR and in the Court's case-law. As for the UN treaty bodies, they place less emphasis on the state power to regulate immigration than the ECtHR does in its case law. Indeed, none of the cases mentioned in this section contains any *obiter dicta* regarding the 'long-established maxim' of state sovereignty in the area of immigration, and failed communications tend to be based on the applicants' lack of evidence or the failure to meet a *prima facie* standard of proof in relation to a human rights' violation.[174] The CCPR, in the case of *Touissant*, even relies on the jurisprudence of the Inter-American Court of Human Rights, which, as

[173] ibid, paras 11.7, 11.8.
[174] For example, *M.P. v Denmark* Com no 2643/2015 (CCPR 2017); *E.A. v Sweden* Com no 690/2015 (CAT Committee 2017).

explained below, is particularly progressive and 'pro-*homine*' oriented in relation to migrants' rights.[175]

This section has mostly focussed on examples from the case-law and jurisprudence of the ECtHR and the UN treaty bodies. However, in the immigration context, the Westphalian influence has also been directly enshrined in the texts of some human rights treaties, with the effect of excluding irregular migrants from the treaty's personal scope or legalising clear differentiation – if not real discrimination – on the ground of legal status. Such is the case of the European Social Charter (ESC) and the UN Convention on the Rights of Migrant Workers (CMW), respectively. In the next section, the right to health for irregular migrants will be used as an example to assess the extent of such exclusions and significant limitations of rights.

4. Explicit limitations on the Right to Health of Irregular Migrants in Human Rights Treaty Law

4.1. The Convention on Migrant Workers

As explained in the previous sections, the uneasy balancing of sovereign powers in the field of immigration with human rights law has often led to judicial or quasi-judicial interpretation of 'universal' human rights law in ways that are detrimental to undocumented people. Furthermore, this conceptual friction has also underpinned the justification of directly condoning differential treatments in human rights treaty norms. The right to health – which will be analysed in detail in the following chapters – is a particularly instructive example of an area in which 'sovereign' immigration policies have negatively shaped the rights of irregular migrants in some international treaties.

Unlike the ICCPR, ICESCR and the ECHR, the CMW explicitly regulates differential treatment for regular as opposed to irregular migrants as human rights holders. On the one hand, this instrument represents an overall

[175] *Toussaint* (n 172) para 11.7. See *infra* at Section 5.

improvement in the protection of the rights of migrant workers and makes them visible within human rights law.[176] On the other hand, it 'constitutionalises' a double divide ('citizens/non-citizens' and 'regular/irregular migrants') in international human rights law. Indeed, the CMW has been described as a 'hybrid instrument',[177] aimed at achieving greater protection of migrants' rights while also reaffirming state territorial sovereignty as a well-founded principle of international and immigration law. For example, the unequal treatment of irregular and documented migrant workers emerges in relation to the right to healthcare. Article 28 CMW stipulates that:

> Workers and members of their families shall have the right to receive any medical care that is *urgently required for the preservation of their life or the avoidance of irreparable harm to their health* on the basis of equality of treatment with nationals of the State concerned. Such emergency medical care shall not be refused them by reason of any irregularity with regard to stay or employment.[178]

By contrast, Article 43 CMW establishes that documented or regular migrant workers 'shall enjoy *equality of treatment* with nationals of the State of employment in relation to […] (e) access to social and health services […]'.[179]

This emergency-oriented approach appears to be a backward step in terms of minimum treatment vis-à-vis Article 12 ICESCR on the right to health.[180] Indeed, the normative content of the latter, as articulated by the UN CESCR, is *prima facie* universal and vindicates a core standard equivalent to 'essential primary healthcare for all', with a particular emphasis on non-

[176] Isabelle Slinckx, 'Migrants' Rights in UN Human Rights Conventions' in Paul De Guchteneire, Antonie Pécoud and Ryszard Cholewinski (eds) *Migration and Human Rights – The United Nations Convention on Migrant Workers' Rights* (CUP 2009) 122, 146.
[177] Bosniak (n 66) 316. See in particular Articles 34 and 79 of the CMW, which recall the exclusive state right to regulate immigration.
[178] CMW (n 14, Introduction) Article 28. Emphasis added.
[179] ibid, Article 43. Emphasis added.
[180] ICESCR (n 14, Introduction), Article 12: 'The States Parties to the present Covenant recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.

discrimination of vulnerable groups,[181] to which irregular migrants belong.[182] Although the CMW is not widely ratified,[183] and its monitoring committee has encouraged a contextual interpretation of its text,[184] the differential treatment it condones, which effectively excludes irregular migrants from services and rights, has been openly written into a binding human rights document.

4.2. The European Social Charter

The second example of a treaty text that clearly restricts the human rights of irregular migrants in the context of health care – and beyond – is the ESC.[185] This is the sister treaty, in the area of socio-economic rights, of the ECHR. In contrast to the European Convention, which applies to 'everyone' within state jurisdictions,[186] the Appendix of the Charter places irregular migrants outside the personal scope of the treaty: '[…] the persons covered […] include foreigners only in so far as they are nationals of other contracting parties lawfully resident or working regularly within the territory of the contracting party concerned […]'. Even though immigration was not a particularly hot topic at the time of the drafting of the Charter, and the drafters principally concerned with eliminating barriers to socio-economic rights for the nationals

[181] See, CESCR, GC14 (n 27, Introduction) para 43, and CESCR, GC20 (n 93) para 30. See Section 7, Chapter 2 and Section 1.2, Chapter 3.
[182] CESCR, Statement (n 153); Stefano Angeleri, 'The Impact of the Economic Crisis on the Right to Health of Irregular Migrants, as Reflected in the Jurisprudence of the UN Committee on Economic, Social and Cultural Rights' (2017) *European Journal of Migration and Law* 19(2) 165.
[183] As of March 2019, only 54 states are parties to this Convention, neither of them from the EU, Euan MacDonald and Ryszard Cholewinski, *The Migrant Workers Convention in Europe: Obstacles to the Ratification of the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families: EU/EEA Perspectives.* (UNESCO Publishing 2007) 51.
[184] CMW Committee, GC2 (n 22, Introduction) para 72: '[…] Article 12 of the International Covenant on Economic, Social and Cultural Rights provides for the right to the highest attainable standard of health for all persons. States parties are therefore obliged to ensure that all persons, irrespective of their migration status, have effective access to at least a minimum level of health care on a non-discriminatory basis. The Committee on Economic, Social and Cultural Rights considers this to encompass primary health care, as well as preventive, curative and palliative health services […]'.
[185] European Social Charter and European Social Charter (Revised) (n 15, Introduction).
[186] ECHR (n 15 Introduction) Article 1.

of European countries, the limited scope results from the assumption that socio-economic rights are a matter solely for nationals and 'legal communities' as identifiable taxpayers.[187] Having said this, a contextual and purposive interpretation of the Appendix, in conjunction with a series of substantive rights within the Charter, has led the European Committee of Social Rights (ECSR) – the quasi-judicial body that oversees the implementation of the ESC – to gradually grant basic social rights to irregular migrants. The turning point was the decision in the *FIDH* case,[188] in 2004, which concerned access to medical care by irregular migrant children. On that occasion, the ECSR, arguing for the complementary nature of the ESC and ECHR, the interdependence and indivisibility of all human rights, and the protection of human dignity, concluded that a 'legislation or practice which denies entitlements to medical assistance to foreign nationals, within the territory of a State Party, even if they are there illegally, is contrary to the Charter'.[189] In subsequent cases, the ECSR extended its legal reasoning beyond the ordinary meaning of the Appendix, stating that the Charter must be interpreted 'in the light of other applicable rules of international law'.[190] This implicitly refers to those treaties of universal application that entitle 'everyone' to the right to health, such as the Convention of the Rights of the Child (CRC) and the ICESCR. Furthermore, the ECSR has declared that the realisation of social rights for irregular migrants must be pursued when linked to the requirement to secure the 'realisation of the most fundamental rights of these persons, as well as their human dignity'.[191] This passage, intended as a protection-oriented argument, seems to qualify the realisation of minimum health-related services in instrumentalist terms.

---

[187] Francesca Biondi Dal Monte, 'Lo Stato Sociale di Fronte alle Migrazioni. Diritti Sociali, Appartenenza e Dignità della Persona' (2012) *Rivista del Gruppo di Pisa* 3(12). See also "Travaux préparatoires" of the ESC (n 2, Introduction).
[188] *International Federation of Human Rights League (FIDH) v France* Com no 14/2003 (ECSR 2004).
[189] ibid, paras 26-32.
[190] *Defence for Children International (DCI) v the Netherlands* Com no 47/2008 (ECSR 2009) para 35; *Defence for Children International (DCI) v Belgium* Com no 69/2011 (ECSR 2012) paras 29, 33; *Conference of European Churches (CEC) v the Netherlands* Com no 30/2013 (ECSR 2014) para 68.
[191] *CEC* (n 190) para 74. See also *DCI v Belgium* (n 190) para 36.

The interpretative extension of the personal scope of the Charter is not considered the rule but rather is exceptional under certain circumstances (such as those of most of the above cases, which concerned 'unlawful children' who were deemed particularly vulnerable because of their limited autonomy).[192] Regardless of this, the ECSR reached the conclusion that at least the right to 'emergency assistance' (either social or medical) of Article 13(4) ESC – which is linked to the preservation of the most fundamental rights – should apply to all irregular migrants, including adults.[193] This creative interpretation constitutes a progressive step towards the universal personal application of the ESC, even though the right to health for irregular migrants in the European human rights system is not ultimately framed in equal terms for 'everyone'. As will be highlighted in Chapters 3 and 4, the European frameworks at best entitle irregular migrants to 'emergency' or 'urgent' care, whereas Europeans, immigrants with regular legal status and irregular minors enjoy a more extensive standard of care. However, the ECSR states, somewhat cryptically, that while 'an individual's need must be sufficiently urgent and serious to entitle them to assistance under Article 13(4), this criterion must not be interpreted too narrowly'.[194]

The variety of legal sources and bodies that interpret human rights provisions generate confusion regarding the real shape and content of irregular immigrants' rights. The legal uncertainty concerns, first and foremost, whether irregular migrants hold human rights or simply some rights, and, as in the case of the right to health, what the 'levels' of these guarantees are. Although not without contradictions, international and European human rights law has served to open international legal avenues to protect the human rights of irregular migrants in terms of both standard setting and interpretation. The partial achievements reported in the previous sections bear witness to the sensitivity of these legal frameworks to undocumented people.

---

[192] *DCI v Belgium* (n 190) para 35; *CEC* (n 190) para 71.
[193] *CEC* (n 190) paras 73, 75; *European Federation of National Organisations working with the Homeless (FEANTSA) v the Netherlands* Com no 86/2012 (ECSR 2014) paras 171, 173, 182-183, 186.
[194] *CEC* (n 190) para 105; *FEANTSA* (n 193) para 171.

5. Further Contextual Reflections on Migrants' Rights

5.1. The pro-migrant approach of the Inter-American system of human rights

The previous sections demonstrate the oscillations within international and European law between the need for immigration law enforcement and human rights. The European human rights system emphasises immigration enforcement and recognises violations of the human rights of irregular migrants in exceptional and severely abusive cases.[195] The Inter-American system of human rights is briefly analysed at this juncture because, although it is beyond the stated geographic scope of this research,[196] it has been particularly responsive to the call of equality vis-à-vis sovereign powers with respect to immigration management. This approach is particularly evident in the Inter-American Court's Advisory Opinion (AO) on the rights of undocumented migrants.[197] This was the result of a request filed by Mexico regarding the treatment and rights of Mexican undocumented migrant workers in the US. In particular, the question posed to the Inter-American Court was whether excluding undocumented migrants from labour rights was human-rights compliant. It is interesting to note that the Court essentially acknowledged the vulnerability of undocumented migrants, referring to an 'individual situation of absence or difference of *power* with regard to non-migrants', and recognised them as potential victims of discrimination.[198] In the AO, the principles of non-discrimination and equality are so essential to the entire human rights legal framework to be considered part of *jus cogens* and thus regarded as norms that would prevail over any other in international law norm. According to this AO, human rights, including labour rights, which are essential to 'develop fully as a human being', must be enjoyed by

[195] See *supra* at Sections 3.1, 3.2, and *infra* at Chapters 3, 4.
[196] See Section 'Methodology and Research Limits' in Introduction.
[197] *Juridical Condition and Rights of the Undocumented Migrants*, Advisory Opinion OC-18, IACtHR Series A no 18 (17 September 2003).
[198] ibid, para 112.

everyone without discrimination, including discrimination on the ground of legal status.[199]

After 10 years, the Court reiterated these highly protective conclusions in another AO on the rights of migrant children, by unequivocally asserting that '[…] the State must:

> Respect the said rights, because they are based, precisely, on the attributes of the human personality […] regardless of […] whether the person is there temporarily, in transit, legally, or in an irregular migratory situation.[200]

This brief reference to the Inter-American system shows that the restrictive approach to the rights of undocumented people as justified by the principle of state sovereignty *is not the only way* but is, rather, a deliberate choice that legal systems, including certain branches of international human rights law, make.

5.2. The Global Compact for Migration

This analysis would be incomplete without briefly mentioning that, since 2016, the adoption of the New York Declaration and the outcomes of the two 'Global Compacts', under the auspices of the UN, have been shaping a non-binding cooperative framework to address large movements of migrants and refugees.[201] Although these instruments are not legally binding, they restate existing international obligations and set up quite detailed priorities, good practice, action plans, and follow-up mechanisms to deal with the challenges of international migration.

The Compact for Migration, like the documents analysed in this chapter, constantly wavers between the principle of state sovereignty, with all

---

[199] ibid, paras 158, 169, 170. For further analysis, see Dembour (n 5) 296-304; Beth Lyon, 'Inter-American Court of Human Rights Defines Unauthorized Migrant Workers' Rights for the Hemisphere: A Comment on Advisory Opinion 18' (2003) *NYU Review of Law & Social Change* 28 547.

[200] *Rights and Guarantees of Children in the Context of Migration and/or in Need of International Protection,* Advisory Opinion OC-21, IACtHR (19 August 2014) para 62.

[201] New York Declaration (n 63); Global Compact for Safe, Orderly and Regular Migration and Global Compact on Refugees (n 86).

its negative implications for irregular migrants, and a genuine commitment to the holistic protection of the rights of all migrants. This tension was palpable in the negotiations that led to the text adopted at the Conference of Marrakech and endorsed by the UN General Assembly in December 2018.

The zero draft of the Compact did not contain any explicit distinction between the treatment of regular and irregular migrants.[202] However, the paragraph on 'national sovereignty' as a 'guiding principle' in the final draft, insisted upon by the EU bloc during the negotiations, reads as follows:

> The Global Compact reaffirms the sovereign right of States to determine their national migration policy and their prerogative to govern migration within their jurisdiction, in conformity with international law. Within their sovereign jurisdiction, States may distinguish between regular and irregular migration status, including as they determine their legislative and policy measures for the implementation of the Global Compact […].[203]

It is also significant that, in relation to the actual enjoyment of rights by irregular migrants, the zero draft contains several references to the establishment of 'firewalls' – which means that public service provision or labour inspection should be structured so as not to expose irregular migrants to immigration enforcement authorities, whereas the final draft makes this separation less clear.[204] The final text requires states to 'ensure that cooperation between service providers and immigration authorities does not exacerbate the vulnerabilities of irregular migrants by compromising' their human rights,[205] but it does not incontrovertibly dictate that public service providers should refrain from reporting situations of irregularity to the immigration authorities.

---

[202] Zero Draft of the Global Compact for Safe, Orderly and Regular Migration (5 February 2018) para 13, <https://refugeesmigrants.un.org/sites/default/files/180205_gcm_zero_draft_final.pdf> accessed 1 March 2019.
[203] GCM (n 86) para 15; Elspeth Guild and Katharine T. Weatherhead, 'Tensions as the EU negotiates the Global Compact for Safe, Orderly and Regular Migration' (*EU Migration Law Blog*, 6 July 2018) <http://eumigrationlawblog.eu/tensions-as-the-eu-negotiates-the-global-compact-for-safe-orderly-and-regular-migration/> accessed 1 March 2019.
[204] Zero Draft (n 202) paras 20.j; 21.g; 29.c.
[205] GCM (n 86) para 31.b.

As far as immigration detention is concerned, Objective 13 of the Global Compact reads promising on paper since it requires states to ensure that detention is a measure of last resort, 'follow[s] due process, is non-arbitrary, based on law, necessity, proportionality and individual assessments'.[206] This emphasis on the procedural guarantees and on the necessity of detention is at odds with the limited applicability of the proportionality test of the ECtHR judgement in the case of *Saadi*.[207]

Conclusions

This chapter attempted to clarify, in relation to the topic at hand, the concepts of sovereignty, human rights, and how their interrelations shape human rights treaty provisions, their interpretation, and ultimately the enjoyment of human rights by irregular migrants. In doing so, it showed the Westphalian system of international society, based on the inviolability of state borders and territories, to be a central argument in the establishment of immigration control as an exclusively domestic and sovereign power. However, the doctrine of absolute sovereignty in relation to immigration is not a 'natural' feature of the Westphalian system but is the result of a trend that has grown since the late 19th century and that is still upheld today. Even certain norms of international and European human rights law, naturally aimed at limiting the exercise of exclusive state authority in a territory and over a population, have recognised state control over migration flows as a legitimate state power and a well-established principle of international (human rights) law. The case law of the human rights bodies has navigated between a universally-oriented human rights approach and a respect for sovereign domestic policies, while also demonstrating an awareness that the vulnerability of irregular migrants to human rights abuses is high in the context of immigration control. These clashes have contributed to the development of an asymmetric conceptualisation, interpretation, and implementation of human rights

[206] GCM (n 86).
[207] *Saadi* (n 109).

standards for irregular migrants. The brief reference to the Inter-American jurisprudence demonstrated a different way of grappling with the rights of migrants in international law, whereby sovereign powers to regulate immigration are not the starting point for human rights monitoring and adjudication. The case of the right to health provides a significant example of the structural difficulty of applying human rights regimes universally, regardless of legal immigration status. The legal and structural difficulties that irregular migrants encounter with regard to their right to health are not only a consequence of the harsh impact of sovereign powers in the areas of immigration and health. The non-neutrality of international and European human rights law in relation to socio-economic rights – as fleshed out in the following chapter – is an important factor that constrains the full realisation of the right to health of irregular migrants.

Chapter 2
The Normative Contours of the Right to Health

This chapter, like the previous one, sets the contours for this research. Chapter 1 examined why the structure of international law and the interpretation of the principle of sovereignty in relation to immigration affect the formulation and implementation of human rights for irregular migrants. This chapter outlines the development of the right to health in international and regional human rights law, while being cognizant that health is an area where states have maintained high levels of discretion or state sovereignty. The 'sovereignty-human rights' clash in the context of immigration and the inconsistent protection of the right to health in international and European legal frameworks are the two major barriers to a genuinely universal right to health for everyone, regardless of legal status. This chapter summarises the history of the 'right to health' in different international frameworks, supplementing the analysis with reference to the meta-legal contributions of global public health. Section 1 discusses the emergence of health as a subject of interest in international fora since the 19th century, putting emphasis on public health. The literature in the field of public health helps flesh out and clarify the normative content of the human right to health. Section 2 gives a brief account of health as a social right in the mid-20th century, when socio-economic rights were officially included in the human rights project. Section 3 locates the right to health within philosophical debates on human rights, to understand what the valued interests behind its normative scope are. The extensive Section 4 provides an overview of the elaboration, monitoring and implementation of the right to health in the context of the ICESCR, which is the treaty that provides the fullest international conception of this right. Section 5 grapples with the contribution of other UN bodies to the development of health-related entitlements. Section 6 extends the scope of the research to justiciability of health issues before the European Court of Human Rights (ECHR) and the European Committee of Social Rights (ECSR). European regional standards are dominated by the ECHR, and health

care issues are relevant in this legal framework mostly when systemic deficiencies occur. Finally, Section 7 focusses on non-discrimination and vulnerability, which are essential features of the human rights approach to health, and which push international human rights obligations and, at times, European human rights obligations towards the realisation of meaningful standards of 'substantial equality'. Arguments concerning non-discrimination and vulnerability in the fields of health in relation to irregular migrants are developed further in Chapter 3.

1. The Origins of Health as a Social Interest Prior to WWII

This section sketches the contexts within which health became a multifaceted object of international concern and of human rights law in the decades preceding the UDHR.

The roots of the right to health are deeply connected to the history of 'public health',[1] which is the reason for recalling, in this research, some of the contemporary standards of global public health as sources of applicable rules. Public health is:

> The science and the art of preventing disease, prolonging life, and promoting physical health and efficiency through organized community efforts for the sanitation of the environment, the control of community infections, the education of the individual in principles of personal hygiene, the organization of medical and nursing services for the *early diagnosis and preventive treatment of disease*, and the development of the social machinery which will ensure to every individual in the community a *standard of living adequate for the maintenance of health.*[2]

[1] For example, Brigit Toebes, *The Right to Health as a Human Right in International Law* (Hart Publishing 1999) 7; John Tobin, *The Right to Health in International Law* (OUP 2012) 9.

[2] Charles-Edward Amory Winslow, *The Evolution and Significance of the Modern Public Health Campaign* (Yale University Press 1923), reprinted in (1984) *Journal of Public Health Policy* 1, 3. Emphasis added.

While medicine targets individual health, public health addresses threats to the health of populations and communities.

Transmissible diseases, inadequate drinking water and sanitation, and the lack of access to medical care have been, to varying degrees, public social concerns throughout human history from Ancient Egypt through the Middle Ages to the present day.[3] Yet, prior to the 18th century, responsibility for cases of disease or illness fell mainly to private entities, such as churches or charities as providers of medical care. Furthermore, natural rights theories and declarations focused exclusively on civil rights, and these did not apply to health.[4] However, in response to the unhealthy working and living conditions of the working class in the 19th century, public health and social medicine movements began to advocate for the 'role of the state in securing the health of individuals', without however employing any 'natural rights' terminology.[5] During the industrial revolution(s) in Europe, dire living and working conditions were seen as risk factors for epidemic diseases and social instability, as well as threats to the strategic capacity of modern nation-states. It was generally agreed that a healthy working class would benefit society.[6] This was an essentially 'utilitarian' approach, distant from the 20th-century culture of dignity-based human rights.

These growing health-related concerns for peoples and national communities, together with the willingness to coordinate efforts for the prevention of transmissible disease at international level, led to a series of 'international sanitary conferences', the first of which was held in Paris in 1851. At the 11th International Sanitary Conference, it was agreed that an international health office would be established. This led to the creation of the *Office International d'Hygiène Publique,* subsequently to be replaced by

[3] Jonathan Mann, *Health and Human Rights: A Reader* (Routledge 1999) 11. For further details on the historical perspective of public health, see George Rosen, *A History of Public Health* (first published 1958, John Hopkins University Press 1993).
[4] Ed Bates, 'History', in Moeckli et al. (n 48, Chapter 1) 3–9. Neither the 1776 United States Declaration of Independence nor the 1789 French Declaration on the Rights of Men explicitly mention health as a fundamental right.
[5] Gerald M. Oppenheimer, Ronald Bayer and James Colgrove, 'Health and Human Rights: Old Wine in New Bottles?' (2002) *Journal of Law, Medicine & Ethics* 30(4) 522.
[6] Rosen (n 3) 170.

the Health Organisation of the League of Nations, the predecessor of today's World Health Organization (WHO). The Constitution of the WHO included the first internationally recognised definition of health and the right to health.[7] It is important to highlight that public health and medicine, two complementary but different fields, are both represented within the WHO. Whereas the former focuses on prevention, health promotion and 'communities', the latter traditionally revolves around the provision of health care and treatment to 'individuals'.[8]

In the 19th century, another branch of international law that was rich in health-related components emerged: the *corpus legis* known as international humanitarian law, which today deals, *inter alia*, with medical treatment for persons 'hors de combat' – sick and wounded soldiers at sea or on land, prisoners of war and civilians during armed conflicts.[9]

In the early 20th century, health was also a strategic tool in international relations. As part of the Paris Peace Conference, held in 1919 after the end of WWI, the League of Nations (LON) was established with the aim of achieving global peace and security while preserving national sovereignty.[10] Article 25 of the Covenant of the LON recognised the strategic role of health in achieving and maintaining global peace.[11] Against the same historical backdrop, the growing ideal of social justice and concerns about the conditions of workers throughout the world led to the foundation of the International Labour Organisation (ILO). Since its establishment, this organisation has actively addressed work-related risks to health and has

[7] WHO Constitution (n 25, Introduction). For details, see 2. *infra.*

[8] Johnathan Mann, 'Medicine and Public Health, Ethics and Human Rights' (1997) *Hasting Centre Report* 27 6, 7; Audrey R. Chapman, 'Core Obligations Related to the Right to Health' in Audrey R. Chapman and Sage Russell (eds) *Core Obligations: Building a Framework for Economic, Social and Cultural Rights* (Intersentia 2002) 185, 187.

[9] Since the 1864, some states adopted the Geneva Convention for the Amelioration of the Condition of the Wounded in Armies in the Field. For further details, see Katherine H. A. Footer and Leonard S. Rubenstein, 'A Human Rights Approach to Health Care in Conflict' (2013) *International Review of the Red Cross* 95(889) 167; Gilles Giacca, *Economic, Social and Cultural Rights in Armed Conflicts* (OUP 2014) 164.

[10] Tobin (n 1) 23.

[11] Covenant of the League of Nations (28 April 1919, entry into force 10 January 2020) Article 25: 'The Members […] agree to encourage […] national Red Cross Organisations having as purposes the improvement of health, the prevention of disease, and the mitigation of suffering throughout the World'.

played a prominent role in international standard-setting in the field of occupational safety and health.[12]

An analysis of the pre-1948 factors that resulted in the international recognition of the modern right to health as a social right would be incomplete without considering the important voices and experiences that came from the Americas, which significantly influenced the drafting of the UDHR. The Latin American approach to human rights was greatly influenced by socialist ideologies and Catholic values, which focussed on the material needs of the poor and on a common belonging to the human family.[13] These underlying values contributed to shaping how socio-economic rights were formulated in the UDHR, which include health in its holistic sense as a core component of the right to an adequate standard of living as set out in Article 25.[14]

The history of public health and social medicine over the last two centuries, the shift in its motivations from instrumentalism to humanitarianism, the industrial revolution, emerging social movements, and the contribution of Latin American Catholic values and views on social justice to the UDHR may all be read as important catalysts for the emergence of the right to health as a social human right in the aftermath of WWII. Finally, it is worth remembering that the United States had supported the idea of socio-economic rights as an issue of primary concern before the rise of the Cold War. Former US President F.D. Roosevelt, influenced by the legacy of the 'Great Depression' and the emergence of the modern welfare state,[15]

[12] The Preamble of the Constitution of the International Labour Organisation (ILO) (adopted 1 April 1919 entry into force 28 June 1919) mentions 'the protection of the workers against sickness, disease and injury arising out of his employment' as one of the goals of the organization. For details, see Benjamin O. Alli, *Fundamental Principles of Occupational Health and Safety* (2nd edn, ILO Publishing 2008) 17.

[13] For further details, see Mary Ann Glendon, 'The Forgotten Crucible: The Latin American Influence on the Universal Human Rights Idea' (2003) *Harvard Human Rights Journal* 16 27, 32, 36–37; Paolo G. Carozza, 'From Conquest to Constitutions: Retrieving a Latin American Tradition of the Idea of Human Rights' (2003) *Human Rights Quarterly* 25(2) 281.

[14] For further analysis, see 2 *infra.*

[15] The welfare state is a system whereby the 'state undertakes to protect the health and well-being of its citizens, especially those in financial or social need, by means of grants, pensions, and other benefits', <https://en.oxforddictionaries.com/definition/welfare_state> accessed 1 March 2019. This rests on the idea that the social provision of goods must 'be treated as rights possessed by all people as citizens', see David Kelly, *A Life of One's Own: Individual Rights and the Welfare State* (Cato Institute 1998) 1. Also, 'socio-economic rights represent the

famously included 'freedom from want' and a call to widen the opportunities for medical care in his 1941 'Four Freedoms' speech.[16]

This section has provided a short overview of the cultural and political context in which the language of contemporary human rights practice and health-related issues finally met, giving rise to the international recognition of the human right to health (although with different wordings) in both the 1946 WHO Constitution and the 1948 UDHR. The following sections locate the right to health, as a social right of a universal and indivisible nature, within post-1945 human rights history, which is the frame of reference for this research.

2. The 1940s: Early Proclamations of the Right to Health and the Universalisation of Social Rights as Human Rights

In 1945 the Charter of the UN was adopted with the primary aim of establishing a new international order based on international peace and security. Both 'health' and 'human rights' featured in Article 55 of the Charter, which stipulated that:

> With a view to the creation of conditions of stability and well-being […] among Nations […] the UN shall promote the solution of international […] health […] related problems […] and universal respect for […] human rights.[17]

Furthermore, the drafting of the 1946 WHO Constitution, considered as the Magna Carta of health,[18] reflected the idea that health is an essential factor in the attainment of security, peace, and well-being for individuals and nations. In the WHO Constitution, health is regarded as a 'state of complete physical, mental and social well-being and not merely as the absence of disease or infirmity'. It is seen as a 'value', and, for the first time, as a

legal dimension of the welfare state', see Luca Baccelli, 'Welfare, Diritti Sociali, Conflitti. Ci Salveranno i Barbari?' (2014) *Ragion Pratica* 87.

[16] Franklin Delano Roosevelt, 'The State of the Union Address to Congress' (6 January 1941).

[17] UN Charter (n 29, Chapter 1).

[18] Thomas Parran, 'Charter for World Health' (1946) *Public Health Reports* 61 1265.

'fundamental human right' of every human being.[19] The WHO Constitution had the merit of gathering key elements of debates around the health as a multi-layered interdisciplinary concept with ethical, strategic, political, legal, and medical connotations. The WHO combines the 'negative aspects of public health' – vaccination and other specific means of combating infection – with its 'positive aspects', that is the 'improvement of public health by better food, physical education, medical care, [and] health insurance'.[20] Accordingly, incorporating the concept of social medicine, 'governments have a responsibility for the health of their peoples which can be fulfilled only by the provision of adequate *health and social measures'*.[21]

The recognition of the right to health in international human rights is also reflected in Article 25 of the UDHR, according to which '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, medical care, and necessary social services […]'.[22] Although this wording does not grant to the right to health any conceptual autonomy, its significance lies in the fact that the UDHR appeared to adopt a holistic approach to health – one still valid today – by considering both health care and other social factors of health as constitutive elements of the right to an adequate standard of living. The drafting history of the UDHR provides evidence that an autonomous right to health care – or to medical care - had been under debate in the Commission on Human Rights. The Commission, however preferred to eventually link it to what contemporary human rights would define as 'underlying determinants of health' to highlight the composite nature of 'adequate living standards'.[23] The Universal Declaration contained a set of 'principles' that were meant to

[19] WHO Constitution (n 25, Introduction) Preamble. Emphasis added.
[20] Andrija Stampar, 'Suggestions Relating to the Constitution of an International Health Organization' (1949) *WHO Official Records* 1 (Annex 9), as referred to in Lawrence O. Gostin and Benjamin Mason Meier, 'The Origins of Human Rights in Global Health' in Benjamin Mason Meier and Lawrence O. Gostin (eds) *Human Rights in Global Health: Rights-Based Governance for a Globalizing World* (OUP 2018) 28.
[21] WHO Constitution (n 25, Introduction) Preamble. Emphasis added.
[22] UDHR (n 1, Introduction) Article 25.
[23] Commission on Human Rights – Drafting Committee, Draft Outline of International Bill of Rights (4 June 1947) UN Doc E/CN.4/AC.1/3. See also Gostin and Meier (n 20) 29–31.

be spelled out in greater detail in a subsequent legal instrument of a binding nature, which would also indicate corresponding state obligations.[24]

Another merit of the drafting choices of the UDHR, with regard to the 'indivisibility' of human rights, is the absence of any explicit hierarchy or priority of rights and the delineation, in the same document, of civil, political, economic, social and cultural rights that 'everyone *has*'. Furthermore, the Preamble, in referring to the goal of achieving 'better standards of life in larger freedom', evokes the universal necessity of meeting the material needs of people while defending their autonomy and dignity. This corresponds to guarantees of equality and freedom for everyone, two major underlying principles of human rights (law). Human rights are 'indivisible, interrelated and interdependent'; they constitute a unified system, in which all human rights have the same worth and mutually reinforce each other.[25]

Thanks to the UDHR, socio-economic rights were recognised internationally as 'universal human rights'. Although the Declaration was not legally binding on states, it represented authoritative international recognition of the importance of welfare and health for the 'dignity and free development of human personality'.[26] Until that moment, welfare measures and social rights were exclusively a subject of domestic choice, a way of guaranteeing political stability to market-based Western economies vis-à-vis emerging radical labour movements and socialist states. Domestic welfare benefits played a stabilising function in the shift from absolute monarchy to mass democracy,[27] and the institutionalisation of these rights of a redistributive nature within domestic legal frameworks gave birth to the 'modern welfare

[24] Asbjørn Eide and Wenche Barth Eide, 'Article 25' in Gudmundur Alfredsson and Asbjørn Eide (eds) *The Universal Declaration of Human Rights: A Common Standard of Achievement* (Martinus Nijhoff Publishers 1999) 523.

[25] World Conference on Human Rights, Vienna Declaration and Programme of Action Vienna (12 July 1993) A/CONF.157/23, para 5: 'All human rights are universal, indivisible and interdependent and interrelated. The international community must treat human rights globally in a fair and equal manner, on the same footing, and with the same emphasis. While the significance of national and regional particularities and various historical, cultural and religious backgrounds must be borne in mind, it is the duty of States, regardless of their political, economic and cultural systems, to promote and protect all human rights and fundamental freedoms.'

[26] UDHR (n 1, Introduction) Article 22.

[27] Bard-Anders Andreassen, 'Article 22' in Alfredsson and Eide (n 24) 453.

state'.[28] T.H. Marshall, one of the most authoritative scholars of the mid-20th century on social rights, linked the recognition of social rights to the evolution of national citizenship in the 20th century. Therein, citizenship was meant as 'a status bestowed on those who are full members of a community'.[29] However, social citizenship may be referred to as a crucial aspect of sovereignty: states allocated social benefits to stable members of a national community. This is what makes modern citizenship a 'basic form of spatial closure'.[30]

Unlike the different political ideologies in which social rights in the UDHR were grounded,[31] the Western liberal position embraced by Marshall regarded social rights as necessary to balance the inequality created by the capitalist system and essential for the enjoyment of a 'modicum of economic welfare and security'.[32] Although the European social model was influenced by this definition of social citizenship and by the emerging 'social states' in continental Europe, Marshall's approach reflected a particularly British perspective.[33] Conversely, the broad principles of the UDHR were meant to apply universally:[34] 'everyone' – not only a national/citizen – had *prima facie* the right to demand of her state 'that minimum' social goods and services be provided to meet her basic material needs.

---

[28] Ulrich Preuss, 'The Concept of Rights and the Welfare State' in Gunter Teubner (ed) *Dilemmas of Law in the Welfare State* (Walter de Gruyter 1986) 151.
[29] Thomas Humphrey Marshall, *Citizenship and Social Class* (CUP 1950) 28.
[30] Maurizio Ferrara, 'Towards an "Open" Social Citizenship? The New Boundaries of Welfare in the European Union' in Gráinne de Búrca (ed) *EU Law and the Welfare State. In Search of Solidarity* (OUP 2005) 11.
[31] UN-sponsored economic and social rights drew on three main ideologies: developmentalism, socialism and liberalism, see Ulrike Davy, 'Social Citizenship Going International: Changes in the Reading of UN-Sponsored Economic and Social Rights' (2013) *International Journal of Social Welfare* 22(SUPPL.1) S15, S22–23.
[32] Marshall (n 29) 11.
[33] Colm O'Cinneide, 'Austerity and the Faded Dream of "Social Europe"' in Aoife Nolan (ed) *Economic and Social Rights after the Global Financial Crisis* (CUP 2014) 169, 172. Social states are a sub-category of welfare states where the State assumes constitutional obligations to intervene in the economic and social spheres, in some instances by constitutionalising social rights. This model originated from the German 'Sozialstaat'. See George S. Katrougalos, 'The (Dim) Perspectives of the European Social Citizenship' (2012) *Jean Monnet Working Paper NYU School of Law* 5(7) 9.
[34] The adjective 'universal' has at least a double meaning in this context: It refers both to the 'geographical application' of the Declaration and to the 'personal application', which encompasses 'every human being' who is present in a state, regardless of her nationality *inter alia.*

Unfortunately, with the rise of the Cold War, the ideological clash between the free-market-oriented world and the socialist bloc undermined, for decades, the equal value and the effective enforcement of socio-economic rights vis-à-vis civil and political rights. The disagreement within the UN member states on the nature and form of implementation of 'different' human rights led the UN General Assembly (UNGA) to pass the 'Separation Resolution', which mandated the Commission of Human Rights to discuss and draft two different general treaties on human rights: the ICCPR and the ICESCR.[35] Similarly, in the European and American regional human rights systems, different treaties were being designed to protect, separately, civil and political rights on the one hand and socio-economic rights on the other.[36] Therefore, the principle of the 'indivisibility' of human rights, which means that all human rights have the same worth, was set off course for decades, and the situation has still not been completely reversed today.

Before proceeding to discuss further the elaboration and development of the right to health as it emerged from legally binding human rights instruments, it is worth briefly considering how the 'philosophies' of human rights attach to health a certain key role within the human rights framework, especially when the terminologies of 'human needs' or 'capabilities' are employed.

3. Philosophical Justifications for the Right to Health

This section does not aspire to provide a full and detailed account of all applicable theories of human rights but rather aims to grapple with a few of them to understand what the international right to health actually protects and why mere 'human survival' is not a convincing target of this right.

The orthodox philosophical approach to human rights is that all human beings possess such rights by virtue of their humanity; they are regarded as

[35] UNGA Res 543(VI) 'Preparation of two Draft International Covenants on Human Rights' (5 February 1952). ICCPR, ICESCR (n 13, Introduction).
[36] ECHR, ESC (n 15, Introduction), ACHR (n 87, Chapter 1), Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights, (adopted 17 November 1988, entry into force 16 November 1999) A-52.

inherent in humans. This suggests that they exist independently from, and prior to, any legal recognition. This view is rooted in the school of natural rights, which has developed since the 17th century and which generally recognises the existence of pre-institutional moral rights that can be identified using 'reason'.[37] This 'naturalistic' view made its way into Article 1 UDHR, which states that 'all human beings are born free and equal in dignity and rights'. Early philosophers of this school, such as Thomas Hobbes and John Locke,[38] identified a few civil liberties as natural rights. The value that underpinned most of the theories of the 'age of enlightenment' was human 'freedom', especially freedom from state interference in people's lives, liberty and property.

Hence, the inclusion of socio-economic rights within human rights required a partial reshaping of the fundamental underlying values of the philosophy and practice of human rights. Freedom and the 'negative' role of the state had to be reconfigured.[39] Freedom, rather than being understood as the absence of state interference, can be conceptualised as the removal of constraints on 'human agency'. For example, Amartya Sen identifies poor economic opportunity, systematic social deprivation, and tyranny as such constraints.[40] Individuals cannot achieve their full potential and develop true agency and freedom without adequate social context and social inputs.[41] Also, human dignity, the value underlying human rights law,[42] can be interpreted in a 'socio-relational' fashion. Indeed, recognising the equal worth of everyone requires redress of the disadvantages of the worst off and creation of the best opportunities for the development of 'capabilities' for the benefit of individuals and society as a whole.[43] Martha Nussbaum makes it clear that:

---

[37] Bates (n 4) 3–8.
[38] Thomas Hobbes, *Leviathan* (first published 1651, OUP 2008); John Locke, *Second Treatise of Government* (first published 1690, Hackett Publishing 1980).
[39] Sandra Fredman and Meghan Campbell, 'Introduction' in Fredman and Campbell (eds) *Social and Economic Rights and Constitutional Law* (Edward Elgar 2016) xii–xviii.
[40] Amartya Sen, *Development as Freedom* (OUP 1999) 3.
[41] Jürgen Habermas, *Between Facts and Norms* (MIT Press 1997); Joseph Raz, *The Morality of Freedom* (Clarendon Press 1986) 124.
[42] ICCPR, ICECSR (n 14, Introduction) Preamble(s): '[…] these rights derive from the inherent dignity of the human person'.
[43] Sandra Liebenberg, 'The Value of Human Dignity in Interpreting Socio-Economic Rights' (2005) *South African Journal on Human Rights* 21(1) 1.

> A dignified free being shapes his or her life in cooperation and reciprocity with others […] A life that is really human is one that is shaped throughout by these human powers of practical reason and sociability.[44]

During the second half of the 20th century, both legal positivism – which is concerned with the analytical study of law(s) – and those 'political philosophies' that focus on the 'role' that human rights play in society, resulted in a paradigmatic shift in the justification of human rights.[45] Speculation about their metaphysical justification has become less popular today than questions on what having rights means, what valued features of human lives are protected by human rights, and how a comprehensive theory of rights, capable of justifying the 'practice' of human rights, should be designed.[46]

Whereas an orthodox view considers human rights to be inherent features of human beings, the main contemporary approaches to the justification of human rights tend to frame them in instrumentalist or practice-based terms. Instrumental justifications consider human rights as essential means to realise 'valued features of human lives'.[47] These features or values to which human rights are functional are, depending on the theory, 'agency',[48] 'a good life',[49] 'basic needs',[50] and 'capabilities'.[51] Theories that focus on agency hold that human rights protect the capacity to pursue autonomous choices without interference, thus framing human rights protection in generally negative terms. Theories of 'a good life' and 'basic needs' appear more consistent with the development and final aim of socio-economic rights.

---

[44] Martha Nussbaum, *Women and Human Development – The Capabilities Approach* (CUP 2000) 72.
[45] John Rawls, 'The Law of People' in Stephen Shute and Susan Hurley (eds) *On Human Rights – The Oxford Amnesty Lectures 1993* (Basic Books 1983) 41, 68.
[46] Siegfried Van Duffel, 'Moral Philosophy' in Shelton (n 32, Chapter 1) 32.
[47] Rowan Cruft, S. Matthew Liao and Massimo Renzo, 'The Philosophical Foundations of Human Rights. An Overview' in Cruft, Liao and Renzo (eds) *Philosophical Foundations of Human Rights* (OUP 2015) 11.
[48] James Griffin, *On Human Rights* (OUP 2008) 180.
[49] S. Matthew Liao, 'Human Rights as Fundamental Conditions for a Good Life' in Cruft, Liao, Renzo (n 47).
[50] David Miller, 'Grounding Human Rights' (2012) *Critical Review of International Social and Political Philosophy* 15(4) 407.
[51] Nussbaum (n 4, Introduction) 20–26.

Indeed, they assert that human rights are conditions for pursuing either a good life or a minimally decent life by meeting certain human needs. Other scholars, most notably Sen and Nussbaum, adopt a 'capability approach' to human rights, whereby these rights should protect certain human capabilities that are necessary to choose, to act, and, ultimately, to achieve certain functioning[52] or a flourishing life.[53]

If human rights protect agency from interference, the right to health seems to play a purely functional role. Indeed, James Griffin rejected the idea of the 'right to the highest attainable standard of health' because this attainment would not be a necessary condition to protect the foundational value of human rights, which is human agency or autonomy. According to this author, 'we have a right to life because it is a necessary condition of agency; and a right to health 'care' for our functioning effectively as agents'.[54] He regards human rights as minimalist and urgent moral claims. While this conceptualisation may fit with indirect health protection through civil and political rights, it does not explain the existence of all the rights in the socio-economic rights treaties.

By contrast, Norman Daniels, a scholar of 'human needs', resorts to Rawls' theory of justice as fairness to argue that the right to health provides fair equality of opportunities. Furthermore, the existence of obligations to protect individual opportunity, thus promoting and restoring health – through both health care and measures addressing the social determinants of health – is key to his theory.[55] Jennifer Ruger has criticised Daniels' theories because the Rawlsian approach he adopts is 'resource-oriented' and focusses on 'inputs for health, means and goods' rather than on 'outputs, results and capabilities'. Ruger applies Sen's theory of capabilities to health. She holds that human rights – including the right to health – play a critical role in identifying the nature and scope of obligations for realising the human

[52] ibid.
[53] Sen (n 4, Introduction) 320.
[54] James Griffin, 'Discrepancies Between the Best Philosophical Account of Human Rights and the International Law of Human Rights' (2001) *Proceedings of the Aristotelian Society* 7.
[55] Daniels (n 5, Introduction) 14–15.

capabilities and functions necessary to achieve the Aristotelian concept of a 'flourishing life'.[56] Ruger's theory combines Sen's theoretical approach on the one hand and 'incompletely theorised agreements' on the other. She defines international human rights treaties as instances of incompletely theorised socio-legal-institutional 'practice', which express overlapping consensus and moral commitment to the fact that health is an interest/right worthy of recognition. Although treaties do not achieve any agreement on the 'conceptual' foundation of the right to health or on the specific outcomes of the controversies that may arise, 'human needs' and 'capabilities' theories seem to explain the interests that the right to health targets. Moreover, they do so in a way that overall corresponds to the level of entitlement pursued by socio-economic treaties, a level that is pitched significantly higher than mere basic 'human survival'.

This picture would not be complete without brief mention of the critical voices concerning the right to health. Authoritative philosophers, such as Onora O'Neill, have dismissed the concept of the 'highest attainable standard of health' as utopian and unachievable at a global level: since universal health cannot be provided, the assertion of a human right to health is mistaken and correlative state obligations cannot be held by any agent of international law.[57] Other scholars have also demonstrated unease in dealing with the concept of 'health' as it seems to imply the 'right to be healthy'. Accordingly, they recognise only 'health care' as a legitimate right worthy of legal and ethical justification.[58] As will be explained in the following sections, the practice of human rights has clarified that the right to health is not the right to be healthy, but neither does it mean just health care or medical care because it extends to the underlying determinants of health.

[56] Jennifer Ruger, 'Towards a Theory of a Right to Health: Capability and Incompletely Theorised Agreements' (2006) *Yale Journal of Law & the Humanities* 18 273.
[57] Onora O'Neill, 'The Dark Side of Human Rights' (2005) *International Affairs* 81 427.
[58] Kristen Hessler and Allen Buchanan, 'Specifying the Content of the Human Right to Health Care' in Rosamond Rhodes, Margaret P. Battin and Anita Silvers (eds) *Medicine and Social Justice: Essays on the Distribution of Health Care* (OUP 2002) 84; Norman Daniels, *Just Health Care* (CUP 1985) 6.

4. The Right to the Highest Attainable Standard of Health in the Context of the ICESCR

As this research strives to assess which contributions international and European human rights law can offer to enhance the protection of the right to health of irregular migrants, this section explores how the ICESCR - which provides 'the fullest and most definitive conception of the right to health' in international human rights law -[59] unpacks the scope of this right and the corresponding state obligations. Other important sources of regional and international human rights law will be referred to in the following sections.

As stated above, the post-1948 ideological disagreement on the different nature of socio-economic human rights led states to engage in parallel negotiations on two separate treaties. The ICCPR was designed to generate immediate binding state obligations 'to respect and to ensure'[60] people's civil and political rights. Conversely, Article 2(1) of the ICESCR urges:

> Each State Party to […] take steps, individually and through international assistance and cooperation, […] to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.[61]

This provision is of prime importance for a full understanding of state obligations under the ICESCR and has a dynamic relationship with all the other provisions of the Covenant, including Article 12 on the right to health. Most importantly, Article 2 imposes the general obligation to 'progressively' realise each one of the substantive rights to its full extent over a period (of unspecified duration) by adopting appropriate steps or measures.[62] The

[59] Audrey R. Chapman, 'Conceptualizing the Right to Health: A Violation Approach' (1998) *Tennessee Law Review* 65 389, 398.
[60] ICCPR (n 14, Introduction) Article 2(1).
[61] ICESCR (n 14, Introduction) Article 2(1).
[62] UNCHR, '*Note verbale dated 5 December 1986 from the Permanent Mission of the Netherlands to the United Nations Office at Geneva addressed to the Centre for Human*

rationale underpinning this type of state duty is the conviction that the implementation of socio-economic rights requires 'positive' state measures and the allocation of economic resources and that countries with different degrees of development cannot meet the same goals at the same time.[63] Social rights, at the time of the negotiation of the ICESCR (and still today in many countries), were considered to be more like programmatic directives or policies than legal entitlements for immediate implementation and enforcement.[64] Closely connected to the rule of 'progressive realisation', the obligation to devote the maximum available resources to socio-economic rights, while representing a limit for the immediate realisation of rights, also creates a duty with regard to budget allocation and public expenditures that cannot be unduly deferred.[65]

The margin of discretion granted the state for meeting international obligations is broad. The state maintains discretion on the form of incorporation and on the nature of the concrete measures adopted, although they must causally pursue the progressive realisation to the maximum of available resources.[66] Although general obligations under the ICESCR are of a progressive or gradual nature, Article 2 explicitly establishes at least two different types of 'immediate' obligations of states: to take (immediate) steps towards the full realisation of rights and to do so in a non-discriminatory manner.[67] Early interpretative activities added that, regardless of their level of economic development, states parties must secure 'respect for minimum subsistence rights for all'.[68]

Rights ("Limburg Principles")' (8 January 1987) UN Doc E/CN.4/1987/17, para 21, interpreted this temporal requirement as the state duty to 'move as expeditiously as possible towards the realisation' of the Covenant's rights; CESCR, 'General Comment No. 3: The nature of States parties' obligations (Article 2, para 1, of the Covenant) (14 December 1990) UN Doc E/1991/23.

[63] For further details, see ibid (CESCR, GC3) para 9.

[64] Daniel J. Whelan and Jack Donnelly, 'The West, Economic and Social Rights, and the Global Human Rights Regime: Setting the Record Straight' (2007) *Human Rights Quarterly* 29(4) 908. For further details, see sections 4.2. and 7 *infra.*

[65] CESCR, GC14 (n 27, Introduction) para 31; Limburg Principles (n 62) para 21.

[66] CESCR, 'General Comment No. 9, (the Domestic Application of the Covenant)' (3 December 1998) UN Doc E/C.12/1998/24.

[67] For further details, see sections 4.2. and 7 *infra.*

[68] Limburg Principles (n 62) para 25.

4.1. A textual analysis of Article 12 ICESCR

During the early stages of the drafting of a UN binding instrument on human rights, which was eventually split into two covenants, and when health issues were being debated in the Human Rights Commission, the WHO secretariat assumed leadership. A WHO draft proposal included a definition of health and placed emphasis on social measures for realising the underlying determinants of health.[69] However, with the beginning of the Cold War, the WHO stopped actively engaging with the drafting of international human rights instruments and began to position itself as a 'technical organization', abandoning, for decades, an explicit human rights approach.[70]

The influence of more restrictive US and Russian proposals and the compromise reached in the UN Commission on Human Rights led to an early draft article on the right to health that read as follows:

> The States parties to this Covenant recognize the right of everyone to the enjoyment of the highest standard of health obtainable. With a view to implementing and safeguarding this right, each State party hereto *undertakes to provide legislative* measures to promote and protect health and in particular:
>
> 1. to reduce infant mortality and to provide for healthy development of the child;
>
> 2. to *improve nutrition, housing, sanitation, recreation, economic and working conditions* and other aspects of environmental hygiene;
>
> 3. to control epidemic, endemic and other diseases;
>
> 4. to provide conditions which would assure the right of *all its nationals* to a medical service and medical attention in the event of sickness.[71]

[69] UNCHR, 'Suggestions Submitted by the Director of the World Health Organisation' (18 April 1951) UN Doc E/CN.4/544 2.

[70] Benjamin Mason Meier and Florian Kastler, 'Development of Human Rights through WHO', in Gostin and Meier (n 20) 111, 112–126.

[71] UNCHR, 'Summary Record of the 223rd Meeting' (13 June 1951) UN Doc E/CN.4/SR.223. Emphasis added.

This draft included a first paragraph with more detailed general state obligations of conduct and a paragraph 2(2) providing for a more extensive list of the social or underlying determinants of health than the list that eventually featured in the final text of the ICESCR, while limiting medical services to state nationals or citizens.

Further debates and proposals in the Commission on Human Rights, involving US representatives who eventually dismissed socio-economic rights as 'aspirational', resulted in the exclusion from the final 1957 draft article on the right to health of any reference to a definition of health, the concept of social well-being or an extensive list of the determinants of health.[72]

Article 12 ICESCR, in its adopted formulation, establishes both obligations of result and obligations of conduct in its first and second paragraphs, respectively. In international law, obligations of conduct are state duties that require a certain course of action by the state, while obligations of result require the ratifying state to 'achieve, or prevent, a particular result by means of its own choice'.[73]

The first paragraph of Article 12 stipulates that 'the States Parties to the present Covenant recognise the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'. First, it must be noted that the universal application of the right to health is conveyed by the word 'everyone': the right to health as a human right is therein grounded in the 'dignity' of every 'human person' as a rights holder.[74] Therefore, the personal scope of application is not limited to state nationals, as it was in previous drafts.[75] Second, the choice of the verb 'recognise' appears to give less immediate operative force to the provision than 'having a right to […]'. Unlike the unaccepted draft proposal drawn up by the director of the WHO,

[72] UNGA, 'Draft International Covenants on Human Rights' (28 January 1957) A/C.3/SR.743. The draft article on the right to health therein is the same as that of the 1966 ICESCR. For an overview of the *travaux preparatoires*, see Toebes (n 1) 40–51.
[73] International Law Commission, Yearbook of the International Law Commission (1999 vol. II part 2) A/CN.4/SER.A/1999/Add.l (Part 2) 57–62.
[74] ICESCR (n 14, Introduction) Preamble.
[75] UNCHR (n 69).

which had included the formulation 'every human being *shall* have the right to […]',[76] the adopted terminology grants state parties a certain degree of discretion[77] in selecting the type of measure and the time span for its progressive domestic implementation. Third, the interest that the right to health protects is 'the highest attainable standard of physical and mental health' for everyone. Therefore, the 'full realisation' of this right is represented by creating those conditions, within and outside health systems, that produce for everyone their highest attainable standard of health. States are not bound to guarantee a 'state of complete physical, mental and social well-being'[78] for every individual. In other words, the right to health is not to be understood as the right to be 'healthy',[79] but as the right to be afforded the conditions to achieve the highest attainable level of physical and mental health, which can be different for everyone. Fourth, reference is made to both physical and mental health, which is an extremely important acknowledgement of the twofold dimension of health. [80]

Furthermore, the second paragraph of Article 12 prescribes that:

> The steps to be taken by the States Parties to the present Covenant to achieve the full realisation of this right shall *include* those necessary for:
>
> (a) The provision for the reduction of the stillbirth rate and of infant mortality and for the healthy development of the child;
>
> (b) The improvement of all aspects of environmental and industrial hygiene;
>
> (c) The prevention, treatment and control of epidemic, endemic, occupational and other diseases;
>
> (d) The creation of conditions which would assure *to all* medical service and medical attention in the event of sickness.[81]

[76] UNCHR (n 71) 1.
[77] Manisuli Ssenyonjo, *Economic, Social and Cultural Rights in International Law* (Hart Publishing 2016) 514–515.
[78] WHO Constitution (n 25, Introduction).
[79] CESCR, GC14 (n 27, Introduction) para 7.
[80] See 'Future Research' in the Concluding Chapter.
[81] ICESCR (n 14, Introduction) Article 12. Emphasis added.

This is a non-exhaustive list of broadly shaped 'obligations of conduct' for states, which are deemed necessary to fully realise the right to health. Regarding subparagraph a), the drafting history of the article demonstrates state agreement on the prioritisation of children's health, grounded in the special vulnerability of people during their first years of life.[82] Since poor health during childhood can result in poor health as adults, health measures targeted at children can be read as an important socio-developmental factor of health.[83] Subparagraph (b) above emphasises that the realisation of the right to health is deeply linked to certain environmental standards. This wording, which requires states to improve environmental conditions, explicitly focuses on industrial health and compels states to take measures to avoid the risk of harm in the workplace. This 'step' is also identified by the CESCR as an underlying determinant of health.[84] The normative analysis in the following sub-section identifies other determinants of health that are interpreted as implicitly included in the scope of this norm. Subparagraph (c), regarding measures to avoid the spread of diseases with a focus on prevention and control, requires individualised and collective measures to be taken by medical and public health decision-makers. It is worth noting the close link here between human rights and public health policies for the protection and well-being of people.[85] Finally, subparagraph (d) refers to the establishment of an 'equitable' health care system, with medical services and staff that are accessible to 'all'.

Article 12(2) lists many of the key elements that characterise the contemporary approach to the right to health: a targeting of the vulnerable groups (reflected in the case of children), a focus on the underlying environmental and occupational preconditions of health, the need to combine

[82] Toebes (n 1) 48.
[83] Michael Wadsworth and Suzie Butterworth, 'Early Life', in Michael Marmot and Richard G. Wilkinson, *Social Determinants of Health* (2nd edn, OUP 2006) 31. Further details *infra* at 4.3.2.1.
[84] CESCR, GC14 (n 27, Introduction) paras 4, 11.
[85] Johnathan Mann et al., 'Health and Human Rights' (1994) *Journal of Health and Human Rights* 1 6, 7; Sophia Gruskin et al. (eds) *Perspective on Health and Human Rights* (Routledge 2005) 35, 40.

collective measures with individual treatment, and a health care system with universal personal scope that targets the health needs of the population.

4.2. The normative content of the international right to health and the correlative state obligations

This section describes the genesis and development of a series of analytical frameworks that the human rights community has employed over the last 30 years to clarify and operationalise socio-economic international obligations, including those regarding the right to health. This analytical exercise demonstrates that all of these are vulnerability-focussed and that the CESCR addresses, either directly or indirectly, the meta-legal concepts of the 'determinants of health', 'primary health care', and 'universal health coverage'.

4.2.1. The scope of the right to health

The right to health is not the right to be healthy but the right 'to enjoy a variety of facilities, goods, services and conditions necessary for the realization of the highest attainable standard of health'.[86] The Committee on Economic Social and Cultural Rights (CESCR) elaborated this extended formulation, and as such the scope of the right to health extends 'to timely and appropriate health care' and to the underlying determinants of health.[87]

The scope is the general content of a right, its overall normative content, and includes some elements to be realised progressively and other immediately.[88] The CESCR's elaboration demonstrates awareness that to achieve the highest attainable standard of physical and mental health, individualised medical measures are not enough and that steps, including

[86] CESCR, GC14 (n 27, Introduction) para 9.
[87] ibid, para 11.
[88] Toebes (n 1) 243.

those of collective nature, involving the promotion of socio-economic preconditions for health are necessary.[89]

The right to health entails entitlements and freedoms concerning both health care and the underlying determinants of health. On the one hand, the right to health care includes 'entitlements to preventive, promotional, curative and palliative health' (i.e., the right to prevention, treatment, and control of diseases and to have access to essential medicines and the provision of health-related education and information).[90] On the other hand, the 'underlying determinants of health' refer to 'a wide range of socio-economic factors that promote conditions in which people can lead a healthy life', such as 'food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment'.[91] Public health studies define these as 'social determinants of health', although these concepts are not completely overlapping, as indicated in Chapter 4; they are socio-economic factors that shape health outcomes and that need to be duly considered by inter-sectoral public policies, to reduce and eliminate inequality in health.[92] Not only do these living and working conditions affect, either positively or negatively, the enjoyment of the highest attainable standard of physical and mental health, they are also interests protected by other human rights, including the right to an adequate standard of living (Article 11 ICESCR).

As for freedoms in the health sector, brief mention should be made of those health-related elements of a series of civil and political rights. For instance, the 'right to control one's health and body, including sexual and reproductive freedom, and the right to be free from […] non-consensual medical treatment and experimentation' are specifications of the right to

[89] For a graphic representation of the elements of the scope of this right and their respective source, see Maite San Giorgi, *The Human Right to Equal Access to Health Care* (Intersentia 2012) 15–16.
[90] CESCR, GC14 (n 27, Introduction) paras 16–17; San Giorgi (ibid) 20–25.
[91] CESCR (ibid) para 4.
[92] WHO – Commission on Social Determinants of Health (CSDH), *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health: Final Report of the Commission on Social Determinants of Health* (World Health Organization 2008) l. Further details in Chapter 4.

personal integrity and freedom from torture and inhuman and degrading treatment.[93] These overlaps between rights exemplify the principle of the interrelatedness of human rights, which stipulates that human rights cannot be realised in isolation and the enjoyment of a particular right is dependent upon the enjoyment and realisation of other rights.[94] Finally, this interrelatedness allows the indirect protection of health in those legal systems where the social entitlement to health does not constitute a legally enforceable right.[95] This indirect protection takes place also at international and European level, for example before the Human Rights Committee (CCPR) and the ECtHR.

4.2.2. The 'tripartite typology'

The major conceptual framework for human rights obligations is arguably the 'tripartite typology', which clarifies the nature of state obligations at international level. This framework, originally presented by Shue,[96] developed by Eide,[97] and finally endorsed by the CESCR,[98] classifies state obligations, for the realisation of human rights law in domestic jurisdictions, according to three groups: the obligation to respect, the obligation to protect, and the obligation to fulfil.

The obligation to respect the right to health requires states to refrain from all kinds of acts that negatively interfere, directly or indirectly, with this right. For example, states should refrain from denying or limiting equal access to health care services on a discriminatory basis, marketing unsafe drugs, withholding or misrepresenting health information, or unlawfully polluting

[93] CESCR, GC14 (n 27, Introduction) para 8.
[94] Vienna Declaration and Programme of Action (n 25).
[95] For instance, see the case law of the CCPR and the ECtHR, respectively at Sections 5.1, and 6.1 *infra*.
[96] Shue asserts that for every basic right (of either a civil, political, economic, social or cultural nature) there are three types of correlative obligations: 'to avoid depriving; 'to protect from deprivation'; and 'to aid the deprived'. Henry Shue, *Basic Rights: Subsistence, Affluence, and U.S. Foreign Policy* (first published 1980, Princeton University Press 1996).
[97] Asbjørn Eide, 'Report of the Special Rapporteur on the Right to Adequate Food as a Human Right - The New International Economic Order and the Promotion of Human Rights' (7 July 1987) UN Doc E/CN.4/Sub.2/1987/23.
[98] CESCR, GC14 (n 27, Introduction) paras 33–37.

air, water or soil.[99] The obligation to protect the right to health obliges states to take measures to prevent third parties from engaging in activities that might affect the right to health of individuals and communities. For instance, states should ensure that the privatisation of the health sector does not constitute a threat to the availability, accessibility, acceptability, and quality of health services and conditions, in particular for vulnerable people, that health professionals provide care to persons with disabilities with their free and informed consent, and that private actors do not unlawfully pollute the environment.[100] Finally, the obligation to fulfil binds states to adopt appropriate legislative, administrative, budgetary, judicial, and promotional measures to ensure for each person within their jurisdiction 'opportunities to obtain satisfaction of those needs, recognised in the human rights instruments, which cannot be secured by personal efforts'.[101] *Inter alia*, states must adopt active budget-sensitive measures to:

> Ensure provision of health care, including immunisation programmes against the major infectious diseases, and ensure equal access for all to the underlying determinants of health, such as nutritiously safe food and potable drinking water, basic sanitation, and adequate housing and living conditions.[102]

The tripartite typology, which contributed to a shift away from the categorisation of human rights in 'generations' or as 'negative' or 'positive', has the beneficial effect of unifying the content of substantive human rights, identifying that both freedoms and entitlements and both passive and active measures are common features of all human rights, regardless of their classification as civil and political or economic, social and cultural.

Accordingly, states are required to achieve the above goals by means of all appropriate measures, 'including legislative, administrative, judicial, economic, social and educational' provisions.[103] These measures should be

[99] ibid, para 34; For further examples, see Ssenyonjo (n 77) 532–535.
[100] CESCR, CG14 (n 27, Introduction) para 35; Ssenyonjo (n 77) 535–537.
[101] Eide (n 97) 37.
[102] The obligation to fulfil can be break down into the obligations to 'facilitate', 'promote', and 'provide', see CESCR, GC14 (n 33, Introduction) paras 36 – 37.
[103] Limburg Principles (n 62) para 17.

'deliberate, concrete and targeted'.[104] Upon ratification of the ICESCR, states should commit to recognising and realising the right to health 'through numerous, complementary approaches, such as the formulation of health policies, the implementation of health programmes developed by the WHO, or the adoption of specific legal instruments'.[105] However, with the purpose of underlining the principle of the indivisibility of human rights, the CESCR has increasingly placed more emphasis on its legal enforcement.[106]

4.2.3. The 'AAAQ-AP' framework

Since 1991, the CESCR has complemented the normative analysis of the substantive rights of the ICESCR with the identification of 'certain aspects' that must be considered to fully understand the scope of rights and their correlative state obligations.[107] In relation to the right to health, these aspects or 'elements'[108] or 'guiding principles'[109] led to the development of the 'AAAQ' framework. This interpretative approach urges states to perform services, to provide goods and facilities, and to guarantee health-related conditions to meet the following elements of the right to health: (i) Availability, (ii) Accessibility, (iii) Acceptability, and (iv) Good Quality.

'Availability' (i) requires the distribution of functioning facilities, goods, services, and programmes regarding health care and the underlying determinants of health in sufficient quantity within a state. 'Accessibility' (ii), which has four overlapping sub-dimensions that are critical for this research, means that health-related services, goods, facilities, and conditions must be 1) physically accessible (including for children, adolescents, older persons, persons with disabilities, and other vulnerable groups); 2) affordable; and 3)

[104] CESCR, 'General Comment No. 13 (the right to education – Article 13 of the Covenant)' (8 December 1999) UN Doc E/C.12/1999/10, para 43.
[105] CESCR GC14 (n 27, Introduction) para 1.
[106] ibid, paras 33, 35, 36, 48, 50, 53, and CESCR, 'General Comment No. 15 (the right to water)' (20 January 2003) UN Doc E/C.12/2002/11, paras 23, 26, 42, 45, 46.
[107] CESCR, 'General Comment No. 4 (the right to adequate housing – Article 11 (1) of the Covenant) (13 December 1991) UN Doc E/1992/23, para 8.
[108] CESCR, GC14 (n 27, Introduction) para 12.
[109] Brigit Toebes et al., *Health and Human Rights in Europe* (Intersentia 2012) 94–96.

accessible to all without discrimination. The element of accessibility also implies 4) the right to seek, receive and impart health-related information in an accessible format for all by guaranteeing data confidentiality. 'Acceptability' (iii) determines that facilities, goods, and services should respect medical ethics and be gender-sensitive and culturally appropriate. Finally, 'quality' (iv) signifies that health services must be scientifically and medically appropriate and of good quality, providing, for example, trained health professionals, scientifically approved hospital equipment, unexpired drugs, adequate sanitation, and safe drinking water.[110]

Furthermore, two other 'dimensions' are increasingly referred to as essential pillars of the human rights approach to health: 'Accountability' and 'Participation'. Accountability includes the establishment of processes whereby domestic authorities show, explain, and justify how they have discharged their obligations regarding the right to the highest attainable standard of physical and mental health, such as state-reporting mechanisms and the provision of access to individual remedies of various natures and levels.[111] Participation, which includes a bottom-up approach to norms, means that the general public and vulnerable groups should be consulted, either directly or indirectly, as part of the process of implementing the right to health, which includes the establishment of public policies and decision-making that guarantees fair and transparent processes.[112]

The success of this analytical framework in human rights practice is, for example, apparent in the language of the provision on health in the 2006 Convention on the Rights of Persons with Disabilities (CRPD). Indeed, Article 25 CRPD focuses on non-discrimination on the basis of disability with respect to the enjoyment the right to health. States are required to 'provide

[110] CESCR, GC14 (n 27, Introduction). For an overview of the case law on the 'AAAQ framework', see Ssenyonjo (n 77) 525–523.
[111]Helen Potts, 'Accountability and the Right to the Highest Attainable Standard of Health' (2008) University of Essex Human Rights Centre 13 <http://repository.essex.ac.uk/9717/1/accountability-right-highest-attainable-standard-health.pdf> accessed 1 March 2019.
[112] Helen Potts, 'Participation and the Right to the Highest Attainable Standard of Health' (2008) University of Essex Human Rights Centre 16 <http://repository.essex.ac.uk/9714/> accessed 1 March 2019.

those health services needed by persons with disabilities specifically because of their disabilities',[113] which represents the dimension of 'availability'. Furthermore, health care must be 'affordable', 'geographically accessible' and of good 'quality'.[114]

4.2.4. The 'core framework'

A distinctive feature of international socio-economic obligations, including obligations regarding the right to health, is their 'progressive implementation' as per Article 2 ICESCR. These rights were meant to be realised in 'stages, as resources permitted'.[115] This rule allows a broad margin of discretion with respect to means and time of implementation and, if abused, constitutes a real loophole for states. Hence, since the 1980s, with the intent of clarifying international socio-economic commitments, preventing socio-economic rights from losing their *raison d'être*,[116] and assisting their monitoring and strengthen their justiciability,[117] scholars began to develop the concept of the 'core' content of social rights. This development included Shue's 'basic rights to subsistence',[118] Andreassen's 'practical minimal floor of well-being',[119] and Örücü's 'core and essential rights'.[120]

There are several theories that link 'rights' with the word 'core'.[121] Some refer to 'core rights', which implies a hierarchy of rights as is the case with Shue's 'basic rights' as 'preconditions for other rights'. Others refer to an 'inviolable core content of selected human rights' that cannot be limited vis-à-vis competing principles, rights, and legitimate state interests. This is

[113] CRPD (n 14, Introduction) Article 25 (b).
[114] CRPD (n 14, Introduction) Article 25 (a), (c), (d).
[115] Chapman and Russell (n 8) 4.
[116] CESCR, GC3 (n 62) para 10.
[117] Fons Coomans, 'In Search of the Core Content of the Right to Education', in Chapman and Russell (n 8) 217.
[118] Shue (n 96) 18.
[119] Bård-Anders Andreassen et al, 'Assessing Human Rights Performance in Developing Countries: The Case for a Minimal Threshold Approach to the Economic and Social Rights', in Bård-Anders Andreassen and Asbjørn Eide (eds) *Human Rights in Developing Countries* (Academic Press 1987) 333, 334.
[120] Esin Örücü, 'The Core of Rights and Freedoms: The Limits of Limits', in Tom Campbell et al. (eds) *Human Rights from Rhetoric to Reality* (Blackwell 1986) 47.
[121] Martin Scheinin, 'Core Rights and Obligations', in Shelton (n 32 Chapter 1) 527.

the case with Alexy's theory of rights, which differentiates between 'principles' (or human rights) that allow a process of weighing and balancing on the one hand and 'rules' (or core elements of human rights) that do not allow for such processes on the other.[122] Still more theories were developed to grant prescribed content to socio-economic rights, accord relative priority to certain entitlements, set high standards of justification for states to discharge their obligations and prevent their progressive implementation from delaying or denying the realisation of social rights.[123]

This last group of 'core theories' received embryonic recognition in the 1987 Limburg Principles on the implementation of the ICESCR. Therein, international obligations were interpreted, *inter alia*, as entailing the protection of 'minimum subsistence rights' and the 'provision of essential services'.[124] This approach has received both praise and criticism. On the one hand, it was welcomed as an attempt to concretise entitlements and obligations concerning economic and social rights that represent a 'survival kit' or a 'floor' below which socio-economic conditions and services should not be permitted to fall without bringing about immediate breaches of human rights. On the other hand, it was criticised for lacking explicit grounding in any human rights treaty text,[125] for leaving room for the creation of maximum 'ceilings' of implementation rather than minimum floors,[126] and for generally unclear conceptualisation. For example, scholars and human rights adjudicators have failed to agree on the nature of the 'protected interests' referred to in the core framework. A 'needs-based' core would tend to protect mere 'survival' and 'life', whereas a 'value-based' core would emphasise human dignity, and set higher standards for 'what it means to be human'[127] and to develop human capabilities.

[122] Robert Alexy, *A Theory of Constitutional Rights* (first published 1994, OUP 2002).
[123] Katherine G. Young, 'The Minimum Core of Economic and Social Rights: A Concept in Search of Content' (2008) *The Yale Journal of International Law* 33 113, 116.
[124] Limburg Principles (n 62) paras 25, 35, 47, 55.
[125] Tobin (n 1).
[126] Chapman and Russell (n 8) 9.
[127] Young (n 123) 126–138.

The CESCR's General Comments Nos. 3 and 14 apply the core framework to the right to health. However, these two general comments exemplify two slightly different approaches. On the one hand, General Comment No. 3, on the nature of state obligations in the ICESCR, refers to 'minimum core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each right' including 'essential primary healthcare', although core obligations were susceptible to limitation, provided that the state had discharged its high burden of proof on the mobilisation and use of all available resources.[128] On the other hand, General Comment No. 14 lists a series of non-limitable and immediate core obligations. Although there are scholarly debates concerning the nature of the core obligations and their desirability and usefulness,[129] the approach of the two general comments suggests a general shift from 'core content' to 'core obligations' and to an 'immediate effect' of these obligations before the state 'moves into the territory of progressive realisation'.[130] Although it might be considered a nuance, the 'obligation-based approach' focusses more on timing, priorities, and the structural aspects of health.[131] General Comment No. 14 spells out core obligations by first referring to General Comment No. 3, which prescribes that states must 'ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant', including 'essential primary health care'[132] and then identifies the following set of core obligations:

> a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups;

[128] CESCR, GC3 (n 62) para 10.
[129] For details, see Lisa Forman et al., 'Conceptualizing Minimum Core Obligations under the Right to Health: How Should We Define and Implement the "Morality of the Depths"' (2016) *The International Journal of Human Rights* 20(4) 531, 536.
[130] Chapman and Russel (n 8) 14.
[131] Forman et al. (n 129) 537; Chapman and Russell (n 8) 9.
[132] CESCR, GC14 (n 27, Introduction) para 43. This paragraph of the General Comment also refers to the Declaration of Alma Ata as a main tool of interpretation ('compelling guidance') of the core obligations. For further analysis, see section 4.2.3 *infra*.

> b) To ensure access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
> c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
> d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
> e) To ensure equitable distribution of all health facilities, goods and services;
> f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; […] periodically reviewed, on the basis of a participatory and transparent process; they shall include methods, such as right to health indicators and benchmarks, […] with particular attention to all vulnerable or marginalised groups.[133]

These six core obligations incorporate elements of the other two previously mentioned obligations of immediate realisation, namely, the principle of non-discrimination with regard to the enjoyment of rights (a) and the obligation to take immediate steps towards the realisation of rights (f). Overall, these obligations (in particular a, e, and f) are more procedural than substantive; participation, monitoring, and non-discrimination are central provisions. The other obligations listed do not specify which goods, services, facilities, and conditions should be immediately accessible, apart from essential drugs. Having said this, the focus of these provisions – bearing in mind the CESCR's 'obligations of comparable priority' –[134] appears to be on

[133] ibid, para 43. a) – f).
[134] CESCR, GC14 (n 27, Introduction) 44: 'The Committee also confirms that the following are obligations of comparable priority: (a) To ensure reproductive, maternal (pre-natal as well as post-natal) and child health care; (b) To provide immunization against the major infectious diseases occurring in the community; (c) To take measures to prevent, treat and control epidemic and endemic diseases; (d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them; (e) To provide appropriate training for health personnel, including education on health and human rights'.

vulnerable individuals and groups and on a holistic approach to health that would complement 'equitable' medical care with social measures. Although the core framework does not prescribe detailed health and social services as international obligations, prioritising vulnerable people does however give an indication of the health services that states must prioritise and fund, which are primary and preventive health care services that can benefit a large portion of the population and prevent health conditions becoming chronic and severe.[135]

Unlike international human rights law, minimum services are more clearly identified in the 'essential health packages' that many countries, within the ambit of policy-making, have decided to adopt.[136] These are 'health service interventions that are considered important and that society decides should be provided to everyone'.[137] Although their goals present some synergies with the 'core obligations' of the right to health, their concrete shaping is influenced by a neoliberal philosophy that encourages the framing of public health intervention in 'minimalist' terms so as to guarantee a consistent share to the private health care sector.[138] It is worth mentioning the risk that essential health packages may be confused with the minimum acceptable levels of the universal right to health. In contrast to 'core obligations' and the 'AAAQ framework', essential health packages do not focus on equitable measures to protect vulnerable groups and individuals, either in terms of availability or affordability of health services and care.[139]

4.2.5. International meta-legal health standards

4.2.5.1. The Declaration of Alma-Ata and the concept of 'primary health care'

[135] Chapman (n 8) 212, 214.
[136] Audrey R. Chapman, Lisa Forman and Everaldo Lamprea, 'Evaluating Essential Health Packages from a Human Rights Perspective' (2017) *Journal of Human Rights* 16(2) 141, 142.
[137] Eleuther Tarimo and World Health Organization. Division of Analysis, Research and Assessment, 'Essential Health Service Packages: Uses, Abuse and Future Directions' (1997) *ARA Paper number 15* WHO/ARA/CC.7.
[138] Chapman, Forman and Lamprea (n 136) 143, 151; World Bank, *World Development Report 1993 – Investing in Health* (OUP 1993) 8.
[139] Chapman, Forman and Lamprea (n 136) 153–154.

General Comment No. 14, on the interpretation of health-focussed state obligations in the context of the ICESCR, explicitly states that 'the Alma-Ata Declaration provides *compelling guidance* on the core obligations arising from article 12'.[140]

The Declaration of Alma-Ata was the outcome document of the International Conference on Primary Health Care, held in Almaty, Kazakhstan, under the auspices of the WHO and UNESCO in 1978.[141] This was one of the most important international events in the area of health and development to be held in the last four decades, with representatives from 134 states. Its purpose was to identify a strategy to tackle inequalities in health through inter-sectoral measures.

The Declaration, which recognises health as a fundamental human right, clarifies that the highest attainable standard of health and the goal of 'health for all' may be achieved through health and social measures in accordance with a 'primary health care' (PHC) strategy.[142]

Primary health care is defined as:

> Essential healthcare […] based on […] scientifically sound […] methods […] made universally accessible […] at a cost […] [that is] affordable. […] It is the first level of contact of individuals […] with the national health system.[143]

The Declaration lists a series of 'underlying determinants of health' as socio-economic factors that should be addressed and clarifies that PHC:

> addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services' and 'includes at least […] appropriate treatment of common diseases and injuries; and provision of essential drugs.[144]

The influence of public health on the Declaration is palpable from those paragraphs that identify education, prevention, the participation of

[140] CESCR, GC14 (n 27, Introduction) para 43. Emphasis added.
[141] Declaration of Alma-Ata (n 28, Introduction).
[142] ibid, paras I, V. Emphasis added.
[143] ibid, para VI.
[144] ibid, para VII. See also, WHA Res 62.12 'Primary Health Care, Including Health System Strengthening' (22 May 2009) Doc A/62/8, para 1(3).

communities and people, an interdisciplinary multi-sectoral approach, vulnerability, and equity as core pillars of the Declaration.[145] This socio-economic approach to health was incorporated into the WHO's 'Health for All' strategy during the 1970s, which 'echo[ed] the needs approach of human rights advocates'.[146] After 20 years of neglect, the WHO was reformulating a human rights approach to health.[147]

In international human rights law, Article 24 of the 1989 CRC, unlike Article 12 ICESCR, makes explicit reference to the concept of PHC. Article 24 is a detailed provision that focusses on preventive, curative and rehabilitative measures and, *inter alia*, requires states 'to ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care […]'.[148] This makes explicit the priority allocation of resources to PHC, as explained above, vis-à-vis the development of tertiary health care.[149]

Whereas the provisions on the right to health in the CRC and the ICESCR appear different, their normative content has been substantially reconciled by General Comment No. 14. Indeed, the right to health is therein regarded as both the right to 'curative, preventive and rehabilitative'[150] care and to those conditions and factors referred to as the underlying determinants of health. However, the CESCR's general comment failed to clearly outline

[145] For further details, see Helen Potts, 'Public Health, Primary Health Care, and the Right to Health', in Gunilla Backman (ed) *The Right to Health. Theory and Practice* (Studentlitteratur 2012) 93, 98–104.
[146] Benjamin Mason Meier et al., 'ALMA-ATA at 40: A Milestone in the Evolution of the Right to Health and an Enduring Legacy for Human Rights in Global Health' (Health and Human Rights Journal Blog, 5 September 2018) <https://www.hhrjournal.org/category/blog/> accessed 1 December 2018.
[147] Gostin and Meier (n 20) 35, 115–119.
[148] CRC (n 14, Introduction) Article 24.2(b). CRC Committee, 'General Comment No. 15 on the right of the child to the enjoyment of the highest attainable standard of health (Article 24)' (17 April 2013) UN Doc CRC/C/GC/15, para 73 clearly specifies that health-related core obligation in the case of children include '(b) Ensuring universal coverage of quality primary health services, including prevention, health promotion, care and treatment services, and essential drugs; (c) Providing an adequate response to the underlying determinants of children's health'.
[149] On this point, see Wenche Barth Eide and Asbjørn Eide, *A Commentary on the United Nations Convention on the Rights of the Child, Article 24: The Right to Health* (Brill / Nijhoff 2006) 21.
[150] CESCR GC14 (n 27, Introduction) para 17.

the levels of health care or the services of the health system that require priority or immediate measures.

PHC in the Declaration is a broader concept than just 'primary care' in health systems: the former includes the latter. Whereas primary care consists of the 'treatment of relatively common minor illnesses provided on an outpatient or community care' basis,[151] the PHC approach in the Declaration targets global and jurisdictional health inequalities and encourages states to adopt inter-sectoral preventive, promotional and curative measures targeting both health and social conditions, which includes the prioritisation of 'primary care' in health systems.[152]

Forty years after the Declaration of Alma-Ata, the Astana Declaration on Primary Health Care, adopted in Kazakhstan in October 2018, reaffirmed the commitment of the signatory member states and the WHO to the values and principles of Alma-Ata and to 'the fundamental right of every human being to the enjoyment of the highest attainable standard of health "without distinction of any kind"'.[153] The Declaration of Astana specifies, among other important multi-sectoral measures, one of its main objectives to be the enhancement of 'capacity and infrastructure for primary care – the first contact with health services – prioritising essential public health functions'.[154]

The Astana Declaration, which places renewed emphasis on 'primary care' as a priority of the PHC approach, may bring about new international resolutions towards more service-specific care and universal community care standards, with potential (although only recommendatory) effects at national level. Finally, this Declaration recognises PHC as a cornerstone of the WHO's goal of 'universal health coverage' (UHC) and the UN Sustainable Development Goal 3.8.

---

[151] Fundamental Rights Agency of the European Union (FRA), 'Healthcare Entitlements of Migrants in an Irregular Situation in the EU-28' (FRA website) <http://fra.europa.eu/en/theme/asylum-migration-borders/healthcare-entitlements> accessed 1 March 2019.

[152] Helen Keleher, 'Why Primary Health Care Offers a More Comprehensive Approach for Tackling Health Inequalities than Primary Care' (2001) *Australian Journal of Primary Health* 7(2) 57.

[153] Global Conference on Primary Health Care, Declaration of Astana (25–26 October 2018) WHO/HIS/SDS/2018.61, para I. Emphasis added.

[154] ibid, para V.

4.2.5.2. Political commitments to achieve 'universal health coverage'

The WHO-supported Declaration of Astana, the Committee on the Rights of the Child, and the UN through the 2030 Agenda for Sustainable Development, among other global actors, refer to the achievement of UHC as a priority for the health sector.[155]

Universal health coverage means extending and achieving 'access to quality essential health care services and access to safe, effective, quality and affordable essential medicines and vaccines for all'.[156] The UNGA and the World Health Assembly (WHA), the latter being the decision-making body of the WHO, have, on several occasions, clarified the meaning of UHC as including 'access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative and rehabilitative basic health services […] with a special emphasis on the poor, vulnerable and marginalised segments of the population'.[157] The WHO's UHC initiative aims at ensuring equitable access to quality health services without incurring financial hardship on individuals.[158]

It is worth noting that UHC, as a dimension of the 2030 Agenda, is a political commitment that requires a 'long-term process of progressive realization',[159] whereas the obligations regarding the right to health are legally binding on states and include obligations of both a progressive and an immediate nature. The achievement of UHC is explicitly linked to the realisation of Article 25 UDHR,[160] and the Agenda for Sustainable

[155] ibid, Preamble, para. II; CRC Committee, CG15 (n 148) para 73; UNGA Res 70/1 'Transforming Our World: The 2030 Agenda for Sustainable Development' (25 September 2015) Goal 3.8.
[156] ibid. (UNGA).
[157] UNGA Res 67/81 'Global Health and Foreign Policy' (12 December 2012); WHA Res 69.1. 'Strengthening Essential Public Health Functions in Support of the Achievement of Universal Health Coverage' (27 May 2016); Lisa Forman et al., 'What Do Core Obligations under the Right to Health Bring to Universal Health Coverage? ' (2016) *Health and Human Rights Journal* 18(2) 23.
[158] Mason Meier et al. (n 146).
[159] Audrey R. Chapman, *Global Health, Human Rights, and the Challenge of Neoliberal Policies* (CUP 2016) 284.
[160] WHA Res. 64.9 Agenda Item 31.4. 'Sustainable Health Financing Structures and Universal Coverage' (24 May 2011).

Development is grounded in the UDHR.[161] Universal health coverage has been defined as a 'practical expression of the right to health',[162] however, for UHC to be genuinely compliant with human rights and the right to health, its realisation needs to prioritise 'the worst off, expanding coverage to everyone and reducing out-of-pocket payments, all while ensuring that disadvantaged groups are not left behind'.[163]

The aforementioned resolutions of both the WHA and the UNGA appear to be process-oriented and mainly focus on non-discrimination and the universal application of existing or to-be-established basic services rather than unpacking a specific set of services and care provisions. This process-based approach is substantially harmonised with the obligations on the right to health set out in the CESCR's General Comment No. 14 core obligations, which focus on non-discriminatory access to health services and basic determinants for vulnerable people, including the crucial dimension of affordability. [164]

Regardless of the recommendatory nature of these instruments, the synergy with international standards on the right to health may reinforce a teleological interpretation of this right that selects the least restrictive way to realise the highest attainable standard of health, including 'prioritizing investments in primary and preventive care, which benefits a far larger sector of the population, [and] over expensive specialised health services, often accessible only to a small, privileged fraction of the population'.[165]

As indicated in Chapter 1, an understating of both the potential and the limits of international human rights law would not be complete without assessing its international accountability mechanisms. This is why the sub-sections that follow focus on monitoring mechanisms and their findings with

[161] UNGA (n 155) para 10.
[162] WHO, 'Positioning Health in the Post-2015 Development Agenda' – WHO Discussion Paper (October 2012).
[163] WHO, 'Making Fair Choices on the Path to Universal Health Coverage: Final Report of the WHO Consultative Group on Equity and Universal Health Coverage' (2014) as referred to by Dainius Pūras, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health' (5 August 2016) UN Doc A/71/304, para 81.
[164] Forman et al. (n 157).
[165] Pūras (n 163) para 82.

regard to the realisation of this right at UN level, as well as on individual- and collective-case-based complaints.

4.3. Accountability for the ICESCR and the CESCR

Economic, social, and, cultural rights, including the right to health, have long been neglected in human rights law, being regarded as 'different' from civil and political rights and labelled as highly resource-dependant issues for the government to manage and, as such, non-enforceable or justiciable in courts.[166] This section sketches some general observations on the special conceptualisation of, and accountability with respect to, socio-economic rights that have ultimately affected the protection of these rights, including the right to health, at domestic and international level. This situation has widened the gap between rhetoric and the reality of 'indivisibility' in human rights law, with critical consequences for human rights holders, such as irregular migrants, who are in a position of institutional and social exclusion and material vulnerability.

4.3.1. Priorities in state reporting on the right to health

Evidence of this detrimental approach to social rights, fuelled by the polarisation of ideologies during the Cold War, can be observed, at international level, in the 'original' absence of any treaty body entrusted with the supervision of the ICESCR. Until the late 1980s, monitoring activities were entrusted to the UN Economic and Social Council, a governmental UN entity.[167] When the CESCR was eventually established,[168] it was only competent to assess state reports in dialogue with state representatives. Unlike

[166] For more details about the root causes of this prejudice against socio-economic rights, see Paul O'Connell, *Vindicating Socio-Economic Rights* (Routledge 2012) 8.
[167] ICESCR (n 14, Introduction) Articles 16–22 describe the functions of the ECOSOC in relation to socio-economic rights. On the general mandate of the ECOSOC, see Chapter X of the UN Charter (n 29 Chapter 1).
[168] The Committee on Economic, Social and Cultural Rights (CESCR) was established under the ECOSOC (United Nations Economic and Social Council) Res 1985/17 (28 May 1985).

the other treaty monitoring bodies, it had no competence to receive individual or collective complaints. Only recently, in 2008, when the Optional Protocol (OP-ICESCR) was adopted, was the CESCR made consistent with other UN treaty bodies.[169]

The purpose, scope, and form of state reports on the domestic implementation of the ICESCR were shaped in General Comment No. 1[170] and in the General Guidelines published by the CESCR in 1991 and 2008.[171] This periodic reporting mechanism allows the Committee to regularly monitor the measures that states have adopted to progressively realise, in a non-discriminatory manner, the rights recognised in the Covenant. When considering state reports, the CESCR has the primary function of establishing and developing constructive written and oral dialogue with the state concerned. However, alternative sources of information can also be obtained from NGOs,[172] other international organisations, and UN agencies. Among the weak points of this monitoring procedure are the quality of state cooperation, in terms of timely submissions and the accuracy of the information provided, and the frequent inability of the Committee itself to respond in a timely manner.[173]

This mechanism concludes with non-binding findings and recommendations called 'Concluding Observations' (COs). While the normative force of the process may be limited, its strength lies in the fact that domestic laws and other measures concerning socio-economic rights are periodically assessed in all ratifying states.[174]

---

[169] OP-ICESCR (n 42, Chapter 1).
[170] CESCR, 'General Comment No. 1, Reporting by States parties' (27 July 1981) UN Doc E/1989/22.
[171] The 1991 Guidelines (UN Doc E/C.12/1991/1) have been replaced by the CESCR, 'Guidelines on Treaty-Specific Documents to be Submitted by State Parties under Articles 16 and 17 of the ICESCR' (23 March 2009) UN Doc E/C.12/2008.2.
[172] CESCR, 'NGO Participation in Activities of the Committee on Economic, Social and Cultural Rights' (7 July 2000) UN Doc E/C.12/2000/6.
[173] For details, see Marco Odello and Francesco Seatzu, *The UN Committee on Economic, Social and Cultural Rights: The Law, Process and Practice* (Routledge 2013) 155–185.
[174] Michael O'Flaherty, 'Towards Integration of United Nations Human Rights Treaty Body Recommendations: The Rights-Based Approach Model', in Mashood Baderin and Robert McCorquodale (eds) *Economic, Social, and Cultural Rights in Action* (OUP 2007) 27.

From a procedural point of view, a significant majority of the COs of CESCR complain about the lack of formal incorporation of the rights set out in ICESCR into the domestic legal order,[175] which prevents these rights from being claimable standards before state organs. As explained in Chapter 1, for those countries which model the relationship between international and domestic law according to a dualist tradition, international law must be transposed into the domestic legal order if it is to play a role in law- and policy-making and judicial review. The domestic protection of socio-economic rights is central for the overall protection of human rights because domestic redress mechanisms are designed, in the international human rights framework, as 'first instance bodies'. International accountability, although not a review mechanism for domestic proceedings, is intended to be subsidiary and residual in all human rights instruments.[176]

In relation to the right to health, the 2008 guidelines for state reporting, are inspired by both the text of Article 12 ICESCR and the 'AAAQ framework' in General Comment No. 14. The analysis of the COs that were issued during the last few years evidences the CESCR's concern for the following recurring health-related issues.

A major recurring concern raised in the COs is the inadequate budgetary allocation for health.[177] The requirement for the provision of maximum available resources has always been somewhat vague for monitoring purposes, in terms of both the type of resources to be included in

[175] For example, the great majority of the Concluding Observations of the CESCR from 2015 onwards show 'concerns' about the lack of incorporation of either the treaty or its substantial provisions. See 'Concluding Observations' on the website of the CESCR: <http://www.ohchr.org/EN/HRBodies/CESCR/Pages/CESCRIndex.aspx> accessed 1 October 2018.

[176] On the concept of 'subsidiarity', see Neuman (n 43, Chapter 1).

[177] For example, CESCR, COs on the reports submitted by: Ireland (8 July 2015) UN Doc E/C.12/IRL/CO/3, para 28; Greece (27 October 2015) UN Doc E/C.12/GRC/CO/2, para 35; Italy (28 October 2015) UN Doc E/C.12/ITA/CO/5, para 49; Uganda (7 July 2015) UN Doc E/C.12/UGA/CO/1, para 32; Canada (22 March 2016) UN Doc E/C.12/CAN/CO/6, para 9; Kenya (5 April 2016) UN Doc E/C.12/KEN/CO/2–5, para 51; Lebanon (23 October 2016) UN Doc E/C.12/LBN/CO/2, para 10; Philippines (25 October 2016) UN Doc E/C.12/PHL/CO/5–6, para 15; Cyprus (28 October 2016) UN Doc E/C.12/CYP/CO/6, para 39; Pakistan (20 July 2017) UN Doc E/C.12/PAK/CO/1, para 75; Sri Lanka (4 August 2017) UN Doc E/C.12/LKA/CO/5, para 57.

this assessment and the measurement of their 'maximum' availability.[178] Some European countries were expressly advised to pay attention to the Committee Chairperson's Open Letter of 16 May 2012 on socio-economic rights in the context of the economic and financial crisis.[179] In these countries, budget cuts and austerity measures had disproportionately affected the allocation of (maximum) available resources to public services and the equitable enjoyment of the right to health among other social rights, including through the adoption of 'retrogressive measures'.[180] Alternatives must be carefully considered,[181] and anti-crisis measures, which may include legislative setbacks, must be temporary, non-discriminatory, and respectful of the core content of rights.[182] These limits to retrogression, like the overall conceptualisation of the right to health, are focussed once more on the protection of vulnerable people from discriminatory practices.

Another crucial concern is the accessibility of primary or basic health services, facilities, goods, information, and conditions, mostly in terms of geographical distribution[183] and for certain vulnerable groups, including migrants, ethnic minorities, and people with disabilities.[184] Furthermore,

[178] Abby Kendrick, 'Measuring Compliance: Social Rights and the Maximum Available Resources Dilemma' (2017) *Human Rights Quarterly* 39(3) 657; CESCR, 'An Evaluation of the Obligation to Take Steps to the 'Maximum Available Resources' under an Optional Protocol to the Covenant – Statement' (21 September 2007) UN Doc E/C.12/2007/1.

[179] Chairperson CESCR, 'Letter to States Parties on Economic, Social and Cultural Rights in the Context of the Economic and Financial Crisis' (16 May 2012). See CESCR, COs concerning reporting cycles of: Italy (n 177) para 9; Ireland (n 177) para 11; Greece (n 177) para 8; the United Kingdom of Great Britain and Northern Ireland (the 'UK') (13 July 2016) UN Doc E/C.12/GBR/CO/6, para 19; Cyprus (n 177) para 12.

[180] Magdalena Sepúlveda Carmona, 'Alternatives to Austerity: A Human Rights Framework for Economic Recovery', in Nolan (n 33) 23, 30–40. Sally-Anne Way, Nicholas Lusiani and Ignacio Saiz, 'Economic and Social Rights in the 'Great Recession': Towards a Human Rights-Centred Economic Policy in Times of Crisis' in Eibe Riedel, Gilles Giacca, and Christophe Golay (eds) *Economic, Social, and Cultural Rights in International Law. Contemporary Issues and Challenges* (OUP 2014) 86.

[181] For example, CESCR, GC3 (n 62) para 9; CESCR GC14 (n 33, Introduction) para 32.

[182] Chairman of the CESCR, Letter (n 179).

[183] For example, CESCR, COs on the Reports of: FYROM (14 July 2016) UN Doc E/C.12/MKD/CO/2–4, para 47; Lebanon (n 177) para 57; France (12 July 2016) UN Doc E/C.12/FRA/CO/4, para 46; Honduras (10 July 2016) UN Doc E/C.12/HND/CO/2, para 51; Kenya (n 177) para 51; Italy (n 177) para 46; Morocco (21 October 2015) UN Doc E/C.12/MAR/CO/4, para 45; Sudan (26 October 2015) UN Doc E/C.12/SDN/CO/2, para 21; Paraguay (19 March 2015) UN Doc E/C.12/PRY/CO/4, para 28.

[184] Most of the CESCR's COs refer either directly or indirectly to 'vulnerability and non-discrimination'. For example, this is the case of the reporting procedures of (among others): Australia (11 July 2017) UN Doc E/C.12/AUS/CO/5, para 43; the Netherlands (6 July 2017)

'sexual and reproductive health' is receiving increasing attention. This terminology applies to those situations related to well-being and autonomy in relation to sexuality and reproductive behaviour,[185] including contraception, education on sexual health, discrimination against LGBTQI people, and accessibility of services for preventing or terminating a pregnancy.[186] Finally, the Committee has demonstrated growing sensitivity to the need to adopt appropriate measures to safeguard mental health among the general population and specific vulnerable groups.[187] The above findings confirm the Committee's strong commitment towards vulnerable groups and individuals for whom social rights, including the right to health, are extremely delicate tools with which to strive for dignified standards of living.

To monitor whether domestic legislation and policies comply with international obligations of both an immediate or progressive nature, human rights bodies, including the CESCR, have begun to refer to the importance of human rights 'indicators'. These are specific pieces of information on the state or condition of an object, event, activity, or outcome that can be related to human rights norms and standards and that address and reflect human rights

UN Doc E/C.12/NLD/CO/6, paras 39, 46, 48; Tunisia (14 November 2016) UN Doc E/C.12/TUN/CO/3, para 32; Cyprus (n 177) para 39; Philippines (25 October 2016) UN Doc E/C.12/PHL/CO/5–6, para 15; Poland (25 October 2016) UN Doc E/C.12/POL/CO/6, para 41; FYROM (n 183) para 47; UK (n 179) para 55; Sweden (13 June 2016) UN Doc E/C.12/SWE/CO/6, para 32; France (n 183) para 19; Honduras (n 183) paras 24–26; Kenya (n 177) para 22; Uganda (n 177) para 32; Ireland (n 177) para 14; Chile (6 July 2015) UN Doc E/C.12/CHL/CO/4, para 28.

[185] The CESCR recently issued a General Comment in this area. CESCR, 'General Comment No. 22 on the Right to Sexual and Reproductive Health – Article 12 of the ICESCR (2 May 2016) UN Doc E/C.12/GC/22.

[186] For example, CESCR, COs concerning reporting cycles of: Uruguay (20 July 2017) UN Doc E/C.12/URY/CO/5, para 52; Pakistan (n 177) para 78; Philippines (n 177) para 51; Poland (n 184) para. 46; Costa Rica (20 October 2016) UN Doc E/C.12/CRI/CO/5, para 53; Dominican Republic (20 October 2016) UN Doc E/C.12/DOM/CO/4, para 60; FYROM (n 183) para 49; Burkina Faso (12 July 2016) UN Doc E/C.12/BFA/CO/1, para 47; Honduras (n 183) para 53; Kenya (n 177) para 53; Canada (n. 177) para 51; Italy (n 177) para 49; Morocco (n 183) para 45; Thailand (12 July 2015) UN Doc E/C.12/THA/CO/1–2, para 30; Uganda (n 177) para. 35; Ireland (n 177) para 30; Venezuela (6 June 2015) UN Doc E/C.12/VEN/CO/3, para 28; Chile (n 184) para 29; Paraguay (n 183) para 29.

[187] For example, CESCR, COs concerning reporting cycles of: Sri Lanka (n 177) paras 59–60; Uruguay (n 186) para 53; Australia (n 184) para. 45; Cyprus (n 177) para 39; Poland (n 184) para 51; UK (n 184) para 57; Sweden (n 184) para 43; Greece (n 177) paras 35–36; Uganda (n 177) para 34; Ireland (n 177) para 29.

principles and concerns.[188] In the context of socio-economic rights, indicators are deemed particularly important tools because they provide a methodology for evaluating the progressive realisation of these rights, and they hold the state accountable for the discharge of its responsibilities.[189] With regard to the right to health, the CESCR has encouraged states to create and use indicators and set benchmarks to monitor the appropriateness of the health-related measures they adopt in relation to the various elements of the 'AAAQ-AP' framework.[190] Furthermore, since a human rights-based approach to health requires that special attention be given to disadvantaged and vulnerable groups and individuals, indicators should go beyond the national average. Indicators (information) should be disaggregated on various vulnerability grounds to shed light on potential discrimination.[191]

4.3.2. Justiciability of socio-economic rights and the Optional Protocol to the ICESCR

The term 'justiciability' refers to the 'ability to claim a remedy before an independent and impartial body when a violation of a right has occurred or is likely to occur'.[192] Indeed, the ICESCR was not originally complemented by a treaty body entrusted with receiving case-based communications concerning violations of its provisions. The most common arguments against the judicial adjudication of social rights, among them the right to health, are

[188] These can be both 'quantitative' and 'qualitative', the former being an equivalent of statistics (using numbers, percentages or indices), while the latter covers any information articulated as a narrative or in a 'categorical' form. Indicators can also be categorised as 'structural', 'process', or 'outcome' when they relate commitments, efforts, or results, respectively. For examples of indicators in relation to the right to health, See OHCHR 'Human Rights Indicators, A Guide to Measurement and Implementation' (2012) HR/PUB/12/5 16, 90.

[189] Paul Hunt and Gillian MacNaughton, 'A Human Rights-Based Approach to Health Indicators', in Baderin and McCorquodale (n 174) 303.

[190] CESCR, GC14 (n 27, Introduction) para 57; OHCHR (n 188) 32; Sophia Gruskin and Laura Ferguson, 'Using Indicators to Determine the Contribution of Human Rights to Public Health Efforts' (2009) *Bulletin of the World Health Organization* 87 714.

[191] OHCHR (n 188) 68.

[192] International Commission of Jurists, 'Report on Courts and the Legal Enforcement of Economic, Social and Cultural Rights: Comparative Experiences of Justiciability' (2009) 6 <https://www.icj.org/courts-and-the-legal-enforcement-of-economic-social-and-cultural-rights/> accessed 1 March 2019.

related to the apparent vagueness of their formulation and their programmatic nature and progressive realisation. Regarding the lack of clarity around social rights and obligations, improved specification of existing health standards by way of both general comments and judicial or quasi-judicial decisions in national and international tribunals militate against this criticism.[193] Concerning the 'programmatic' and non-judicial nature of health-related obligations, it is worth recalling that this kind of criticism normally revolves around the principle of the 'separation of powers', according to which only the relevant government branch would be entitled to take technical decisions involving resource allocation on economic and social issues.[194] An example of this approach comes from Ireland, where the right to health is not directly justiciable. This is because social rights are referred to in the Irish Constitution as non-justiciable 'directive principles of social policy', and health-related issues and decisions lie with the government and the legislator.[195] Some legal traditions respond to this criticism by arguing that the primary purpose of the 'separation of powers' is to avoid a concentration of power that may lead to arbitrariness and that the regulation of mutual checks on the exercise of power(s) between state apparatuses are desirable.[196] This is related to a theory of 'checks and balances' between state powers that would allow the judicial review of policies and laws against a set of criteria, namely human rights law, as a means to protect individual rights – particularly those of the least privileged members – from arbitrary majoritarian decisions.[197] Once again, international and regional human rights bodies have developed a discrete collection of case law on the justiciability

[193] For further analysis, Colleen M. Flood and Aeyal Gross, 'Litigating the Right to Health: What Can We Learn from a Comparative Law and Health Care Systems Approach' (2014) *Health and Human Rights Journal* 16(2) 62, 64; Alicia Ely Yamin and Fiona Lander, 'Implementing a Circle of Accountability: A Proposed Framework for Judiciaries and Other Actors in Enforcing Health-Related Rights' (2015) *Journal of Human Rights* 14(3) 312.
[194] San Giorgi (n 89) 80–81.
[195] Adam McAuley, 'The Challenges to Realising the Right to Health in Ireland', in Brigit Toebes et al. (eds) *The Right to Health – A Multi-Country Study of Law, Policy and Practice* (Springer 2014) 375, 377.
[196] Eric Barendt, 'Separation of Powers and Constitutional Governments' (1996) *Public Law* 599, 606.
[197] International Commission of Jurists (n 192) 82; Jeanne M. Woods, 'Justiciable Social Rights as a Critique of the Liberal Paradigm' (2003) *Texas International Law Journal* 38 763, 773.

of 'at least some elements' of the right to health.[198] Besides, the extent and the quality of domestic adjudication on the right to health depends on a series of factors, including the vertical sources that enshrine it, be they constitutional, legislative, or jurisprudential, the 'form' in which the international treaties are 'incorporated' into domestic law,[199] and the type of health care system, be it universalist, corporatist, or private/public'.[200] According to some comparative legal studies, approximately 70% of countries worldwide have enacted constitutions that protect health rights in some form, and around 40% of these constitutions make the right to health justiciable.[201] Judicialisation of health-related rights has taken place in many domestic legal orders, especially in middle-income countries such as South Africa and certain states in the Latin American region.[202] The CESCR, in its General Comment No. 9, emphasises that it is a precise state duty to give effect to the rights contained in the ICESCR, including through appropriate means of redress or remedies – among them third-party independent adjudication – for individuals or groups.[203]

These significant developments have not completely reversed the overall reluctance to qualify socio-economic rights as fully justiciable rights in international law. Ten years after the adoption of the OP-ICESCR, only 24 states have ratified this instrument, and very few have employed the complaint procedure therein.[204] Indeed, its long process of negotiation was

[198] The CESCR, since the drafting of its General Comment No. 3 (n 62) para 5, has always upheld the desirability of having social rights justiciable. See also, CESCR, GC14 (n 33, Introduction) paras 59, 60.
[199] CESCR, GC9 (n 66).
[200] Flood and Gross (n 193).
[201] Courtney Jung, Ran Hirschl and Evan Rosevear, 'Economic and Social Rights in National Constitutions' (2014) *American Journal of Comparative Law* 62 1043. See also, Eleonor D. Kinney and Brian Alexander Clark, 'Provisions for Health and Health Care in the Constitutions of the Countries of the World' (2004) *Cornell International Law Journal* 37(2) 285.
[202] Alicia Ely Yamin and Rebecca Cantor, *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Harvard University Press 2011) 312.
[203] CESCR, GC9 (n 66) paras 1, 2.
[204] Source: OHCHR website <http://indicators.ohchr.org/> accessed 14 March 201.

not easy and reflected a deep-rooted prejudice against socio-economic rights.[205]

With the adoption of this Protocol, individuals (and groups of individuals) can now file communications with the CESCR alleging that a state has violated one of their substantive socio-economic rights. Individual complaint procedures are a remarkable feature of international human rights law.[206] They empower individuals to directly vindicate their socio-economic rights by claiming their material needs or capabilities before an (albeit subsidiary) international body. Considering the generally progressive nature of the ICESCR's obligations, the CESCR's examination of communications is framed as an assessment of the reasonableness or appropriateness of the steps taken by states to realise the substantive treaty provisions.[207] This case-based evaluation assesses whether the respondent state adopted 'all appropriate' measures[208] with the least restrictive impact on the, either immediate or progressive, realisation of rights.[209]

So far, the CESCR has 'adjudicated' just four cases on the merits, none of which focussed on the right to health. In these cases, two of which were on the right to housing and two on social security, the CESCR demonstrated a reliance on the analytical frameworks of its general comments,[210] including the 'core framework'.[211] For example, in the case of *Trujillo*, the CESCR held that the Ecuadorian social security regulation failed to offer adequate social security benefits. In particular, both contributory and non-contributory benefits were found to be discriminatory in their application to women engaged in unpaid domestic work. This case is significant for the purpose of this research because the Committee largely employed the

[205] On the origins, evolution and legal status of the OP-ICESCR, see Odello and Seatzu (n 173) 47–78.
[206] Gerd Oberleitner, *Global Human Rights Institutions: Between Remedy and Ritual* (Polity Press 2007) 97.
[207] OP-ICESCR (n 42, Chapter 1) Article 8(4); ICESCR (n 14, Introduction) Article 2: '[...] by all appropriate means […]'.
[208] *Miguel Ángel López Rodríguez v Spain* Com no 1/2013 (CESCR 2013) para 11.3; *Ben Djazia et al v Spain* Com no 15/2015 (CESCR 2017) paras 15.5, 16.6.
[209] *I.D.G. v Spain* Com no 2/2014 (CESCR 2015) paras 12.1, 14.
[210] ibid, paras 11.3, 12.1, 16, 17(c).
[211] CESCR (*López Rodríguez*) (n 208) para 10.3; *Trujillo Calero v Ecuador* Com no 10/2015 (CESCR 2018) para 14.2–3.

arguments of vulnerability, discrimination, and core obligations to ground a finding of violation of the state's 'immediate' obligations under Article 9 ICESCR.[212] Also, in consideration of the 2007 CESCR's statement on the use of 'maximum available resources', it is likely that future 'adjudication', including adjudication on Article 12 ICESCR, will be settled by measuring the appropriateness of deliberate and concrete steps towards the realisation of rights, their time frame, efforts to optimise resources, considerations of non-discrimination as immediate obligation, and the priority to be accorded to vulnerable people in both progressive and immediate measures of implementation.[213]

Considering the lack of case-based jurisprudence on Article 12 ICESCR, it is useful to broaden our analysis of health-related rights to the findings of other UN bodies and subsequently to those of the major regional human rights systems. The latter have employed different procedural and substantial solutions, mostly in relation to the justiciability of the right to health.

5. Health-Related Rights in Other UN Mechanisms

5.1. The jurisprudence of other UN Treaty bodies

The Human Rights Committee (previously HRC, now referred to as CCPR), the Committee on the Elimination of Discrimination against Women (CEDAW Committee), and the CRPD Committee have employed the standards of the ICCPR, CEDAW, and CRPD, respectively, to adjudicate, both directly and indirectly, on health-related cases.

The jurisprudence of the CCPR has demonstrated to especially elaborate on situations of health deprivation that trigger the applicability of Articles 6 (right to life) and 7 (freedom from cruel, inhuman, or degrading

[212] ibid (*Trujillo*) paras 14, 17, 19.
[213] See CESCR, Statement (n 178) paras 8–11; CESCR, GC14 (n 27, Introduction).

treatment or punishment) ICCPR.[214] For example, in cases concerning the prolonged detention of asylum seekers in Australian off-shore migrant camps and the consequences for the migrants' mental health, the CCPR:

> Considers that the combination of the arbitrary character of the authors' detention, its protracted and/or indefinite duration, the refusal to provide information and procedural rights to the authors and the difficult conditions of detention are cumulatively inflicting serious psychological harm upon them, and constitute treatment contrary to article 7 of the Covenant.[215]

Although medical treatment was available during detention, the Committee found that the actual mental health services provided were not sufficient to mitigate the consequences of indefinite detention.

In the case of *Chiti*, the CCPR found that a prolonged arbitrary detention in inhuman conditions, with denial of adequate food, a clean environment, and health care, which eventually led to the premature death of an ill person were flagrant violations of, *inter alia*, Articles 6 and 7 ICCPR.[216]

The CEDAW Committee also upheld a number of significant health-related decisions. For instance, in the case of *Alyne da Silva Pimentel Teixeira*, concerning a Brazilian national of African descent who had died during childbirth, the CEDAW Committee recalled its General Recommendation No. 24 regarding the duty of states 'to ensure women's right to safe motherhood and emergency obstetric services, and to allocate to these services the maximum extent of available resources'. The Committee continued by stating that the stipulation therein 'that measures to eliminate discrimination against women are considered to be inappropriate in a health care system which lacks services to prevent, detect and treat illnesses specific to women'. The Committee found violations of Articles 2 and 16 CEDAW

[214]These cases are mostly detention-related, for instance, see *Turdukan Zhumbaeva v Kyrgyzstan* Com no 1756/2008 (CCPR 2011); *McCallum v South Africa* Com no 1818/2008 (CCPR 2010); *Tolipkhuzhaev v Uzbekistan* Com no 1280/2004 (CCPR 2009); *Dorothy Kakem Titiahonjo v Cameroon* Com no 1186/2003 (CCPR 2007).
[215] *F.K.A.G. et al. v Australia* Com no 2049/2011 (CCPR 2013) para 9.8; *M.M.M. v Australia* Com no 2136/2012 (CCPR 2013) para 10.7.
[216] *Joyce Nawila Chiti v Zambia* Com no 1303/2004 (CCPR 2012) para 12.2–4.

because the death of the mother and the child resulted from a lack of adequate medical services for pregnant women, which reflected inadequate national health care policies.[217] The Committee finally concluded that Brazilian authorities discriminated against the deceased women based not only on her sex but also on her African descent and socio-economic status.[218] *L.C.* was another dramatic case of discrimination against women that concerned the lack of timely access to therapeutic abortion for a sexually abused and suicidal 13-year-old girl.[219] Her access to the required emergency spinal surgery was significantly delayed because that intervention could have jeopardised her pregnancy. The foetus was eventually miscarried, and the applicant remained paralysed from the neck down as a result of the lack of timely emergency treatment. The Committee highlighted that it was cruel and stereotyping to blame and generate guilt in a girl 'for acts that were totally beyond her control, such as being sexually abused and consequently suffering a mental imbalance that worsened when she learned that she was pregnant'.[220] It further stated that the lack of legislative and administrative measures regulating access to therapeutic abortion in Peru:

> Condemns women to legal insecurity insofar as protection of their rights is completely at the mercy of gender prejudices and stereotypes, […]. The sociocultural pattern based on a stereotypical function of a woman and her reproductive capacity guided the medical decision on which the physical and mental integrity of L.C. depended, subjecting her to discrimination by placing her on an unequal footing with men with respect to the enjoyment of her human rights.[221]

Concerning the CRPD, people with disabilities should enjoy their right to health without discrimination on the grounds of disability (Article 25) and be offered 'habilitation' and rehabilitation services to maximise their

[217] *Alyne da Silva Pimentel Teixeira v Brazil* Com no 17/2008 (CEDAW 2011) paras 7.3, 7.4, 7.6.
[218] ibid, para 7.7.
[219] *L.C. v Peru* Com no 22/2009 (CEDAW 2011).
[220] ibid, para 7.2.
[221] ibid, para 7.12.

independence, abilities, and full participation in all aspects of life (Article 26).[222] In just a few years, the CRPD Committee has issued a series of decisions related to health and disability. For example, in *X. (v. Argentina)*, the Committee held in favour of the applicant who had filed a complaint alleging a case of discrimination regarding health on the grounds of disability because of the unsuitable detention conditions and the insufficient rehabilitative care offered to him as an inmate with a physical disability.[223] Rehabilitative care is at the core of another case heard before the CRPD Committee: in *H.M.,* a refusal to grant planning permission for the construction of a hydrotherapy pool for the rehabilitation of a person with a physical disability, on the grounds of the pool's incompatibility with the city development plan, was considered a violation, *inter alia,* of state obligations under Articles 25 and 26 CRPD on health, habilitation, and rehabilitation. Indeed, it was concluded that the 'author's health condition is critical and access to a hydrotherapy pool at home is essential and an effective […] means to meet her health needs'[224]. The Committee found that the required measures of 'special accommodation' would not impose a 'disproportionate or undue burden' on the state.[225] Finally, it is worth mentioning the case of *X. (v. Tanzania)*, which concerned discrimination and violence against Albino people. The applicant, who had had half an arm hacked off because of his albinism considered his albinism to be a disability because of the different impairments and conditions that this rare, genetically inherited disorder entails.[226] Indeed, in that cultural context, albinos were said to 'have been suffering different forms of persecution and discrimination, many of which are grounded in myths', including the belief that 'body parts of persons with albinism have magic powers, such as providing wealth and prosperity'.[227] The Committee concluded that the state had violated, *inter alia*, Articles 4 (general human rights obligations for people with disabilities), 15 (freedom

[222] CRPD (n 13, Introduction).
[223] *X. v Argentina* Com no 8/2012 (CRPD 2014) paras 8.1–8.10.
[224] *H.M. v Sweden* Com no 3/2011 (CRPD 2012) para 8.5.
[225] ibid.
[226] *X. v United Republic of Tanzania* Com no 22/2014 (CRPD 2017) para 3.1.
[227] ibid, para 2.3.

from inhuman and degrading treatment), and 17 (protecting the integrity of the person) CRPD by failing 'to take all necessary measures to prevent acts of violence similar to those suffered by the author and to efficiently investigate and punish those acts in the author's case'.[228]

This subsection, without claiming completeness, demonstrates that detention and degrading socio-economic situations can trigger the protection of prominent civil rights before the CCPR to address health-related interests. Moreover, special situations of discrimination and vulnerability to ill-health on the grounds of disability and gender are often at issue before group-specific treaty bodies. While this interrelated character of health confers it with special legal value in the UN human rights system, it is worth noting that the human rights system, at least in its case-based jurisprudence, is particularly responsive to severe situations of health or social deprivation that involve people in vulnerable positions.

5.2. UN-Charter-based tools

This overview of international monitoring mechanisms would not be complete without brief mention of the Special Procedures (SPs) of the Human Rights Council (HRC), as some of their reports will also be referred to in the following chapters to demonstrate their support for generous social human rights standards. The SPs are ancillary 'independent' bodies of the HRC,[229] that perform thematic and country-specific assessments and assist in the monitoring of human rights through fact-finding missions (for which they are granted unique access to states), communications to inter-governmental actors, public and press statements, and annual reporting to the HRC and to the UNGA.[230]

---

[228] ibid, paras 8.6, 8.7

[229] See an introduction to the Special Procedures of the HRC at <https://www.ohchr.org/en/hrbodies/sp/pages/welcomepage.aspx> accessed 1 March 2019.

[230] For further analysis see Aoife Nolan, Rosa Freedman and Thérèse Murphy, *The United Nations Special Procedures System* (Nottingham Studies on Human Rights) (Brill 2017); Thérèse Murphy and Amrei Müller, 'The United Nations Special Procedures – Peopling Human Rights, Peopling Global Health' in Benjamin Mason Meier and Lawrence O. Gostin (n 20) 487, 488–493.

Concerning the right to health, the Human Rights Commission appointed the first UN Special Rapporteur (SR) on the Right to Health in 2002, and the mandate has been periodically renewed by the HRC ever since.[231] The mandate of the SR includes monitoring the realisation of the right to health by conducting thematic reports and country visits in all UN member states. The activity is of both a fact-finding and recommendatory nature and is aimed at informing intergovernmental debates in the HRC and the UNGA on health-related issues and human rights.

In 15 years of this mandate, the three SRs have worked closely with the CESCR and the WHO to develop an analytical framework for the right to health in order to clarify its contours and to make it an 'operational' right.[232] It is impossible to recall here the extremely wide-ranging topics to which the rapporteurs have contributed. For example, they have conducted extensive studies on the criminalisation of sexual and reproductive health, health indicators, the determinants of health, drug policy, the role of pharmaceutical companies, the health of adolescents, and mental health.[233] The common feature of these reports and missions is arguably to grant special attention to situations of discrimination and vulnerability and place significant emphasis on preventive, promotional and primary health measures.[234]

It is finally worth noting that the HRC, the intergovernmental body that replaced the former Human Rights Commission, also runs special inter-

[231] UNCHR Res no 2002/31 (April 2002).
[232] Paul Hunt, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health' (17 January 2007) UN Doc A/HRC/4/28; Paul Hunt, 'Configuring the UN Human Rights System in the 'Era of Implementation': Mainland and Archipelago' (2017) *Human Rights Quarterly* 39 489.
[233] For an overview of the work of the mandate holders, see Dainius Pūras, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health' (2 April 2015) UN Doc A/HRC/29/33, paras 13–31.
[234] For example Dainius Pūras, 'Report of the Special Rapporteur on the Right to the Highest Attainable Standard of Physical and Mental Health (main focus: the right to mental health of people on the move' (28 July 2018) UN Doc A/73/216, ibid '(main focus:the right to health in early childhood' (30 July 2015) UN Doc A/70/213 2015; Anand Grover, 'Report of the Special Rapporteur on the Right to the Highest Attainable Standard of Physical and Mental Health (main focus: migrant worker's right to health' (15 May 2013) UN Doc A/HRC/23/41 2013; ibid '(main focus: right to health and criminalization of same-sex conduct and sexual orientation, sex work and HIV transmission)' (27 April 2010) UN Doc A/HRC/14/20 2010.

state peer-review monitoring of the state of human rights in all UN member states. The Universal Periodic Review (UPR) scrutinises all UN member states every five years. Although the UNGA, when establishing the HRC, reaffirmed 'that all human rights are universal, indivisible, interrelated, interdependent, and mutually reinforcing and that all human rights must be treated in a fair and equal manner, on the same footing, and with the same emphasis',[235] socio-economic rights issues have to date been granted less attention in the UPR than civil and political rights.[236]

While socio-economic rights overall receive less attention than civil and political rights during the HRC's UPR, the former Human Rights Commission and the HRC have established important SPs, whose reports often represent very progressive and interdisciplinary takes on the human rights-based approach, as indicated in Chapter 4.

The following section outlines the contributions of the European regional human rights systems to the protection of the right to health. In European regional framework of human rights, the primary role of the ECtHR in adjudicating (civil and political) human rights and the still marginal role played by the ECSR has tended to frame health issues – that are worthy of human rights protection – in overall emergency terms.

6. European Standards on the Right to Health

Against the previously analysed background of international human rights law, this section explores whether 'health' and the 'right to health' fall within the material scope of the standards that of the general human rights treaties of the Council of Europe and, if so, how. Regional systems may be advantageous in principle with regard to the effective implementation of supranational

[235] UNGA Res 60/251 (15 March 2006) A/RES/60/251.

[236] Center for Economic and Social Rights, 'The Universal Periodic Review: A Skewed Agenda? Trends Analysis of the UPR's Coverage of Economic, Social and Cultural Rights' – Report of the CESR – Social Justice Through Human Rights (June 2016) <http://www.cesr.org/universal-periodic-review-skewed-agenda> accessed 1 March 2019. This report evidences that only 17% of the recommendations generated by the UPR concern socio-economic rights issues.

norms because regions are relatively homogeneous, and regional adjudicators are 'likely to achieve greater enforceability of their decisions partly because of the political will […] to do so by the regional system itself'.[237]

Although the European human rights system has been experiencing an increasing justiciability of social interest or social rights over the last 20 years,[238] the primary role that the civil-rights focussed ECHR plays in Europe accounts for a reduced level of protection of (the right to) health in these legal frameworks compared to international human rights law.

The major European (i.e. Council of Europe) treaties to which reference is made in this section are the ECHR and ESC. Although the ECHR is devoted to the protection of civil and political rights, the ECtHR – the most highly regarded human rights adjudicator in Europe – has developed sophisticated and domestically binding case law on the health-related components of various rights. By contrast, the 1961 ESC (and its revised 1996 version) is devoted to the protection of socio-economic rights, including the (collectively) justiciable right to health. It should be noted, however that the decisions of the monitoring body - the ECSR – are not technically binding. This again underscores the different approaches to civil and political rights, on the one hand, and socio-economic rights on the other.

6.1. The ECHR: Systemic deficiencies and regulatory obligations

The ECHR does not contain any clear-cut state obligation to realise the 'right to the highest attainable standard of health' for everyone in law or policies because this is included in the ESC. Regardless of this, the ECtHR has recognised that 'health care is important in a democratic society'.[239] Even

[237] Jeremy Sarkin, 'The Role of Regional Systems in Enforcing State Human Rights Compliance: Evaluating the African Commission on Human and People's Rights and the New African Court of Justice and Human Rights with Comparative Lessons from the Council of Europe and Organization of American States' (2010) *Inter-American and European Human Rights Journal* 1(2) 199, 209–210.
[238] Carole Nivard, *La Justiciabilité des Droits Sociaux. Etude de Droit Conventionnel Européen* (Bruylant 2012) 701.
[239] *Villnow v Belgium* App no 16938/05 (ECHR Decision 2008). Council of Europe/European Court of Human Rights, 'Thematic Report – Health-Related Issues in the Case-Law of the European Court of Human Rights' (2015)

though the ECHR is essentially directed at the protection of civil and political rights, many of these rights 'have implications of a socio-economic nature', and the ECtHR has acknowledged that 'there is no water-tight division' between civil and social rights.[240] Therefore, health issues are scrutinised through the lens of the provisions of the ECHR and thus considered as health-related interests of civil rights, in particular under Articles 2 (the 'right to life'), 3 ('prohibition of torture and inhuman and degrading treatment'), 5 (the 'right to liberty'), and 8 (the 'right to respect for private and family life').

Relevant cases involve, for their compliance with Article 3 ECHR, assessments of the deportation of ill people – examined in detail in the following chapter,[241] the extradition of people with mental disabilities,[242] forcible medical interventions,[243] and the dire living conditions of asylum seekers or migrants either in detention or not.[244] Issues concerning the violation of Article 8 ECHR have arisen in cases of restricted access to medical records, breaches of the confidentiality of personal health-related information,[245] and exposure to environmental hazards.[246] The general principle is that the actual detriment to the applicant's health and well-being needs to reach a certain 'level of severity' to fall within the scope of Article 8 ECHR.[247] Cases of discrimination on the grounds of health (e.g., denial of a residence permit because a person had been found to be HIV positive) were deemed to violate Article 8 in conjunction with Article 14 ECHR (prohibition of discrimination).[248] Furthermore, when people with mental disabilities were denied their liberty, including in unsuitable and unhealthy penitentiary

<https://www.echr.coe.int/Documents/Research_report_health.pdf accessed 1 March 2019> accessed 1 March 2019.

[240] *Airey v Ireland* App no 6289/73 (ECHR 1979) para 26.

[241] *N. v the United Kingdom* (n 111, Chapter 1).

[242] *Aswat v the United Kingdom* App no 17299/12 (ECHR 2013), *Bensaid v the United Kingdom* App no 44599/98 (ECHR 2001).

[243] *Jalloh v Germany* App no 54810/00 (ECHR 2006).

[244] *M.S.S.* (n 120, Chapter 1); *Aden Amhed v Malta* App no 55352/12 (ECHR 2013).

[245] *K.H. and Others v Slovakia* App no 32881/04 (ECHR 2009); *L.L. v France* App no 7508/02 (ECHR 2006).

[246] *Guerra and Others v Italy* App no 14967/89 (ECHR 1998); *Lopez Ostra v Spain* App no 16798/90 (ECHR 1994).

[247] *Fadeyeva v Russia* App no 55723/00 (ECHR 2005) para 69.

[248] *Kiyutin v Russia* App no 2700/10 (ECHR 2011).

facilities, the Court often found violations of both Articles 3 and 5.[249] Finally, when deaths occurred because of flagrant or systemic malfunctioning of the health system, issues arose under Article 2.[250]

To provide a complete picture of the applicable case law would go beyond the scope of this research. However, it is important to note that, where issues of 'access' and 'quality' of health care are concerned, the case law on Articles 2 and 3 ECHR has been particularly restrictive.[251] In this regard, the Strasbourg Court carries out a concrete case-based, rather than abstract, assessment on health care policies and system.[252] A violation of Article 2 ECHR 'may arise' when there is a systemic denial of health care to individuals,[253] including when the 'authorities of a contracting state put an individual's life at risk through the denial of health care that they have undertaken to make available to the population in general'.[254] In the case of *Câmpeanu*, the Court ruled on the case of a young Roma man who was HIV positive and mentally disabled and had been in state care for all his life. He died in a psychiatric hospital because of the inappropriate medical care and treatment he had received. The Grand Chamber found that Romania had violated the applicant's right to life under Article 2 ECHR because, in a context of systemic deficiencies, the authorities had unreasonably put his life in danger, notwithstanding his multi-layered vulnerability and in consideration of the proven inadequate medical care.[255] Similar importance granted to a situation of severe socio-economic deprivation, children's vulnerability, and state awareness of the violation of rights resulted in a finding of violation of Article 2 ECHR in the case *Nencheva and others*. In this case, the lives of fifteen children and young people, who eventually died,

[249] *L.B. v Belgium* App no 22831/2008 (ECHR 2012); *W.D. v Belgium* App no 73548/13 (ECHR 2016).
[250] *Centre of Legal Resources on behalf of Valentin Câmpeanu v Romania* App no 47848/08 (ECHR 2014); *Mehmet Şentürk and Bekir Şentürk v Turkey* App no 13423/09 (ECHR 2013) paras 84 – 97.
[251] For further details, see Chapter 3.
[252] *Hristozov et al. v Bulgaria* App nos 47039/11, 358/12 (ECHR 2012) para 105; *Cyprus v Turkey* App no 25781/94 (ECHR 2001) para 219.
[253] ibid (*Cyprus v Turkey*).
[254] *Şentürk and Şentürk* (n 250) para 88.
[255] *Câmpeanu* (n 250).

had been entrusted to the care of the state that failed to adequately protect them from serious and immediate threats to their lives, including cold and shortages of food, medicines, and basic necessities.[256]

Regarding the level of inadequacy of health care measures necessary to trigger the protective function of the ECHR in individual cases, outside of cases of dire and systemic socio-economic deprivation, the Court consistently require states to establish procedural regulatory policies. These should exist and compel hospitals, whether public or private, to adopt appropriate measures for the protection of their patients' lives. Furthermore, the relatives of deceased patients should have effective access to independent judicial proceedings to determine who is responsible for their next to kin's death.[257] Thus, states have positive duties to 'regulate' and grant effective judicial remedies. However, Article 2 ECHR may be engaged in very exceptional circumstances when a patient's life is knowingly put in danger by the denial of access to life-saving treatment in a dysfunctional health care system.[258] It is worth noting here that the significant case law of the Court concerning limits to the deportation of people with health problems demonstrates that only extremely severe health conditions may trigger the applicability of Article 3 ECHR to prevent their *refoulement*. This is comprehensively assessed in Chapters 3 and 4.

6.2. The ESC: European 'averages' and socio-economic protection

The ESC, the Council of Europe's general treaty on socio-economic rights, contains many health-related provisions, including Articles 3 (right to safe and healthy working conditions), 11 (right to protection of health), and 13 (right to social and medical assistance). In this legal system, the protection of health has a special legal value: 'human dignity is the fundamental value and

[256] *Nencheva and others v Bulgaria* App no 48609/06 (ECHR 2013).
[257] *Calvelli and Ciglio v Italy* App no 32967/96 (ECHR 2002) para 49. Similarly, *Oyal v Turkey* App no 4864/05(ECHR 2010) para 66.
[258] *Yirdem et al v Turkey* App no 72781/12 (ECHR 2018); *Lopes de Sousa Fernandes v Portugal* App no 56080/13 (ECHR 2017).

indeed the core of positive human rights law […] and health care is a prerequisite for the preservation of human dignity'.[259] Part I of the ESC recognises that 'everyone has the right to benefit from any measures enabling him to enjoy the highest standard of health attainable'.[260] The extension of medical assistance to the nationals of other member states of the Charter was one of the major goals of the charter according to its drafting history.[261]

While the ESC is arguably the most detailed socio-economic treaty, it is a peculiar international instrument for at least three reasons: it is not entirely binding on state parties, but states can select a minimum number of articles and comply with the respective duties; its personal scope normally extends to the nationals of the member states; and it provides 'collective accountability' mechanisms. Article 11 is the core health-related clause in the ESC, but it is optional. It imposes obligations of 'curative, promotional and preventive health', focusing on state duties a of collective nature [262]. Article 13 on social and medical assistance is one of the core provisions of the Charter and emphasises more on individual social and health needs than Article 11.

The ECSR has developed an analytical framework for the monitoring of 'state reports' based on disaggregated thematic indicators and has interpreted the collected data by reaching conclusions of 'conformity' of state measures with the Charter where there is a progressive enhancement of standards, also in consideration of the 'European averages'.[263]

---

[259] *FIDH* (n 188, Chapter 1) para 31.
[260] ESC (n 15, Introduction) Part I para 11.
[261] For example, see Committee of Ministers of the Council of Europe (Social Committee) Third Session (8 November 1956) in Collected "Travaux préparatoires" of the European Social Charter, 870-872, which refers to the European Convention on Social and Medical Assistance (11 December 1953) ETS No. 14.
[262] ESC (n 15, Introduction) Article 11: '[…] With a view to ensuring the effective exercise of the right to protection of health, the Contracting Parties undertake, either directly or in co-operation 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'. For further detail, see Giuseppe Palmisano, 'L'Obbligo dello Stato di Tutelare il Diritto alla Salute ai sensi della Carta Sociale Europea', in Laura Pineschi (ed) *La Tutela della Salute nel Diritto Internazionale ed Europeo tra Interessi Globali e Interessi Particolari* (Editoriale Scientifica 2017) 189, 191; Claire Lougarre, 'What Does the Right to Health Mean? An Interpretation of Article 11 of the European Social Charter by the European Committee of Social Rights' (2015) *Netherlands Quarterly of Human Rights* 33(3) 326, 330.
[263] Lougarre (ibid) 344–354. For example, ECSR, Conclusions 2005, *Lithuania.*

The ECSR has also heard and adjudicated (collective) complaints in a series of health-related cases, that were brought before the Committee by a number of authorised international NGOs and trade unions.[264] On the accessibility of 'curative' health care for irregular migrant children, the ECSR has adopted a particularly protective approach since 2004.[265] Within the context of the 'irregular migrant saga', analysed in Chapters 1, 3, and 4, the ECSR has extended the personal scope of the treaty to guarantee the right to health to undocumented people, pursuant to a contextual and teleological interpretation of the international treaty.

Regarding the availability and accessibility of health care services, in two cases against Italy, the ECSR held that:

> Once states introduce statutory provisions allowing abortion in some situations, they are obliged to organise their health service system in such a way as to ensure that the effective exercise of freedom of conscience by health professionals in a professional context does not prevent patients from obtaining access to services to which they are legally entitled under the applicable legislation.[266]

The removal of 'causes of ill-health resulting from environmental threats such as pollution' was the subject matter of the case of *Marangopoulos Foundation.*[267] This case concerned the disposal of highly polluting industrial waste into the river Asopos for over 40 years. On the merits, the ECSR concluded that Greece had failed to fulfil its obligations under Articles 11(1) and 11(3) of the Charter by failing to take appropriate measures to remove, as far as possible, causes of ill-health, to prevent diseases, and to provide

[264] ESC-Revised (n 15, Introduction) Article D; Markus Jaeger, 'The Additional Protocol to the ESC Providing for a System of Collective Complaints' (1997) *Leiden Journal of International Law* 10 (1) 69; Regis Brillat, 'The Supervisory Machinery of the European Social Charter: Recent Developments and their Impact', in Gráinne de Búrca and Bruno de Witte (eds) *Social Rights in Europe* (OUP 2005) 31.
[265] *FIDH* (n 188, Chapter 1).
[266] *IPPF EN v Italy* Com n 87/2010 (ECSR 2013) para 69; *CGIL v Italy* Com no 91/2013 (ECSR 2015) paras 166–167.
[267] *Marangopoulos Foundation for Human Rights v Greece* Com no 30/2005 (ECSR 2006) paras 195, 202.

advisory and educational facilities for the promotion of health, as required by Article 11(2).

Assessing whether the right to protection of health can be effectively exercised, the ECSR, as also indicated in the following section, pays particular attention to the situation of disadvantaged and vulnerable groups, as required by the joint interpretation of the non-discrimination clause in the Charter with its substantive rights. The ECSR:

> Assesses the conditions under which the *whole* population has access to health care, taking into account also the Council of Europe Parliamentary Assembly Recommendation 1626 (2003) on 'reform of health care systems in Europe: reconciling equity, quality and efficiency'.[268]

On the basis of these premises, the ECSR, for example, held that France had violated Article 11 ESC by not adopting sufficient targeted preventive and promotional health care measures, including screening, where migrant Roma children and pregnant women were concerned:

> The particular situation of Roma requires the Government to take specific measures in order to address their particular problems. Treating the migrant Roma in the same manner as the rest of the population when they are in a different situation constitutes discrimination.[269]

Even if the decisions of the ECS, in these and other cases, have established very protective standards, their effects at domestic level – as indicated in Chapter 5 - risk being overshadowed by the binding judgements of the ECtHR. In spite of their substantial differences, both the decisions of the ESCR and the judgements of the ECtHR, as indicated in this and the following section, capture a distinctive feature of human rights: the protection of vulnerable people from discrimination. As will be discussed in the following chapters 3 and 4, this feature can prove useful in enhancing the

[268] *Médecins du Monde – International v France* Com no 67/2011 (ECSR 2012) para 163. Emphasis added.
[269] ibid.

prevention, promotion, and treatment of irregular migrants' health in human rights law.

7. The Principle of Non-Discrimination, Vulnerable Groups, and the Right to Health

7.1. Equality, non-discrimination, and marginalisation

Non-discrimination and equality are basic general principles of human rights, as discussed in Chapter 1. They appear in the Preambles and the substantive provisions of all human rights instruments.[270] Equality is a relatively modern construct in the area of law and is commonly associated with the Aristotelian maxim 'likes should be treated alike'.[271] This apparently intuitive sentence harbours several controversial debates. Mention has already been made of the comparability problem, which is particularly acute in the context of irregular migration. Furthermore, the equality maxim does not specify the (equal) level of dignified treatment that should be enjoyed.[272] Finally, the prohibition on discrimination does not mean that every differential treatment on a suspect ground is prohibited.

A differentiation that has a legal basis, aims at protecting legitimate public interests, and that is proportional is deemed not to constitute discrimination and is thus permissible.[273] These justifications lie at the core of many differentiations that involve irregular migrants.

The prohibition of discrimination has been traditionally understood as the negative restatement of the principle of equality because when prohibited grounds and characteristics are removed from decision-making processes,

[270] Jarlath Clifford, 'Equality', in Shelton (n 32 Chapter 1) 420, 430 describes the impact and the role of equality in human rights law as a 'preambular objective' and as performing a 'descriptive' and a 'substantive' function.
[271] Ross-Aristotele (n 94, Chapter 1).
[272] On these debates, see Sandra Fredman, *Discrimination Law* (2nd edn, OUP 2011) 8 – 14; Clifford (n 32, Chapter 1) 424.
[273] For instance, CESCR, GC20 (n 93, Chapter 1) para 13. See also Section 2.2, Chapter and Section 3.1, Chapter 3.

everyone is *prima facie* treated equally.[274] Formal equality ('equality before the law' or 'equality of treatment') is nevertheless particularly controversial because offering the very same treatment to people in different socio-economic or personal situations may give rise to substantive inequality with regard to the ability to enjoy human rights. Martha Nussbaum has lucidly written that 'what people can achieve is influenced by economic opportunities, political liberties, social powers and enabling conditions of good health, basic education and the encouragement and cultivation of initiatives'.[275] The removal of barriers to full equality requires an acknowledgement of human diversity, difference in starting positions, and the targeting of social and personal disadvantage. Accordingly, legal theory has developed the concept of 'substantive equality', to which the theories of 'equality of opportunities' and 'equality of results' belong.[276] This means that states, through law and policy, should abandon the neutrality of the formal equality approach and treat people differently according to their capacity to enjoy human rights. Acknowledging power asymmetries entails the adoption of the necessary measures, including those of a positive nature, to either equalise people's starting points or capabilities or to directly achieve equality of outcomes, even if this implies more favourable treatment for certain disadvantaged individuals and groups.[277]

Discrimination is normally linked to the marginalisation of specific individuals or groups and is generally at the root of fundamental structural inequalities in society. An essential feature of the human rights-based approach is the commitment to protecting the rights of vulnerable and disadvantaged individuals and groups.[278] After all, human rights law is

[274] Klaartje Wentholt, 'Formal and Substantive Equal Treatment: The Limitations and Potential of the Legal Concept of Equality', in Peter R. Rodrigues and Titia Loenen (eds) *Non- Discrimination Law: Comparative Perspectives* (Kluwer / Brill 1999) 54.
[275] Nussbaum (n 44) 90–91.
[276] Fredman (n 272) 14–19.
[277] Mark Bell, 'The Right to Equality and Non-Discrimination' in Tamara Hervey and Jeff Kenner (eds) *Economic and Social Rights Under the EU Charter of Fundamental Rights – A Legal Perspective* (Hart Publishing 2003) 95; Hilary Charlesworth, 'Concepts of Equality in International Law', in Grant Huscroft and Paul Rishworth (eds) *Litigating Rights: Perspectives from Domestic and International Law* (Hart Publishing 2002) 137.
[278] Audrey R. Chapman and Benjamin Carbonetti, 'Human Rights Protections for Vulnerable and Disadvantaged Groups: The Contributions of the UN Committee on Economic, Social

founded on the fundamental principle of the inherent dignity and equal worth of every human being and sets out minimum conditions for a dignified life for all: not only should the worst off not be left behind but they should be prioritised in the realisation of rights.[279] Therefore, the vulnerability approach to human rights law may require the adoption of measures against formal and substantial discrimination, although the concept may inherently hide 'inclusionary' and 'exclusionary' effects.

7.2. What is vulnerability in human rights?

The root of the word 'vulnerability' comes from the Latin 'vulnerare' which means 'to hurt' or 'to wound'. Accordingly, to be vulnerable is to be 'exposed to the possibility of being attacked or harmed, either physically or emotionally' and to be 'in need of special care, support […]'.[280]

The concept of vulnerability as it is employed in the social sciences and in legal scholarship is as popular and attractive as it is complex and confusing.[281] This concept, although it has not been clearly conceptualised,[282] has, along with the concepts of 'marginalisation' and 'disadvantage', been widely used by international and regional human rights bodies [283] and is a mantra for the CESCR.

Human rights and vulnerability are conceptually linked. Indeed, the UDHR states that 'disregard and contempt for human rights have resulted in barbarous acts which have outraged the conscience of mankind'.[284] This

---

and Cultural Rights' (2011) *Human Rights Quarterly* 33 682, 683; Paul Hunt, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (Main focus: A human rights-based approach to health indicators)' (3 March 2006) UN Doc E/CN.4/2006/48, 25.

[279] ibid (Chapman and Carbonetti) 726.

[280] Oxford Dictionaries, 'vulnerable', <https://en.oxforddictionaries.com/definition/vulnerable> accessed 1 March 2019.

[281] Kate Brown, Kathryn Ecclestone and Nick Emmel, 'The Many Faces of Vulnerability' (2017) *Social Policy and Society* 16(3) 497.

[282] Chapman and Carbonetti (n 278) 725.

[283] Reference to the jurisprudence of both international and regional human rights' committees and courts can be found in Ingrid Nifosi-Sutton, *The Protection of Vulnerable Groups under International Human Rights Law* (Routledge 2017).

[284] UDHR (n 1, Introduction) Preamble.

appears to be an implicit acknowledgement that human vulnerability is threatened by the arbitrary exercise of state powers. Furthermore, vulnerability has entered the arena of human rights law because vulnerable individuals can find it more difficult to exercise their human rights and are more likely to become or remain victims of formal or substantive discrimination. Human rights belong to everyone, and (positive) state duties to rebalance opportunities by removing obstacles to their exercise so as to tackle situations of individual vulnerability are a distinctive feature of contemporary human rights law.

The scholarship is divided on the conceptualisation of 'vulnerability'. On the one hand, vulnerability is described as a universal constant, an inherent trait of the human condition,[285] which represents the 'raison d'être' of human rights.[286] On the other hand, the dominant doctrine makes use of this concept in relation to specific groups and individuals who, due to their group membership or individual characteristics, find themselves in a marginalised or disadvantaged position.[287] Furthermore, these individual or group features can expose people's 'inherent vulnerability', arising from corporeality or dependence on others, or their 'situational vulnerability', which is context-specific. The latter underlines the fact that individual or group situations of vulnerability may be caused or exacerbated by exogenous factors, such as their socio-political context.[288]

In relation to the source of potential harm, 'vulnerability' means to be at risk[289] of suffering harm of a physical, moral, psychological, economic, or

[285] Martha Albertson Fineman, 'The Vulnerable Subject: Anchoring Equality in the Human Condition' (2008) *Yale Journal of Law and Feminism* 20(1) 1; and Bryan Turner, *Vulnerability and Human Rights* (The Pennsylvania State University Press 2006) 2, 89.
[286] ibid (Turner) 1.
[287] Francesca Ippolito and Sara Iglesias Sánchez (eds) *Protecting Vulnerable Groups – The European Human Rights Framework* (Bloomsbury-Hart 2015) 1–5.
[288] Catriona Mackenzie, Wendy Rogers and Susan Dodds, 'Introduction: What is Vulnerability and Why Does It Matters for Moral Theory?', in Catriona Mackenzie, Wendy Rogers and Susan Dodds (eds) *Vulnerability. New Essays in Ethics and Feminist Philosophy* (OUP 2014) 1.
[289] For reflections on a vulnerability-related 'risk of suffering' vs. 'actual suffering', see Robert Chambers, 'Vulnerability, Coping and Policy' (2006) *Institute of Development Studies Bulletin* 37(4) 33.

institutional nature.[290] A brief digression to some already-mentioned cases of the ECtHR may help to clarify the different sources of vulnerability. For instance, in *Rahimi,* a case that concerned the placement of an irregular migrant child in an immigration detention camp, the Strasbourg Court, in finding a violation of Article 5 ECHR on the right to liberty, took into consideration the physical and psychological risk of harm for an extremely vulnerable unaccompanied minor. Moreover, the applicant's socio-economic vulnerability, due to the 'abominable' material conditions of the refugee camp, contributed to the Court's finding of a violation of Article 3 ECHR.[291] *M.S.S.* is another notorious example of a case in which the risk of harm to the physical, mental, and socio-economic well-being of particularly vulnerable people was considered central in the arguments of the Court. In this case, which concerned the return of an Afghan asylum seeker to Greece from Belgium, both the economic and institutional natures of the above risk were highlighted.[292]

7.3. Non-discrimination and vulnerability for the CESCR, the ECtHR and the ECSR

Article 2(2) ICESCR stipulates that states:

> Undertake to guarantee that the rights enunciated in the […] Covenant will be exercised without discrimination of any kind as to race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.[293]

Against a backdrop of general obligations regarding progressive realisation, the unambiguous textual interpretation of this provision qualifies

[290] Lourdes Peroni and Alexandra Timmer, 'Vulnerable Groups: The Promise of an Emerging Concept in European Human Rights Convention Law' (2013) *International Journal of Constitutional Law* 11(4) 1056, 1058.
[291] *Rahimi* (n 130, Chapter 1) paras 62, 85–86, 95–96, 108–110. Angeleri (n 182, Chapter 1) 171.
[292] *M.S.S.* (n 120, Chapter 1) para 263. Angeleri (ibid).
[293] Analogous provisions are contained at Article 2 UDHR (n 1, Introduction); Article 2(1) ICCPR; Article 1(1) ICERD; Article 1 CEDAW (n 14, Introduction); Article 14 ECHR (n 15, Introduction). An authoritative interpretation of Article 2(2) ICESCR is given by the CESCR, GC20 (n 93, Chapter 1).

the protection from discrimination when enjoying rights as an obligation of immediate application. Accordingly, to avoid both formal and substantial discrimination, formal barriers restricting socio-economic rights must be lifted, and special measures must be adopted 'to bring disadvantaged or marginalised persons or groups of persons to the same substantive level as others'.[294]

'Discrimination' and 'vulnerability' are deeply interlinked concepts: social or legal discrimination generates situations of personal vulnerability, and the identification of vulnerabilities often exposes inadequacies in state, or state-backed, practice. Despite the fact that vulnerable individuals and groups are central in shaping the normative content of social rights and the priorities of state obligations, there is no agreement on the criteria for identifying vulnerable and disadvantaged populations, no accepted definition of vulnerability, and no standard list of such groups.[295]

Although the CESCR largely use the terminology of vulnerability to identify 'priorities' in human rights monitoring and in state implementation, it does not provide a definition or conceptualisation of vulnerability, which is sometimes linked to some either fixed or variable status or to the personal impact of human rights violations.[296] It also fails to systematically identify who vulnerable human rights holders are, although it has drafted a list of 'non-exhaustive examples' of statuses relevant for protection against discrimination, thus indirectly identifying possible vulnerable individuals and groups.[297] A provisional list, as the practice of the CESCR indicates, should include at least women, children, refugees and migrants, internally displaced people, stateless people, ethnic minorities, people with disabilities, elderly persons, people with marginalising health statuses, such as HIV positive persons, and LGBTQI people.

[294] CESCR, 'General Comment No. 16, the equal right of men and women to the enjoyment of all economic, social and cultural rights' (Article 3 of the ICESCR)' (11 August 2005) UN Doc E/C.12/2005/4/Corr.1, para 15.
[295] Chapman and Carbonetti (n 278) 683, 724.
[296] ibid, 721.
[297] CESCR, GC20 (n 93, Chapter 1) paras 15–35; ibid, 723–724.

Since the year 2000, the ECtHR has also increasingly made use of this concept by referring to the 'special vulnerability' of certain groups, among other human rights victims: first, Roma people and, subsequently, people with disabilities, HIV positive people, and asylum seekers.[298] The ECtHR's acknowledgement of this relational, particular, and harm-based vulnerability has affected the decision-making of this body in cases where these people are the alleged victims of human rights violations. This has included the elaboration of positive obligations, such as an exceptional obligation 'to secure shelter to particularly vulnerable individuals' under Article 8 ECHR.[299] Other consequences of the case law on 'special vulnerability' are beneficial effects for the applicant when the ECtHR assesses the level of severity that must be attained to trigger the violation of an absolute right, and during the proportionality test of a limitable right, by limiting the state margin of appreciation.[300] In the European context, the concept of vulnerability has allowed the Court to 'address several aspects of substantive equality' for certain 'identified' disadvantaged groups who, according to the ECtHR, are likely to be exposed to harm and to experience, *inter alia,* material deprivation and social exclusion more than other people. Although this approach is a feature of several judgements of the Court, it has not reached the status of consistent practice with foreseeable outcomes.[301]

The ECSR has made use of this concept in relation to Romani people, people with disabilities, pensioners, (unaccompanied) migrant children, and in general people who fall below the threshold of poverty, when state law and practice fail to fully realise the rights of the ESC.[302] In the complaint

[298] *Chapman v the United Kingdom* App no 27238/95 (ECHR 2001) para 96: 'the vulnerable position of Gypsies as a minority means that some special consideration should be given to their needs and their different lifestyle both in the relevant regulatory planning framework and in reaching decisions in particular cases'. Similarly, for example, *D.H. and others v the Czech Republic* App no 57325/00 (ECHR 2007) para 182; *Alajos Kiss v Hungary* App no 38832/06 (ECHR 2010) para 42; *M.S.S.* (n 120, Chapter 1) para 251; *Kiyutin v Russia* App no 2700/10 (ECHR 2011) para 63.
[299] *Yordanova v Bulgaria* App no 25446/06 (ECHR 2012) para 130.
[300] ibid 129-133; *M.S.S.* (n 120, Chapter 1) paras 232, 233, 251, 259, 262; *Kiyutin* (n 298) para 63. For further analysis, see Peroni and Timmer (n 290) 1074–82.
[301] ibid 1084.
[302] For example, *European Roma Rights Centre (ERRC) v Bulgaria* Com no 46/2007 (ECSR 2008) para 38; *European Roma and Travellers Forum (ERTF) v Czech Republic* Com no 104/2014 (ECSR 2016) para 119; *DCI v Belgium* (n 190, Chapter 1) para 141; *International*

procedure before the ECSR, the concept of 'vulnerability' has been employed to emphasise the inappropriate measures of the responding state in dealing with certain people's 'particular' situation of socio-economic deprivation that should have deserved special attention and positive measures. Indeed, states are required to 'pay particular attention to the impact of their choices on the most vulnerable groups and on the other persons concerned'.[303] Interestingly, the Committee complements his 'vulnerable groups' approach with 'human vulnerability'-targeted measures when, for example, in relation to irregular migrant adults it was stated that 'the right to emergency shelter and to other emergency social assistance is not limited to those belonging to vulnerable groups, but extends to all individuals in a precarious situation pursuant to their human dignity'.[304]

7.4. Non-discrimination and health

In the context of health, the concepts of discrimination and vulnerability generate a couple of interlinked relations. First, 'health status' is one of the prohibited grounds of discrimination in the enjoyment of human rights, including the right to health.[305] Discrimination on the grounds of health was repeatedly held by the ECtHR when Russia, on a series of occasions, refused to issue residence permits on the grounds that the foreign national applicants in question were HIV positive.[306] Second, discrimination (and stigma)

Association Autism-Europe v France, Com no13/2002 (ECSR 2003) para 53; *Federation of employed pensioners of Greece (IKA-ETAM) v Greece* Com no 76/2012 /ECSR 2012) paras 73, 81.

[303] *DCI v Belgium* (n 190, Chapter 1) para 72.

[304] *FEANTSA* (n 193, Chapter 1) para 184-185.

[305] CESCR, GC20 (n 93, Chapter 1) para 33: 'Discrimination on the ground of health status takes place '[…] for example, when HIV status is used as the basis for differential treatment with regard to access to education, employment, health care, travel, social security, housing and asylum. States party should also adopt measures to address widespread stigmatisation of persons on the basis of their health status, such as mental illness, diseases such as leprosy and women who have suffered obstetric fistula, which often undermines the ability of individuals to enjoy fully their Covenant rights. Denial of access to health insurance on the basis of health status will amount to discrimination if no reasonable or objective criteria can justify such differentiation'.

[306] *Kiyutin* (n 298); *Novruc and others v Russia* App nos 31039/11, 48511/11, 76810/12, 14618/13 and 13817/14 (ECHR 2016).

threatens the enjoyment of the right to health for specific vulnerable individuals or groups.[307] An ECSR case regarding the limited and discriminatory access to health care by Romani People in Bulgaria plainly exemplifies this relationship:

> 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. This interpretation imposes itself because of the non-discrimination requirement [in the ESC] in conjunction with the substantive rights of the Charter (Conclusions 2005, Statement of Interpretation on Article 11).[308]

All the operational frameworks for human rights obligations mentioned earlier in this chapter appear to be 'vulnerability sensitive', which means that negative and positive non-discriminatory measures regarding vulnerable people are central for discharging state obligations of all types. Indeed, the 'violations-based approach' to identifying the content of rights / obligations,[309] the core obligations, the 'tripartite typology', and the 'AAAQ-AP' framework all highlight the degree of priority that should be given to the needs of particular groups or individuals when the state implements its obligations to respect, protect, and fulfil the right to health.[310] Furthermore, as previously mentioned, the CESCR in its General Comment No. 3 on state obligations stated that even in times of severe resource constraints, socially vulnerable people must be protected by the adoption of relatively low-cost targeted programmes.[311] Thus, vulnerability lies at the core of progressive and immediate measures concerning health.

---

[307] Grover (n 234) para 64.
[308] *ERTF* (n 302) para 112, see also *MDM v France* (n 268) para 144.
[309] Audrey R. Chapman, 'A Violations Approach for Monitoring the International Covenant on Economic, Social and Cultural Rights' (1996) *Human Rights Quarterly* 18 23.
[310] CESCR, GC14 (n 27, Introduction) paras 43, 50–52.
[311] CESCR, GC3 (n 62) para 12.

As this doctoral thesis asks whether international and European human rights law can offer consistent solutions to enhance the right to health of irregular migrants, it should be noted that a genuine commitment to these migrants' actual vulnerabilities can prove particularly useful to expand their access to meaningful levels of health prevention, promotion, and treatment.

This does not mean the same treatment for all because health-related needs vary widely among individuals, nor does it signify that all medical technologies must be immediately accessible to all or even that the state is completely responsible for the health status of everyone. However, it does mean that policies on health care and the right to health that include 'equity' and non-discrimination as their core cannot allow disproportionate or unjustified differentiations, such as those that lead to the provision of only emergency care and life-saving measures for irregular migrants who are normally socially excluded and economically disadvantaged.

Conclusions

This chapter provided an overview of the normative content of the right to health and its corresponding state obligations as they emerge in international and regional human rights law, with the intent to show the significant developments of the last number of years, as well as the inconsistencies within and between different legal frameworks. Indeed, agreement on the scope and nature of these international norms and their domestic implementation has proved somewhat difficult, due to the high levels of state discretion where the protection of health is concerned and the overreliance on, and 'over-visibility' of, health as an interest indirectly protected through civil and political rights, mostly in the European context.

This does not mean that the right to health is itself difficult to conceptualise or implement but that states, although they might agree, in principle, on minimum and general international provisions, have demonstrated reluctance to interpret this right in a progressive and holistic way, perhaps preferring minimalist and life-saving approaches that obscure

the desire to preserve their sovereign powers in dealing with resource-demanding health issues, outside of a system of international full accountability.

Furthermore, the WHO's unstable commitment to international human rights practice, over the last 70 years, has equally affected the capability of the Declaration of Alma-Ata, with its significant conceptualisation of health, to guide developments concerning the right to health in international and regional human rights fora.[312]

Like migration, the field of health is extremely sovereignty-sensitive. States are at the centre of health protection: state sovereignty may be referred to as a critical 'political determinant' of health because only where there is a functioning democratic government can health (care) be guaranteed. The precarious living conditions and standards of health protection in a 'failed state' such as Libya and in Venezuela reveal the centrality of states in guaranteeing the respect, protection, and fulfilment of the right to health in the context of a state-based international society.[313]

Whereas sovereignty is a precondition of effective health protection, international and regional law on the right to health should strive to limit state discretionary powers in framing priorities on resource allocation and health services and conditions that are necessary to achieve the highest attainable standard of physical and mental health, based on universality of access and equity. However, as mentioned in Chapter 1, progress in this area is affected by a compromise-oriented human rights law system. On the one hand, at UN level, standards concerning the right to health have developed rapidly, but international accountability procedures have a limited strength and the identification of immediate core obligations and the minimum essential services, goods, conditions that are necessary to attain the highest possible standard of health remain partially unspecified.[314] On the other hand, in

[312] Mason Meier and Kastler (n 70) 112–126.
[313] Francesco Francioni, 'Sovranità Statale e Tutela della Salute come Bene Pubblico Globale' in Pineschi (n 262) 51, 57.
[314] The Committee, without a clear explanation of services, refers to 'essential primary health care' or 'curative, preventive, rehabilitative' health measures. See, for instance, CESCR, GC14 (n 27, Introduction) paras 17, 43.

Europe, the ECHR, while has partially expanded its adjudication in the area of social issues, lacks material competence on the 'right to health' and has elaborated a systemic deficiencies and regulatory approach where health care issues are concerned. The ECSR has produced very protective and vulnerability-oriented decisions in collective cases concerning health care, however, the structural special features of the ESC's system and the relative weakness of its accountability mechanisms have jeopardised its normative authority.

Overall, the greater visibility of human rights case law of the civil and political rights bodies, such as the CCPR and the ECHR, compared to the standard-setting of the CESCR and the ECSR, has partially contributed to shaping international obligations concerning health as relating to 'emergency' or 'life-saving' issues.

The inconsistencies with regard to the international solutions, which lack anchoring in clearer common standards, may be resolved by adopting the Alma-Ata approach, recently recast as the Declaration of Astana. The set of standards set out in these declarations orient the discussion on health to PHC, 'the social determinants of health', and UHC, all of which are concepts that present certain synergies with the principles of non-discrimination and vulnerability in human rights practice.

For the purposes of this research, these meta-legal concepts may help with the interpretation of 'core obligations' regarding the right to health and other health-related obligations of all international and European human rights frameworks, in a non-exceptional and non-emergency-oriented way, where irregular migrants are concerned. Indeed, even though the concept of 'core obligations' may be incompletely agreed upon, the priority assigned to 'vulnerable groups' and 'equitable access' is clear.

Hence, the next chapter describes, compares, and analyses the international and European jurisprudence on the right to 'health care' or 'medical care' of undocumented people, leaving the 'determinants of health' for Chapter 4. The assessment uncovers several inconsistencies. Elaborating on the concepts of PHC and non-discrimination of vulnerable people, the

analysis rejects the protection of health for irregular migrants – which coincides with 'urgent' or 'life-saving' treatment – and suggests embracing interpretative techniques with respect to international human rights law that favour more generous standards. It also encourages a more consistent use of vocabulary related to health care by international bodies, also by considering recent WHO recommendations on PHC and UHC.

Chapter 3
The Right to Health Care of Irregular Migrants in European and International Human Rights Law

The previous two chapters elaborated on the difficulties involved in fully including the rights of irregular migrants within the human rights paradigm and in imbuing the right to health with clear normative content across different international legal frameworks. As this research attempts to evaluate whether significant arguments exist within international and European law to influence the legal conceptualisation of the right to heath of irregular migrants, this chapter and the following one critically assess the right to health care of irregular migrants and the applicability of the concept of the social or underlying determinants of health to irregular migrants, respectively, in European and international human rights law.

This chapter compares the European and international human rights position on the right to health care of irregular migrants and explores how the international position can be further developed to provide a fuller conception of the right. Section 1 briefly recalls the root causes of unequal treatment and offers an overview on how the concept of vulnerability applies to migrants and irregular migrants. Section 2 sheds light on the generally restrictive European approach where the health of irregular migrants is concerned, which is mostly affected by competence limitations of the ECtHR and the ECSR. Section 3 shows how international human rights law has employed the concepts of vulnerability, non-discrimination and core obligations to prevent retrogressive and overly restrictive measures being taken concerning the social rights of migrants, and in particular the right to health. International human rights law generates, although not always consistently, negative and positive immediate obligations that are vulnerability-oriented and that go beyond the provision of only urgent or life-saving health treatment, as inspired by the primary health care (PHC) approach. This section describes, assesses and further develops the arguments of international human rights

law. Section 4 shows how a growing number of human rights bodies are engaged with the development of new standards, which confirm that health care of irregular migrants should not be treated as an emergency issue. Developments include the ban on retrogressive austerity measures that especially affect vulnerable people, generous health care measures for migrant children and their parents, special measures in the area of sexual and reproductive health, and growing support for the establishment of firewalls that may guarantee effective use of health-related services for irregular migrants.

1. Irregular Migrants: Between Exclusionary Measures and Vulnerability

1.1. A brief recapitulation of the exclusionary approach of state sovereignty

As mentioned in chapter 1, the domestic establishment and enforcement of norms on the entry, residence, and expulsion of aliens a matter of state sovereignty has also gained recognition as an established maxim of international law.[1] Thus, although immigration control and enforcement can be considered one of 'the last bastion[s] of sovereignty',[2] domestic powers, both legislative and executive, in this area are not absolute, and international asylum and human rights law can curtail the arbitrary treatment of people by national authorities. European and international human rights law set forth, in principle, inalienable and universal rights that are inextricability linked to the concept of human dignity, regardless of a person's legal or administrative status.[3]

Nonetheless, when the rights of migrants are at stake, narratives of emergency, crisis, border control, security, and limited resources counterweigh the fact that migrants belong to the 'human family' and can lead

[1] For example, New York Declaration for Refugees and Migrants (n 63, Chapter 1) para 24; *ABC* (n 63, Chapter 1) para 67; CMW (n 14 Introduction) Article 79.
[2] Dauvergne (n 51, Chapter 1) 600–601.
[3] Grant (n 33, Chapter 1) 25–47.

to *de jure* (set out in law) and *de facto* (due to structural or situational circumstances) limitations of rights.[4] This phenomenon is even more acute in relation to irregular migrants, whose existence represents a breach of the sovereign power to enforce border control and to exclude aliens from state territories. Irregular migrants, who normally avoid contact with host states' authorities for fear of deportation, are often exposed to sub-standard living conditions, labour exploitation, and social exclusion.[5] Against a background of material deprivation, not only is the enjoyment and vindication of the rights of irregular migrants problematic – since it requires their engagement with state authorities – but the entitlements themselves are at times unevenly set out, including in international law.[6]

The clash between sovereignty and human rights in the field of immigration and the spread of bias against perceived resource-dependant and hardly-justiciable socio-economic rights has led to a situation in which states often treat irregular migrants' health as a matter of emergency and urgent treatment. Indeed, to discourage undesired irregular migrants from entering and staying in their territories, states have resorted to restricting the fundamental rights of this group from 'the inside', for example, by raising legal or administrative barriers to accessing public service providers.[7]

This strategy has often been justified for budget-related reasons, namely as a tool to contain public expenditure and to achieve sustainable public services.[8] Furthermore, as indicated in Chapters 2 and 4, the development of the right to health as a social right has undermined its universal scope as the 'welfare state' – the ideological and structural context

[4] De Guchteneire, Pecoud and Cholewinski (n 176, Chapter 1) 30–33; Marco Gestri, 'Conclusioni Generali', in Giuseppe Nesi (ed) *Migrazioni e Diritto Internazionale: Verso il Superamento dell'Emergenza?* (Editoriale Scientifica 2018) 643, 659–669.
[5] For an overview of the precarious situations in which irregular migrants live, see FRA Report (n 7, Introduction).
[6] CMW (n 14, Introduction) Articles 28, 43.
[7] FRA Report (n 7, Introduction); Bosniak (n 66, Chapter 1) 325; Alessia Di Pascale, 'Italy and Unauthorized Migration: Between State Sovereignty and Human Rights Obligations', in Ruth Rubio-Marín (ed) *Human Rights and Immigration* (OUP 2014) 278, 279.
[8] Regarding the case of Spain, see Alex Boso and Mihaela Vancea, 'Should Irregular Migrants Have the Right to Healthcare? Lessons Learnt from the Spanish Case' (2016) *Critical Social Policy* 36(2) 225, 226, 235; in relation to the UK, see Platform for International Cooperation on Undocumented Migrants, 'PICUM Quarterly, January–March 2016' (2016) <http://picum.org/en/news/quarterlies/49848/> accessed 1 March 2019.

within which social rights are implemented – tends to create boundaries of 'belonging' between who is deserving and who is not, who is a member of the polity and who is not.[9]

For these reasons, the discussion that follows shows that the European regional system of human rights tends to interpret the right to health of irregular migrants as a right to emergency care, which leaves health promotion and the prevention and treatment of non-severe or non-critical health situations outside its scope. The World Health Organization (WHO) considers that 'emergency health care' entails the treatment of critical or acute health conditions that require an immediate medical response.[10] From the outset, it is worth mentioning that the formulation of a right to health in these terms (solely for people identified by their irregular immigration status) does not seem to, *prima facie*, comply with a textual and purposive interpretation of the mainstreamed international right to health as 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'.[11]

As this thesis, in particular with reference to international human rights law, employs the concept of vulnerability for the normative purpose of enhancing targeted rights-protection, the next subsection overviews how this concepts applies to migrants and irregular migrants. Indeed, against a background of clear socio-economic deprivation, the legal recognition of the special vulnerability of irregular migrants is contested at international and European level

1.2. Irregular migrants and their vulnerability

Where migrants are concerned, vulnerable situations and the greater risk of human rights abuse can originate from pre-migration factors, from events and

[9] See Section 2, Chapter 2 and Section 1, Chapter 4 on the welfare state and migrants' rights.
[10] See 'Emergency Care' for the World Health Organization <http://www.who.int/emergencycare/systems/en> accessed 1 March 2019. See also 'emergency-related' terms in *Mosby's Dictionary of Medicine, Nursing & Health* Professions (10th edn, Elsevier 2017) 607–608.
[11] ICESCR (n 14, Introduction) Article 12. Emphasis added.

living conditions that take place during transit or in the destination country or may arise because of an individual migrant's identity or personal situation.[12]

Certain sub-groups of migrants are generally considered more 'vulnerable' than others. For example, the 2016 New York Declaration for Refugees and Migrants explicitly presents a non-exhaustive list of 'migrants in vulnerable situations':

> Women at risk, children, especially those who are unaccompanied or separated from their families, members of ethnic and religious minorities, victims of violence, older persons, persons with disabilities, persons who are discriminated against on any basis, indigenous peoples, victims of human trafficking, and victims of exploitation and abuse in the context of the smuggling of migrants.[13]

This list is also recalled in the final text of the Global Compact for Migration.[14] Apart from a series of references to how gender can increase migrants' vulnerability, the main focus of that document is the special vulnerability of migrant children.[15] This is not surprising; children have been traditionally associated with the concept of vulnerability because of the disproportionate impact of certain adverse and external factors on their ongoing development and, for what is of interest here, their health.[16] In accordance with the focus on children and gender issues, addressing the vulnerability of migrants by providing access to health care is explicitly mentioned only in relation to women, girls, and unaccompanied children.[17]

Thus, the Global Compact's idea of vulnerability is mainly linked to the personal situation of certain sub-groups of migrants, such as children,

---

[12] OHCHR and GMG, 'Principles and Guidelines, supported by practical guidance, on the human rights protection of migrants in vulnerable situations' (OHCHR 2008) 6–7 <https://www.ohchr.org/EN/Issues/Migration/Pages/VulnerableSituations.aspx> accessed 1 March 2019. See also Francesca Ippolito, 'La Vulnerabilità come Criterio Emergente per una Maggiore Tutela del Migrante nel contesto Internazionale', in Nesi (n 4) 447–466.
[13] New York Declaration (n 63, Chapter 1) para 23.
[14] GCM (n 86, Chapter 1) Preamble para 7.
[15] ibid, Objective 7.
[16] Brown, Ecclestone and Emmel (n 283, Chapter 2) 499. Wadsworth and Butterworth (n 83, Chapter 2).
[17] CGM (n 86, Chapter 1) Objective 7, para 23, letters c) and f).

women, and people exploited in work environments, while irregular legal status is not explicitly indicated as a source of 'vulnerability' *per se*. Nonetheless, the recommendations to facilitate case-by-case status regularisation and help those transitioning from one regular status to another implicitly indicate that irregularity of status is a major source of real vulnerability.[18]

The ECtHR adopts a similar approach a similar approach on the qualification of 'vulnerable migrants', as indicated in the mentioned case of *Khlaifia*:

> The applicants were weakened physically and psychologically because they had just made a dangerous crossing of the Mediterranean. Nevertheless, the applicants, who were not asylum-seekers, did not have the specific vulnerability inherent in that status, and did not claim to have endured traumatic experiences in their country of origin […] they belonged neither to the category of elderly persons nor to that of minors.[19]

The inclusion of irregular migrants in the overall category of vulnerable people is, however, more openly accepted by, *inter alia*, the CESCR itself,[20] the Inter-American Commission on Human Rights,[21] and the SR on the Right to Health and the SR on the Rights of Migrants.[22] These human rights bodies accept legal status as a suspect ground of differentiation or a prohibited ground of discrimination, thus implicitly acknowledging that

[18] ibid, Objective 7, para 23, letters h) and i); Idil Atak, 'GCM Commentary: Objective 7: Address and Reduce Vulnerabilities in Migration' (*Refugee Law Initiative Blog*, 30 October 2018) <https://rli.blogs.sas.ac.uk/> accessed 15 January 2019.
[19] *Khlaifia GC* (n 124, Chapter 1) para 194.
[20] For example, CESCR, COs on the third periodic report of France (9 June 2008) UN Doc E/C.12/FRA/CO/3, para 26; CESCR, List of issues in relation to the combined fourth and fifth periodic report of the Netherlands and the fourth periodic report of the Netherlands Antilles (22 December 2009) UN Docs E/C.12/NLD/4–5, UN Doc E/C.12/NLD/4/Add.1, para 27: '[…] the situation of the most disadvantaged and marginalized individuals and groups, such as immigrants without legal residence […]'.
[21] *Juridical Condition and Rights of the Undocumented Migrants* (n 198, Chapter 1) para 112.
[22] The particular 'vulnerability' of undocumented migrants had been recognised since the document of appointment of the Special Rapporteur on the Rights of Migrants, pursuant to UNGA Res 1999/44 (27 April 1999) UN Doc E-CN_4-RES-99–44. Grover (234, Chapter 2).

irregular migrants are in a comparable situation with other human beings with regular or citizenship status in relation to the enjoyment of human rights.

Discussing the health-related rights of irregular migrants exposes the tensions that exist between human rights, citizenship, and the sovereign state,[23] which are at the origin of all the various types of vulnerability experienced by these people. First, they are institutionally vulnerable because they are unable to 'call upon the basic protective functions of the state in which they reside for fear of deportation'.[24] As a consequence of being thus disempowered in enjoying and claiming their human rights,[25] most irregular migrants live in the shadows, in precarious living and working conditions, and are exposed to physical, moral, psychological, and economic risks of harm. Against a background of social and institutional exclusion, they are often reliant on the protection of local NGOs.

Whatever the approach to 'vulnerability', either group-based or individual/universal, irregular migrants seem to qualify as *de facto* vulnerable rights' holders. As a group, they encounter institutional aversion, structural and state-made vulnerabilities, which in concrete terms means they have less access to public services, including health care. This reduced accessibility is due both to laws and policies that restrict the possibility of providing health care to irregular migrants on an equal basis with citizens or regular migrants (with regard to the entitlement per se or the affordability of the service) and to factual barriers, such as language barriers, lack of information, and a lack of responsiveness among health care staff.[26] Beyond their 'group identity', as intrinsically vulnerable human beings, irregular migrants are generally socio-economically vulnerable because of the lower quantity and quality of the resources and assets they command,[27] including health-related goods and services. These situations of disadvantage in enjoying fundamental rights are

[23] Turner (n 285, Chapter 2) 2.
[24] Ramji-Nogales (n 104, Chapter 1) 1045.
[25] Migrants' vulnerability has been described as essentially 'structural' and 'cultural', and therefore not natural but 'social' in nature, Jorge A. Bustamante, 'Immigrants' Vulnerability as Subjects of Human Rights' (2002) *International Migration Review* 36(2) 339.
[26] FRA Report (n 7, Introduction) 71–83.
[27] Albertson Fineman (n 285, Chapter 2) 10 and Peadar Kirby, *Vulnerability and Violence* (Pluto Press 2005) 54–55.

also described as 'precariousness', by some scholars and by the ECSR. For these scholars, unlike 'vulnerability', this terminology places emphasis on the systemic and contextual state-made production of a precarious status and avoids 'victim-blaming', for the ECSR 'precariousness' indicates a 'situational vulnerability' which triggers certain targeted state duties.[28]

Whether they are a vulnerable group or human beings in vulnerable or precarious positions, it has long been acknowledged by the CESCR that irregular migrants' legal and factual situations contain elements of vulnerability, which qualifies them for special attention in its assessment of state reports and as targets for protective initiatives.[29] It is worth anticipating that the CESCR, beyond making cursory mention in its reporting procedures, recently issued a 'statement' that clearly qualified irregular migrants as 'specifically vulnerable' people, deserving of being target of core obligations regarding the right to health and other social rights.[30]

The following section provides an overview of the norms and case law concerning access to health care for irregular migrants in European human rights law. This section portrays what a minimalist position regarding the right to health looks like and sets the scene for the following sections to draw out what a 'thicker' conception of the right to health for irregular migrants might look like. The critical remarks that follow acknowledge that all

[28] Shauna Erin Labman, *'At Law's Border: Unsettling Refugee Resettlement'*, PhD Thesis defended at the University of British Columbia on 15 November 2012 https://open.library.ubc.ca/cIRcle/collections/ubctheses/24/items/1.0071854>; Idil Atak, Delphine Nakache, Elspeth Guild and François Crépeau, 'Migrants in Vulnerable Situations' and the Global Compact for Safe Orderly and Regular Migration' (16 February 2018) *Queen Mary School of Law Legal Studies Research Paper No. 273/2018* 4 <https://ssrn.com/abstract=3124392> accessed 1 March 2019; *FEANTSA* (n 194, Chapter 1) paras 184-185.

[29] For example, CESCR, COs on the reports submitted by: France (n 20) para 26: '[…] persons belonging to disadvantaged and marginalized groups, such as asylum-seekers and undocumented migrant workers […]'; Greece (n 177, Chapter 2) para 36: 'The Committee recommends that the State party […] I take steps to ensure that all persons belonging to disadvantaged and marginalized groups, in particular asylum seekers and undocumented migrants and members of their families, have access to basic health care […]'; Cyprus (n 177, Chapter 2) para 270: 'Persons belonging to vulnerable groups, including illegal immigrants, prisoners, children of illegal immigrants, and asylum seekers, are entitled to the necessary medical care free of charge'. CESCR, Third Periodic report of Ireland (8 November 2013) UN Doc E/C.12/IRL/3, para 24: 'Vulnerable groups. One stakeholder expressed concern over the situation of undocumented persons in Ireland […]'.

[30] CESCR, Statement (n 153, Chapter 1) III.

international treaties recognise that greater legal protection (including for the right to health of irregular migrants) may be granted by domestic statutes rather than at regional or international level.[31]

2. European Human Rights Law on Health Care for Irregular Migrants

The case-law of the ECtHR and the ECSR, which oversee the ECHR and the ESC, respectively, has grappled, although to different extents, with the socio-economic conditions of irregular migrants. Both these human rights bodies, however, have essentially reaffirmed an emergency approach in relation to their human right to health. This is partly a consequence of their lack of full formal competences in the area of social rights of migrants in an irregular situation. Indeed, as previously mentioned, the material scope of the ECHR primarily covers civil and political rights, while the personal scope of the ESC is, as a general rule, restricted to nationals of its member states and regular migrants.

2.1. The ECHR and the limitation of its material scope

As previously observed, although the ECHR sets forth rights that are essentially civil and political, the ECtHR has long considered, in principle, that 'many [ECHR rights] have implications of a social or economic nature' and that 'there is no water-tight division separating that sphere from the field covered by the Convention'.[32]

As far as health is concerned, as highlighted in Chapter 2, Articles 2 (right to life), 3 (prohibition of torture and inhuman or degrading treatment), and 8 (right to private and family life) ECHR have been widely employed to ground claims regarding a lack of respect and protection for the health of individuals.[33] For instance, as previously indicated, in a case in which it was

[31] For example, ECHR (n 15, Introduction); ESC (n 15, Introduction) Article H. For an overview of the domestic legal guarantees in this area, see Spencer and Hughes (n 7, Introduction) 9–29.
[32] *Airey* (n 240, Chapter 2) 26.
[33] See Section 6.1, Chapter 2.

found that deaths had occurred because access to appropriate health care had been denied, the Court ruled in favour of the applicants, finding violations of Article 2 ECHR on the right to life. However, in cases such as this, only systemic state deficiencies, together with the special vulnerabilities of the deceased victims, led the Court to conclude that the state had failed to comply with its positive obligations in relation to the right to life.[34] The prohibition of torture and inhuman and degrading treatment set forth in Article 3 ECHR has also been relied upon in health-related cases. However, established and widespread case law of the Court of Strasbourg indicates that ill treatment must be of a 'minimum level of severity' to trigger the applicability of this norm. Furthermore, 'the assessment of this minimum [level of severity] is, in the nature of things, relative, and it depends on all the circumstances of the case […]'.[35] From this type of argument, it seems clear that interference with an individual's health must take a particularly abusive form to fit the material scope of these provisions and that no freestanding right to health exists in the ECHR framework.

With regard to migrants, a fluctuating body of case law has developed involving cases where the principle of *non-refoulment* is employed to prevent the deportation, removal or extradition of people with severe health conditions.[36] In *D. (v. UK)*, regarding the deportation of a person in the terminal stages of AIDS, the Court found the existence of 'very exceptional circumstances' under which Article 3 ECHR could be invoked, that is, a 'real risk of dying under distressing circumstances'.[37] Conversely, in *N (v. UK)*, the applicant's condition (suffering from AIDS, but not in terminal stages) was not considered so critical because she was not at imminent risk of dying.[38] The overall trend in this case law is to refer to the 'relative' assessment of minimum severity with a considerably high threshold and in exceptional situations.

[34] For example, *Câmpeanu*; *Şentürk and Şentürk* (n 250, Chapter 2).
[35] *Kudła v Poland* App no 30210/96 (ECHR 2000) para 91. Emphasis added.
[36] *D. v UK* (n 115, Chapter 1); *N. v UK* App no 26565/05 (ECHR 2008); *Paposhvili v Belgium* App no 41738/10 (ECHR 2016) paras 172–183.
[37] Ibid (*D.*) paras 43, 52–53.
[38] *N.* (n 36) paras 42–51.

Of utmost significance for this research is the following *obiter dictum*, that exposes the approach of the ECtHR, where non-emergency health situations are concerned in the context of expulsion of aliens. In *A.S.*, the Court held that Article 3 does not place an obligation on the state to provide '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'.[39]

In the most recent of these key-cases at the time of writing, *Paposhvili*, the Grand Chamber of the ECtHR, recalling its previous judgements in this field, clarified the scope of the exceptional circumstances in which severe health conditions can prevent the removal of aliens:

> He or she, *although not at imminent risk of dying*, would face *a real risk*, on account of the absence of appropriate treatment in the receiving country or the lack of access to such treatment, *of being exposed to a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering or to a significant reduction in life expectancy*.[40]

As an aside it can be noted that in these cases the recognition of health care needs in the context of deportation clashes with the sovereign power to expel because a certain (severe) state of health may prevent the person's deportation. These situations differ from regulating accessibility to health (and social services) of irregular migrants, as discussed below, outside of deportation proceedings and without the granting of any regularisation of status (although temporarily for health reasons).

As indicated in the following chapter on the socio-economic determinants of health, the Court of Strasbourg's case law in relation to social and health care for irregular migrants appears to be informed by a logic of emergency, multi-layered vulnerabilities, and exceptional positive

[39] *A.S. v Switzerland* App no 39350/13 (ECHR 2015) para 31, *N. v UK* (n 36) para 44. When a case raises issues concerning the allocation of resources, the Court makes wide use of the concept of 'margin of appreciation', i.e., *Da Conceição Mateus and Santos Januário v Portugal* App nos 62235/12, 57725/12 (ECHR 2013, Decision) para 22.
[40] *Paposhvili* (n 36) para 183. Emphasis added.

obligations.[41] The Court has not specifically articulated the normative content of state obligations around health protection, beyond regulatory duties and the avoidance of systemic deficiencies with severe individual consequences.[42] Furthermore, unlike asylum seekers in dire conditions, irregular migrants in need of social and medical protection are not considered especially vulnerable – and thus worthy of generating substantial and procedural positive duties for the states – *per se*.[43] Due to these material limitations and restraints, the ECtHR appears to be committed to the protection of undocumented people's survival and freedom from inhuman or degrading treatment, rather than their individual highest attainable standard of health.

2.2. The ECSR: Between courage and limitations of mandate

Whereas the ECHR does not directly grapple with the right to health, this right does feature in the material scope of the ESC.[44] Most notably, Article 11 ESC sets forth obligations to provide curative, promotional, and preventive health measures, and Article 13 ESC provides the legal basis for the right to social and medical assistance for people 'without adequate resources'.

As mentioned in Chapter 1, although the ESC specifically deals with socio-economic rights, including the right to health, its Appendix excludes 'unlawful' migrants from its competence *ratione personae*. This is an unusual situation for a human rights treaty, and one that differentiates the ESC from its sibling, the ECHR. However, this textual limitation has not prevented the ECSR from partially extending the personal scope of the treaty to irregular migrants. Thus, based on the complementary nature of the ESC and the ECHR (the latter, as previously discussed, has a universal personal scope), human

[41] See Section 2.2.1, Chapter 4.
[42] *Cyprus v Turkey* (n 252, Chapter 2) para 219; *Şentürk and Şentürk* (n 250, Chapter 2).
[43] *M.S.S.* (n 120, Chapter 1) para 263: '[…] the Court considers that the Greek authorities have not had due regard to the applicant's vulnerability as an asylum-seeker […]'; cfr. *Hunde v The Netherlands* App no 17931/16 (ECHR 2016, Decision) paras 45–60; *Khlaifia* 2016 (n 124, Chapter 1) para 194. *Aden Ahmed v Malta* App no 55352/12 (ECHR 2013) para 97: '[…] The applicant was in a vulnerable position, not only because of the fact that she was an irregular migrant […] but also because of her fragile health'.
[44] ESC (n 15, Introduction).

dignity, and the indivisibility of human rights, the Committee has ruled out domestic measures that exclude irregular migrants from medical assistance.[45] The ECSR has also justified this extension by reiterating that the Charter, as an instrument of international law, must be interpreted 'in the light of other applicable rules of international law'.[46] Finally, so as to realise the objective of the treaty, individual rights and corresponding state obligations should not be excessively restricted.[47] Although most decisions of the ECSR have concerned the extension of medical and social assistance to undocumented migrant children, the Committee has made clear that at least emergency health care – which is connected with the realisation of other fundamental rights – should be provided to all irregular migrants.[48]

Regardless of its creative 'ultra-textual' interpretation, the ECSR nonetheless pitches the legal standard of protection for irregular migrant adults at the level of 'emergency measures'. In relation to 'medical assistance', however, the ECSR has stated that even though 'an individual's need must be sufficiently urgent and serious to entitle them to assistance under Article 13(4), this criterion must not be interpreted too narrowly'.[49]

The ECSR's understanding of the 'right to the protection of health' is broad and interrelated with other social issues, and for this reason a more detailed analysis of its case law is carried out in Chapter 4 in relation to the concept of underlying determinants of health.[50] However, at this point, it must be remembered that the ECSR draws a distinction between traditional vulnerable groups like children or ethnic minorities and other people that are in a precarious situation, like irregular migrants. Accordingly, at least emergency levels of social rights must be guaranteed to protect irregular migrants' human dignity.[51] The vulnerability of irregular migrants, who are excluded from the personal scope of the treaty by the text in spite of their

[45] *FIDH* (n 188, Chapter 1) paras 26–32.
[46] *DCI (v The Netherlands)* (n 190, Chapter 1) para 35; *CEC* (n 190, Chapter 1) para 68.
[47] ibid (*DCI*) para 36.
[48] *CEC* (n 193, Chapter 1) paras 73, 75; *FEANTSA* (n 193, Chapter 1) paras 171, 173, 182–183, 186.
[49] ibid (*CEC*) para 105; (*FEANTSA)* para 171.
[50] See Section 2.2, Chapter 4.
[51] *FEANTSA* (n 193, Chapter 1) paras 184-185.

precarious socio-economic living conditions, has led the ECSR to require states to adopt positive duties to protect and promote their health, albeit ones framed at a broad level of generality and in cases of a certain severity.

The next section shows the extent to which international human rights law, unlike European human rights law, tends to go beyond an emergency approach to the health care of irregular migrants. The CESCR's understanding of 'vulnerability' and 'core obligations' can guide human rights arguments over and above a life-saving approach to health.

3. International Human Rights Law and the Level of Health Care for Vulnerable Migrants

This section demonstrates that international human rights law, through the UN human rights treaties and the jurisprudence of their monitoring bodies, offers protection-oriented arguments that support – with the concepts of vulnerability, non-discrimination, and the core of social rights – the desirability of a thicker right to health of irregular migrants that extends beyond the provision of emergency health care in urgent situations. This section builds on the practice of the CESCR and develops it further to unpack an implicit substantive normative approach that is grounded on the standards that the WHO and the UNGA have been recommending on a universal basis, in particular primary health care (PHC).

Building on the reflections at the end of chapter 2, this section digs deep into the concepts of vulnerability, non-discrimination, and classification of state obligations. This analysis is developed in the context of the international human rights obligations because, unlike the ECtHR and, to a certain extent the ECSR, the CESCR considers irregular migrants especially vulnerable *per se* and, as such, deserving of special monitoring attention and a priority target of progressive and core obligations in relation to the right to health, including protection from austerity measures due to economic adjustments and crisis.

3.1. Non-discrimination in the enjoyment of the right to health as a core obligation

This subsection presents a series of arguments as to why the principle of discrimination in international human rights law, previously discussed in general terms and that is a rule that must be immediately realised by states, prevents whittling down the right to health of irregular migrants to the provision of only emergency or urgent health care. Discrimination is explicitly prohibited in Article 2(2) ICESCR. The concept, it will be recalled, refers to unjustifiable, differential treatment of similarly-situated individuals on prohibited or suspect grounds, and these have been interpreted to include nationality or other status. Nonetheless, differential treatment of irregular migrants may be upheld if it is provided for by law, pursues a legitimate aim and remains proportionate to that aim. The question of whether the aim of immigration control is a legitimate one and whether curtailing of the right to health of irregular migrants is proportionate to that aim has been considered by the CESCR, as elaborated on below.

3.1.1. Emergency treatment and non-discrimination

Any measure, even if justified by budgetary reasons, that targets individuals exclusively for their administrative status and limits their right to health to the extent of providing only urgent or life-saving treatment would seem difficult to defend for the following reasons.

First, in general, differential treatment on the basis of lack of available resources is not an objective and reasonable justification per se.[52] According to the CESCR, when resources are available to realise the right to health, both immediately and progressively, their use should not perpetrate discrimination. This is indicated by the wording of Article 2(2) ICESCR read in conjunction with Article 2(1) ICESCR.[53] Second, while 'the protection of

[52] CESCR, GC20 (n 93, Chapter 1) para 13. Emphasis added.
[53] ICESCR (n 14, Introduction) Article 2(2): 'The States Parties to the present Covenant undertake to guarantee that the rights enunciated in the present Covenant will be exercised

public resources, which are necessary for the realisation of individuals' rights'[54] is, in principle, legitimate justification for limiting the Covenant rights, as they may serve the public interest of 'promoting general welfare in a democratic society', the radical withdrawal of any entitlement to health care other than emergency treatments from irregular migrants is likely to be difficult to defend in a 'proportionality' test. This test would entail verifying that there is a reasonable relationship of proportionality between the purpose of the measures or omissions and their effects. It would also include assessing whether the least restrictive measures have been considered and whether the measures adopted (dis)proportionally impact on certain individuals. Third, it is debatable, from both a public health and a budgetary perspective, whether the criterion of promoting the 'general welfare of a society as a whole' (as the condition / legitimate aim for rights' limitations in Article 4 ICESCR) is met by leaving this part of the actual state population without, *inter alia,* preventive and primary care. Indeed, meeting only the urgent or life-saving health needs of a part of the population is likely to expose the population at large to higher public health-related risks. Moreover, budgetary studies have demonstrated that the cost associated with urgent intervention is higher than that of implementing preventive and essential primary care.[55] Fourth, rules on human rights treaty interpretation, of both a textual and a purposive nature,[56] do not support interpretations that tend to restrict state obligations to the greatest possible extent.[57] Indeed, a joint reading of Articles 2(1), 2(2), and 12 ICESCR clearly suggests that 'everyone' is entitled to the right to the

without discrimination of any kind […]'. CESCR, GC14 (n 33, Introduction) para 52 indicates as example of the violation of the obligation to fulfil the right to health 'insufficient expenditure or misallocation of public resources which results in the non-enjoyment of the right to health by individuals or groups, particularly the vulnerable or marginalized'. For the interpretation of the obligation of non-discrimination as a duty of 'immediate application', see *infra* in the main body of this chapter.

[54] *López Rodríguez* (n 208, Chapter 2) para 13.3.

[55] For further details, see Boso and Vancea (n 8) 238; European Union Agency for Fundamental Rights, *Cost of Exclusion from Healthcare: The Case of Migrants in an Irregular Situation* (EU Publishing 2015); and David Ingleby and Roumyana Petrova-Benedict 'Recommendations on Access to Health Services for Migrants in an Irregular Situation: An Expert Consensus' (2016) IOM Europe.

[56] VCLT (n 25, Chapter 1) Article 31.

[57] The case-law of the ECtHR has embraced this approach since the case of *Wemhoff v Germany* App no 2122/64 (ECHR 1968) para 8.

highest attainable standard of health, which includes 'the creation of conditions which would assure to all medical service and medical attention' and that the 'object and the purpose' of the treaty (namely the universal progressive full realisation of rights) would be hindered by too restrictive an interpretation of state obligations towards irregular migrants. Despite this, policies on the removal of irregular migrants and the reduction of what states often define as 'pull factors'[58] have led to situations, in several countries, where the health-related rights of migrants are severely legally or factually curtailed.[59]

As the CESCR has not yet developed a rich case-based jurisprudence, the analysis of the Committee's approach to non-discrimination and irregular migration was conducted by examining its COs, which, as previously explained, are the result of the periodic state reporting mechanism.[60] In its assessment of state reports, the Committee has adopted different approaches: 1) it has explicitly expressed concern about *de facto* and *de jure* discrimination affecting the right to health of irregular migrants;[61] 2) it has mentioned suspected differential treatment, often expressing concern about accessibility of the health system, but without qualifying it as discrimination;[62] 3) notwithstanding the reference to non-justified or suspected differential treatment during the reporting cycle, it has not raised any specific issue in its final recommendations.[63]

---

[58] Bernard Ryan and Virginia Mantouvalou, 'The Labour and Social Rights of Migrants in International Law', in Rubio-Marín (n 7) 177.

[59] FRA Report, (n 7, Introduction) 71 and Spence and Hughes (n 7, Introduction) 9–29.

[60] See *supra* at Section 4.3.1, Chapter 2.

[61] For example, CESCR, List of issues in relation to the sixth periodic report of Cyprus (12 April 2013) UN Doc E/C.12/CYP/Q/6, para 9; CESCR, COs on the fifth periodic report of Norway (13 December 2013) UN Doc E/C.12/NOR/CO/5, paras 7 and 21.

[62] See CESCR, COs on the sixth periodic report of Finland (17 December 2014) UN Doc E/C.12/FIN/CO/6, para 27; CESCR, COs on the third periodic report of France (n 20) paras 21, 47.

[63] See CESCR, fourth periodic report submitted by Belgium (9 July 2010) UN Doc E/C.12/BEL/4, para 243 '[…] Although illegal immigrants can only claim emergency medical care […]'. No further mention of undocumented migrants appears in subsequent documents or in the 2013 COs on Belgian report; CESCR, Replies to the list of issues to the sixth periodic report of Sweden (6 April 2016) UN Doc E/C.12/SWE/Q/6/Add.1, para 115: 'Asylum seekers and undocumented persons that are 18 years of age and above shall be offered health and dental care that cannot be deferred […]'. In the subsequent COs (24 June 2016) UN Doc E/C.12/SWE/CO/6, while concern was raised in relation to the adequate access to healthcare for asylum seekers (paras 31–32), the Committee did not issue similar

In relation to the first two points, considering both the weak normative character of the COs and the fact that the purpose of the monitoring procedure is not to find violations but to make recommendations, the presence or the absence of the word 'discrimination' may not appear crucial. Yet, the absence of any mention of concern – point 3) above – indicates missed opportunities for both developing a consistent international practice and pushing the improvement of domestic standards. Against this background, the adoption of the CESCR's 2017 statement on state duties towards refugees and migrants – which in principle qualifies as discrimination any differential treatments on the base of irregular legal status – may prove useful for the future development of a consistent and protective jurisprudence, also in the context of the CESCR's complaint procedure.

3.1.2. Core obligations and non-discrimination

Moreover, it is worth mentioning that while the ICESCR normally imposes obligations to progressively realise rights within the limits of available resources, a textual interpretation of Article 2(2) indicates that states (immediately) 'undertake to guarantee that the rights enunciated in the present Covenant will be exercised without discrimination'. This requires that, regardless of the stage of realisation of a certain right, when health-related services and goods are available for general users, they must be immediately accessible without discrimination to everyone, particularly to vulnerable people, including people who do not have legal immigration status. Regarding European countries, which are at the centre of scrutiny because of their rising anti-immigrant sentiments, the Committee has often raised concerns about the lack of accessibility of services for vulnerable groups due to legal or factual barriers, rather than identifying problems about the very existence (availability) of health care services.[64].

recommendations in relation to undocumented migrants despite the fact that they received the same restricted access according to the domestic legislation.

[64] For example, CESCR, COs on the fourth periodic report of Austria (13 December 2013) UN Doc E/C.12/AUT/CO/4, paras 21–22; List of issues in relation to the sixth periodic report of the UK (3 November 2015) UN Doc E/C.12/GBR/Q/6, para 26.

As previously indicated, the CESCR's General Comment no. 14 has shaped the principle of non-discrimination as a fundamental element of state core obligations concerning the right to health and health care, by listing, *inter alia*, the following core obligations:

> a) Ensuring the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalized groups; b) providing essential drugs; c) ensuring equitable distribution of health services; d) adopting and implementing a national public health strategy and plan of action […] addressing the health concerns of the whole population […] with particular attention to all vulnerable or marginalized groups.[65]

These obligations reflect the goal of establishing a universally inclusive health care system,[66] based on substantive equality and aimed at meeting people's health needs.

Core obligations and/or rights – intensely debated concepts in the legal literature – [67] have been developed in order to prevent the progressive realization of socio-economic rights within available resources from undermining or delaying the implementation of minimum or essential levels of each right.[68] With regard to the right to health, the Committee has established that, in accordance with the compelling findings of the Declaration of Alma-Ata on PHC,[69] states have a minimum duty to guarantee, at the very least, **'**essential primary health care'.[70] Given that the non-discrimination clause in the ICESCR is not subject to the rule of progressive realisation and that core obligations apply particularly to vulnerable people

[65] CESCR, GC14 (n 27, Introduction) para 43, a), d), e) and f).
[66] CESCR, Guidelines (n 171, Chapter 2) para 55: 'Indicate whether the State party has adopted a national health policy and whether a national health system with universal access to primary health care is in place'.
[67] Legal scholars have not reached agreement on whether COs are to be intended as obligations of conduct or obligations of result, on whether they are non-derogable or retractable in nature, or on whether are universal or country-specific in application. See Section 4.2.4, Chapter 2 and, for further analysis, Forman et al. (n 129 Chapter 2) 531–548; Young (n 123, Chapter 2).
[68] CESCR, CG3 (n 62, Chapter 2) para 10.
[69] Declaration of Alma-Ata (n 28, Introduction)
[70] CESCR, GC14 (n 27, Introduction) para 43.

or groups, states ought to guarantee irregular migrants access to services, conditions, and goods that do not contradict the concept of PHC.

Recalling the findings of the previous chapter, when the Alma-Ata standard of essential 'primary health care' is mentioned, it is important to clarify that it does not mean only the provision of 'primary care' and 'emergency care' but also includes the social or underlying determinants of health in the scope of health-related measures.[71] Leaving the analysis of the determinants of health to the next chapter, as far as health care is concerned, PHC means 'essential health care' that 'addresses the main health problems in the community, providing promotive, preventive, curative and rehabilitative services' and that 'includes at least […] appropriate treatment of common diseases and injuries; [the] provision of essential drugs [and] immunization against major infectious diseases'.[72]

This framework is also substantially harmonised with the UN's recommendation on UHC. This global governance goal, which is more extensively presented in Chapter 2, guarantees 'access to quality essential health care services and access to safe, effective, quality, and affordable essential medicines and vaccines for all'.[73] On several occasions, the UNGA and the WHA have clarified that UHC includes 'access, without discrimination, to nationally determined sets of the needed promotive, preventive, curative and rehabilitative basic health services […] with a special emphasis on the poor, vulnerable and marginalized segments of the population'.[74]

The core obligations of General Comment no. 14 appear to be more 'procedural' and 'structural' than focussed on the 'substantive notion' of 'essential primary health care' originally indicated in General Comment no. 3.[75] Although General Comment no. 14 provides that health-related state duties encompass both medical care and the determinants of health and briefly

[71] Declaration of Alma-Ata (n 28, Introduction); Potts (n 145, Chapter 2) 93–111.
[72] ibid (Alma-Ata) para VII; Toebes (n 1, Chapter 2) 348..
[73] UNGA Res 70/1 (n 155, Chapter 2).
[74] UNGA Res 67/81 (n 157, Chapter 2); WHA Res 69.1, Forman et al. (n 157, Chapter 2) 23–34.
[75] Forman et al. (n 129, Chapter 2).

references the Declaration of Alma-Ata, it fails to clearly extract from the concept of PHC that primary care is the essential (starting point of) health care that Alma-Ata requires.

However, an indication of this trend can be read between the lines of the 'obligations of comparable priority', when the CESCR requires states to:

> (b) To provide immunization against the major infectious diseases occurring in the community; (c) To take measures to prevent, treat and control epidemic and endemic diseases; (d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them.[76]

An interpretation of health care obligations that follows the 'compelling guidance' of the Declaration of Alma-Ata implies that the CESCR requires states to provide at least a certain level of preventive and primary care as among its immediate measures regarding health care for irregular migrants.

However, the COs have not been always unequivocal on this point. At times reference is made to the lack of 'adequate' health care for irregular migrants,[77] which seems to hint at a threshold of provision that is not so different from the health care that must be provided to citizens and regular migrants.[78] In other documents, it is noted that emergency health care is not enough and that 'basic' services should be provided.[79] The word 'basic' is confusing: it can be associated with either rights that are preconditions of other rights,[80] the type of services,[81] or with a minimal, although not specified, level of entitlement. This lack of substantial clarity, including that on the findings of discrimination above,[82] may have prevented the ICESCR and the

[76] CESCR, GC14 (n 27, Introduction) para 44.
[77] CESCR's COs on the reporting cycles of: France (n 20) para 47, Austria (n 64) para 21.
[78] Gillian MacNaughton, 'Beyond a Minimum Threshold: The Right to Social Equality', in Lanse Minkler (ed) *The State of Economic and Social Human Rights* (CUP 2013) 282–284.
[79] CESCR's COs on the reporting cycles of: Denmark (6 June 2013) UN Doc E/C.12/DNK/CO/5, para 18; Greece (n 177, Chapter 2) para 36.
[80] Shue (n 96, Chapter 2).
[81] For example, the Global Compact for Migration (n 86, Chapter 1) objective 15 urges states to 'provide access to basic services for migrants'.
[82] See *supra* at Section 3.1.1.

CESCR from providing useful guidance on policy change for those countries that guarantee no health care services or only 'emergency care' treatment or that reduce, factually or administratively, access to health care for irregular migrants.[83]

Finally, more uncertainty regarding the prescribed standard of health care for everyone is brought about by the provisions of the 1990 UN Convention on Migrant Workers and Members of their Families (hereinafter CMW) which, at odds with the universality of the ICESCR, crystallised a double 'citizens/non-citizens' and 'regular/irregular migrants' divide in international human rights law where health care is concerned.[84] Many states appear to comply more with the 'emergency care' standard for undocumented people set out by the CMW than with the ICESCR.

In doing so, they only care for and safeguard undocumented people's 'lives', rather than their 'essential health needs' or a standard of 'dignified best attainable health'. Pitching a standard of health protection which coincides with 'life' or 'survival' contradicts decades of human rights debates and reaffirms the outdated superiority of civil rights over social rights. Moreover, the inconsistency of standards within the very same UN human rights instruments might have the effect of debilitating the already-weak legal force of the monitoring procedure, adding confusion with regard to states' compliance with, and interpretation of, international human rights obligations.

3.1.3. What is 'essential health care'?

Core obligations regarding the right to health in the CESCR's General Comments 3 and 14 refer to the standard of 'essential primary health care'. While the meanings of 'primary care' and PHC were previously clarified, it is significant to question what 'essential' stands for in that context. The adjective 'essential' is synonymous with 'extremely important' or

[83] FRA Report (n 7, Introduction) 71–83.
[84] See Section 4.1, Chapter 1.

'fundamental'[85] or refers to something 'that is such by its essence'. Placed near 'health care', it expresses an order of priorities in health care or medical care or a (set of) treatment that are necessary to meet people's health needs.

Furthermore, the specific human interest to which health care is essential is, however, open to question. Urgent or emergency care is instrumental or 'essential' to preserve 'vital functioning' or save 'life'; other levels of health care, including 'preventive' and 'primary care', are instrumental or 'essential' to maintain or achieve good health outcomes outside life-saving situations, that is, regular prevention and treatment of common diseases.

A certain number of international documents, including the CESCR's General Comment No. 3 in relation to core obligations and the Declarations of Alma-Ata and Astana, employ 'essential' in relation to standards of treatment and health care.[86] These documents refer to 'essential' health care as something different from emergency care. For instance, the EU Return Directive, a piece of EU law which poses rules governing the return of irregular migrants to their origin countries, mentions 'emergency health care and essential treatment of illness',[87] and the Declaration of Astana refers to states' commitment to:

> Enhance capacity and infrastructure for primary care – the first contact with health services – prioritizing essential public health functions […] to meet all people's health needs across the life course through comprehensive preventive, promotive, curative, rehabilitative services and palliative care.[88]

The priority that global health initiatives – such as PHC and UHC – and human rights law accord to vulnerable groups would be hindered if one of these groups, such as 'irregular migrants', received only emergency

[85] Oxford Dictionaries, 'essential' <https://en.oxforddictionaries.com/definition/essential> accessed 1 March 2019.
[86] CESCR (n 62, Chapter 2); Declaration of Alma-Ata (n 28, Introduction); Declaration of Astana (n 153, Chapter 2).
[87] European Parliament and Council Directive 2008/115/EC of 16 December 2008 laying down common standards and procedures in Member States for returning illegally staying third-country nationals [2008] OJ L348/98, Article 14.1(b).
[88] Astana (n 153, Chapter 2) para V.

treatment and was thus ineligible for essential health care services available in the country. Such a concern has recently been raised by the CESCR in relation to the 2012 restrictive and retrogressive Spanish act that regulated access to health care for irregular migrants in terms of exceptional and urgent treatment only. In that case, the CESCR pushed its jurisprudence to the point of urging Spain to take 'all necessary steps to ensure that irregular migrants have access to all necessary health-care services, without discrimination'.[89] This generous approach is confirmed in the COs on the 2018 report of Germany as the state is recommended to adopt 'all measures necessary to ensure that all persons in the State party […] have equal access to preventive, curative and palliative health services, regardless of their legal status and documentation' and to review domestic restrictive law and policies.[90]

Finally, the SR on the Right to Health stated that 'the principle of non-discriminatory access is eroded when irregular migrant workers are not allowed to access non-emergency health care services'.[91] Essential health care requires the establishment of UHC policies that explicitly commit to prioritising the poor and marginalised in the process of expanding coverage and in determining which services to provide in order to avoid entrenching inequality.[92]

Although full clarity is still somewhat lacking on what 'essential' health care is in international law, it seems sufficiently clear that this does not correspond to 'emergency or urgent' medical treatment but extends to certain elements of PHC, such as preventive and primary care, at least under international human rights law and the recommendations of global governance and health actors.

---

[89] CESCR, COs on the sixth periodic report of Spain (25 April 2018) UN Doc E/C.12/ESP/CO/6, paras 41–42.
[90] CESCR, COs on the sixth periodic report of Germany (27 November 2018) UN Doc E/C.12/DEU/CO/6, para 59.
[91] Grover (n 234, Chapter 2) para 40
[92] Dainius Pūras, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (focus: Agenda 2030)' (5 August 2016) UN Doc. A/71/150, para 17. See also, UNGA Res 67/81 (n 157, Chapter 2); WHA Res 69.1, Forman et al. (n 157, Chapter 2) 23–34.

3.2. Irregular migrants and the typologies of the right to health

In addition to immediate 'core obligations' regarding the right to health, other typologies that classify human rights obligations, of either an immediate or progressive nature, are helpful for clarifying states' duties concerning the right to health of irregular migrants.

Recalling the 'Respect, Protect, Fulfil' typology in the previous chapter, states meet their 'obligations to respect' the right to health by, *inter alia*:

> Refraining from denying or limiting equal access for all persons, including prisoners or detainees, minorities, asylum-seekers and illegal immigrants, to preventive, curative and palliative health services; abstaining from enforcing discriminatory practices as a State policy […].[93]

'Obligations to protect' bind states to adopt measures, including legislation, to ensure equal access to health care services provided by third parties to irregular migrants. In this regard, privatisation of the health sector may constitute a threat to the availability, accessibility, acceptability, and quality of health facilities, goods, and services for irregular migrants, as their socio-economic disadvantage and irregular legal status place them in a especially precarious or vulnerable position vis-à-vis third parties' market regulation of basic services.[94] Finally, 'obligations to fulfil' a genuinely universal right to health require states to grant recognition to the right to health of undocumented people in their legal system and to adopt a detailed national health policy that addresses the health of irregular migrants. These obligations require that adequate health care information be provided in an understandable language and that the health care system be made genuinely accessible for undocumented people. The Committee, in this regard, demonstrates to embrace the idea that the ICESCR is a source of 'positive duties to promote equality' in law and policy, which is particularly crucial for

[93] CESCR, GC14 (n 27, Introduction) para 34.
[94] ibid, para 35.

under-represented, powerless, and overall vulnerable groups who may encounter difficulties in directly claiming their human rights in political and legal procedures.[95]

Considering all the various dimensions of health care separately, international human right law, according to the 'AAAQ Typology' requires states to make health care services, goods, facilities (and the underlying determinants) 'available', 'accessible', 'acceptable', and of 'good quality'. Scholars and practitioners in the field of human rights have added 'accountability' and 'participation' to this list.[96] Arguably, the most critical dimensions for irregular migrants are 'acceptability', 'accessibility', 'accountability', and 'participation'.

The health care system must be culturally appropriate or 'acceptable', that is, respectful of 'the culture of individuals, minorities, peoples and communities', including migrants.[97] Furthermore, discrimination in 'accessing' health care, either in the form of ineligibility or excessive limitations to urgent care, is a major issue experienced by irregular migrants. Denial of accessible health care may also occur when requirements for excessive 'out-of-pocket payments' prevent poor irregular people from accessing health services. Regardless of the public or private nature of the service provider, 'primary and emergency care' must remain affordable for everyone. Furthermore, access is *de facto* restricted or prevented when health care staff are under a duty to report irregular migrants to immigration authorities or when the refusal of treatment is simply unaccountable. For instance, the law in Germany states that health care other than emergency treatment should not be free of charge. The cost of the service can be subsidised only if people enter into contact with a social security office, which has a duty to report the status of irregularity to the authorities.[98] In such a case, the entitlement is practically nullified by the combined effect of the non-affordability of the service (an element of the 'accessibility' of the right to

[95] Fredman (n 272, Chapter 2) 299–300.
[96] See *supra* at 4.2.2, Chapter 2.
[97] CESCR (n 27, introduction) para 12.c.
[98] Spencer and Hughes (n 7, Introduction) 12, 16.

health) and by the measures to combat irregular flows.[99]. In Italy, a country where the law is among the least restrictive in the area of access to health care for everyone,[100] administrative barriers to recouping the cost of the health care service have often led hospitals to turn undocumented people away and informally recommend that they rely on NGO clinics.[101] Thus, as migrants' legal status can considerably reduce access to health care, in law and in practice, international bodies are beginning to support the idea of 'firewalls', as indicated in Section 4 below.

This leads to consideration of another critical dimension of the right to health: 'accountability'. Administrative or judicial redress mechanisms must be structured to guarantee the 'anonymity' of undocumented people when they access services to realise their social human rights.[102] Finally, 'participation' is critical for similar reasons. Indeed, it remains difficult for the voices of undocumented people to be heard due to their fear of deportation and to general institutional and state-made barriers to their enjoyment of their rights.

These problems were known to the drafters of the Global Compact for Migration, which, in relation to 'access to basic services' for migrants, stipulates that states should commit, *inter alia*, to:

> Incorporate the health needs of migrants in national and local health care policies and plans, such as by strengthening capacities for service provision, facilitating affordable and non-discriminatory access, reducing communication barriers, and training health care providers on culturally-sensitive service delivery.[103]

[99] CESCR, CG14 (n 27, Introduction) para 12(b)(iii).
[100] See Section 4, Chapter 5.
[101] European Union Agency for Fundamental Rights, *Migrants in an Irregular Situation: Access to Healthcare in 10 European Union Member States* (Publications Office of the European Union) 41–43; NAGA ONLUS, 'Curare non è permesso: Indagine sull'accesso alle cure per i cittadini stranieri irregolari negli ospedali milanesi -Report' <www.naga.it> accessed 1 March 2019.
[102] See *infra* at Section 4.2 on 'Firewalls […]'.
[103] Global Compact for Migration (n 86, Chapter 1) para 31 e).

However, the Global Compact interprets the principle of non-discrimination in a way that does not completely extend to differentiations based on legal status, stipulating that '[…] differential provision of services based on migration status might apply'.[104] This can comply with human rights law when differentiation is 'proportionate' and does not result in an undue limitation of preventive, primary, and emergency care, which is an assessment that the final text of the Global Compact fails remind. The recommendations of the Global Compact, even though they do not refer explicitly to the establishment of 'firewalls', emphasise the need for practical access, as well as formal legal entitlements, to health care.[105]

The next section, on the 'recent developments' of the human rights community in this area, precisely includes the increasing greater support for the idea of practical accessibility to health and social services (through 'firewalls') for irregular migrants. This, together with the other reported developments in the jurisprudence of the human rights bodies, demonstrates a growing, or at least non-decreasing, commitment of international human rights bodies to the idea that irregular migrants' health cannot be limited to emergency measures.

4. Recent Developments

This section sheds light on some important developments that confirm the progressive trend of international human rights law towards the right to health care of vulnerable people, among them irregular migrants, outside of situations of emergency.

It is worth once again recalling that in 2017, the CESCR issued a statement that describes how the concept of core obligations, vulnerability, and non-discrimination specifically play out for asylum seekers and irregular migrants in the context of the ICESCR. This document adds to the overall

[104] ibid, 31 a)
[105] Bethany Hastie, 'GCM Commentary: Objective 15: Provide access to basic services for migrants' (*Refugee Law Initiative Blog* 15 October 2018) <https://rli.blogs.sas.ac.uk/> accessed 1 March 2019.

protective jurisprudence of the CESCR and is particularly significant given the rising anti-migrant sentiments in the Global North.

Apart from this, other initiatives have interpreted international law in a *pro-homine* way: the statements of both the CESCR and the ECSR on the 'austerity measures' prioritise the protection of vulnerable people; a growing number of international human rights bodies are supporting the idea that public service delivery should be strictly separated from public immigration authorities; finally, a certain number of human rights treaty bodies have issued some particularly protective general comments in the area of sexual and reproductive health and children's health, that seem to outlaw differentiations between irregular migrants and country nationals.

4.1. Core obligations, budget constraints, and state practice

This section shows how the jurisprudence of the CESCR and the ECSR resist measures that may have retrogressive effects on the social rights of vulnerable groups in times of austerity, including measures related to accessibility of health care.[106] In the context of the recent global recession and widespread use of austerity measures, which has coincided with the so-called 'migration crisis', measures that disproportionally affected the worst-off were declared inadmissible in both international and European social rights law. In order to avoid over-generalisations, this subsection assesses how these phenomena affected a series of European countries.

The European social model has experienced gradual decay stemming from neoliberal theories since the 1970s, and during the last decade, many European countries have witnessed an intensification of austerity policies that are detrimental to this model and to social rights in general.[107] Cuts to public spending have had a negative impact on socio-economic rights because they are so sensitive to resource allocation, and this has exposed people's material

[106] This section is adapted from Angeleri (n 182, Chapter 1), 182.
[107] O'Cinneide (n 33, Chapter 2) 181; Diego Giannone, 'Measuring and Monitoring Social Rights in a Neoliberal Age: Between the United Nations' Rhetoric and States' Practice' (2015) *Global Change, Peace & Security* 27(2) 173, 176–179.

vulnerability. The protection of socio-economic rights helps people meet their material needs and supports their capabilities when individual or systemic causes prevent them from achieving adequate living conditions, including adequate health-related assistance and care.

As far as health care is concerned, resource constraints have been used to justify a substandard right to health for the undocumented in recent years. In Greece, severe public cuts have generated a crisis in the health system,[108] justifying the retention of domestic legislation that bars irregular migrants from accessing health care, save for the most urgent and life-saving treatment. In the UK, where irregular migrants are currently entitled to free GP 'consultations', but only if they manage to be accepted onto a GP's list,[109] the health-related entitlements of irregular migrants have been restricted in recent years,[110] and public discussions on extending charges for primary care services have recently taken place.[111] To date, Spain remains the most prominent example of a state where unlawful, discriminatory, and explicitly retrogressive measures have targeted irregular migrants. Criticism from advocacy and international bodies has been strong, and, only now, after most Spanish regions – taking advantage of their high degree of autonomy in the area of health – have restored universal public health services for everyone, has the central government lifted the limitations on access and care for irregular migrants.[112]

[108] CESCR, Replies to the List of issues to the second periodic report of Greece (6 August 2015) UN Doc E/C.12/GRC/Q/2/Add.1, para 102.
[109] Milena Chimienti and John Solomos, 'How Do International Human Rights Influence National Healthcare Provisions for Irregular Migrants? A Case Study in France and the United Kingdom' (2015) *Journal of Human Rights* 1, 1–5.
[110] CESCR, COs on the periodic report of the UK (n 179, Chapter 2) para 55.
[111] Department of Health, '*Making a Fair Contribution. A Consultation on the Extension of Charging Overseas Visitors and Migrants Using the NHS in England*' (2015) Visitor and Migrant NHS Cost Recovery Programme. For a 'clinical' perspective on this initiative, see Lucinda Hiam and Martin McKee, 'Making a Fair Contribution: Is Charging Migrants for Healthcare in Line with NHS Principles?' (2016) *Journal of the Royal Society of Medicine* 109(6) 226.
[112] For further details, see Boso and Vancea (n 8) and PICUM (n 8); Real Decreto-ley 7/2018 'Acceso universal al Sistema Nacional de Salud' (27 July 2018) in Spanish <https://www.boe.es/diario_boe/txt.php?id=BOE-A-2018-10752> accessed 15 January 2019.

The economic crisis, as justification for retrogressive measures that limit social entitlements, has only marginally affected the international legal framework for the social rights of irregular migrants. This is because the CESCR, and similarly the ECSR, has always been sufficiently clear by stating that the right to health on a non-discriminatory basis for vulnerable people is a priority of immediate domestic implementation even in times of budgetary constraints.[113]

4.1.1. The CESCR's approach to austerity measures

The response of the CESCR to the economic crisis and austerity came with the Committee Chairman's 2012 'Open Letter to States Parties'.[114] This statement, while making the *prima facie* ban on retrogressive measures less strict,[115] insists that the principle of non-discrimination in relation to vulnerable groups and the core content of rights should not be affected by temporary and proportionate austerity measures and legislative setbacks.

Therefore, retrogressive flexibilities in relation to socio-economic rights in times of crisis bring little, if any, change to international legislative and interpretative standards on the right to essential primary health care for irregular migrants. These rights should be safeguarded against austerity measures through positive actions and should not be the subject of discrimination in law, policy, or practice. Despite this, the narrative of crisis has, as indicated above, fuelled domestic setbacks in Spain and justified the maintenance of a discriminatory *status quo* with the erroneous identification of emergency care as the minimum acceptable standard of care for people in

[113] CESCR, GC3 (n 62, Chapter 2) para 12; CESCR, GC14 (n 27, Introduction) para 18.
[114] Letter of Chairperson (n 179, Chapter 2).
[115] The 'Letter' (ibid) represented a paradigmatic shift from a 'business as usual model' within ICESCR that allowed flexibility through Article 2(1) and 4 but barred exceptional or emergency responses – reflected in the doctrine of non-retrogression – to an 'accommodation model' which allows derogation-style deviations from the Covenant. See the critical remarks of Ben T.C. Warwick, 'Socio-Economic Rights During Economic Crises: A Changed Approach to Non-Retrogression' (2016) *International and Comparative Law Quarterly* 65(1) 249.

irregular situations, in Greece. [116] Economic justifications appear to hide the ever-present tension between human rights regimes at the international level and those at the level of the nation-state and their different ideas about entitlement to rights.[117]

The reaction of the Committee vis-à-vis domestic reluctance to properly implement international standards of health care for irregular migrants in times of crises has not always been unequivocal in terms of either legal argumentation or terminology. The Committee has more frequently mentioned its 2012 Open Letter (the official approach to economic crisis-related retrogressive measures) in relation to those European countries that appear to have used the 'narrative of crisis' in their reports[118] and has explicitly condemned the limitation of medical care to emergency care for people of irregular status in the cases of Greece, Spain, and the UK.[119] Without reference to the crisis, concerns about the provision of only emergency health care were raised in the reporting documents of other states such as Finland, Norway and Germany.[120] Having said this, today, the combination of the CESCR's statements on austerity measures (2012) and state duties for migrants' rights (2017) raise a strong barrier to the legality of domestic retrogressive measures that lower the accessibility of the right to health care of irregular migrants below primary care as an essential element of PHC.

[116] In 2012, in consideration of the measures of austerity that hit the public services, the Minister of Health reminded public hospitals' personnel not to provide free medical care beyond 'emergency care'. Charges applies even to maternal care. See, PICUM, Picum Bullettin <http://picum.org/en/news/bulletins/34547/#cat_25446> accessed 15 November 2017; Spencer and Hughes (n 7, Introduction) 17.
[117] Chimienti and Solomos (n 117) 1-5.
[118] For example, CESCR's COs on the periodic report of Spain (n 89); Iceland (11 December 2012) UN Doc E/C.12/ISL/CO/4; Portugal (8 December 2014) UN Doc E/C.12/PRT/CO/4; Czech Republic (23 June 2014) UN Doc E/C.12/CZE/CO/2; Romania (9 December 2014) UN Doc E/C.12/ROU/CO/3-5; Italy (n 177, Chapter 2); Greece (n 177, Chapter 2); Ireland (n 177, Chapter 2); the UK (n 179, Chapter 2).
[119] CESCR, COs on periodic report of Greece (ibid) para 35; Spain (ibid) paras 41–42; UK (ibid) paras 18, 55, 56.
[120] CESCR, COs on the periodic report of Finland (n 62) para 27; Norway (n 61) para 21: similarly: 'The Committee is concerned that irregular migrants […] do not have access to health-care services other than emergency health-care services'; Germany (n 90).

4.1.2. The ECSR and austerity

Before the CESCR issued its 'open letter' on the relationship between austerity measures and the realisation of socio-economic rights, the ECSR issued an ambitious statement on the effective realisation of social rights in cases of budgetary austerity. This is included in the 2009 General Introduction to the Conclusions and spells out that:

> The economic crisis should not have as a consequence the reduction of the protection of the rights recognised by the Charter. Hence, the governments are bound to take all necessary steps to ensure that the rights of the Charter are effectively guaranteed at a period of time when beneficiaries need the protection most.[121]

Budget cuts to public spending may be a public interest worthy of consideration, but European social rights law, in relation to people's economic 'vulnerability' in times of crisis, require states to fully honour their international progressive duties under the ESC.

In particular, the ESC requires states that wish to take urgent measures to combat the economic crisis to conduct 'the minimum level of research and analysis into the effects of such far-reaching measures that is necessary to assess in a meaningful manner their full impact on vulnerable groups in society'.[122]

Against the often-recalled background of the retrogressive measures introduced in Spain in 2012, which denied irregular migrants access to health care except in 'special situations', the ECSR expressed serious concerns on the legitimacy of such measures, stating, *inter alia*, that 'the economic crisis cannot serve as a pretext for a restriction or denial of access to health care that affects the very substance of that right'.[123]

This conclusion seems to represent an advancement vis-à-vis the position held in the collective complaints procedure that the health and social

[121] ECSR, General Introduction to Conclusions XIX–2 2009 para 15.
[122] *Federation of Employed Pensioners of Greece (IKA-ETAM) v Greece* Com no 76/2012 (ECSR 2012) para 79.
[123] ECSR, Conclusions XX–2 Spain, Article 11(1) ESC.

care of irregular migrants are of concern for the ECSR only when their health and social needs are sufficiently 'urgent and severe'.[124] The progressive full realisation of the social rights of vulnerable or precarious people, including irregular migrants, remains a core issue for the ECSR to monitor, in times of economic crisis and austerity as at any other time.

4.2. 'Firewalls' to guarantee the effective enjoyment of health services by irregular migrants

Realising a right to health that prioritise vulnerable and disadvantaged people, such as those frameworks set out in the CESCR's General Comment No. 14 and the UN debates on the UHC, involves consideration of how to remove existing barriers to the enjoyment of the right to health and access to health care. Whereas it is beyond doubt that a right to health of irregular migrants exists in international and regional human rights law and in many national legal frameworks,[125] it is less clear whether there is agreement on what exactly this right should entail. Having a right does not, in the field of law, just mean to have it codified in a statute, a constitution, or a treaty; procedures are equally important for the effective realisation of a right and should include administrative procedures that guarantee the accessibility to public services and complaint mechanisms. For instance, the ECHR and the ESC often reaffirm that they do not guarantee rights that are 'theoretical or illusory but rights that are practical and effective'.[126]

Irregular migrants experience various barriers to the effective enjoyment of their human rights: their 'irregular' immigration status, compounded by poverty, is the major cause of their 'unfreedom'.[127] The implementation of immigration policies aimed at detecting, processing, deporting, and often criminalising people who do not comply with immigration requirements has rendered very difficult the enjoyment of human

[124] See *supra* at Section 2.2.
[125] Spencer and Hughes (n 7, Introduction).
[126] For example, *Airey* (n 239, Chapter 2); *DCI v the Netherlands* (n 190, Chapter 1) para 27.
[127] See the use of 'unfreedom' by Sen (n 40, Chapter 2) 3.

rights, especially when, as in the cases of health and education, they require state duties to be fulfilled through public authorities and services. To avoid this erosion of public service provision, academics and international bodies have proposed establishing 'firewalls' between immigration enforcement and social services.[128] As far as health care is concerned, establishing 'firewalls' entails, at least, 1) that health care providers and administrative staff involved in the health system have no duty to report migrants' irregular status to immigration authorities; 2) that immigration authorities are prevented from apprehending irregular stayers near health care facilities; and 3) the organisation of health care services, including methods for recouping the cost of services, that guarantees personal data is not disclosed and shared with immigration authorities. These mechanisms do exist in a number of states,[129] including Italy, the case of which is explained in detail in Chapter 5. They represent a balanced solution between international and domestic obligations to provide effective social rights to everyone and the enforcement of sovereign immigration policies. As such mechanisms are normally provided through ordinary statutes and administrative measures, which means they are delicate and at risk of being dismantled in the current political climate of securitisation of borders, new technologies of control, and a general view of (irregular) migrants as a 'danger'.[130]

If the right to health is to be genuinely universal, the establishment of 'firewalls' for the enjoyment of social rights needs to be considered by international and national monitoring mechanisms and to be explicitly recognised as a proportionate solution to the 'human rights-sovereignty' clash in international and domestic courts and tribunals.

---

[128] Joseph Carens, 'The Rights of Irregular Migrants' (2008) *Ethics and International Affairs* 22(2) 163; European Commission against Racism and Intolerance of the Council of Europe (ECRI) 'ECRI General Policy Recommendation No. 16 on Safeguarding Irregularly Present Migrants from Discrimination' (16 March 2016) Ref Doc CRI (2016)16.

[129] François Crépeau and Bethany Hastie, 'The Case for "Firewall" Protections for Irregular Migrants: Safeguarding Fundamental Rights' (2015) *European Journal of Migration and Law* 17 (2–3) 157.

[130] Didier Bigo, 'Criminalisation of "Migrants": The Side Effect of the Will to Control the Frontiers and the Sovereign Illusion', in Bogusz et al. (n 24, Introduction) 61.

The use of firewalls has begun to gain international recognition among, for example, the European Commission against Racism and Intolerance of the Council of Europe, the SR on the Right to Health, and the CRC and CMW Committees.[131] The CESCR has also recently recommended that Germany establish:

> A clear separation (firewall) between public service providers and immigration enforcement authorities, including through repealing section 87 (2) of the Residence Act, to ensure that irregular migrant workers can access basic services without fear.[132]

4.3. Migrant children and the area of sexual and reproductive health

4.3.1. The right to health of all migrant children

Similar 'firewalls' measures were recommended by the Committee of the CRC and the CMW in their recent Joint General Comments, which urge states to:

> Prohibit the sharing of patients' data between health institutions and immigration authorities as well as immigration enforcement operations on or near public health premises, as these effectively limit or deprive migrant children or children born to migrant parents in an irregular situation of their right to health. Effective firewalls should be put in place in order to ensure their right to health.[133]

In the previous chapter, mention was made of the fact that Article 24 CRC, more clearly than other treaties, spells out obligations in relation to PHC. In that regard, the CRC Committee clarified that health care-related core obligations include, substantively, 'ensuring universal coverage of quality primary health services, including prevention, health promotion, care

[131] ECRI (n 128); Grover (n 234, Chapter 2) paras 5, 41; CRC and CMW Committees JCG 4/23 (n 154, Chapter 1) para 56.
[132] CESCR, COs Germany (n 90) para 27.
[133] CMW Committee and CRC Committee, JCG 4/23 (n 154, Chapter 1) para 56.

and treatment services, and essential drugs', and, procedurally, duties of periodic review and monitoring on domestic law and policies regarding the health of children.[134]

In the case of migrant children, the principle of the best interest of the child and the physical, mental, moral, spiritual, and social dimensions of their development, pushed the CRC and CMW Committees to state that 'every migrant child should have access to health care *equal* to that of nationals, regardless of their migration status' and 'migrant children should have access to health services without being required to present a residence permit or asylum registration'. [135]

This pitches the level of children's health care that international human rights law imposes on states at a higher standard than that relating to irregular migrant adults. Significantly enough, the principles of children's development and best interest, as interpreted in CMW/CRC's general comments Nos. 3/22, require states to avoid 'restrictions on adult migrants' right to health on the basis of their nationality or migration status' because such restrictions might affect 'their children's right to health, life and development'.[136] This argument, read in the light of the standards developed by the CESCR, can benefit at least those irregular migrants who are carers of minors, because providing them with only emergency health care in life-saving situations is hardly compatible with those conditions that enable 'the survival, growth and development of their child, including the physical, mental, moral, spiritual and social dimensions of their development'.[137]

[134] CRC Committee, GC15 (n 148, Chapter 2) para 73.
[135] CMW Committee and CRC Committee, JGC 4/23 (n 154, Chapter 1) para 55, 56. Emphasis added.
[136] ibid, para 58. See also, CMW Committee and CRC Committee, JGC 3/22 (n 154, Chapter 1) para 44: '[…] States parties should ensure that children's development, and their best interests, are taken fully into account when it comes to policies and decisions aimed at regulating their parents' access to social rights, regardless of their migration status. Similarly, children's right to development, and their best interests, should be taken into consideration when States address, in general or individually, the situation of migrants residing irregular […]'.
[137] CRC Committee, GC15 (n 148, Chapter 2) para 16.

4.3.2. Positive equalising measures for sexual and reproductive health

Partially building on other instruments of international human rights law,[138] the 2016 CESCR's General Comment No. 22 on sexual and reproductive health has positively contributed to limit legal status-based differentiation regarding access to health care.[139] As far as our target group is concerned, the CESCR states that:

> Prisoners, stateless persons, asylum seekers and undocumented migrants, given their additional vulnerability by condition of their detention or legal status, are […] groups with specific needs that require the State to take particular steps to ensure their access to sexual and reproductive information, goods and health care.[140]

This favour for vulnerable groups, and among them for precarious migrants, is confirmed by the assertive vocabulary that the CESCR used to spell out the 'core obligations' that Article 12 ICESCR generates in this area. Accordingly, state have:

> (a) To *repeal or eliminate laws*, policies and practices that criminalize, obstruct or undermine access by individuals *or a particular group* to sexual and reproductive health facilities, services, goods and information […] (c) *To guarantee universal and equitable access* to affordable, acceptable and quality sexual and reproductive health services, goods and facilities, in particular for women and *disadvantaged and marginalized groups*.[141]

Sexual and reproductive health care should be immediately, universally and equitably accessible by everyone, including irregular migrants that are a priority target for the CESCR, and this obligation is

[138] CEDAW Committee, 'General Recommendation No. 24: Article 12 of the Convention (women and health) (1999) para 6; CEDAW Committee, General Recommendation No. 26 on women migrant workers (5 December 2008) UN Doc CEDAW/C/2009/WP.1/R, paras 17, 18.
[139] CESCR, GC22 (n 185, Chapter 2).
[140] ibid, para 31.
[141] ibid, para 49. Emphasis added.

reinforced by a strong vocabulary ('repeal and eliminate laws and policies') that the CESCR rarely uses.

Conclusions

This chapter showed the different extents to which the right to health care of irregular migrants is protected in European and international human rights law, and how the arguments of international human rights law can be further clarified and developed to generate both procedural and substantive duties for states in relation to primary health care. Borrowing from the analysis of Young on 'core content', discussed in the previous chapter, the European approach seems to embrace an urgent and severe medical 'needs-based minimum core' regarding the right to health.[142] Although it draws on the value of 'human dignity', this is used to rule out only the most severe deprivations of health care. The international system, drawing on the indivisibility of rights, recognises 'thicker' protection and promotion of health as the right to the highest attainable standards of health of an equitable and vulnerability-focussed nature.

Legally qualifying irregular migrants as especially vulnerable people has the consequence that they are among the priority targets of human rights monitoring and that states have specific duties towards them, including duties of a positive nature, and in the field of health. The ECtHR, with its conservative case law vis-à-vis the principle of sovereign immigration management, has expressly avoided doing so, unlike in the case of asylum seekers. The ECHR's scope on civil and political rights has pushed the Court to protect health interests when important violations of the right to life and the freedom from degrading treatment had taken place. This also prevented the Court from directly protecting and promoting the human interest of the highest attainable standard of health of irregular migrants. A partial departure from this logic seems to be the recent quasi-legal jurisprudence of the ECSR.

[142] Young (n 123, Chapter 2).

Unlike the ECHR, several UN bodies, in particular the CESCR, have employed arguments on vulnerability and non-discrimination (as core obligations concerning the right to health) to establish procedural and substantive duties regarding the health care of irregular migrants.

However, the inclusive approach of international human rights law often lacks full clarity: For example, the terminology that the CESCR uses, in its reporting procedure, to describe what discrimination is and the 'level' of minimum acceptable health care for irregular migrants is somewhat confusing. This may jeopardise the operational validity of the 'priority' granted to vulnerable people by the Committee's jurisprudence and is likely to be translated into a lower degree of normative influence, as reflected in some pieces of domestic regulation.

This research elaborated on the international practice and the existing literature to develop a more substantive normative approach based on an unbiased proportionality test of discrimination and the technical concept of PHC. These would push international obligations to prioritise preventive and primary care of irregular migrants – together with emergency care and not in opposition to that - as essential elements of the PHC approach, to be safeguarded with the use of 'firewalls'.

While this chapter uncovers the complexities of conceptualising and implementing access to health care for all, the conceptualisation and operationalisation of other social rights – that support the determinants of health – for irregular migrants are even more constrained. Where these migrants are concerned, the international legal protection of 'other' social rights that support the determinants of health appears to be pitched at a 'survival level' and, in most of the international frameworks, aimed at meeting their 'urgent' needs. Accordingly, the next chapter puts to the test the genuine universality of the inter-sectoral measures that human rights law and public health require.

Chapter 4
The Determinants of the Health of Irregular Migrants in European and International Human Rights Law

The realisation of the right to health requires a well-functioning health care system and measures that support, in the form of prevention and promotion, the determinants of health. This is a straightforward maxim of public health; however, very little human rights literature has grappled with the realisation of social rights other than the right to health, as an aspect of health promotion, especially where undocumented people are concerned. Such social rights include the right to adequate food and water, clothing and housing, social assistance and healthy working conditions.

To comprehensively answer the research question of this thesis and thus evaluate how international and European human rights law address and enhance the right to health of irregular migrants, the social or underlying determinants of health (SDH or UDH) cannot be neglected. Indeed, the WHO recently noted that poor health amongst the migrant population in Europe is significantly linked to poor living condition in destination countries.[1]

The previous chapter, which focused on the levels of access to health care for irregular migrants, revealed significant inconsistencies between the various legal frameworks and a clash between the European survival approach and the international emphasis on primary health care and non-discrimination. This chapter, while noting the fact that the determinants of health are emerging priorities at both the international and the European level, finds that the socio-economic conditions of irregular migrants tend to give

[1] WHO European Region / Italian National Institute for Health, Migration and Poverty (INMP), 'Report on the health of refugees and migrants in the WHO European Region' (WHO 2018) <http://www.euro.who.int/en/media-centre/sections/press-releases/2019/migrants-and-refugees-at-higher-risk-of-developing-ill-health-than-host-populations-reveals-first-ever-who-report-on-the-health-of-displaced-people-in-europe> accessed 21 March 2019.

rise to human rights violations at both levels only when a significant threshold of severity is met.

This chapter is more speculative than the previous one. This is because the determinants of health are a relatively neglected concept in the main frame of reference – human rights law – especially when it comes to irregular migrants in Europe. Accordingly, the chapter is structured slightly differently from the previous one and dedicates greater attention to the theoretical underpinning of the SDH or UDH, mainly to expose the inconsistencies between their aim of empowering vulnerable groups, and the stark reality of life for irregular migrants.

On a conceptual level, Section 1 is split into two subsections. The first of them describes how the determinants of health – employed in research on both public health and human rights – fit within the human rights paradigm. In particular they describe the SDH/UDH and their relations with the principle of indivisibility of rights and the previously mentioned (descriptive and normative) concept of vulnerability. The second sub-section explains the conceptual obstacles to fitting the UDH/SDH within the human rights paradigm where irregular migrants are concerned. It shows why the construct of the welfare state – which targets 'exclusive' forms of social vulnerability – proves to be problematic in relation to precarious forms of immigration and how the 'empowering' function of addressing the determinants of health is emasculated by an authoritarian construction of power.

On an applied level, Sections 2 and 3 test the concepts of determinants of health, which have a universal personal scope, against the reality of the European and international human rights jurisprudence on irregular migrants. Attention is given to those human rights findings that directly employ the terminology of SDH or UDH as well as to those decisions that remind states of their duty to grant a certain level of social rights – that indirectly support the determinants of health – to irregular migrants. As the human rights protection of the UDH involves addressing several other socio-economic rights beyond the right to health, the extensive analysis in the previous chapter on the right to health care cannot be reproduced here for each socio-economic

determinant. The cases referred to in these sections are examples of a trend, which necessitates further research focussing on the relationships between the enjoyment and implementation of individual socio-economic rights and their potential contribution to good health outcomes for irregular migrants.

1. A Conceptual Analysis of the Determinants of Health for Vulnerable Migrants

As previously indicated, this section is dived in two parts: it first explores how the SDH/UDH fit within the human rights paradigm; second, it unpacks the conceptual obstacles to accommodating the determinants of health of irregular migrants in human rights practice.

1.1. The links between the concept(s) of determinants of health and the human rights paradigm

1.1.1. The social and underlying determinants of health

The determinants of health are closely associated with the idea that human health outcomes or statuses are not exclusively shaped by medical factors but are the result of extra-medical factors, such as the socio-economic conditions in which people live and work and their power to change them. This concept is grounded in public health, social medicine, and epidemiology and has gained recognition in human rights law and ethics.[2]

Authoritative global recognition of the SDH is, for example, contained in a series of WHA resolutions, which endorse the 2008 Report of the WHO's Commission on the Social Determinants of Health (CSDH) and the 2011 Rio

[2] *Ex multis*, Amory Winslow (n 2, Chapter 2); Declaration of Alma-Ata (n 28, Introduction) VII.3; UNCHR – WHO Suggestions (n 69, Chapter 2); Marmot and Wilkinson (n 83, Chapter 2); Paula Braveman, 'Social Conditions, Health Equity, and Human Rights' (2010) *Health and Human Rights Journal* 12(2) 31; Chapman (n 159, Chapter 2) 248–253; Daniels (n 5, Introduction) 79–102.

Political Declaration on Social Determinants of Health.[3] These documents define the SDH as a combination of the conditions of daily life and the underlying structural determinants of health. The former constitute the conditions in which people are 'born, grow, live, work, and age' and that shape their health status, such as their access to health care, education, housing, and work opportunities.[4] The latter refers to the inequitable distribution of 'power, money, and resources', which are the 'structural drivers of those conditions of daily life – globally, nationally, and locally'.[5]

In international human rights law, the CESCR has interpreted the right to health set out in Article 12 ICESCR as encompassing the UDH. Therefore, as previously mentioned, the scope of this right embraces:

> A wide range of socio-economic factors that promote conditions in which people can lead a healthy life and extends to the 'underlying determinants of health', such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.[6]

Furthermore, the CESCR recognises, albeit in a cursory way, 'resource distribution', 'gender', and 'education' as determinants of health.[7] Overlaps between the public health and human rights arguments are acknowledged by the former SR on the right to health when, in his 2005 report to the UNGA, he recognised that 'there is considerable congruity between the CSDH's mandate and the underlying determinants of health (UDH) dimension of the right to health'.[8] The UDH can receive legal protection in human rights law if that body of law adequately upholds both the right to health and other socio-economic rights that support it, such as the right to an adequate standard of living, water, housing, and a healthy environment. This

[3] WHA Res 62.14 'Reducing Health Inequities through Action on the Social Determinants of Health' (21 May 2009); WHA Res 65.8 'The Outcome of the World Conference on Social Determinants of Health' (26 May 2012).
[4] WHO-CSDH, 'Closing the Gap' (n 92, Chapter 2) 1.
[5] ibid, 2.
[6] CESCR, GC14 (n 27, Introduction) para 4.
[7] ibid, paras 10, 16.
[8] Paul Hunt, Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (12 September 2005) UN Doc No A/60/348, para 7.

highlights the interconnectedness of socio-economic rights, an interconnectedness which empowers people and enhances the individual and collective enjoyment of healthy living conditions.

However, although this chapter often refers to 'the determinants of health' without distinguishing between the SDH and the UDH, these concepts do differ slightly: human rights law – often preoccupied with a biomedical approach to health, particularly in Europe – largely omits to explicitly include 'income, power, resources, and social class' among the determinants of health.[9] The SDH, as embraced by the WHO in its recommendations, shed light on consistent patterns of inequality and their impact on health.[10] Therefore, appropriate health measures should strive to achieve health equity by tackling, *inter alia*, the structural determinants of social class divisions. This programmatic call for a rebalancing of power dynamics is less apparent in human rights law, despite a growing interest in the relation between poverty and human rights.[11] Although socio-economic rights provide, in principle, a legal tool to protect the rights supporting the UDH (and, at least in part, the SDH), they are more focused on progressive state measures and on the immediate realisation of the 'minimum essential level of each right' on a non-discriminatory basis than on addressing the underlying structural causes of inequality.[12]

As health equity is a 'concept based on the ethical notion of distributive justice',[13] it is appropriate to consider some of the most authoritative theories that provide ethical justifications for the SDH. The SDH, as defined by the Report and embraced by the WHO, are conceptualised as the 'means' to achieve health equity through the elimination of differences among sub-national groups and intra-national communities in terms of health

[9] Chapman (n 159, Chapter 2) 250–251, 255–257.
[10] Kristi Heather Kenyon, Lisa Forman and Claire E. Brolan (2018) 'Editorial. Deepening the Relationship between Human Rights and the Social Determinants of Health: A Focus on Indivisibility and Power' *Health and Human Rights Journal* 20(2) 1, 8.
[11] For example, see the CESCR, Statement on Poverty and the International Covenant on Economic, Social and Cultural Rights (4 May 2001) UN Doc.E/C.12/2001/10; ECSR, Conclusions 2013 - Statement of interpretation on Article 30 ESC (2013) Doc no 2013_163_06/Ob/EN.
[12] CESCR, GC3 (n 62, Chapter 2) para 10.
[13] Braveman (n 2) 31.

outcomes. This instrumentality can also be seen in Norman Daniels' and Amartya Sen's justifications of the right to health and human rights. According to them, human rights are essential means to realise further 'valued features of human lives'.[14] Daniels calls these valued features 'basic needs' while Sen speaks of 'human capabilities'. Daniels draws on Rawls' theory of justice as fairness to argue that the right to health – including the promotion and restoration of health through the determinants of health and health care – entails the provision of a fair range of individual equal opportunities for people to function and have their basic needs met.[15] Sen and Nussbaum, proponents of the 'capability approach', theorise that human rights – including the right to health care and to the determinants of health – protect the opportunity to choose, to act, and ultimately to achieve certain functions or a flourishing life.[16] Sen's capability approach is expressly referred to in the Report of the CSDH.[17]

1.1.2. The determinants of health and the concept of vulnerability

As explained at the end of chapter 2, the CESCR has clarified that the progressive and immediate establishment of 'facilities, goods, services, and *conditions* necessary for the realization of the highest attainable standard of health' should be available, accessible, acceptable, and of good quality (AAAQ) for everyone, in particular for vulnerable people.[18] Accordingly, the concept of vulnerability provides a useful conceptual bridge between the SDH and the human right to health. Indeed, human vulnerability to ill-health is the common target of both the 'intersectoral' measures that address the SDH with the aim of achieving health equity and the 'interrelated' human rights approach, dealt with below.[19] The social environment, and in particular social

[14] Siegfried Van Duffel, 'Moral Philosophy', in Shelton (n 32, Chapter 1) 33.
[15] Daniels (n 5, Introduction) 20–21.
[16] Sen (n 4, Introduction) 332; Nussbaum (n 4, Introduction) 20–26.
[17] CSDH (n 92, Chapter 2) 1.
[18] CESCR, GC14 (n 27, Introduction) paras 9, 12, 18, 43(a), 43(f). Emphasis added.
[19] World Conference on Social Determinants of Health: Rio Political Declaration on Social Determinants of Health (19–21 October 2011) paras 1, 6; on the concept of 'interrelatedness' of human rights see *infra* at Section 1.1.3.

affiliations and social status, may be important risk factors (vulnerability factors) in relation to psychosocial health.[20] Thus, the Report of the CSDH emphasises the key role of the SDH in 'closing the gap' created by health inequities within and between societies, implying the need to target the situation of people who are especially vulnerable to ill-health because of the ways in which the structural drivers of inequality play out in their circumstances.[21]

Furthermore, as previously highlighted, whereas some scholars identify with the protection of 'human vulnerability' in the face of arbitrary state power as the raison d'être of human rights, the dominant human rights practice conceptualises group-based vulnerability and emphasises non-discrimination as an immediate core state obligation and an essential tool in striving to improve the health of the worst off.[22]

To address the socio-economic vulnerability of disadvantaged groups, including in the field of health, the human rights community employs the concept of substantive equality, whereby recognising the special vulnerability of a certain group and individuals corresponds to the necessity for a certain type of targeted state duty, also of a positive nature. This requires abandoning the paradigm of formal equality – i.e. treating everybody in the same way without acknowledging realistic differences in opportunities or capabilities – and adopting measures to reach true equality of opportunity and outcome and to free human capabilities.[23] The analysis at the end of Chapter 2 offers examples of how both European and international courts and tribunals employed vulnerability in a normative way to address substantive discrimination. Similarly, the WHO Report on the SDH recommends that states adopt 'active intersectoral measures' to tackle substantive discrimination in health and strive to achieve health equity, particularly for the worst off.[24]

[20] Richard G. Wilkinson, 'Ourselves and Others – For Better or Worse: Social Vulnerability and Inequality', in Marmot and Wilkinson (n 83, Chapter 2) 341, 344.
[21] CSDH (n 92, Chapter 2) 42, 49, 55, 60, 71, 84, 97, 171, 174.
[22] See Section 7, Chapter 2.
[23] Fredman (n 272, Chapter 2) 25–33.
[24] CSDH (n 92, Chapter 2) 200–206; WHA 62.14 (n 2).

1.1.3. Indivisibility and inter-relatedness

The concept of indivisibility is integral to both the determinants of health and human rights law, and links both fields. Indeed, it is only by attaching the same value and worth to every human right that individual dignity and valued human interests can be protected and people can live dignified, empowered, and flourishing lives.

The term 'indivisibility' commonly refers to the characteristic whereby something cannot be separated from something else. In human rights law, it specifically refers to states' duty to treat all human rights 'globally in a fair and equal manner, on the same footing, and with the same emphasis'.[25] The human rights emphasis on indivisibility has evolved through times of ideological disagreement between states on the translation of human rights obligations into binding instruments and on the separation of civil and political rights on the one hand from economic, social and cultural rights on the other.[26] Indivisibility means that all rights are equally important and should be regarded as such to respect, protect, and fulfil human dignity, freedom, and equality. The concepts of 'interrelatedness' and 'interdependency' are often mentioned together with 'indivisibility' in connection with human rights. These refer to the fact that no human right can be realised in isolation: each right requires the enjoyment of other rights to function and often represents a precondition or element of other human rights. The right to water is a good example:

> Water is a limited natural resource and a public good fundamental for life and health […]. The right to water is […] inextricably related to the right to the highest attainable standard of health […] and the rights to adequate housing and adequate food […]. The right should also be seen in conjunction with other rights

[25] Vienna Declaration and Programme of Action (n 25, Chapter 2) para 5.
[26] Daniel J. Whelan, *Indivisible Human Rights (*University of Pennsylvania Press 2011) 1–10.

> enshrined in the International Bill of Human Rights, foremost amongst them the right to life and human dignity.[27]

As previously indicated, Article 25 UDHR is also significant in its stipulation that the right to health, the right to social security, and the right to an adequate standard of living are inextricably linked for the realisation of a dignified healthy life. For the WHO, the SDH exemplify the characteristics of interdependence and interrelatedness with regard to certain conditions of life – i.e. the interests protected by socio-economic rights – and the underlying power structures that affect health outcomes.[28] Overall, intersectoral or inter-dependant measures, that protects and promotes health beyond health care, should address unhealthy living conditions by also challenging the causes of structural inequality in health.

In sum, the public health and human rights fields share, explicitly or implicitly, various concepts – vulnerability, substantive equality, indivisibility – which help situate the SHD/UDH within the human rights conception of the right to health. However, as the next section describes, human rights as a branch of international law also accommodates state interests, interests which are particularly acute in the area of irregular migration. This undermines the SDH/UDH as essential elements of the human right to health of irregular migrants.

1.2. Conceptual obstacles to accommodating the determinants of health of irregular migrants within the human rights paradigm

As previously argued, irregular migrants – because of their irregular immigration status, socio-economic-institutional exclusion, and the consequential lower quality and quantity of resources they command – are particularly 'vulnerable' to human rights violations, although they are not always recognised as such and thus deserving of especially empowering measures in all legal frameworks. Recalling the arguments of the previous

[27] CESCR, GC15 (n 106, Chapter 2).
[28] WHA Res 65.8 (n 3) 1.

chapters on how the clash between sovereignty and migrants' rights plays out in their situation of vulnerability, this subsection addresses the current failings of the welfare system(s) and of the construct of 'power as empowerment' in genuinely enhancing irregular migrants' rights.

1.2.1. Immigration and welfare rights

The implementation of social rights (that support the determinants of health) in the Western world is intimately linked to the establishment of a 'welfare state' or 'social state'.[29] As Chapter 2 explains, the history of social rights goes hand in hand with that of the Western welfare state, and both phenomena have gained international mainstream recognition since World War II.[30] Public health research has also recognised the need to consider the SDH from a welfare state perspective.[31]

The dominant literature on social policy recognises that immigration represents a threat to a strong welfare state.[32] Welfare is essentially a 'protectionist and nationalist' concept according to which limited resources are transferred from the better off to the worse off 'within a given society'.[33] Whereas nationalism and the idea of the welfare state worked in the UK as a 'social glue' between citizens and non-citizens and helped to rebuild the nation and establish national solidarity during the years following the end of World War II, contemporary forms of nationalism operate according to a set of values that run counter to the granting of social benefits to all immigrants.[34]

---

[29] See Section 2, Chapter 2, in particular Katrougalos (n 33, Chapter 2).
[30] Toomas Kotkas, 'The Short and Insignificant History of Social Rights Discourse in the Nordic Welfare State', in Toomas Kotkas and Kenneth Veitch (eds) *Social Rights in the Welfare State: Origins and Transformations* (Routledge 2016) 15.
[31] Clare Bambara, 'Going Beyond the Three Worlds of Welfare Capitalism: Regime Theory and Public Health Research' (2007) *Journal of Epidemiology & Community Health* 61(12) 1098.
[32] Diane Sainsbury, *Welfare States and Immigrant Rights. The Politics of Inclusion and Exclusion* (OUP 2012) 1–10.
[33] Gunnar Myrdal, *Beyond the Welfare State: Economic Planning in the Welfare States and its Economic Implications* (Duckworth 1960) as referred to in Han Entzinger, 'Open Borders and the Welfare State', in Antoine Pécoud and Paul de Guchteneire (eds) *Migration without Borders: Essays on the Free Movement of People* (Berghan / UNESCO 2007) 119.
[34] Gerard Delanty, 'Beyond the Nation-State: National Identity and Citizenship in a Multicultural Society – A Response to Rex' (1996) *Sociological Research Online* 1(3) 1.

Social heterogeneity is even described as a factor that undermines solidarity within nations and that contributes to working-class fragmentation.[35] Finally, since the 1980s, a rising trend of neoliberal ideologies and policies – interlinked with race, poverty, and immigration – has fuelled a gradual dismantling of the welfare state and a shift from universal access to 'residual approaches' for socially excluded people.[36]

Granting social rights to migrants would conceptually destabilise the traditional T.H. Marshal scheme of rights acquisition 'from civil rights to political rights, and from the latter to social rights', because it would mean that, before gaining political rights in a state, migrants would enjoy social rights by virtue of their legally recognised or actual 'residence' rather than on the ground of their citizenship or nationality.[37] Research in the area of social policy has debated whether it is desirable for the (financial) sustainability of national systems to extend welfare provisions to migrants and whether different welfare regimes influence the quality and quantity of social benefits available to non-nationals.[38] The influential analysis of welfare state regimes by Gøsta Esping-Andersen also encounters conceptual difficulties where migrants – particularly irregular migrants – are concerned.[39] Esping-Andersen classifies welfare state regimes as liberal, conservative, or social democratic. In liberal regimes, welfare is funded by the market and the state, and state provision is minimal and is aimed at poverty reduction for the neediest. Conservative or corporatist regimes regard 'work' as a basis for entitlement to generous welfare provisions and support residual programmes for the non-employed population. In social democratic systems, 'citizenship/(legal) residence' is the basis for entitlement and the guarantor of

[35] Gary P. Freeman, 'Migration and the Political Economy of the Welfare State' (1986) *Annals of the American Academy of Political and Social Science* 485, 51.
[36] Katie Bales, 'Asylum Seekers, Social Rights and the Rise of New Nationalism: From an Inclusive to Exclusive British Welfare State?', in Kotkas and Veitch (n 30) 109; Stephen Castles and Carl-Ulrik Schierup, 'Migration and Ethnic Minorities', in Francis G. Castles et al. (eds) *The Oxford Handbook of the Welfare State* (OUP 2010) 278, 287–288.
[37] Virginie Guiraudon, 'The Marshallian Triptych Reordered: The Role of Courts and Bureaucracy in Furthering Migrants' Social Rights', in Michael Bommes and Andrew Geddes (eds) *Immigration and Welfare: Challenging the Borders of the Welfare State* (Routledge 2000) 72.
[38] Sainsbury (n 32).
[39] Gøsta Esping-Andersen, *The Three Worlds of Welfare Capitalism* (Polity Press 1990).

universal access to welfare. Since the second and third systems generally reserve 'income maintenance' and 'well-being' (e.g. through health and social assistance systems) for regular workers, regular residents, and citizens, it is intuitive that irregular migrants fall, in principle, outside of these welfare systems. Liberal regimes are 'conceptually' a better fit for undocumented people, although they are less generous in terms of the quality of benefits and more likely to be emergency-oriented as they target 'poverty alleviation'.[40] It is important to recall, for the analysis in Chapter 5, that Mediterranean forms of 'conservative welfare' distinguish between the provision of universal health care and other more restrictive work-related, corporatist social benefits.[41]

While human rights scholars cannot overlook these policy-based considerations, their entire discipline revolves around some universal minimum (legal) entitlements for the protection of human dignity, equality, and freedom, regardless of people's nationality or immigration status. However, in spite of the declared universal scope of human rights, international and European human rights law tend to use regular presence and/or prolonged residence rather than personhood as the main criteria for enjoying socio-economic rights to their full extent. The teachings of Hannah Arendt are instructive in this regard. She regarded citizenship as the legal belonging to a political community and hence as the 'right to have rights'.[42]

For instance, a comparison between Sections III and IV of the CMW demonstrates that documented or regular migrants should 'enjoy equality of treatment' with nationals in relation to education, housing, and social and health services, whereas irregular migrants should enjoy only 'the basic right of access to education' and 'medical care that is urgently required for the preservation of [...] life or the avoidance of irreparable harm'.[43] In the European context, the case law of the ECtHR has begun, with the case of

[40] Sainsbury (n 32) 7–113.
[41] Maurizio Ferrara, 'The South European Countries', in Francis G Castles et al. (n 36) 616, 621.
[42] Hannah Arendt, *The Origins of Totalitarianism* (first published 1950, Harcourt 1968) 177, 278.
[43] CMW (n 14, Introduction) Articles 28, 30, 43.

Gaygusuz, to consider that states should put forward 'very weighty reasons' to justify different treatments in relation to the enjoyment of rights based on the ground of 'nationality'. In the above case, the Strasbourg Court ruled out the denial of social security benefits on the sole ground of nationality to a regular migrant with over 10 years' residence in Austria, because it was discriminatory and hence incompatible with Articles 14 and 1 Protocol 1 ECHR.[44] However, as the pages that follow show, unlike 'nationality', which is considered a suspect ground for differentiation,[45] 'irregular immigration status' has not been fully recognised by the ECtHR as an illegitimate criterion for differential treatment where human rights, and in particular social rights, are concerned.[46]

Even though irregular migrants are guaranteed a certain minimum level of protection in all international human rights frameworks, the question of what is meant by the 'minimum acceptable level' of socio-economic rights that support the determinants of health – whether it is a value-based and dignified minimum or a needs-based and survival minimum,[47] a 'minimal' or an 'adequate' provision of social benefits –[48] remains unclear.

The next subsection demonstrates that irregular immigration status, which is the result of restrictive domestic powers in the area of immigration, seems to negate the empowering aspects of human rights and the determinants of health, thus leading to the reduction of the social rights of irregular migrants – other than the previously discussed right to health care in international law – to bare survival level.

1.2.2. The constructions of power and the rights of irregular migrants

[44] *Gaygusuz* (n 97, Chapter 1) para 42.
[45] For a critical analysis of *Gaygusuz* in the light of subsequent contradicting cases before the ECtHR, see Dembour (n 5, Chapter 1) 251–281.
[46] *Anakomba Yula v Belgium* App no 45413/07 (ECHR 2009) para 37; *Ponomaryov and Others v Bulgaria* App no 5335/05 (ECHR 2011) para 54.
[47] Young (n 123, Chapter 2).
[48] David Bilchiz, *Poverty and Fundamental Rights: The Justification and Enforcement of Socio-Economic Rights* (OUP 2007) 187–188.

Addressing the determinants of health, on a conceptual level, aims to 'enable' or 'empower' people to reach their highest attainable standard of health. Addressing them systemically aims at achieving health equity by considering extra-medical factors and adopting intersectoral measures. For this reason, power and indivisibility are used as conceptual angles to examine the SDH.[49] Whereas, 'indivisibility', 'interrelatedness' and 'interconnectedness' deal as conceptualised in human rights doctrine, with 'relationships between rights', 'power' grapples with 'relationships between subjects', be they individuals, institutions, or states.

Power is a contested and interdisciplinary concept. While this research does not intend to give a full account of the abundant literature on this concept, it does make a distinction between 'power over' (authority) and 'power to' (empowerment).[50] The former can be described as 'the probability that one actor within a social relationship will be in a position to carry out his own will despite resistance […]'.[51] The latter represents 'the human ability not just to act but to act in concrete', to be enabled, as suggested by the Latin etymology *potere*, which means to be capable of doing something.[52]

In international human rights law, power can be synonymous with state authority or sovereignty, which – as demonstrated in Chapter 1 - is itself a structural principle of international law. This is precisely the target of human rights, as they limit or qualify state powers while they empower people vis-à-vis the arbitrary exercise of state authority. Therefore, international human rights law incorporates both dimensions of power, which can generate friction and inconsistencies between rules and foundational principles within the same legal framework. As far as irregular migrants are concerned the balancing between 'sovereignty as power over' and the interpretation of the human right to the determinants of health as 'empowerment' may lead to

[49] Kenyon, Forman and Brolan (n 10) 1–8.
[50] Amy Allen, 'Feminist Perspectives on Power' in *The Stanford Encyclopedia of Philosophy* (2005–2016) <https://plato.stanford.edu/entries/feminist-power/> accessed 1 March 2019.
[51] Max Weber, *Economy and Society: An Outline of Interpretive Sociology* (University of California Press 1978) 53.
[52] Hannah Arendt, *On Violence* (Harcourt Brace & Co. 1970) 44.

often unpredictable legal consequences that are difficult to justify under a genuinely embraced human-rights-based approach.

Indeed, the CESCR acknowledges that:

> […] the lack of documentation frequently makes it impossible for parents to send their children to school, or for migrants to have access to health care, including emergency medical treatment, to take up employment, to apply for social housing or to engage in an economic activity in a self-employed capacity.[53]

The institutional and social exclusion of irregular migrants, together with their consequential precarious living conditions, constitute unfavourable determinants of health. Against this background, in the context of migration, 'power' is often synonymous with 'state authority to regulate immigration by way of executive discretion', and this power is recognised, although with different intensity, in both international and European human rights law.[54]

In the fields of public health and social medicine, states' authority to regulate is implied. However, greater attention is drawn to the enabling or empowering function of maintaining certain conditions of life and to the distribution of resources, money, and power, which correspond to the concept of 'empowerment'. Indeed, the WHO member states have been urged to 'contribute to the empowerment of individuals and groups, especially those who are marginalized, and to take steps to improve the societal conditions that affect their health'.[55] However, it is to be noticed that the Report of the CSDH and the WHO's resolutions discussed in this chapter do not significantly elaborate on the special powerlessness and vulnerability of irregular migrants. The former, for instance, explicitly mentions irregular migrants only once in relation to their precarious employment and exploitation in the informal economy.[56]

[53] CESCR, Statement (n 153, Chapter 1) para 11.
[54] See Chapter 1.
[55] WHA Res 62.14 (n 3) para 3(7).
[56] CSDH (n 92, Chapter 2) 80.

1.3. Is the commitment of empowering irregular migrants with indivisible rights a mere rhetoric?

Whereas irregular migrants are undeniably people in a vulnerable of precarious socio-economic situation in our societies, the conceptual obstacles to normatively accommodate their determinants of health within human rights, public welfare and public health are several in number. As far as human rights practice is concerned, power - when it defines the individual 'empowerment' of people who do not have the right to stay in a certain territory - is antithetical to the dominant doctrine of the power of states to exclude. Indeed, power as 'authority to exclude' is behind the maintenance of an enjoyment of the social rights that support the determinants of health to a bare minimum level, as exemplified by some cases in the following sections.

The concepts of interdependence, interrelatedness, and the indivisibility of human rights are, in principle, aimed at assigning the same dignity and value to all human rights and at bridging the conceptual gap between traditionally enforceable civil and political rights and non-justiciable economic, social, and cultural rights. In legal practice, they facilitate the indirect judicial protection of socio-economic interests through civil rights-related litigation, rather than equalised, parallel, or integrated forms of protection.[57] Whereas this jurisprudence on indirect protection is undeniably significant in advancing the socio-economic judicial protection of people,[58] where otherwise impossible, it has also framed the legal protection of (health care and) the determinants of health, in exceptional terms, by instrumentally safeguarding life and personal integrity rather than health as a human and social value in itself. As mentioned in this and the previous chapter, European human rights law has tended to acknowledge violations of irregular migrants' rights only when they are in dire need of socio-economic protection as 'a

[57] See Section 6.1, Chapter 2, and Section 2.1, Chapter 3.
[58] Ioana Cismas, 'The Intersection of Economic Social and Cultural Rights and Civil and Political Rights' in Eibe Riedel, Gilles Giacca and Christophe Golay (eds) *Economic Social and Cultural Rights in International Law: Contemporary Issues and Challenges* (OUP 2015) 448. Ingrid Leijten, *Core Socio-Economic Rights and the European Court of Human Rights* (CUP 2018) 259-316.

finding to the contrary would place too great a burden on the contracting states'.[59]

The analysis of the human rights practice that follows, regarding the social rights that support the determinants of health, regardless of immigration status, unveils certain inconsistencies between international and European standards. In the contentious areas of immigration, welfare, and health, these partial inconsistencies reveal different ways of accommodating the relation between human rights and state sovereignty and between 'universalism and particularism'.[60]

2. European Human Rights and the Determinants of Health of Irregular Migrants

European human rights law makes no 'explicit' mention of the 'determinants of health' within the scope of health-related rights. However, laws and cases regarding the socio-economic conditions of migrants have been adjudicated before the ECtHR and the ECSR. It is also important to recall, once again, the limited material and personal competence of the ECHR and the ESC when issues concerning the socio-economic rights of irregular migrants are raised,[61] and that the sovereign state power to establish immigration policies represents the starting point for most of the case law of these European human rights adjudicators. These factors have affected the quality of the legal standards and the case law that the European human rights systems have developed in the area of social rights.

2.1. The case law of the ECtHR

As a consequence of the interrelatedness of civil and political and socio-economic rights, the Strasbourg Court has, since the 1980s, extended the material scope of the civil rights of the ECHR to situations that have

[59] *A.S.* (n 22, Chapter 3) para 31.
[60] Dembour (n 5, Chapter 1) 251.
[61] See Sections 3.2, 4.2, Chapter 1; Section 6, Chapter 2; Section 2, Chapter 3.

implications of a social or economic nature.[62] However, the level of 'deprivation and want incompatible with human dignity' that is needed to reach the threshold of applicability of the ECHR in the socio-economic area is difficult to achieve.[63] Furthermore, it is worth noting in relation to 'general measures of economic and social strategy' – including measures of socio-economic assistance – that state parties to the ECHR have a wide margin of discretion. As a general rule, only 'manifestly unreasonable' socio-economic measures are ruled out by the Court.[64] In relation to social support and housing, under Articles 2 (life), 3 (prohibition of inhuman or degrading treatment), and 8 (private and family life) ECHR, only situations of poverty affecting the most marginalised groups and those who are fully dependent on state support seem to qualify for protection under ECHR.[65]

Most of the applicable standards concerning migrants' health have been developed in 'removal cases', where the Court has assessed whether the removal of an unhealthy migrant from a state and his or her deportation to a certain country risk breaching the principle of 'non-refoulement' implicit in Article 3 ECHR. The ECtHR, as demonstrated in the previous chapter, has clarified the scope of the exceptional circumstances in which severe, irreversible and declining health conditions may prevent the removal of aliens.[66]

As previously mentioned, the Court often begins its analysis of migrant-related cases by clarifying that it is a well-established principle of international law that states can set norms on immigration to prevent irregular

[62] *Airey* (n 239, Chapter 2) para 26.
[63] *Budina v Russia* App no 45603/05 (Decision ECHR 2009).
[64] For example, *Stec and Others v the United Kingdom* App nos 65731/01 and 65900/01 (ECHR 2006) para 52; *Carson and Others v the United Kingdom* App no 42184/05 (ECHR 2010) para 61.
[65] For example, *Ndikumana v the Netherlands* App no 4714/06 (ECHR Decision 2014) para 44; *M.S.S.* (n 120, Chapter 1) paras 249–264; *James et al v the United Kingdom* App no 8793/79 (ECHR 1986) para 47; *Yordanova et al v Bulgaria* App no 25446/06 (ECHR 2012) para 130. For further analysis, see Nicola Napoletano, 'Estensione e limiti della dimensione economica e sociale della Convenzione Europea dei Diritti Umani in tempi di crisi economico-finanziaria' (2014) *Diritti Umani e Diritto Internazionale* 8(2) 389, 394–417. Leijten (n 58) 259.
[66] *Paposhvili v Belgium* (n 36, Chapter 3) paras 172–183; further details at Section 6.1, Chapter 2, Section 2.1, Chapter 3.

flows.[67] This starting point extends state discretion when implementing 'non-absolute' human rights,[68] and raises the threshold of protection of 'absolute rights' so that only dire deprivations give rise to a violation of European human rights law.

For example, in a series of cases regarding the conditions of detention of irregular migrants and asylum seekers in Greece, the Court held that the material conditions of detention centres constituted degrading treatment that violated migrants' human dignity.[69] These findings were linked to extreme situations of unhealthy living conditions in overcrowded detention facilities characterised by an absence of cleanliness, appalling conditions of hygiene and sanitation, inadequate medical care, and/or lack of facilities for leisure or meals.

The approach of the Court with regard to the social and health care of irregular migrants can be illustrated by comparing the arguments used in the case of *M.S.S.* with those employed in the case of *Hunde*.[70] The former concerned severe socio-economic deprivation to which asylum seekers were exposed in Greece, which left unmet their 'most basic needs: food, hygiene and a place to live'.[71] The latter involved a claim regarding emergency social care for irregular migrants in the Netherlands, in particular, access to shelter. Whereas the dire living conditions and the special vulnerability and state dependency of asylum seekers led the Court to find a violation of Article 3 ECHR in *M.S.S.*, the lack of legal status of Mr. Hunde and of a situation of 'extreme poverty' did not qualify him as sufficiently 'vulnerable' to fall under the protection of the same article. This resulted in his application being deemed manifestly ill-founded and thus inadmissible. Similarly, irregular migrants were not considered particularly vulnerable when their conditions of migrant detention where scrutinized in the case of *Khlaifia*. Indeed,

[67] See Section 3.1, Chapter 1.
[68] *Saadi* (n 109, Chapter 1).
[69] *A.A. v Greece* App no 12186/08 (ECHR 2010) paras 49–65; *C.D. and Others v Greece* App nos 33441/10, 33468/10 and 33476/10 (ECHR 2013) paras 35–37, 47–54; *F.H. v Greece* App no 78456/11 (ECHR 2014) paras 96–102.
[70] ECtHR, *M.S.S.* (n 120, Chapter 1) paras 249–264; *Hunde* (n 43, Chapter 3) paras 55, 59.
[71] ibid (*M.S.S.*) para 254.

although the Court recognised that the migrant centre in that case 'was not suited to stays of more than a few days', the relative assessment of the level of severity that must be met under article 3 ECHR resulted in a finding of no violation.[72]

Unlike in the case of *Hunde* and *Khlaifia*, the Court categorised irregular migrants as vulnerable people in the recent case of *Chowdury and Others.*[73] Here, however, the finding of 'vulnerability' was linked to the specific circumstances of the case, which concerned trafficked (irregular) migrants who were kept in dire living and working conditions and subjected to forced labour under the threat of armed men, which is covered by Article 4(2) of the ECHR.[74]

Two further cases elucidate the ECtHR's approach to the right to education and housing and its general approach to the social rights of migrants with either irregular or precarious immigration status. In *Ponomaryovi,* the Court assessed the state practice of charging regular and irregular migrants different secondary education fees under the lens of Protocol 1, Article 2 on the right to education, in combination with the prohibition of discrimination in Article 14. The case is interesting because, notwithstanding the finding of a violation on the merits (the case concerned two Russian-born brothers that had been living in Bulgaria since their childhood before they became irregular at the age of 18), the following *obiter* statement reveals a distinct 'sovereigntist' stance:

> [the] state may have legitimate reasons for curtailing the use of resource-hungry public services – such as welfare programmes, public benefits and health care – by short-term and illegal immigrants, who, as a rule, do not contribute to their funding. It may also, in certain circumstances, justifiably differentiate between different categories of aliens residing in its territory. […]

[72] *Khlaifia* 2016 (n 124, Chapter 1) para 197.
[73] *Chowdury and Others v Greece* App no 21884/15 (ECHR 2017), para 97 : 'la Cour note que les requérants ont commencé à travailler alors qu'ils se trouvaient dans une situation de vulnérabilité, en tant que migrants en situation irrégulière n'ayant pas de ressources et courant le risque d'être arrêtés, détenus et expulses. […]'.
[74] ibid, paras 92–101.

> In assessing that proportionality, the Court does not need, in the very specific circumstances of this case, to determine whether the Bulgarian State is entitled to deprive all unlawfully residing aliens of educational benefits […] It must confine its attention, as far as possible, to the particular circumstances of the case before it. […] The applicants were not in the position of individuals arriving in the country unlawfully and then laying claim to the use of its public services, including free schooling.[75]

Conversely, in the case of *Bah*, the Court did not find a violation of Articles 14 and 8 ECHR in relation to the denial of social housing to a person who had indefinite leave to remain and who wanted to live with her son who only had conditional leave to remain. The judgement is significant because, although the Court accepted that 'immigration status can amount to a ground of (prohibited) distinction' for the purposes of the non-discrimination clause as per Article 14 ECHR, in this case:

> Given the element of choice involved in immigration status, […] while differential treatment based on this ground must still be objectively and reasonably justifiable, the justification required will not be as weighty as in the case of a distinction based, for example, on nationality. Furthermore, given that the subject matter of this case – the provision of housing to those in need – is predominantly socio-economic in nature, the margin of appreciation accorded to the Government will be relatively wide.[76]

This case is instructive because the Court links the findings of non-violation to a series of factors, including the preservation of limited welfare resources and the element of 'choice' attached to immigration. Such findings are likely to severely limit the qualification threshold for claims of socio-economic discrimination where irregular or precarious migrants are concerned.

---

[75] *Ponomaryov* (n 46) paras 51–64.
[76] *Bah v the United Kingdom* App no 56328/07 (ECHR 2011) paras 45, 47.

Overall, the ECtHR, lacking socio-economic competence and emphasising state sovereign immigration powers, has not developed empowering and interrelated standards regarding the welfare and material conditions of irregular migrants.

2.2. The growing jurisprudence of the ECSR

The ECSR has upheld a series of decisions on the socio-economic conditions of irregular migrants. It has 'adjudicated' on the merits of collective complaints in this area, despite the limited personal applicability of the norms of the ESC.[77] Although these decisions do not use the term 'determinants of health', they clearly demonstrate the reliance of the ECSR on the link between health and socio-economic conditions to prohibit certain exclusionary state practices.

In *DCI (v. The Netherlands)*, the ECSR held that 'children unlawfully present' are entitled to the right to (temporary) shelter as *per* Article 31(2) ESC, whereas the lasting right to housing in Article 31(1) ESC 'would run counter to the state's alien policy objective of encouraging persons unlawfully on its territory to return to their countries of origin'.[78] Having said this, human dignity, which is central to the Committee's arguments, requires that 'even temporary shelter must fulfil the demands of safety, health, and hygiene, including basic amenities, i.e. clean water and sufficient lighting and heating'.[79]

In *DCI (v. Belgium)*, the ECSR considered that the failure to provide care and assistance, including adequate reception facilities, to unaccompanied minors exposed them to 'serious risks for their lives and health'. In this decision, the Committee held that the state's failure to provide foreign minors with housing and foster homes led to a violation of Article 11 ESC on the

[77] See Section 4.2, Chapter 1, and Sections 2.2, Chapter 3.
[78] *DCI (v the Netherlands)* (n 190, Chapter 1) paras 41–48.
[79] ibid, para 62.

right to protection of health, thereby highlighting the interconnected nature of human rights.[80]

In *CEC,* which was a collective complaint concerning the right of undocumented adults to emergency social (and medical) assistance as per Article 13(4), the ECSR found that the respondent state had not met the irregular migrants' immediate and urgent needs in failing to provide shelter, food, emergency medical care, and clothing, which are necessary for protecting human dignity and for the 'basic subsistence of any human being'.[81] In justifying the right of everyone, including irregular migrants, to decent living standards, the ECSR made direct reference to the CESCR's concept of 'core obligations', which include access to 'basic shelter and essential food for everyone' and are 'linked to the dignity of the human person'.[82] With regard to the severity of the situation of socio-economic deprivation that would trigger the applicability of the Charter, the ECSR clarified that the criteria of 'urgency and seriousness' concerning individual material needs must not be interpreted too narrowly.[83]

The decision in the case of *FEANTSA* confirmed that states must provide emergency social assistance to everyone to meet their urgent and immediate needs, including shelter, food, and clothing.[84] Furthermore, the ECSR considered that the denial of such assistance as a measure to combat irregular migration is not acceptable, as it does not seem necessary to achieve the aims of immigration policy and appears disproportionate.[85] In these last two cases, the dire situation of social emergency in which homeless migrants were living and the risk of irreparable harm led the ECSR to issue two decisions on interim measures while the decisions on the merits were pending.[86]

---

[80] *DCI (v Belgium)* (n 190, Chapter1) paras 82, 117.
[81] *CEC* (n 190, Chapter 1) paras 105–126.
[82] ibid, paras 113–115.
[83] ibid, para 105; *FEANTSA* (n 193, Chapter 1) para 171.
[84] ibid (*FEANTSA*) paras 171–173.
[85] ibid, paras 180–183.
[86] *Conference of European Churches (CEC) v the Netherlands* Com no 30/2013 (ECSR decision on immediate measures 2013); *European Federation of National Organisations working with the Homeless (FEANTSA) v the Netherlands* Com no 86/2012 (ECSR decision on immediate measures 2013). For further analysis, see Carole Nivard, 'Précisions sur les

The last case in this saga is the recent case of *EUROCEF*, where the ECSR held, *inter alia*, that providing inadequate accommodation for unaccompanied foreign minors is likely to make them more vulnerable to homelessness, a factor that runs counter to the right to health set out in Article 11 ESC.[87] In this case, the Committee seemed to regard the quality and capacity of the French reception system as proxies for the determinants of health and returned similar findings to *DCI (v. Belgium)* above.

This decision is significant for another reason: it declares that Article 30 ESC (the right to be protected against poverty and social exclusion) is applicable to irregular migrant children. This is in contrast to the decisions in *DCI (v. Belgium)* and *FEANTSA*.[88] Until this case, the ECSR had always been reluctant to accept that irregular people – who are in theory excluded from the ESC's personal scope – could benefit from a 'co-ordinated approach, aimed at preventing and removing obstacles to access the fundamental social rights, in particular employment, housing, training, education, culture and social and medical assistance' that the right to be protected against poverty entails. The reason for such reluctance lies in the tensions between proactive and inclusive measures and the willingness to exclude and ultimately deport non-authorised migrants. This does not mean that the ECSR has abandoned an emergency-oriented approach to the rights of irregular migrants. However, where migrant children are concerned, states are now required to take positive 'measures to prevent and remove obstacles to access fundamental social rights', including the allocation of sufficient resources and the establishment of coordinated, intersectoral, and universal anti-poverty policies and corresponding monitoring and enforcement mechanisms.[89] However, having declared the abstract applicability of Article 30 ESC to irregular migrant

droits de la Charte sociale Européenne bénéficiant aux étrangers en situation irrégulière' (2014) *La Revue des Droits de L'Homme – Actualité Droits-Libertés* 1–12 < https://journals.openedition.org/revdh/982> accessed September 2018.

[87] *European Committee for Home-Based Priority Action for the Child and the Family (EUROCEF) v France* Com no114/2015 (ECSR 2018) paras 141, 152.

[88] ibid, paras 57, 180–186; *FEANTSA* (n 193, Chapter 1) paras 211.

[89] ECSR, *Statement of Interpretation on Article 30* (2013) <https://hudoc.esc.coe.int> accessed 1 March 2019.

children, in the case at hand, the ECSR failed to establish a violation of the same due to the disagreement of five Committee members.[90]

The ECSR is aware of the interconnected nature of human rights and of the link between social conditions and health. The relevant case law of the ECSR is relatively progressive, even though the social deprivations that trigger its protection, where adult irregular migrants are concerned, are those that require 'emergency' or 'urgent' medical and social care, at least in relation to Article 13 ESC.[91]

3. International Human Rights and the Determinants of Health of Irregular Migrants

Unlike the European system, international human rights law seems to have achieved, at least in theory, a certain level of synergy with the technical standards of global health governance on the determinants of health.

3.1. The Universal Declaration of Human Rights

The 'manifesto' of international human rights is the UDHR. However, it does not encapsulate an autonomous right to health. Rather, Article 25(1) UDHR combines this right with the right to an adequate standard of living and draws a link with the right to social security:

> 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.[92]

[90] *EUROCEF* (n 87) 'Separate Dissenting Opinion of Petros Stangos'.
[91] For example, *CEC* (n 190, Chapter 1) paras 73, 75; *FEANTSA* (n 193, Chapter 1) paras 171, 173, 182–183, 186.
[92] UDHR (n 1, Introduction) Article 25.

This formulation is significant as it implicitly recognises the link between living conditions and health, which is at the core of the concepts of SDH and UDH.

The drafting history of Article 25 UDHR reflects different trends regarding health as a human right. The first draft by the Drafting Committee of the UDHR contained a right to 'medical care' and a state 'obligation' to promote public health in Article 35, a right to good working conditions in Article 38, and a right to food, housing, and healthy living in Article 42.[93] The representatives of the United States and France submitted proposals for alternative texts which accentuated social measures to promote the 'highest' or 'best' attainable standard of health, beyond the mere provision of medical care.[94] Furthermore, the analysis of the applicable provisions of national constitutions concerning health protection showed several references to public health and social security measures.[95]

After the second session of the Human Rights Commission in December 1947, the original focus on medical care shifted to a broader concept of health, and this is apparent in the proposed draft:

> Everyone without distinction as to economic and social conditions has the right to the preservation of his health through the highest standard of food, clothing, housing and medical care which the resources of the State or community can provide. The responsibility of the State and community for the health and

[93] Commission on Human Rights (n 23, Chapter 2).

[94] Emphasis added. See Commission on Human Rights – Drafting Committee, 'United States Revised Suggestions for Redrafts of Certain Articles in the Draft Outline' (1 June 1947) UN Doc E/CN.4/AC.1/8, Article 36: 'Everyone, without distinction as to economic or social condition, has a right to the highest attainable standard of health […] [which] can be fulfilled only by provision of adequate health and social measures'; Commission on Human Rights – Drafting Committee, 'Revised Suggestions Submitted by the Representative of France for Articles of the International Declaration of Rights' (20 June 1947) UN Doc E/CN.4/AC.1/W.2/REV.2, Article 33: 'Everyone has a right to the best health conditions possible and to assistance to preserve them. The community shall promote public hygiene and the betterment of housing and food conditions'.

[95] Commission on Human Rights – Drafting Committee, 'International Bill of Rights Documented Outline' (11 June 1947) UN Doc E/CN.4/AC.1/3/add.1, 285–289.

> safety of its people can be fulfilled only by provision of adequate health and social measures.[96]

Subsequent draft texts gradually got closer to the final formulation, which places primary emphasis on the right to an adequate standard of living in close relation to health and social security.[97]

This demonstrates that health and socio-economic well-being have been explicitly bound together since the birth of the post-war international bill of rights. Although this language refers to a 'personal' universality of rights, it should be recalled from the analysis conducted in Chapter 1 that the application of human rights to 'aliens' or 'migrants' was largely absent until the 1970s.

3.2. Relevant UN human rights treaties

Without detracting from the UDHR, the main contemporary source of human rights obligations regarding the right to health care and to the determinants of health in international law is the ICESCR. Since the CESCR has only recently begun to receive individual communications, the following evaluation of the determinants of health for irregular migrants is primarily based on the CESCR's concluding observations (COs) and general comments in the light of other treaty bodies' documents and the reports of the SR on the right to health. It should be noted again that an extensive analysis of the normative scope of each socio-economic right that realises the determinants of health is beyond the scope of this chapter.

3.2.1. The concluding observations of the CESCR

[96] Commission on Human Rights, Report to the Economic and Social Council on the 2nd Session of the Commission' (2–17 December 1947) UN Doc E/600(SUPP), 18; 'Report of the Drafting Committee [on an International Bill of Rights] to the Commission on Human Rights' (21 May 1948) UN Doc E/CN.4/95, 11.
[97] Commission on Human Rights, 'Report of the 3rd Session of the Commission on Human Rights' (24 May –18 June 1948) UN Doc E/800, 13.

For this study, all COs between 2009 and 2018 were scrutinised to identify the latest trends on the social rights of irregular migrants. This time frame was chosen as it coincides with a renewed emphasis on the determinants of health in global public health discourse – a trend which ought, arguably, to have been known to the international human rights institutions.[98] In these findings, the terms 'underlying determinants of health' and 'social determinants of health' are not mentioned. The Committee preferred to scrutinise the living conditions and access to social and health services of people at large and vulnerable groups within the scope of 'other social rights' instead of qualifying them as determinants of health and linking them to Article 12 ICESCR.

Where irregular migrants are concerned, the main areas of concern, addressed in several COs, were the difficulty in accessing health care and the informal and abusive working conditions to which they are exposed.[99] However, important recommendations for establishing a genuinely accessible education system for all, regardless of any irregularity of immigration status, were also recorded.[100] Some recent findings are worth outlining. For example, in the 2017 reporting cycle for the Netherlands, the CESCR found that provisions that link 'access to housing, education and welfare benefits to legal residency status, have contributed to a precarious situation for undocumented migrants and rejected asylum seekers'.[101] Accordingly, the Committee reminded the state of its obligation to 'ensure that all persons in its jurisdiction enjoy the minimum essential levels of each of the rights in the Covenant,

[98] As the Report of the CSDH (n 92, Chapter 2) and the Rio Declaration (n 19) are respectively dated 2008 and 2011.
[99] For example, CESCR, COs on Spain (n 89, Chapter 3) para 42; Germany (n 90, Chapter 3) para 58; The Russian Federation (6 October 2017) UN Doc E/C.12/RUS/CO/6, para 32; Cyprus (n 177, Chapter 2) paras 27, 28, 40; The Netherlands (n 184, Chapter 2) paras 39–41; Poland (n 184, Chapter 2) para 21; the United Kingdom (n 179, Chapter 3) para 55; Canada (n 177, Chapter 2) para 29; Greece (n 177, Chapter 2) paras 35, 11; Tajikistan (25 March 2015) UN Doc E/C.12/TJK/CO/2-3, para 22; Albania (18 December 2013) UN Doc E/C.12/ALB/CO/2-3, para 13; Norway (n 61, Chapter 3) para 21; Denmark (6 June 2013) UN Doc E/C.12/DNK/CO/5, para 18; Kazakhstan (7 June 2010) UN Doc E/C.12/KAZ/CO/1, paras 14, 20; Cyprus (12 June 2009) UN Doc E/C.12/CYP/CO/5, para 15.
[100] CESCR, COs on South Africa (12 October 2018) UN Doc E/C.12/ZAF/CO/1, paras 72, 73; Canada (ibid) para 55.
[101] CESCR, COs on the Netherlands (n 184, Chapter 2) para 39.

including the rights to food, housing, health, water and sanitation', in particular urging the state to:

> (a) Refrain from making access to food, water and housing conditional on an individual' s willingness to return to his or her country of origin;
>
> (b) Put in place a comprehensive strategy to ensure that everyone, including undocumented migrants, enjoy the minimum essential levels of all Covenant rights and ensure it is supported by adequate funding [...].[102]

Although it is not completely clear what the required 'level' of social rights is that the state must guarantee to irregular migrants, the wording 'minimum essential levels' recalls the formulation of General Comment no. 3, which identifies depriving people 'of essential foodstuffs, of essential primary health care, of basic shelter and housing, or of the most basic forms of education' as a failure on the part of the state to meet its obligations under the ICESCR.[103] The COs regarding Germany are similarly significant, because they recommend, for the first time, the establishment of 'firewalls' to allow irregular migrants to access 'basic' services without fear of being reported to the immigration authorities and facing potential deportation.[104] Even though 'firewalls' guarantee the actual enjoyment of social rights that would otherwise remain illusory, the level of recommended social benefits for irregular migrants is 'basic', which, without further qualifiers, seems to indicate that irregular migrants either have access to a subset of the available services or access all available services but to the extent that only their urgent social needs are met. It is finally worth mentioning, in relation to Argentina, the call to lift barriers to immigration status-regularisation to ensure greater enjoyment of social rights for all.[105] After all, irregular migrants' legal status (or lack thereof) is the main factor that prevents their treatment from being equalised to that of citizens and regular migrants.

---

[102] ibid, para 40.
[103] CESCR, GC3 (n. 62, Chapter 2) para 10.
[104] CESCR, COs on Germany (n 90, Chapter 3) paras 26, 27.
[105] CESCR, COs on Argentina (12 October 2018) UN Doc E/C.12/ARG/CO/4, para 39.

As mentioned in the previous chapter, situations of suspect differentiation in the enjoyment of social rights on the ground of irregular legal status are often raised in combination with issues concerning substantive rights.[106] Indeed, the CESCR has for a long time explicitly interpreted 'immigration status' as prohibited or suspect grounds for discrimination.[107]

It is also interesting to note that 'poverty and inequality' often come under scrutiny as part of the monitoring activities of the CESCR during which the link between socio-economic deprivations of vulnerable people, including irregular migrants, and the enjoyment of rights, including the right to health, is brought to the fore.[108] However, the CESCR, in its analysis of multi-layered discrimination, tends not to call into question 'established political power structures, including sovereign control of territory',[109] as factors that keep irregular migrants in general situations of economic deprivation.

3.2.2. The general comments of the CESCR

In its general comments, the CESCR has demonstrated greater awareness of the UDH and SDH than in the COs.

Beginning with General Comment no. 14, having described the UDH as the socio-economic conditions that affect the enjoyment of the right to health and thus included in its scope, the CESCR lists measures that address the UDH as immediate 'core obligations' regarding the right to health and favours measures involving vulnerable groups, to which irregular migrants belong. These core obligations include ensuring (b) 'access to the minimum essential food which is nutritionally adequate and safe, to ensure freedom

[106] See Section 3.1.1, Chapter 3.
[107] CESCR, GC20 (n 93, Chapter 1) para 30; CESCR, Statement (n 153, Chapter 1) para 5.
[108] E.g., CESCR, COs on Poland (n 184, Chapter 2) para 35; Costa Rica (21 October 2016) UN Doc E/C.12/CRI/CO/5, para 39; Dominican Republic (7 October 2016) UN Doc E/C.12/DOM/CO/4, para 48; Greece (n 177, Chapter 2) paras 29, 30; Kyrgyzstan (7 July 2015) UN Doc E/C.12/KGZ/CO/2-3, para 20; Vietnam (15 December 2014) UN Doc E/C.12/VNM/CO/2-4, para 28; Nepal (12 December 2014) UN Doc E/C.12/NPL/CO/3, para 25; Lithuania, (24 June 2014) UN Doc E/C.12/LTU/CO/2, para 18; Denmark (n 184, Chapter 2) para 16.
[109] Jaya Ramji-Nogales, 'Undocumented Migrants and the Failures of Universal Individualism' (2014) *Vanderbilt Journal of Transnational Law* 47 740.

from hunger to everyone' and (c) 'access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water'.[110]

The CESCR's general comment is not very helpful for identifying the minimum acceptable level of these determinants: essential food and freedom from hunger, and basic housing and shelter require different levels of social intervention. In relation to this, the Declaration of Alma-Ata, offers some (partial) clarification with regard to at least some determinants because PHC, to which the CESCR refers, includes at a minimum 'education concerning prevailing health problems and the methods of preventing and controlling them; promotion of food supply and *proper* nutrition; an *adequate supply* of safe water and basic sanitation […]'.[111]

Apart from this limited and programmatic guidance, the lack of further 'qualifiers' for most of the social rights that support the determinants of health makes the identification of the immediate or progressive 'level' of protection and fulfilment somewhat unclear.

Although one may argue that 'adequacy' applies to the programmatic and relative standard of achievement of socio-economic rights, which would not extend to the 'core',[112] the CESCR, *inter alia*, recommends states to guarantee 'equal access for *all* to the underlying determinants of health'.[113] Recalling the previous chapter's analysis of non-discrimination and vulnerability in relation to limiting access to health care, for the CESCR, here too any detrimental or potentially discriminatory treatment that targets irregular migrants, in principle, would need to pass a legitimacy and proportionality test. Accordingly, being irregular migrants qualified as vulnerable people and thus as a target of especially protective measures, their social rights should not be excessively or unnecessarily limited.[114]

General Comment no. 19 analyses the right to social security, which is a very technical matter at the 'core' of the welfare system, and requires states, *inter alia*, to:

---

[110] CESCR, GC14 (n 27, Introduction) para 43.
[111] Alma-Ata (n 28, Introduction).
[112] Bilchiz (n 48).
[113] CESCR, GC14 (n 27, Introduction) para 36.
[114] See Section 3.1.1, Chapter 3 and CESCR, Statement (n 153, Chapter 1).

> Ensure access to a social security scheme that provides a minimum essential level of benefits to all individuals and families that will enable them to acquire at least essential health care, basic shelter and housing, water and sanitation, foodstuffs, and the most basic forms of education.[115]

It also indicates that non-nationals should have:

> Access to non-contributory schemes for income support, affordable access to health care and family support. […] All persons, irrespective of their nationality, residency or immigration status, are entitled to *primary* and *emergency* medical care.[116]

While contributory schemes are, by definition, excluded for workers within the informal economy, among them irregular migrants, non-contributory schemes that support those whose income is below the poverty threshold and that are based on a needs-based assessment should be accessed without discrimination, especially for vulnerable groups.[117] Similar core obligations as those in General Comment no. 14 are established here, and while targeted steps should protect vulnerable groups, legal limitations and differentiation (including on the grounds of legal immigration status), though not prohibited, should be objective and reasonable.[118]

As regards exploitative working conditions, General Comment no. 23, on just and favourable working conditions, acknowledges the special vulnerability of irregular migrants 'to exploitation, long working hours, unfair wages and dangerous and unhealthy working environment'.[119] Accordingly, states are required to take, among other steps, the following targeted procedural measures. First, 'Labour inspectorates should focus on monitoring the rights of workers and not be used for other purposes, such as checking the

[115] CESCR, 'General Comment No. 19, The Right to Social Security (Article 9 ICESCR)' (4 February 2008) UN Doc E/C.12/GC/19, para 59.a).
[116] ibid, para 37.
[117] ibid, para 59.b), e).
[118] ibid, paras 37, 38.
[119] CESCR, 'General Comment no. 23, The Right to Just and Favorable Conditions of Work (Article 7 ICESCR)' (4 March 2016) UN Doc E/C.12/GC/23, para 47(f).

migration status of workers'.[120] Second, 'access to effective judicial or other appropriate remedies, including adequate reparation, restitution, compensation, satisfaction or guarantees of non-repetition […] should not be denied on the grounds that the affected person is an irregular migrant'.[121]

General Comment no. 22, on sexual and reproductive health in Article 12 ICESCR, directly elaborates on both the UDH and the SDH. Regarding the former, recalling the UDH in General Comment no. 14, the CESCR here adds the need for 'effective protection from all forms of violence, torture and discrimination and other human rights violations that have a negative impact on the right to sexual and reproductive health'.[122] Furthermore, the Committee makes a direct interdisciplinary reference to the SDH:

> The right to sexual and reproductive health is also deeply affected by 'social determinants of health', as defined by the WHO. In all countries, patterns of sexual and reproductive health generally reflect social inequalities in society and unequal distribution of power based on gender, ethnic origin, age, disability and other factors. Poverty, income inequality, systemic discrimination and marginalization based on grounds identified by the Committee are all social determinants of sexual and reproductive health, which also have an impact on the enjoyment of an array of other rights as well.[123]

These determinants of health, which include 'harmful practices and gender-based violence' that need to be eliminated, even feature in the immediate core obligations regarding this dimension of the right to health.[124] Finally, in the same document, refugees, stateless persons, asylum seekers, and undocumented migrants are found to have 'additional vulnerability by condition of their detention or legal status'. This requires states to take particular steps to ensure their sexual and reproductive health.[125]

---

[120] ibid, para 54.
[121] ibid, para 57.
[122] CESCR, GC22 (n 185, Chapter 2) para 7.
[123] ibid, para 8.
[124] ibid, para 49(d).
[125] ibid, para 31.

Another applicable reference to the social rights that support the determinants of health, is made in the CESCR's 2017 statement regarding migrants and refugees, which establishes that states have a duty, at least 'to secure freedom from *hunger*, to guarantee access to water to satisfy *basic needs*, access to essential drugs, access to education, complying with *minimum educational standards*'.[126]

Without detracting from the detailed recommendations of the other general comments in this section, this statement, which is the specific document that restates the socio-economic standards of all migrants - including irregular migrants, seems to frame social rights that are not the right to health care in overall general and minimalist terms.

3.2.3. Further applicable jurisprudence

As the Report of the CSDH – in addition to other WHO documents – makes several references to living conditions during childhood as a central determinant of health during an individual's life course, it seems appropriate to briefly recall here the CRC and the applicable standards of the CRC Committee. Indeed, some recent general comments of the CRC Committee acknowledge the SDH and the intersectional vulnerability of migrant children.

Chapters 2 and 3 mention that Article 24 CRC identifies PHC, as per the Declaration of Alma-Ata, as the foundational and explicit approach to the right to health of the child and requires state parties to ensure necessary health care 'within the framework of primary health care [and] the provision of adequate nutritious food and clean drinking-water'.[127] The PHC approach emphasises, *inter alia*, 'the need to eliminate exclusion and reduce social disparities in health; organize health services around people's needs and expectations; [and] integrate health into related sectors'.[128]

[126] CESCR, Statement (n 153, Chapter 1) para 9, recalling the mentions to core obligations in several general comments. Emphasis added.
[127] CRC (n 14, Introduction) Article 24.2 b), c).
[128] CRC Committee, GC15 (n 148, Chapter 2) para 4.

Furthermore, the two recent joint general comments of the CRC Committee and the CMW Committee clearly recognised that 'structural determinants, such as the global economic and financial situation, poverty, unemployment, migration and population displacements, war and civil unrest, discrimination and marginalization' deeply affect children's health.[129] Migration processes, in particular, 'can pose risks, including physical harm, psychological trauma, marginalization, discrimination, xenophobia and sexual and economic exploitation, family separation, immigration raids and detention', many of which are determinants of health.[130]

Regarding substantive legal standards, these human rights bodies have clearly stated that all migrant children should have access 'to health care "equal" to that of nationals, regardless of their migration status', a 'standard of living adequate for their physical, mental, spiritual and moral development', and 'full access to all levels and all aspects of education'.[131] Health care, education, and adequate standards of living should be guaranteed by introducing 'procedures and standards to establish firewalls between public or private service providers, including public or private housing providers, and immigration enforcement authorities'.[132] Whereas international human rights obligations require that irregular migrant adults, outside of the provision of essential primary health care, have access to at least 'basic' levels of social rights, in the case of children, the enjoyment of social rights that support the determinants of health is generally 'equalised' with country nationals.

A certain alignment with the positions of the public health movement, and their emphasis on the SDH can also be found in the arguments and findings of the SR on the right to health. Since 2005, the SR has acknowledged a 'considerable congruity' between the CSDH's mandate and the UDH dimension of the right to health.[133]

[129] ibid, paras 4, 5; CMW and CRC Committees, JGC4/23 (n 154, Chapter 1) para 54.
[130] CMW and CRC Committees, JGC3/22 (n 154, Chapter 1) para 40.
[131] ibid, paras 49, 55, 59.
[132] ibid, paras 52, 56, 60.
[133] Hunt (n 8) paras 5–7.

The former mandate holder, in his report on 'the right to health for migrant workers', which recalls a previous report of the IOM, stated that 'migration' itself should be seen as a UDH. Indeed, the conditions of pre-departure, transit, arrival, and stay in receiving states determine unfavourable health outcomes for migrant workers, including undocumented people.[134] He called for the participation of all migrants – regardless of their status – in trade unions and in the formulation, implementation, monitoring, and enforcement of laws and policies concerning their living and labour conditions, including those related to occupational health.[135] Measures that target an enhancement of irregular migrants' working conditions, including labour inspections, are important determinants of health, as many irregular migrants are precariously employed and even exploited in the sectors like construction and agriculture.[136]

Among other references to the UDH for migrant workers, the SR acknowledged that 'fear of detention and deportation renders migrant workers more vulnerable and unable to enjoy the right to health and its underlying determinants', as these are crucial stress factors that are likely to affect undocumented people's mental health.[137]

The current mandate holder has gone so far as to define 'discrimination and stigma' as:

> Social determinants in the enjoyment of the right to health, as social inequalities and exclusion shape health outcomes and contribute to increasing the burden of disease borne by marginalized groups.[138]

---

[134] Grover (n 234, Chapter 2) para 6; IOM, 'Migration: A Social Determinant of the Health of Migrants' (IOM Background Paper, 2006) 8 < http://www.migrant-health-europe.org/files/FINAL%20DRAFT%20-%20IOM%20SDH.pdf.> accessed 1 March 2019.
[135] ibid (Grover) para14.
[136] ibid, paras 6, 46, 62; Anand Grover, 'Report of the Special Rapporteur on the Right to the Highest Attainable Standard of Physical and Mental Health (main focus: occupational health)' (10 April 2012) UN Doc A/HRC/20/15, paras 38–44; See also, Urmila Bhoola, 'End of Mission Statement of the Special Rapporteur on Contemporary Forms of Slavery, Including its Causes and Consequences - Country Visit to Italy' (3–12 October 2018) <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=23708&LangID=E> accessed 20 March 2019.
[137] ibid, paras 37, 66.
[138] Pūras (n 233, Chapter 2) para 22.

The SR on the Right to Health has made substantial use of the terminology of the CSDH. For example, he has recognised that power asymmetries and unbalanced approaches to health policies, both in terms of material priorities and target groups, represent a 'departure from a holistic approach to human rights' and from 'the need to reduce poverty and inequalities, including those within and *between* regions and countries'.[139]

In a recent report on the relationship between migration and the right to mental health, the SR recognised that a rights-based approach to mental health requires consideration of the societal and community-level determinants of the mental health and well-being of all people, including people on the move,[140] and that:

> Conflict, violence and socioeconomic inequalities – by-products of powerful political structures – are key drivers of displacement and a significant determinant of mental health. Similarly, the discriminatory treatment of many people on the move in host countries reflects complex social hierarchies and power relations[141]

and affects their mental health.

This report recommends a revolutionary change to state policies and law regarding immigration and (mental) health and encourages states 'to ensure that mental health care and support services are rights-based and available to people on the move on an *equal* basis with nationals'.[142] Crucially, it also recommends ceasing the criminalisation of irregular migrants and the fuelling of intolerance and xenophobia towards people on the move, as these are circumstances that directly impact people's mental health.[143] Finally, the SR has recommended the establishment of firewalls in relation to all public services to allow all migrants, regardless of their

[139] ibid, paras 49, 51, 55.
[140] Pūras (n 234, Chapter 2) para 49, 50.
[141] ibid, para 25.
[142] ibid, paras 2, 53, 57, 63, 72. Emphasis added.
[143] ibid, paras 78, 79, 83.

migration status, to enjoy mental health care and support and their determinants.[144]

International human rights law integrates, either directly or indirectly, the standards of the global health movement and extends them to irregular migrants. However, the 'level' of social rights to which irregular migrants are entitled, with some notable exceptions, remains to be clarified and the use of the word 'basic' seems to undermine the emphasis on vulnerable groups and non-discrimination.

The negotiations of the Global Compact for Migration, dealt with next, and its objectives regarding health and social services bear witness to the lack of state commitment to protecting the social rights that support the determinants of health of irregular migrants beyond access to basic services that explicitly include only the sectors of health care and education.

3.3. The Global Compact for Migration and the determinants of health

The Compact for Migration explicitly rests on international human rights law,[145] and its recommendations extend to the socio-economic situation of all migrants, regardless of their legal status.

Objective 15 of the Compact for Migration recommends ensuring that states, *inter alia*, guarantee 'access to basic services for migrants' in a way that 'does not exacerbate vulnerabilities of irregular migrants'. However, as previously indicated in Chapter 3, the word 'firewalls' disappeared from the final version of this recommendation. In terms of the type of 'basic services' that must be accessible to all migrants, the Compact only mentions health care and education, thus failing to 'fully appreciate the interconnected needs and experiences that migrants have, […] which require access to a broad array of services',[146] including housing, employment services, and social assistance, among many others.

[144] ibid, para 56.
[145] GCM (n 86, Chapter 1) paras 2, 4, 15.
[146] Hastie (n 105, Chapter 3).

The Compact also adds that service delivery should not be discriminatory, but that different treatment of regular and irregular migrants is legitimate when it is 'based on law, proportionate, [and] pursue[s] a legitimate aim, in accordance with international human rights law'.[147]

A clear indication of the importance of addressing either the SDH or UDH is absent from the final text of the Compact, although they are cited in the WHO guidelines referred to in the Compact.[148] These WHO guidelines on the promotion of health for refugees and migrants indicates among their 'priorities' the need to 'enhance capacity to address the social determinants of health' of migrants.[149] The recommended way forward consists of 'improving basic services such as water, sanitation, housing and education', as well as multi-sectoral public policy responses.[150]

In other objectives of the compacts, states pledge to address situations that correspond to certain determinants of health, including migrants' working conditions, gender-related vulnerabilities, and structural drivers of migration in origin countries.[151] Not unlike various human rights instruments, already mentioned, the Compact identifies as its 'guiding principles' both the enjoyment of human rights by every migrant and the state power to distinguish between regular and irregular migrants and to expel the former. It will be very interesting to observe whether the implementation of, and the follow up to, this cooperative framework will contribute to better health outcomes for irregular migrants through genuine intersectoral measures at international, regional, domestic, and local level or whether the social rights that support health will be maintained at a bare survival level and without interconnected empowering policy measures.

[147] GCM (n 86, Chapter 1) para 31.
[148] ibid.
[149] WHO, Framework of Priorities and Guiding Principles to Promote the Health of Refugees and Migrants, endorsed by WHA Res 70.15 (31 May 2017) para D.3. < http://www.who.int/migrants/about/framework_refugees-migrants.pdf> accessed 15 March 2019.
[150] ibid.
[151] GCM (n 86, Chapter 1) paras 22.i, 23.c, 18.b.

Conclusions

This chapter employed the concepts of 'empowerment', 'indivisibility', 'interrelatedness', and 'vulnerability' to ground a truly holistic approach to human rights and health. Embracing these entails addressing the determinants of health of everyone to achieve individual well-being and good health outcomes. However, these concepts tend to clash with, and dissipate in the face of, states' desire to socially exclude non-authorised non-nationals as a means of 'constructive deportation'. This chapter tested this hypothesis against the major findings of European and international human rights law.

As for the European human rights system, the ECtHR has adopted a particularly restrictive approach on the social rights of irregular migrants, only covering cases of particularly severe medical issues, forced labour, appalling socio-economic deprivation and the right to education in exceptional circumstances. A positive note, in terms of adjudication on the determinants of health, comes from the ECSR, although it still insists – due to explicit textual limitations – on urgent measures of social protection. Unfortunately, the fact that the most well-known human rights case-based jurisprudence in Europe emanates from the ECtHR, which holds a civil rights mandate, intensifies the impression that measures on health care and the determinants of health are instrumental for safeguarding life and personal integrity rather than health as a human and social value in itself.

In international human rights law, the CESCR, in its General Comment no. 14, incorporated the UDH into the scope of the universal right to health, and this trend has been accentuated in more recent general comments, especially on sexual reproductive health and children's health, also in relation to irregular migrants. Unlike the general comments, the CESCR's COs lack any reference to the determinants of health, but they do address the social rights that support the underlying determinants, including the rights of undocumented people. Furthermore, the SR on the right to health has, since the early 2000s, proved willing to acknowledge the concept of the SDH and has qualified migration itself as a SDH. Regarding the level of social

entitlements of irregular migrants, the jurisprudence oscillates between findings of 'equalised' and 'basic' socio-economic rights. Although the principle of non-discrimination and vulnerability should limit the restriction of social rights that support the determinants of health of irregular migrants, the jurisprudence has proved more tentative than in the case of 'health care', discussed in Chapter 3.

Finally, the negotiations of the Global Compact for Migration demonstrate that where undocumented people are concerned, a selective, minimalist approach to social rights, which largely ignores the interrelated nature of human rights, is preferred as it does not challenge the structural inequalities between and within states.

Human rights themselves have often been criticised as individualist claims that overemphasise formal autonomy and overlook the importance of social ties, group-based identities, the material conditions of living, and actual situations of vulnerability.[152] Furthermore, a selective or atomistic approach reinforces the notion of a hierarchy of rights:

> Ignoring or not adequately addressing one or more rights of a group of the population reinforces cycles of poverty, inequalities, social exclusion, discrimination and violence, and in the longer run has a negative impact on the health and development of society in general.[153]

The problems of applying the current human rights system to irregular migrants are, once again, linked to a Westphalian human rights system, which, accepts significant limitations to the rights of these migrants and, at least partially, 'fails to recognize inequities in the global distribution of wealth, power, opportunity, and social goods that render the playing field uneven'.[154]

International and European human rights law offer different arguments and approaches regarding the determinants of health and the social rights of

[152] Ramji-Nogales (n 109) 703.
[153] Pūras (n 233, Chapter 2) para 45.
[154] Ramji-Nogales (n 109) 710, referring to Martha Albertson Fineman, 'The Vulnerable Subject and the Responsive State' (2010) *Emory Law Journal* 60 251, 253.

irregular migrants. However, apart from some instances in international human rights law, human rights law in general seems to set the protection of the socio-economic conditions that support the determinants of health for irregular migrants, other than medical care, at a 'basic' or 'survival' level.[155]

This creates a distinction between the standards of social rights that irregular migrants are entitled to and those that a country's citizens or settled migrants are granted. Therefore, it can be concluded that the right to health is not evenly protected in all its elements. The 'empowering' effect of the SDH and the UDH is negated by states' policies of reducing social rights and excluding irregular migrants from society, a situation which human rights law does not always address.

Changing direction and genuinely tackling human and social vulnerability to ill-health on a non-discriminatory basis requires raising the level of social rights that support the determinants of health beyond the mere 'survival level' and emergency and exceptional measures. This is particularly the case in high- and middle-income countries, where most of the international case law discussed in this chapter originates.[156] Furthermore, the actual and effective enjoyment of these rights, even at a 'basic level', requires providing holistic and easily accessible service points at the local level and the creation of 'firewalls' for service delivery.

Overall, the determinants of health should be framed in universal terms. This needs to be addressed both conceptually and practically if the debates in the fields of public health and human rights are to be consistent with their 'universal' and 'empowering' aims and if they are to be of any use in ensuring the social right to health of irregular migrants.

[155] CESCR, Statement (n 153, Chapter 1) para 9.
[156] This remark is based on the arguments of Bilchiz (n 48) 188.

Chapter 5
The Right to Health of Irregular Migrants in Italy[1]

This chapter provides an example of how the right to health of irregular migrants is framed at the domestic level, which is where the detailed regulation and concrete implementation of the right take place.

The Italian legal and administrative frameworks are used as a case study. Italy has been chosen for two main reasons: 1) because it has a long-lasting legal and constitutional tradition of upholding indivisible and inalienable social rights, including the right to health for everyone and particularly for the 'needy' or 'indigent' as per Article 32 Italian Constitution;[2] and 2) because, due to its geographical location and (informal) economy,[3] Italy has, over the last 30 years, experienced a general increase in south-north immigration and has a significant number of migrants with irregular or precarious status. Therefore, it is interesting to see how its legal and administrative frameworks have grappled with the living conditions and health of irregular migrants and to investigate whether its national laws reflect the trends evidenced in international and European human rights law.

The chapter is structured as follows. Section 1 offers a brief overview of the Italian legal system, which is necessary to fully appreciate the analysis that follows. Section 2 examines the legal status of non-nationals in Italy in the light of constitutional and statutory sources. Section 3 focusses on the evolution of the right to health in the Republican era in Italy by highlighting the 'complex' nature of this right, its role in the 'social state', and the 'essential' levels of its universal 'personal' and 'geographical' application. Section 4 analyses the statutory protection of the right to health care and the

[1] This Chapter contains many quotations of laws and judgements that were originally drafted in Italian and for which no official translations exist. It is indicated where official sources were available in English, but most translations are my own.
[2] Constitution of the Italian Republic (enacted by the Constituent Assembly 22 December 1947, entered into force 1 January 1948) Official Gazette no 298/1947. In English < http://www.senato.it/application/xmanager/projects/leg17/file/repository/relazioni/libreria/novita/XVII/COST_INGLESE.pdf> accessed 12 March 2019.
[3] Giuseppe Sciortino, *Rebus Immigrazione* (Il Mulino 2017).

interconnected social rights that support the determinants of health of irregular migrants. It also discusses the case law of the Italian Constitutional Court (also referred to as 'the Court' in this chapter) on the division of health and immigration-related competences between the central government and the regions.[4] Section 5 elaborates on the previous sections and discusses the strengths and shortcomings of the Italian response to realising the right to health of irregular migrants in the light of international standards. This chapter also demonstrates how the clash between immigration control and health rights is resolved in the Italian legal framework, partly due to the crucial establishment of 'firewalls'.

1. The Italian Legal System: A Very Brief Overview

As this research is mainly addressed to non-Italian readers, it is worth providing a brief overview of the main features of the Italian legal system. Italy is a representative democracy with a parliamentary system of government.[5] The Republic is 'one and indivisible', meaning that even though legislative competence is split between the central government and the 20 regions, and public administrative powers are significantly decentralised to local authorities, sovereignty lies with the state.[6]

Italy adopts a model of equal bicameralism and the houses of Parliament (i.e. the Chamber of Deputies and Senate of the Republic) hold equal legislative powers, while the government enjoys legislative initiative and executive powers. The latter, however, can exercise limited legislative powers in the form of either legislative decrees (D. Lgs), which are authorised beforehand by the parliament with laws of delegation, or law decrees (LD), which have only temporary validity and are adopted in cases of necessity or

[4] This Court's jurisdiction extends to judicial reviews of ordinary laws by court referral, conflicts of attributions between different levels of government, admissibility of referenda, charges against the President of the Republic, See Vittoria Barsotti et al., *Italian Constitutional Justice in the Global Context* (OUP 2015) 41–66.
[5] Italian Constitution (n 2) Article 1; Pt II, Tit. I–III; Constitutional Court Judgement no 35/2017.
[6] Italian Constitution (n 2) Article 5; Pt II, Tit. V.

urgency.[7] According to the decentralised legal system, the regions exercise important legislative functions outside of the constitutionally established areas of exclusive national competence.[8] For example, 'immigration' is a listed subject matter of national competence; 'health' is an area of shared competence where regional legislation can regulate for more services than those 'essential levels' that are established at national level; and 'social policy' is a residual – non-listed – area where the regions are vested with exclusive legislative powers.

The Italian legal system belongs to a continental civil law tradition within which the sources of law are structured hierarchically. In fact, a joint reading of the civil code and the Constitution indicates that the sources of law are the Constitution, customary international law, EU law, ordinary national and regional laws and incorporated international treaty law, government regulations, and customs.[9]

Regarding international sources, Italy can generally be considered a 'dualist' country. While EU law and customary international law have direct effect and applicability in the domestic legal order,[10] international treaty law – including in the human rights field – must be incorporated in a domestic act to have any normative function for public powers.[11]

The 'ordinary' court system, in both the civil and criminal field, is composed of geographically spread offices of the Justice of the Peace for minor claims, first instance judges (Tribunale Civile, Penale and Corte

[7] ibid, Articles 70, 77.
[8] Italian Constitution (n 2) Article 117. The Italian Republic is administratively split into 19 regions and 2 autonomous provinces which also have legislative powers. When a reference is made to 'regions' in the body of the text, this applies also to the two autonomous provinces that compose the region 'Trentino-Alto Adige'.
[9] Constitution (n 2) Article 10,11, 117; Royal Decree no 262 'Civil Code' (16 March 1942) Article 1.
[10] Although the European Court of Justice had recognised the doctrine of direct effect of EEC law (now EU Law) in domestic legal order since the Case 26/62 'Van Gend en Loos v Nederlandse Administratie der Belastingen' (1963), this Court and the Italian Constitutional Court had maintained strong disagreement for almost two decades on the primacy of EU law over contradicting ordinary domestic law, which ended with the Judgement no 170/1984 of the latter in the case of Granital, see Giuseppe Tesauro, *Diritto dell'Unione Europea* (Cedam 2010) 201–225.
[11] Domestic and international law are two separate spheres of law for the Italian dualist tradition, see Björgvinsson (n 40, Chapter 1) 59.

d'Assise), and second instance judges (Courts of Appeal). The Cassation Court (mainly) reviews appeal judgements to assess whether the law has been correctly applied, but does not re-examine the facts of the dispute, while the Constitutional Court can be summoned only by public bodies and by common judges when they have concerns about the constitutionality of a law that they need to apply in the case pending before them. Finally, regional administrative tribunals (T.A.R.) and the Council of State (Consiglio di Stato) are, respectively, first and second instance administrative courts, which can receive individual claims against alleged illegitimate acts of state administrations.[12] Precedents of the higher courts (in particular the Cassation Court) are persuasive but not binding on lower courts.[13]

2. The Legal Status of Migrants and their Fundamental Rights

The favoured vocabulary of the Italian legal system to indicate the 'legal status of migrants' is the 'juridical condition of foreigners'. 'Foreigners' or 'aliens' in Italian are 'starnieri', derived from the Latin 'extraneus', which suggests the lack of belonging to a polity or some other collective. By and large, this word applies to those people who are non-nationals and are regularly or irregularly present on the territory of the state ('non-citizens' in Italian),[14] although EU law has contributed to the introduction of special and substantially equalised treatment for nationals of other EU member states.[15]

The Italian Constitution refers to the legal status of non-nationals and to immigration in Articles 10(2) and 117(1), letters a) and b) as matters for Parliament to regulate in conformity with international norms and treaties.

[12] Constitution (n 2) Article 125.
[13] For further details, see Barsotti (n 4); Marco Gubitosi, Sara Colombera and Claudio Schiaffino, 'Legal Systems in Italy: Overview', in Thomson Reuters' Practical Law (2018) <https://uk.practicallaw.thomsonreuters.com/w-007-7826?transitionType=Default&contextData=(sc.Default)&firstPage=true&comp=pluk#co_anchor_a496830> accessed 19 March 2019.
[14] Enrico Grosso, 'Straniero (status costituzionale dello)', in *Digesto delle Discipline Pubblicistiche* XV (Utet 1999) 156. In this chapter the words 'aliens', 'foreigners', 'immigrants', and 'migrants' are used interchangeably to identify non-nationals that have entered and remain in Italy, regardless of their legal status, with the exclusion of asylum seekers and other EU nationals.
[15] Boeles (n 50, Chapter 1) 49.

However, as indicated below, the same Article 117 Const. delegates several competences in the area of social policy and rights, including those that affect migrants as human rights holders, to the regions to regulate.[16]

2.1. Statutory rights of non-nationals

As Italy only began to experience immigration in the late 1970s, domestic immigration law was characterised by scattered and emergency-oriented legislative initiatives until the 1990s.[17] At the end of the 20th century, comprehensive regulation in the form of a 'Consolidated Immigration Act' (CIA) was finally enacted.[18] This has been in force ever since, although it has been periodically amended and has shifted towards a more control-oriented regulation than was set out in the original text, including with the criminalisation of irregular entry and stay in the state territory.[19] It contains provisions on general principles regulating immigration policy, conditions of entry and stay in Italy, border control and deportation, criminal sanctions for certain illicit conduct mostly linked to irregular immigration, and fundamental rights of different nuances for both regular and irregular migrants, including the right to health.[20] To understand the timing of the CIA, it is worth noting that EU law incorporated the Schengen Agreements in 1997,

[16] On the clash between national and regional legislative competence on the social rights of irregular migrants, see *infra* at Section 4.3.

[17] Filippo Scuto, *I Diritti Fondamentali della Persona quale Limite al Contrasto dell'Immigrazione Irregolare* (Giuffrè Editore 2012) 183–191.

[18] CIA (n 6, Introduction). This act is still applicable but has been amended several times. In Italian, it is commonly referred to as 'Testo Unico (dell'Immigrazione)'.

[19] Emanuele Rossi, 'Da Cittadini vs. Stranieri a Regolari vs. Irregolari. Considerazioni sull'Evoluzione della Disciplina Giuridica dei Non Cittadini nell'Ordinamento Italiano' (2010) *Rivista di Diritto Costituzionale* 123; Law no 94 (2 July 2009) amended the CIA (n 6 Introduction) by adding Article 10–bis on the crime of 'irregular entry and stay in the state territory'; Alberto Di Martino et al., *The Criminalization of Irregular Immigration Law and Practice in Italy* (Pisa University Press 2013) <https://www.researchgate.net/profile/Francesca_Biondi_Dal_Monte/publication/278403995_The_criminalization_of_irregular_immigration_law_and_practice_in_Italy/links/558027b408ae3f51267a5521/The-criminalization-of-irregular-immigration-law-and-practice-in-Italy.pdf.> accessed 19 March 2019.

[20] For an overview, in English, of the evolution of immigration law in Italy, see François Crépeau, 'Report of the Special Rapporteur on the Human Rights of Migrants, (Country Visit to Italy)' (2012) UN Doc A/HRC/23/46/Add.3, paras 11–35, (2014) UN Doc A/HRC/29/36/Add.2, paras 15–37.

and Italy became a full member of the Schengen system in 1998, with the consequence that any person could travel from Italy into other Schengen countries, most of which are also in the EU, without any internal border check. The trade-off was a commitment on the part of Italy to conduct stricter external border control and genuine enforcement of deportation measures against irregular migrants. The Italian Constitutional Court plainly acknowledged that the comprehensive regulation set out in the CIA responded to these European commitments when it declared inadmissible a referendum to abrogate this act.[21] In relation to the analysis in Chapter 1, the same Court has declared, on different occasions, that the regulation of immigration is necessary or instrumental to protect other public goods and interests such as security, public health, and public order.[22] Immigration policy is defined as 'an essential element of state sovereignty'.[23]

Before providing a picture of the constitutional case law that shapes migrant rights' as human rights, it is interesting to note that Article 16 of the General Provisions of the 1942 Italian Civil Code, which is still valid in the Italian legal system, stipulates that 'any alien is admitted to enjoy the civil rights granted to Italian citizens under conditions of reciprocity'. The dominant case law and scholarship are in agreement on the fact that this provision has a residual application. It is only valid in relation to those rights that are created by the law and that are not 'constitutionally protected' or not 'inalienable and fundamental' *stricto sensu*.[24] However, this provision does not apply to the subject of this chapter, as the right to health is clearly defined as a 'fundamental' individual right in the Constitution itself.

2.2. Constitutional sources of migrants' rights

[21] Constitutional Court Judgement no 31/2000.
[22] For example, Constitutional Court Judgements nos 62/1994, 5/2004, 250/2010.
[23] Constitutional Court Judgements nos 353/1997, 105/2011.
[24] Cassation Court Judgements nos 10504/2009, 4484/2010; Rossi (n 19) 106; Cristina Campiglio, 'Reciprocity in the Treatment of Aliens in Italy: Good Reasons for its Abolition' (2001) *Italian Yearbook of International Law* XI 125.

In the Italian legal framework, as in international and European (human rights) law,[25] there are two principles that guide law and policy-making in relation to immigration and the legal status of foreigners and migrants: sovereignty, which includes the power to control borders and immigration flows, and the recognition of the fundamental rights of everyone. These two approaches qualify and interact with each other.[26]

The constitutional case law regarding the rights of non-nationals began with an extensive interpretation of Article 3 of the Constitution on the principle of equality and has more recently been grounded in Article 2 on the 'inviolable rights' of every person.[27]

Although the text of Article 3 refers to 'citizens', since the late 1960s, the Court has clarified that it must extend to non-nationals when their inviolable and fundamental human rights are at stake.[28] Reliance on Article 3 had allowed for a very flexible principle of 'reasonableness': differential treatment between citizens and non-nationals, including in areas pertaining to fundamental rights, had been permitted by resorting to the argument that 'citizens and non-nationals are in a substantially different position vis-à-vis the state', the former having a stronger and more permanent relationship than the latter.[29] More recently, certain differential treatments between citizens and non-nationals and between different categories of migrants, in relation to their 'fundamental or inalienable rights', have been considered permissible and reasonable provided that the ground for differentiation is not a legal construct such as 'citizenship' but is based on actual differences between the compared situations.[30]

[25] See Sections 1 and 2, Chapter 1.
[26] Giustino D'Orazio, *Lo Straniero nella Costituzione Italiana* (Cedam 1992) 112.
[27] Scuto (n 17) 45–57.
[28] For example, Constitutional Court Judgements nos 120/1967, 54/1979.
[29] Constitutional Court Judgement no 244/1974.
[30] Constitutional Court Judgements nos 2/1999, 432/2005. The Italian concept of 'reasonableness' is slightly different from that of the countries of common law, and the Constitutional case law uses 'reasonableness', 'proportionality', and 'adequacy' interchangeably. For further details, see Barsotti (n 4) 75.

Since 2000, the Court has more widely employed Article 2 of the Constitution to ground the rights of migrants. Article 2, which belongs to the section on 'fundamental principles' of the Italian Republic:

> Recognizes and guarantees the enjoyment of inviolable rights by every human being both as an individual and in the social groups where her personality is developed, which requires the fulfilment of non-derogable duties of political, economic, and social solidarity.

In the Italian legal tradition, the terminology of 'inviolable' or 'inalienable' rights does not refer only to those civil liberties that the state must respect and protect from interference; it also pertains to social rights that must be fulfilled to satisfy people's primary or material interests.[31] It is important to mention that the Constitution does not establish a hierarchy of rights, because:

> All the fundamental rights […] are in a relationship of reciprocal integration, and it is not possible to pinpoint any one of them that has absolute dominance over the others […] and they constitute, as a whole, the expression of human dignity.[32]

The case law of the Italian Constitutional Court has made clear that fundamental or inviolable rights represent a limit to the incorporation of conflicting international law,[33] and to the legitimate exercise of domestic legislative powers, because the Constitution 'contains certain supreme principles that cannot be affected or modified in their essential [or "core"] content either by any constitutional law or any law amending the Constitution'.[34]

The Constitutional Court, adjudicating on Article 2 Const. identified 'the development of every individual person as the final aim of the social organisation (of the state)',[35] and recognised that 'every human being is an

[31] Valerio Onida, 'Relazione', in VV. AA., *I Diritti Fondamentali Oggi, Atti del V Convegno dell'Associazione Italiana dei Costituzionalisti* (Cedam 1995) 69.
[32] Constitutional Court Judgement no 85/2013.
[33] Constitutional Court Judgements nos 48/1979, 168/1991.
[34] Constitutional Court Judgement no 1146/1988.
[35] Constitutional Court Judgement no 167/1999.

inviolable rights holder' and this includes irregular migrants.[36] This means that at least constitutionally protected human rights – with the exception of the right to vote and the right to enter the country – apply to everyone, regardless of their legal status.[37] However, as indicated below, the constitutional case law draws a distinction between the 'universal *recognition*' of rights (in other words, the universal entitlement to human rights) and the *concrete enjoyment* of 'levels of rights', the latter permitting differential treatment of citizens and migrants and, most notably, of regular migrants and irregular migrants.[38] Limitations of rights or differentiations with regard to their enjoyment, which can result from balancing them against other constitutionally protected interests, are permissible and reasonable as long as they do not affect the 'core' content of human rights, which is directly linked to the protection of human dignity.[39] When balancing interests, the Court performs a systemic and non-fragmented interpretation of rights to ensure the 'maximum expansion of rights protection'.[40] The impact of these findings on the right to health of irregular migrants is analysed in Section 4 below.

The development of new human or fundamental rights and the extension of their personal application has undoubtedly been influenced by international and European human rights law. Indeed, the Constitution contains several references to international law, including in relation to the regulation of the legal status of non-nationals provided for in Article 10(2) of the Constitution. On these premises, the Constitutional Court has acknowledged that different formulations of rights in domestic, regional and international law can complement each other and generate a 'multi-level guarantee of fundamental rights'.[41] As evidenced below, however, most of the Italian Constitutional Court's case law on the role of international human

[36] Constitutional Court Judgements nos 105/2001, 198/2000.
[37] Rossi (n 19) 111–119.
[38] Constitutional Court Judgement no 249/2010.
[39] Constitutional Court Judgements nos 219/2008, 509/2000, 105/2001. For further details on the test of 'reasonableness' when balancing rights, see Barsotti (n 4) 76–77.
[40] Constitutional Court Judgements nos 85/2013, 264/2012.
[41] Constitutional Court Judgement no 388/1999.

rights law as a legal source revolves around the ECHR. Hence, other regional and international sources of law on social rights tend to be overlooked.[42] This formalistic approach does not, however, mean that social rights are neglected in the domestic legal system vis-à-vis civil liberties. Indeed, the next section focusses on the normative development of the right to health in the Italian legal tradition, where this right is qualified as a 'fundamental right' and a 'collective interest'.

3. The Right to Health in the Contemporary Italian Legal Framework

As a component of the constitutionalised idea of welfare or the 'social state',[43] Article 32(1) of the Italian Constitutions reads as follows: 'The Republic safeguards health as a fundamental right of the individual and as a collective interest and ensures free medical care to the indigent'. In 1947, the Constituent Assembly agreed on the fundamental nature of this right as a prerequisite for the realisation of other constitutional rights and for the full development of the person.[44] This provision was extremely significant because it was the first time that the right to health was proclaimed and framed in such a contemporary fashion in modern Western constitutionalism.

3.1. The complex nature of the right to health

'The right to health' is a *formula* that simplifies a series of different types of rights. Therefore, the Italian legal literature has often defined it as a 'complex' or 'composite' right.[45] Indeed, as in international law, the domestic right to health encompasses several freedoms and entitlements: the individual right to physical and psychological integrity; the individual right to, and collective

[42] See Section *infra* at Section 5.
[43] See Section 2, Chapter 2.
[44] Constituent Assembly, '(Atti della) Seduta del 24 aprile 1947', 3299.
[45] Massimo Luciani, 'Salute. I) Diritto alla Salute – Dir. Cost' (1994) *Enciclopedia Giuridica* – Vol XXXII (Istituto Enciclopedia Italiana Giovanni Treccani) 4–5; Renato Balduzzi, 'Salute (diritto alla)', in Sabino Cassese (ed) *Dizionario di Diritto Pubblico* – Vol VI (Giuffrè Editore 2006) 5394.

interest in, a healthy environment; the right to preventive and curative health care and the right to free medical care for the 'indigent'; the right to choose and refuse medical treatment; and the collective interest of enforcing certain compulsory health care treatment (in the area of mental health and compulsory vaccinations) in order to protect the health and well-being of the population at large, within the limits of the respect for the dignity of the person.[46] Some of these rights can be considered freedoms or negative rights, whereby the Republic must respect and protect people's right to health, whereas others can be classified as social entitlements that the state is required to fulfil.

A significant amount of literature and case law has been developed on the freedom from interference with personal integrity as an element of the right to health and on the right to claim damages in cases of violation by defining this freedom as a 'primary and absolute right with *erga omnes* effect, also operational in "private-private" litigation'.[47] Another important health-related freedom concerns the choice of whether to accept or refuse treatment, as the principle of 'informed consent' and the controversial regulation of end-of-life issues demonstrate.[48] However, this section will mainly address the 'social' dimension of the right to health, for consistency with the previous chapters.

3.2. The Italian health care system: From a corporativist to a universalist model

The right to access affordable health care and the establishment of a health care system responded to the Republic's constitutional 'duty of solidarity'.[49] For the first 30 years of the Constitution's life, Article 32 Const. was

[46] ibid (Luciani) 5–12; Sergio Bartole and Roberto Bin, *Commentario Breve alla Costituzione* (Cedam 2008) 321–332.
[47] Constitutional Court Judgement no 88/1979 and Corte di Cassazione Sezioni Unite, Judgement no 796/1973. For an overview of the right to health as a 'freedom', see Bartole and Bin (ibid) and Donatella Morana, *La Salute come Diritto Costituzionale* (Giappichelli 2013) 29–60.
[48] Bartole and Bin (n 46) 328–330.
[49] Constitutional Court Judgement no 103/1977.

overshadowed by Article 38 on social security, as the former was considered to be of a programmatic nature while the latter was immediately enforceable. Indeed, until the late 1970s, the organisation of health care was framed as a social health insurance system. Accordingly, access to services of hospital care for economically active people was differentiated on the ground of individual employment position. Free medical care was provided by municipalities as a form of charity to socio-economically disadvantaged people – as required by Article 32 Cost.[50] This situation created concerns in terms of equity.

The right to health care or medical care enshrined in Article 32 was comprehensively realised only with the enactment of the Law No. 833, in 1978, which established the National Health Care System ('Servizio Sanitario Nazionale' - SSN). This determined a shift from a social health insurance system to a universal tax-based health care system.[51] Article 2 of this law endorsed a broad conceptualisation of health which is influenced by biological, ethical and social factors and is in overall consistency with the 'international' conceptualisation of health elaborated in the above chapters. Health is a human right and a public good to be protected through preventive, promotional and curative health care and with measures that address the social or underlying determinants of health. It is interesting to note that this piece of legislation was enacted only three months after the international adoption of the Declaration of Alma-Ata on primary health care,[52] and their respective approaches are quite similar. The Italian SSN is based on the principles of universality of users and health care benefits, along with equity of access.[53] The entire population within the Italian territory, without discrimination based on personal and social conditions, must be able to access the health care system on the basis of their health needs, and this includes migrants. The principle of universality of health services (in Italian

[50] Renato Balduzzi and Guido Carpani, *Manuale di Diritto Sanitario* (Il Mulino 2013) 46–58.
[51] Law no 833/1978 'Istituzione del servizio sanitario nazionale' (SSN Act) Official Gazette no 360 (28 December 1978) Suppl. Ordinario.
[52] Declaration of Alma-Ata (n 28, Introduction).
[53] SSN Act (n 51) Article 1.

'globalità') means that the health care system must guarantee 'prevention, treatment and rehabilitation' of ill-health.

The cost of such a universal, free and localised system had grown significantly in the 1980s, and, in the 1990s, this caused serious concerns about the sustainability of the system and the welfare state in general. Consequently, in the last decade of the 20th century, the system was reshaped by a series of legislative reforms, the result of which is a system that is still universal insofar as it offers free primary and hospital care but that also charges to partially cover the cost of secondary and tertiary care services.[54] Since then, frequent constitutional, legislative, and technical debates have revolved around the identification of 'who gets what' from the national health care system and 'under what conditions'.

3.3. A universal but financially conditioned right to health and the emergence of the 'irreducible core'

The right to health in Italy is 'financially conditioned' because the variety of facilities, services, goods and conditions that are needed for its full 'progressive' realisation require the identification and allocation of resources in the national budget, which naturally detracts from other state interests. The Constitutional Court, in a seminal judgement, recognised that the right to health is directly protected by the Constitution and justiciable but is subject to 'a determination of the tools, times, and mode of implementation' to be identified by the relevant legislative powers. On that occasion, the Court ruled that:

> The constitutionally mandated protection of certain goods takes place gradually, according to a reasonable balancing with other interests and goods which also enjoy constitutional protection, and by taking into account the actual availability of resources.[55]

[54] D. Lgs no 502/92, Official Gazette no 305 (30 December 1992) and D. Lgs no 229, Official Gazette no 165 (16 July 1999) – Supp Ord no 132. See Balduzzi and Carpani (n 50) 65–75.
[55] Constitutional Court Judgement no 455/1990.

The Court concluded that 'each person has a full and unconditional right to benefit from health services that, in conformity with the law, should be provided as public services'.

This emphasis on conflicting interests, including financial constraints on the realisation of social rights, and issues of personal application to migrants have led the Constitutional Court to develop the concept of an 'irreducible core' or 'essential content' of the right to health as an 'inviolable area of human dignity'.[56] This concept requires that 1) minimum health care benefits and health-related conditions be provided universally to avoid any violation of 'human dignity', and 2) discretionary public powers cannot use budgetary considerations to justify protection of the right to health below that threshold. Beyond its core, the right to health is financially conditioned and can be balanced against other constitutional interests.[57] However, the identification of this 'minimum' threshold that protects human dignity is not clearly and generally established by legislation or by the Constitutional case law. As indicated in relation to irregular migrants in the following section, potential violations of the 'irreducible core' appear to be assessed on a case-by-case basis by the Constitutional Court.[58]

To avoid misunderstandings related to terminology, it is worth clarifying that this 'irreducible core' does not correspond to 'the essential level of benefits relating to civil rights and social entitlements' referred to in Article 117(2), letter m) of the Constitution, as the following subsection explains.

[56] See Section 4 *infra.*
[57] For example, Constitutional Court Judgements nos 509/2000, 432/2005, 252/2001. Francesca Biondi Dal Monte, *Dai Diritti Sociali alla Cittadinanza. La Condizione Giuridica dello Straniero tra Ordinamento Italiano e Prospettive Sovranazionali* (Giappichelli 2013) 154; Bartole and Bin (n 46) 327.
[58] Constitutional Court Judgement no 27/1998; for further analysis, see Morana (n 47) 78.

3.4. 'Essential levels' of health care services and Article 117 of the Constitution

Law No. 502/1992 (LEA) introduced the concept of 'essential levels of services (or benefits/assistance)' in the field of health. This was concretely implemented for the first time in 2001, reshaped in 2008, and reformulated again in 2017.[59] Once again, these essential levels do not represent a 'minimum' or 'minimal' level of care but the 'standard' of free or subsidised services that should be offered by the national health care system to everyone in the territory of the Republic.[60] These 'essential' levels of services – determined by law – must be 'appropriate', in clinical and organisational terms, to meet the principles of the SSN.[61] They respond to the idea that, in spite of the regionalisation and localisation of health care which began with the establishment of the SSN and was constitutionalised with a Constitutional amendment in 2001, certain health care standards must be uniformly realised everywhere in the state.

Consistent with the above, the reformed Article 117 of the Constitution regards the 'safeguarding of health' as a subject of shared legislative competence between the national government or parliament and the regions, with the former tasked with identifying general principles to be implemented and the latter granted organisational autonomy.[62] Against this principle, the national competence to determine 'the essential level of benefits relating to civil rights and social entitlements to be guaranteed throughout the nation', which is a commitment to a national welfare state,[63] was constitutionalised with the previously mentioned constitutional amendment to Article 117(2) letter m). Although the formal source of the 2001, 2008, and

[59] D. PCM 29 November 2001, Official Gazette no 33 (08 February 2002); D. PCM 12 January 2017, Official Gazette no 65 (18 March 2017).
[60] Monica Bergo, 'I Nuovi Livelli Essenziali di Assistenza. Al Crocevia fra Tutela della Salute e l'Equilibrio di Bilancio' (2017) *Rivista AIC* 2 4.
[61] D. Lgs no 502/92, Official Gazette no 305 (30 December 1992), Article 1(7); Constitutional Court Judgements nos 185/1998, 121/1999, 282/2002; Giovanni Guiglia, *I Livelli Essenziali delle Prestazioni Sociali alla Luce della Recente Giurisprudenza Costituzionale e dell'Evoluzione Interpretativa* (Cedam 2007) 71.
[62] Constitutional Court Judgement no 282/2002, para 4.
[63] Guiglia (n 61) 67.

2017 'essential level of benefits' is governmental, their actual content is the result of negotiations between the national government, the regions and the autonomous provinces within the 'state-regions conference', a body entrusted with facilitating cooperation between national government and the regions in areas of shared competences.[64]

To sum up, public health care in Italy is organised around a universal tax-based system. National authorities establish the general principles of public health care and enact laws on the essential or standard levels of the service, whereas regional (sub-national) bodies are responsible for more detailed regulation and can even determine the provision of services that go beyond and above essential levels of service provided they can be funded through regional taxation.[65] Regional and national standard-setting must be respectful of the 'irreducible core' of the right to health, as a minimum standard linked to human dignity, to avoid violation of Articles 2, 3, and 32 of the Constitution. Legislative discretion expands beyond the 'core' of the right to health, while the provision of health care as a 'public service' is organised locally according to Article 118 Constitution and the law on the SSN.[66]

In light of the above, the following sections address various problems related to the right to health of irregular migrants. These include differing interpretations regarding what 'level' of government is competent to regulate on the matter (regional or national) and what 'level' of genuinely accessible health care has constitutional protection.

4. The Right to Health of Irregular Migrants in Italy

Recalling the analysis and the case law outlined in the sections above, it is undisputed that irregular migrants, as inviolable rights holders, have a fundamental and constitutionalised right to health. However, when resources are limited and the implementation of rights bears a cost, it is not unusual for

[64] D. Lgs no 502/1992 (n 59) Article 1; Constitutional Court Judgement no 88/2003.
[65] Morana (n 47).
[66] Balduzzi and Carpani (n 50).

'newcomers' such as migrants to be the target of policies that perpetrate 'social exclusion' and limit the concrete enjoyment of social rights.[67] This section mainly discusses the 'contours' of the right to health for irregular migrants, in particular, the 'levels' of health care to which they are entitled and how they enjoy this fundamental right.

4.1. Regional and national powers in the areas of health and immigration: General remarks

An analysis of the conceptualisation and enjoyment of the right to health in Italy cannot overlook the fact that Italy is, as previously mentioned, a decentralised state composed of 20 regions,[68] where normative activities are split between central law-making bodies and regional governing bodies.

Health is an area over which governing bodies at different levels and in different fields hold competing competences, but, as mentioned above, the 'essential levels of benefits' or standard 'levels of health care' to be guaranteed across the country are determined at national level. Although private health care also exists in Italy, the SSN is a tax-based 'public service' that provides and organises concrete health care services through local health units, which are funded by the state and regional budgets. This situation creates significant differences – which constitute inequalities – between the standards in different regions, in terms of the availability, accessibility, acceptability, and quality (AAAQ) of the service.[69]

By contrast, the 'legal status of aliens' and the fields of 'immigration and asylum' fall under national legislative competence as per Article 117(2), letters a) and b) Const. However, the Constitutional Court has made clear that immigration and the legal status of aliens refer to both 'immigration policy' -

[67] Antonino Spadaro, 'I Diritti Sociali di Fronte alla Crisi (Necessità di un Nuovo 'Modello Sociale Europeo': Più Sobrio, Solidale e Sostenibile)' (2011) *Rivista AIC* 4 5; Biondi Dal Monte (n 187, Chapter 1) 4–5.
[68] See *supra* n 8.
[69] Balduzzi and Carapani (n 50) and European Network to Reduce Vulnerabilities in Health / Médecins du Monde, '2017 Legal Report – Access to Healthcare in 16 European Countries' (2017) 69–76 <https://mdmeuroblog.wordpress.com/resources/publications/> accessed 19 March 2019.

which addresses the management of migration flows and the establishment of requirements for entry and stay - and the 'policies for migrants' - which are (social) policies and laws on the treatment of migrants. The latter, which includes establishing the social rights to which migrants are entitled, can also be regulated by the regions and implemented at local level without this infringing the national rules on immigration.[70]

4.2. Statutory and constitutional standards of health care for irregular migrants

Before turning to the constitutional case law on the core content of the right to health for irregular migrants, which has arisen out of litigation regarding 'competence clashes' between the regions and the government, it is worth examining the standards of health care provided for by the CIA and the interpretation of this act in the case law of several Italian courts.

Pursuant to Article 35(3) CIA:

> Aliens that are present on the national territory, who do not comply with the rules concerning entry and residence, are granted, in public and authorized structures, either *urgent* or *essential* outpatient and hospital treatment and continuative care for diseases and injuries, as well as programmes of preventive medicine for the protection of individual and collective health.[71]

The provision goes on to establish a non-exhaustive list of services that must be provided, including reproductive and child health care, on the same basis as Italian nationals.

Regarding the measures consisting of 'programmes of preventive medicine for the protection of individual and collective health', the law and

[70] For example, Constitutional Court Judgements nos 300/2005, 134/2010, 61/2011; Paolo Passaglia, 'Immigrazione e Condizione Giuridica degli Stanieri Extracomunitari' (2006) *Foro Italiano* I 352; Tiziana Caponio, 'Governo Locale e Immigrazione in Italia. Tra Servizi di Welfare e Politiche di Sviluppo (2004) *Le Istituzioni del Federalismo* 789.
[71] CIA (n 6, Introduction) Article 35(3). Emphasis added.

the implementing measures do not elaborate extensively, apart from mentioning:

> […] c) Vaccinations pursuant to the law and within the ambit of regional collective prevention campaigns; d) interventions of international prophylaxis; e) prophylaxis, diagnosis and treatment of infectious diseases and possible decontamination of relevant centres of infection.[72]

Focussing on individual access to health care, Ministerial Circular No. 5/2000, an administrative measure, clarifies what 'urgent' and 'essential' treatments mean. Urgent health care refers to those 'treatments that cannot be postponed without threatening the life or possibly damaging the health of a person', and essential health care means:

> *All* health, diagnostic and therapeutic services, related to pathologies that are not dangerous immediately or in the short term, but which might cause major health damage or endanger the life of the person, due to complications, chronicity or worsened conditions.[73]

These provisions of the CIA and the Circular are reproduced in Article 63 of the 2017 Act on the Essential Levels of (Health) Assistance (LEA), which identifies the standard health services that should be provided to everyone nationally.[74] Lastly, it is important to note that, according to Article 35(5) CIA, when undocumented people access health care services or enter premises where health services are provided, they cannot be reported to the authorities unless the medical staff happens to know about the commission of an offence other than the crime of 'irregular entry or stay' in the country.[75]

Although the Constitutional Court has long established that 'fundamental rights holders are people as human beings and not people as members of a certain polity',[76] it has often missed the opportunity to identify

[72] ibid.
[73] Ministerial Circular (MC) no 5 (24 March 2000) Official Gazette no 126 of 1 June 2000, 36–43. Emphasis added.
[74] LEA 2017 (n 59).
[75] For an overview, see MDM (n 69).
[76] For example, Constitutional Court Judgements nos 105 /2001, 148/2008.

more clearly the level of services that need to be provided in order not to violate the 'core content' (or, in the words of the Court, the 'irreducible core') of the right to health of irregular migrants.[77]

For instance, in a seminal 2001 judgement on the constitutionality of the CIA in a 'removal case', the Court established that an irregular migrant cannot be expelled when the deportation could bring about 'irreparable harm' to the person's right to health. This finding provides for greater protection than that offered by the ECHR because, as previously discussed, the latter tends only to prohibit deportations that are likely to cause irreparable harm in relation to the right to life and freedom from torture rather than the right to health.[78] Despite this, the judgement is somewhat confusing as it initially refers to 'urgent' and 'essential' health care (as per Article 35 CIA) as the standards to be provided but later focusses only on urgent care and treatments that cannot be deferred to draw its conclusions on the 'irreducible' core of this right. Finally, it leaves the identification of cases of 'urgent' and 'undeferrable' health care to the discretion of medical doctors.[79] The latter provision is consistent with other findings of the Court, which hold that it is not for the political powers to decide on the appropriateness of a given therapy in a particular case but rather for those with clinical and scientific expertise.[80]

Other Italian courts, from administrative tribunals to the Court of Cassation, have grappled with the matter at hand, although most judgements regarding Article 35 CIA on the 'level' of health care have been made in cases where a deportation order had already been issued or a residence permit revoked. In these cases, either an administrative order or a judgement was appealed on the grounds that leaving the country would lead to an immediate deterioration in the health of a migrant or a risk to health because of the situation in the country of origin. An analysis of this case law reveals that the health situations that resulted in successful appeals of deportation orders were

[77] Gianfranco Cocco, 'In Direzione Ostinata e Contraria: Spunti in Tema di Diritto alla Salute e Immigrazione', in Renato Balduzzi (ed) *Sistemi Costituzionali, Diritto alla Salute e Organizzazione Sanitaria* (Il Mulino 2009) 92.
[78] See Section 2.1, Chapter 3.
[79] Constitutional Court Judgement no 252/2001, para 4–5. Emphasis added.
[80] Constitutional Court Judgement no 282/2002.

mainly those requiring urgent or undeferrable treatment in order to avoid irreparable harm.[81] Other decisions acknowledged that, according to Article 35 CIA, irregular migrants should have access to urgent and essential health care but these health needs do not constitute grounds for the issue of a residence permit.[82]

It is worth recalling that the instances in which these cases are scrutinised and a judicial interpretation of the right to health is given are 'pathological', which means that the courts are asked to balance health needs against the enforcement of an already-issued (administrative) decision to outlaw the presence of a non-national in the country. This situation is not the same as an assessment of the 'levels or standard' of health care required by the domestic and international law regarding irregular migrants that have not yet received deportation orders. These circumstances have led to the development of a body of case law that tends to be restrictive in its consideration of essential treatment as essential *quoad vitam* or 'for the preservation of life' rather than as 'appropriate' in a clinical sense outside of life saving situations, which the above-mentioned legislation on health care and immigration requires.[83] Nonetheless, other more recent judgements have identified the 'core content' of the right to health of irregular migrants as comprising urgent and properly essential treatments in line with the interpretation of 'essential' that the law – in Article 35 CIA, Circular 5/2000 and Article 63 LEA – determines.[84]

[81] Cass Pen (Sez I) Judgement no 38041/2017; Cass Civ (Sez VI) Ordinanza no 6000/2017; Cons. Stato (Sez VI) Judgement no 8055/2010; Cass Civ (Sez I) Judgement no 1531/2008.
[82] T.A.R. Campania (Salerno, Sez II) Judgement no 558/2014.
[83] Cass Civ (n 84); Cass Civ (Sez I) Ordinanza no 7615/2011; T.A.R Veneto Veneza (Sez III) Judgement no 1303/2008.
[84] T.A.R. Toscana (Firenze, Sez II) Judgement no 695/2011; T.A.R. Campania (n 85); Cass Civ (SU) Judgement no 14500/2013.

4.3. The constitutional case law on competence clashes between regions and the state

As anticipated, the most remarkable constitutional case law in this area has originated in proceedings related to 'conflicts of attribution'. In these cases the central government claimed before the Constitutional Court that some regional acts (introduced by centre-left-wing regional governments) that address social and health services for migrants exceeded the competence of regional bodies.

A 2009 regional law of Tuscany established that 'social measures of assistance that are urgent and cannot be delayed and that are necessary to guarantee the fundamental rights of everyone, consistent with the Constitution and international law', must also apply to irregular migrants.[85] The conservative national government in office at the time – that eventually passed a law on the 'criminalization' of irregular immigration –[86] decided to challenge this regional act by holding, *inter alia*, that it affected the exclusive national competence on the regulation of 'immigration' and the definition of the 'legal status of aliens' of Article 117(2), letters a) and b) of the Constitution. In other words, this was an expression of the often-mentioned clash between sovereign powers on immigration policies and human rights. The Constitutional Court, which relied heavily on the CIA to hold that the region had not overstepped the delegation of powers,[87] made clear that there is:

> An irreducible core of the right to health protected by the Constitution as an inviolable sphere of human dignity, which requires preventing situations of absence of protection that are detrimental to the implementation of that right. […] The right [to

[85] Legge Regionale Toscana (Tuscany's Regional Law) no 29/2009, Official Bulletin of 'Regione Toscana' no 19 (15 June 2009); Cecilia Corsi, 'Diritti Sociali e Immigrazione nel Contraddittorio tra Stato, Regioni e Corte Costituzionale' (2012) *Diritto, Immigrazione e Cittadinanza* 2 43–61; Francesca Biondi Dal Monte, 'Regioni, immigrazione e diritti fondamentali' (2011) *Forum di Quaderni Costituzionali*.
[86] n 19 *supra*.
[87] Corsi (n 85) 51.

> health] must therefore also be granted to foreigners, irrespective of their legal status concerning the entry into and residence in the State. Nonetheless the Parliament *may provide for different procedures for their exercise*.[88]

As highlighted by some scholars, this judgement appears to draw a link between (at least urgent measures of) social assistance and the right to health as interrelated elements of human well-being, which is similar to the commitment in Article 25 UDHR.[89] Unfortunately, the Court did not elaborate on that link and emphasised the connection between urgent or undeferrable measures enshrined in the regional legislation and the core content of the right to health, suggesting an urgency or emergency-oriented approach where the rights of irregular migrants are concerned.

The references to the 'different procedures for the exercise' of the right to health by irregular migrants recalls the fact that, according to the regulation in the CIA, irregular migrants do not register with the SSN. Instead, they access health care services anonymously with an STP code (an acronym for 'temporarily present alien'), which they must request from a local health unit when signing a 'statement of poverty'. The details of how these services are organised are regulated regionally,[90] and further explained in the following sub-section.

During the same year (2009), the national government filed other two appeals against other regional acts concerning health, social inclusion, and social services for migrants on the grounds of infringing the national competence over immigration, public order and criminal law.

One of these cases concerned a law of the southern region of Apulia on the enjoyment of the rights of migrants and their social inclusion, including

---

[88] Constitutional Court Judgement no 269/2010 para 4, in English, < https://www.cortecostituzionale.it/documenti/download/doc/recent_judgments/S2010269_Amirante_Tesauro.pdf> accessed 19 March 2019. Emphasis added.

[89] Biondi (n 85) 4–5; Corsi (n 85) 50.

[90] MC no 5/2000 (n 73) and 'Form 1' annexed to this, 42–44; State-Regions Agreement no 255, Repertorio Atti n 255/CSR (20/ December 2012) 17–21, <http://www.regioni.it/sanita/2012/12/27/conferenza-stato-regioni-del-20-12-2012-accordo-tra-il-governo-le-regioni-e-le-province-autonome-di-trento-e-bolzano-sul-documento-recante-indicazioni-per-la-corretta-applicazione-della-normativa-p-281709/> accessed 19 March 2019.

the adoption of measures to guarantee 'equality of opportunity to access and enjoy fundamental rights and services regarding social assistance, health care, education and living conditions'.[91] Most of the government complaints in this case were considered unfounded or inadmissible. Notably, the Court held that granting access to medicines and free choice of a general practitioner was in conformity with regional powers regarding the implementation of 'essential' health care.[92]

In the second of these cases, the government challenged a law of the Campania region, which was explicitly aimed at achieving 'equality of opportunity' to enjoy fundamental rights for all migrants that lived in the region.[93] In its judgement, the Constitutional Court acknowledged the general social vulnerability of all migrants and reaffirmed that the implementation of the right to education and social assistance are subjects of regional residual competence and that the latter includes a right to shelter for migrants without accommodation.[94] In other words, it denied that the national competence over immigration was affected by the regional social legislation. In that case, the Court cited Article 3 CIA which establishes that:

> Within the ambit of their respective powers and budgetary resources, the regions, provinces, municipalities and other local authorities shall adopt measures that contribute to the pursuit of the objective of removing obstacles which *de facto* prevent the full recognition of the rights and interests guaranteed to foreign nationals within the territory of the State, with particular regard to those relating to housing, language and social integration, in accord with fundamental human rights.[95]

[91] Legge Regionale Puglia (Apulia's Regional Law) no 32 (4 December 2009), in Official Bulletin Puglia no 196 (7 December 2009).
[92] Constitutional Court Judgement no 299/2010, para 2.2.4.
[93] Legge Regionale Campania (Campania's Regional Law) no 6 (8 February 2010) Article 1.
[94] Constitutional Court Judgement no 61/2011, in English, <https://www.cortecostituzionale.it/documenti/download/doc/recent_judgments/S2011061_DeSiervo_Grossi_en.pdf> accessed 19 March 2019.
[95] CIA (n 6, Introduction) Article 3, as referred to in Constitutional Court Judgement no 61/2011, 7 para 2.

The judgement concerned the government's complaints about various social rights for both regular and irregular migrants, including health care and social assistance. The Court recognised the legitimacy of granting a temporary right to shelter for homeless irregular migrants in reception centres within the region as an 'inviolable' right enshrined in Article 2 of the Constitution. This was considered a legitimate measure in the area of 'social services', over which regions are fully competent.[96]

The above cases show that the Italian legal framework, in principle, considers irregular migrants as fundamental social rights holders. However, the various regional competences around social inclusion and social services result in normative fragmentation regarding the actual enjoyment of social rights across the country.[97] Indeed, the Court has considered certain regional acts to be compatible with the constitutional allocation of powers, but it has not always recalled that these standards are required by the unlimitable 'core' of social rights. Furthermore, these findings do not compel all 20 regions to enact such generous standards, which has led to different treatment for irregular migrants depending on the region in which they reside and on whether that region is pro- or anti-immigrant.

As far as the health care of irregular migrants is concerned, national law refers to the obligation to guarantee access to 'urgent' and 'essential treatment'. Without contradicting this legislative standard, the constitutional case law has, however, placed emphasis on the link between 'urgent' / 'undeferrable' treatment – rather than 'essential care' – to identify the 'irreducible' core which preserves human dignity. The jurisprudential 'irreducible core' remains 'vague'.[98] However a clear articulation of the concept is essential to understand which components of the right to health are constitutionally protected against regressive legislative initiatives and cannot be balanced (and thus limited) against other constitutional rights and public interests.

[96] ibid (Const Ct) 7 para 3.
[97] Biondi (n 57) 217–227.
[98] Morana (n 47) 126; Cocco (n 77) 92.

4.4. The right to health care of irregular migrants in practice

It is finally worth looking at how irregular migrants enjoy or exercise their right to health in practice. As briefly mentioned, where the right to treatment is concerned, undocumented adults, who are prevented from registering with the national health care system, access health services with an STP code. The STP code, which can be issued by any local health unit, guarantees anonymous urgent and essential treatments as indicated above for a period of 6 months, in particular:

> Social and health care of pregnancy on the same basis as Italian nationals, child health care in compliance with the UN Convention on the Rights of the Child, vaccinations according to the preventive normative framework as authorized by the regions, international preventive medicine, and prevention and treatment of infectious diseases.[99]

In this way, irregular migrants access health care under similar conditions to Italian nationals: free of charge or with a nominal payment. To avoid being charged the nominal amount, an irregular migrant must demonstrate a state of 'indigence' or a special 'economic vulnerability', and if she manages to do so, a X01 code is assigned. In practice, these procedures and the level of access to services might differ slightly because:

> The regions identify the adequate procedures to guarantee essential and continuing care as per Article 35(3) CIA, in first-level outpatient health services and specialized services to be provided at local health facilities or public/private accredited health centres in the form of general ambulatories or hospitals, possibly in connection with specifically experienced volunteering associations.[100]

[99] CIA (n 6, Introduction) Article 35(3); MC (n 73); State-Regions Agreement (n 90).
[100] D.P.R (President of the Republic's Decree) no 394 'Rules of Implementation of the Consolidated Immigration Act (31 August 1990) Article 43(2) – (8).

In spite of this detailed regulation, the shared competence between national and regional governments has created certain incontinences in terms of uniform regional implementation of 'essential health care'.

Finally, examples of reported factual barriers to health care include the trend for health care staff to refer irregular migrants to voluntary health care clinics – although this is not as prevalent as it was – and the lack of cultural and language mediators in health care. In this regard, communication is perhaps the greatest barrier to accessing health care for both regular and irregular migrants.[101]

4.5. Limited support for the determinants of health for irregular migrants

The section above, by noting that the right to temporary shelter falls under the regional competence on social services and social assistance and that it is related to the right to health, introduces into this analysis the determinants of health' that were discussed in Chapter 4.

Unlike the right to temporary shelter, which is provided for under regional law, the right to housing – as a component of the right to an adequate standard of living – is not a right to which irregular migrants – unlike regular migrants – are entitled under any statutory or constitutional law.

This can be partly explained by the fact that the Constitution does not explicitly qualify 'housing' as an enumerated 'fundamental right'. This lacuna has been filled by the constitutional case law, which began to recognise housing as an inviolable social right in the late 1980s.[102] The conceptualisation of housing for irregular migrants as a social right is also complicated by a 2009 amendment to the CIA, which made it an offence to let property to irregular migrants 'in order to obtain an illegal profit'.[103]

An examination of Article 34 Const. and Article 38 CIA shows that the only other social right supporting the determinants of health that has universal scope and a 'fundamental' nature is the right to education for all

[101] Naga (n 101, Chapter 3), ENRVH/MDM (n 69) 74.
[102] Constitutional Court Judgement no 404/1988.
[103] CIA (n 6, Introduction) Article 12(5–bis).

minors, including migrants. According to Article 38 CIA, all migrant minors are entitled to access a broad range of educational services, and these must be inclusive and multicultural. Compulsory education of minors for eight years is not only a right but also a duty, the violation of which may result in parents being held criminally liable.[104] However, the lack of any regulation prohibiting the irregular status of parents from being reported to the immigration authorities makes the enjoyment of this right by children potentially difficult.

A nationally well-known case that exemplifies the approach of the Italian legal system in relation to the education of children concerned a 2007 Circular of the city of Milan that prevented children of irregular migrants from accessing public pre-school services.[105] The first instance court of Milan ruled the circular unlawful by holding that it was discriminatory in relation to accessing public educational services that were strictly linked to compulsory education. Accordingly, the court held that, because of the Circular, the enjoyment of the right to education of minors was compromised by the irregular status of parents, which also clashed with the 'best interest of the child' as per CRC.[106]

4.6. The strengths and weaknesses of the Italian solution

The most significant strengths of the Italian legal framework consist in the fact that the law guarantees health care outside of life-saving or emergency situations and that the concrete enjoyment of this right is guaranteed by a prohibition (known as a 'firewall') on reporting the irregular migrant health care user to the authorities.[107]

Although no public power explicitly identifies irregular migrants as 'vulnerable people' as such, the Republic's duty of solidarity and the actual

[104] Constitution (n 2) Articles 34(2); D. Lgs. no 297/1994, Official Gazette no 115 (19 May 1994) Article 111.
[105] City of Milan, Circular no 20 (17 December 2007).
[106] Tribunale di Milano (Fist Instance Court of Milan) (Sez I Civ) Ordinanza no 2380/2008, R.G. 11 February 2008.
[107] CIA (n 6, Introduction) Article 35(2), (3).

enjoyment of individual fundamental rights are crucial factors that influence those in power and the courts to consider special measures for these migrants. It is undeniable that the reference to the 'state of indigence' in Article 32 Const., which is the precondition for free medical care, demonstrates that the Italian legal system has always been sensitive to people's socio-economic vulnerability. The fact that irregular migrants can receive an anonymous STP code and thereby access urgent and essential health care demonstrates an awareness of the special institutional and socio-economic vulnerability of irregular migrants. The firewall mechanism guarantees the actual accessibility of health care services.

Unfortunately, the firewall mechanism is fragile as it is contained in ordinary legislation. For example, an early draft of the 2009 amendments to the CIA included the repeal of Article 35(5) relating to the firewall. Had that draft proposal obtained parliamentary support, it would have led to a significant limitation of the enjoyment of the right to health for irregular migrants. It is worth noting that the MPs and political parties that currently sit in the Italian parliament appear to be even less pro-migrant that those that sat in 2009, and the funding of health care for irregular migrants is derived from the budget of the Ministry of Interior Affairs,[108] whose head at the time of writing is the well-known anti-migrant 'Lega Nord' leader Mr Salvini.

Another point of uncertainty concerns whether certain ill-health conditions of an irregular migrant could prevent or suspend the effects of a deportation order. While Article 19 CIA does not mention this situation as one that could prevent deportation, the Constitutional Court has filled this lacuna by granting first-instance judges the power to decide whether health conditions requiring undeferrable treatment should prevail over the enforcement of a deportation order.[109] This means a case-by-case, discretionary assessment conducted outside of the certainty of law. Although, as highlighted above, the case law of the Italian courts is by no means homogeneous in this regard,[110] it is worth mentioning the very restrictive

[108] CIA (n 6, Introduction) Article 35(6).
[109] Constitutional Court Judgement no 252/2001.
[110] See *supra* at Section 3.2.

approach taken in a case before the Court of Cassation in 2008. That Court ruled that continuous health care treatment that is essential for keeping the person alive but that does not result in immediate recovery, does not justify the suspension of the effects of a deportation order.[111] Thus, the lack of clear legislative standards grants judges significant political discretion.

Similar political discretion, at the regional level, has allowed for very different policies on the delivery of public health services to irregular migrants under the guise of 'essential health care'.

The next section compares the right to health of irregular migrants in the Italian legal framework with the international and European human rights systems. This also entails providing an account of the role of various international human rights treaties as sources of law in Italy.

5. The Italian Legal Framework vis-à-vis International and European Human Rights Law

In the constitutional case law concerning the right to health of irregular migrants, the Constitutional Court judgements rely heavily on the statutory provisions of the CIA on 'urgent and essential treatment' to identify the standard of service that should be provided. However, the reasoning of the Court appears to link the 'irreducible core' of the right to health – as an 'inviolable sphere of human dignity' that cannot be levelled down by any legislative initiative or balanced against competing interests by judges – to urgent treatments. Urgent treatments are those that cannot be deferred and that are, therefore, essential to 'life' as a protected good rather than to 'the highest attainable standards of health'.[112] This conclusion may place 'essential' treatment that is not life-saving at the mercy of legislative discretion.

Indeed, the provision of 'essential' treatment is crystallised in the legislation on immigration and that on essential levels of health care

[111] Cassation Court (Sez I civ) Judgement 24 January 2008.
[112] Biondi (n 67) 35.

assistance, the CIA and LEA respectively, the latter being the result of a negotiation between the government, the regions, and the autonomous provinces. Hypothetically, if one day the legislation were to be amended in a detrimental way to a level below the essential treatment threshold (i.e. urgent treatment only) it is not clear whether the Constitutional Court would consider the measure unconstitutional or simply the result of legitimate parliamentary discretion. In this regard, it is uncertain whether the Court would apply the test of 'reasonableness' to outlaw the retrogressive measure. So far, the Court has not employed the test of 'reasonableness' to assess the constitutional consistency of health legislation regarding irregular migrants. It is, at present, superfluous because the right to health of irregular migrants is established in legislation at the level of urgent and essential care, which coincides with the 'irreducible core' of rights – that everybody, regardless of legal status, must enjoy. However, the Constitutional Court did apply the 'reasonableness' test in assessing the constitutionality of a differentiation between citizens and different categories of regular migrants in relation to access to regional welfare services. In this case 'Italian nationality' or 'prolonged residence' of 36 months as criteria to access social services were not considered consistent with other requirements based on the actual 'needs' of people. Therefore, such differentiation was considered discriminatory, unreasonable and unlawful.[113]

As explained above, if the standards of health were lowered, the constitutional provisions that refer to international human rights law as a domestic source of law, namely Articles 10, 11, and 117 of the Constitution, could be employed in order to prevent or annul regressive standards. Indeed, it would be worth taking this approach if the international legal standards were genuinely more generous than the domestic ones. Considering the findings of the previous chapters, this might, at present, be true with regard to international human rights law but not European human rights law. For this reason, it seems appropriate to compare the domestic and international

[113] Constitutional Court Judgement no 40/2011.

standards and to assess the prospective role of the latter in the Italian legal framework.

5.1. Differences and synergies between domestic and international regulation of the right to health of migrants

The current domestic regulation of the right to health of irregular migrants in Italy has not received much attention from international and European human rights monitoring bodies: the review of the COs of the CESCR and the conclusions of the ECSR, over the last two decades, have demonstrated that the domestic legal framework generally conforms to the ICESCR and ESC standards.[114] As highlighted in Section 2 above, in Italy since the 1970s, 'inviolable and fundamental' rights have applied on a universal personal basis, which means that every person is a rights holder, regardless of their legal status. Social rights and the right to health require the realisation of positive duties, and special accommodations are required for irregular migrants who cannot contact public authorities for fear of deportation.[115] At the same time, immigration control remains an essential dimension of national sovereignty. These conflicting interests have led most public authorities to limit, through law and policies, the standards of care for irregular migrants to urgent or emergency social benefits,[116] rather than equalising their entitlements with the social rights of citizens and people with regular immigration status. The only positive exceptions are the right to education of minors and the right to health care. The latter, although with 'different procedures' for its exercise, extends beyond the provision of emergency medical care. The right to health is justiciable in Italy before ordinary and administrative courts, but irregularity of status is a *de facto*

[114] For examples see CESCR, COs on the last report of Italy (n 277, Chapter 2); ECSR, Conclusions on Italy regarding the conformity to Articles 11 and 13 (6 December 2013) Doc nos 2013/def/ITA/11/1-3/EN, 2013/def/ITA/13/1-4/EN; (8 December 2017) Doc nos 2017/def/ITA/11/1-3/EN 2017/def/ITA/13/1-4/EN.
[115] Scuto (n 17) 59.
[116] See Section 4 on the case law concerning regional statutes; CIA (n 6, Introduction) Article 40.

impediment to access to the courts since a court appearance would expose the migrant to the authorities. This is why many of the decisions on the health of irregular migrants pertain to people who have already received a deportation order, a fact that shifts their entitlements towards emergency-oriented situations.

As far as the right to health or medical care is concerned, it can be said that the domestic protection is broader than the standards that have been developed at European level. Furthermore, domestic protection is in conformity with international human rights standards, such as those set out in the ICESCR, particularly with the new emphasis on the actual enjoyment of health care through 'firewalls'. Recalling the findings of Chapter 3, the entitlement to urgent and essential health care, enshrined in Article 35(3) CIA, is generally consistent with the health care priorities of PHC as per General Comment no. 14 and the Declaration of Alma-Ata. Differences in services and goods to be provided to people who can register with the SSN and irregular migrants who are issued an STP code are not so radical that they reduce standards below the threshold of essential health care and primary care.[117] Therefore, the Italian legal framework appears more generous towards irregular migrants than the ECHR and the ESC, which only require states to provide measures to address urgent health needs.[118]

The SSN Act, the LEA decree, and the CIA, have demonstrated that health care is not only considered a synonym of 'treatment' but that it also extends to prevention and promotion, in accordance with, *inter alia*, the Declaration of Alma-Ata and the ICESCR.[119] However, the regulation of health promotion for irregular migrants, including measures on the determinants of health, is underdeveloped. Time constraints did not allow for this research to assess all the regional initiatives in the area of social policy for irregular migrants. However, the analyses in Section 4.3 above demonstrated that the constitutional case law tends to balance the regional

[117] Declaration of Alma-Ata (n 28, Introduction) VI, VII(2); CESCR, GC14 (n 27, Introduction) para 43. For further details, see Chapter 3.
[118] See Sections 2, Chapters 3 and 4 and 4.
[119] Declaration of Alma-Ata (n 28, Introduction); ICESCR (n 14, Introduction).

competence in the area of social policy against national policy on immigration to save protective legislation that meets primary material needs. Indeed, apart from discretionary regional initiatives regarding 'basic' social assistance and a fully-fledged legislative right to education for minors, all other determinants are unregulated. This is not surprising, since, as highlighted in Chapter 4, regulating the social or underlying determinants of health requires structural *pro-homine* policy changes and the establishment of truly interrelated and empowering measures on social rights. The goal of equalising opportunities and capabilities to achieve health equity and well-being clashes with the sovereign power to regulate immigration and expel irregular migrants, which is something to which the Italian legal system is committed.

The core obligations or minimum core content regarding the right to health, which have been elaborated by the CESCR, do not fully coincide with the core content of the right to health of the Italian legal theory. The former is clearly broader than the sole provision of undeferrable treatment: it embraces essential primary health care and the UDH while focussing on non-discrimination and vulnerable groups. The Italian 'irreducible core' of the right to health, which the Constitutional Court has developed in the case of irregular migrants, although at the moment legislatively anchored to essential health care,[120] seems to emphasise on urgent treatments and those treatments that cannot be deferred without 'irreparable harm to health'. Although this conceptualisation is broader than protection from 'irreparable harm to life' or to physical integrity, which is established by the case law of the ECHR,[121] it is significantly more limited than the provision of 'essential health care' and 'primary care' as per the Declaration of Alma-Ata.

Regarding essential health care, the concrete assessment of what is 'essential' is made by doctors on a case-by-case basis.[122] While the government has provided guidelines, the Constitutional Court has so far refrained from plainly declaring whether the 'core' protection extends beyond urgent health care.

[120] MC (n 73).
[121] *Paposhvili* (n 36, Chapter 3).
[122] Constitutional Court Judgement no 252/2001.

5.2. The role of international human and social rights law in the Italian legal framework

As previously mentioned, the current Italian legal standards of health care for irregular migrants do not raise much concern from a human rights perspective. Considering the findings of the previous sections, were these standards to be lowered to bare 'urgent treatment', it is worth assessing whether international law may play a certain role in enhancing human rights protection.

Examining the role of international obligations as among the sources of law in Italy, Article 117 Const. establishes that the legislative power of the state and the regions must be exercised in compliance with the Constitution, EU law, and international (treaty) obligations.[123] Another reference to international norms and treaties is made in Article 10(2) Const., which directly concerns the regulation of the 'legal status of aliens'. This means that Italy is bound by those treaties that are ratified and incorporated into the Italian legal system. These constitutional provisions translate the international principle of *pacta sunt servanda* as per Article 26 Vienna Convention on the Law of Treaties into the constitutional order.[124] Human rights treaties, such as the ICESCR, the ECHR, and the ESC, have been signed, ratified and incorporated into ordinary legislation.[125]

Against this background, the legal impact of these international and European human rights norms at domestic level is somewhat limited: the domestic courts grant normative binding authority – for reasons elaborated on below – only to the jurisprudence of the ECtHR. When one considers the

[123] Article 10(1) Const. refers to the immediate adaptation of the Italian legal order to international customary law, which does not generally apply to the matter at hand.
[124] VCLT (n 25, Chapter 1).
[125] The 1966 ICESCR was ratified and incorporated by Law no 881 (25 October 1977) and published in the Official Gazette on 7 December 1977; The 1950 ECHR was ratified and incorporated by Law no 848 (4 August 1955) and published in the Official Gazette no 221 on 24 September 1955; the 1961 ESC was ratified and incorporated by Law no 929 (3 July 1965) and published in the Official Gazette on 3 August 1965 (suppl. no 193); the 1996 ESC-Revised was ratified and incorporated by Law no 30 (9 February 1999) and published in the Official Gazette no 44 on 23 February 1999 (suppl. no 38).

restrictive approach of the Strasbourg Court to socio-economic rights and, indeed, to irregular migrants' rights, this means that international and European human rights law are unlikely to have a significant levelling up effect.

Two Constitutional Court judgements (Nos. 348 and 349/2007 – the so-called 'twin judgements') have clarified the role of European human rights obligations in the domestic legal order. In the first place, domestic law must be interpreted by choosing, in so far as possible, the meaning that reflects the requirements of the ECHR, as interpreted by the ECtHR.[126] In other words, the case-law of the Strasbourg Court is binding on ordinary judges. However, while ordinary judges 'must' attempt to bridge the gap between domestic law and the ECHR by using the above interpretative technique, in the case of the jurisprudence of other quasi-legal human rights bodies the 'consistent interpretation' technique seems to be optional. For example, domestic judges are not bound by the quasi-judicial case-law of the ECSR, although the Constitutional Court qualifies it as 'authoritative'.[127] This is a consequence of the Article 32 (Jurisdiction of the Court) and 46 (Binding force and execution of judgements) ECHR, whereas similar provisions are not contained, for example, in the ESC and the OP-ICESCR.

Whenever a conflict between domestic law and international human rights law occurs and cannot be resolved through this technique of 'consistent interpretation', Article 117 Const., as interpreted by the Constitutional Court, requires ordinary judges (mandatorily, in case of courts of last instance) to refer the matter to the Constitutional Court. Under this referral mechanism, the Constitutional Court performs a judicial review of the applicable law in the light of the corresponding constitutional provision and in conjunction with the relevant international treaty norm. As clearly established by the 'twin judgements' and other subsequent constitutional case law, only international treaties that are consistent with the Italian Constitution can complement

[126] For example, Constitutional Court Judgement no 349/2007, para 6.2.
[127] Carmela Salazar, 'La Carta Sociale Europea nella Sentenza n. 120 del 2018 della Consulta: Ogni Cosa è Illuminata? (2018) *Quaderni Costituzionali* 4 905. See Constitutional Court Judgements no 120/2018, 194/2018.

constitutional provisions in the judicial review of laws.[128] These proceedings can lead to the striking down of a domestic norm that is inconsistent with international human rights law.[129] In constitutional proceedings, treaties, including human rights treaties, are considered as 'in-between norms' because they can be placed between the Constitution and the ordinary laws in the hierarchy of sources.[130] International human rights treaties do not have direct effect in the domestic legal order, but all the treaties mentioned in this thesis can, under the conditions above, be referred to in the judicial review of laws.[131] However, another clarification is needed: The case law of the ECtHR, by virtue of Articles 32 and 46 ECHR above, is binding on ordinary judges and – only if the case law reflects a consistent jurisprudential practice - on the Constitutional Court.[132] However, the jurisprudence of the ESCR and the CESCR, although can be taken into consideration as a persuasive source of interpretation, does not have this binding precedential value.

To summarise, while all these ratified treaties are domestic sources of law and standards to be applied in the context of constitutional judicial review of legislation, international human rights treaty norms are applied and interpreted at the discretion of the domestic courts, while the only binding jurisprudence is that of the ECtHR.

Although the Constitutional Court has often recalled that different catalogues of human rights (contained in domestic, international, and European sources) complement each other,[133] and that their combined normative scope is aimed at the 'maximum protection' of human rights,[134] the

[128] For example, Constitutional Court Judgement no 348/2007 para 4.7.
[129] The ruling of the Constitutional Court is then remitted to the referring court and the latter resolves the case accordingly, see Barsotti (n 4).
[130] Constitutional Court Judgement no 348/2007 paras 4.4–4.7.
[131] For example, CRC, CRPD and ESC were grounding the Constitutional Court Judgements nos 436/1999, 324/1999, 7/2013, 236/2012, 275/2016, 120/2018, 194/2018.
[132] Constitutional Court Judgement no 236/2011, See also Roberto Romboli, 'La Influenza della Cedu e della Giurisprudenza della Corte Europea dei Diritti Umani nell'Ordinamento Costituzionale Italiano' (2018) *Consulta Online* < http://www.giurcost.org/studi/romboli6.pdf> accessed 25 March 2019.
[133] Constitutional Court Judgement no 388/1999.
[134] Constitutional Court Judgement no 317/2009.

analysis above indicates an overreliance on the ECHR (as interpreted by the ECtHR) as a source of international human rights law.[135]

This study has frequently pointed out that, as far as the right to health of irregular migrants is concerned, Article 12 ICESCR offers the highest protective and vulnerability-centred standards. Therefore, the selective approach of the Italian Constitutional Court, which often disregards treaties that are not the ECHR, has a detrimental effect on the normative impact of international socio-economic rights, and generates some concerns about the multilayered commitment to the idea of the welfare or social state. However, this can also be framed as a consequence of the comparative weakness, in normative and accountability terms, of regional and international law concerning socio-economic rights. This comparative weakness (vis-à-vis civil and political rights) undeniably affects the influence of socio-economic rights at the domestic level. As regards the right to health of irregular migrants in particular, the combined effect of this ECHR-centred approach and the previous findings on the quality of the 'irreducible core' in the constitutional litigation is to make the provision of 'essential health care' particularly fragile vis-à-vis sovereign political will.

Finally, since the jurisprudence on the ECS and the ICESCR can, at best, assist in the interpretation of Italian domestic law, it is extremely important that the standards that these international human rights bodies develop are as clear and consistent as possible.

[135] The preference for the ECHR seems linked to the 'jurisdictional' nature of the European Court of Human Rights and the highly developed case law of the latter. See Giuseppe Palmisano, 'Le Norme Pattizie come Parametro di Costituzionalità delle Leggi: Questioni Chiarite e Questioni Aperte a Dieci Anni dalle Sentenze "Gemelle"' (2018) *Osservatorio sulle Fonti* 1 7–8; Giovanni Serges, 'I trattati Internazionali Diversi dalla Convenzione Europea dei Diritti dell'Uomo nell'Ordinamento Italiano', in Antonietta Di Blase (ed) *Convenzioni sui Diritti Umani e Corti Nazionali* (Roma Tre Press 2014) 196.

Conclusions

This chapter demonstrated the ways in which the Italian legal framework, from ordinary laws to the constitutional case law, is committed to providing health care for everyone. This situation was brought about by a series of factors, including a genuine commitment to the right to health as fundamental right in a social state model, and the development of a constitutional case law centred on the principles of equality and the inalienable rights of every person. The right to health of irregular migrants that emerges from this analysis is a right to 'urgent and essential' health care, as per statutory law and constitutional case law which relies heavily on those statutory standards. This right to health care is indeed closer to the highly protective international human rights law than it is to the entitlements under European law.

One merit of the Italian legislation consists in it having resolved the often-mentioned 'sovereignty-human rights' clash without reducing the scope of the right to health for irregular people to mere life-saving treatment. It has achieved this by providing for 'firewalls' for the effective enjoyment of the right to health by irregular migrants. However, something is missing from the picture insofar as the underlying or social determinants of health are only marginally considered by the law. Furthermore, reading between the lines, the Constitutional Court, which currently supports including 'essential health care' within the scope of the right to health, appears to do so only because statutory laws unambiguously set that standard. This fact, together with a generally weak incorporation of social rights treaties, makes the right to health for irregular migrants particularly fragile vis-à-vis the prospect of regressive legislative reforms in the current anti-immigrant climate. For this reason, the underlying recommendation of the concluding chapter that follows is that international and European law should commit to a comprehensive concept of health and consistent health standards for everyone that do not correspond to the provision of emergency and medical treatment only. In other words, I advocate moving towards a consistent international *corpus juris* that can positively affect domestic standard-setting and judicial

interpretation of a meaningful right to health for irregular migrants in line with the international commitment to the underlying principles of universality and indivisibility.

Conclusions

In 1966, the same year that the ICESCR was adopted by the UN General Assembly, Martin Luther King Jr., leader of the American civil rights movement, affirmed that 'of all the forms of inequality, injustice in health is the most shocking and inhuman'.[1] Although his statement referred to the imbalance that the American private insurance system generated at the domestic level, it can easily be applied to the situation of community outsiders such as irregular migrants or people who are not affiliated with a health care system. Indeed, irregular migrants are often prevented from accessing health care or may encounter specific barriers to the enjoyment of the human right to the highest attainable standard of health as a result of a state's 'choice' to exclude or ignore their health needs.

Since the end of the Second World War, international and European human rights law has played a significant role in shaping domestic legal orders, rights, and policies. However, it has had a reduced level of impact with regard to the right to health as a social right of irregular migrants.

To answer the overall research question of whether and how international and European human rights law can offer meaningful arguments to enhance the full realisation of the right to health of irregular migrants, this thesis was structured in five substantive chapters. The first two chapters identified the structural hurdles that these legal frameworks encounter in this area and ask how they shape the human rights of irregular migrants and the protection of their health interests. Chapters 3 and 4 asked how 'thick' the support of international and European human rights law for measures on both health care and the determinants of health of irregular migrants is. Indeed, these are the two elements of the scope of the right to the highest attainable standard of health which do not receive uniform consideration in the human rights practice. Finally, Chapter 5 took Italy as a case study to investigate how

[1] Reference to original newspaper articles in Physicians for a National Health Program, 'Dr. Martin Luther King on health care injustice' <http://pnhp.org/news/dr-martin-luther-king-on-health-care-injustice/> accessed 1 March 2019.

the normative principles of sovereignty and human rights play out at domestic level in relation to the right to health of irregular migrants. It also examined how international and European social standards are domestically incorporated and if they can be of any normative use.

The purposes of this concluding chapter are: first, to summarise the findings of the previous chapters and, in accordance with various authoritative interpretations of law, offer certain recommendations; second, to highlight some of the major relevant developments in legal or quasi-legal standards that have occurred since the research began, which are discussed in the previous chapters; third, to point to fruitful avenues for future research that might strengthen the findings of this thesis and overcome some of the limitations that were set out in the Introduction.

1. Main Findings

1.1. Chapter 1 – 'Sovereignty and the Human Rights of Irregular Migrants'

To answer the overall research question of what international and European human rights law can offer to enhance the right to health of irregular migrants, Chapter 1 addressed the sub-question of how the clash between the principle of sovereignty in the area of immigration – which is internationally recognised – and the development of universal human rights shapes the conceptualisation of (and the case law on) the rights to which irregular migrants are entitled in international and European human rights law.

To summarise:

1. The analysis of the texts of the fathers of international law, such as Hugo Grotius and Emer de Vattel, reveals that they did not regard 'jus gentium' as a legal system to limit migration flows. On the contrary, individual freedom of movement and the freedom to establish at least a temporary residence outside one's country of nationality was considered 'natural' prior to the end of the 19th century when economic migration served the interests of the Western world. Accordingly, the doctrine of absolute

sovereignty in relation to immigration is not a 'natural' feature of the international concept of state sovereignty.

2. At the end of the 19th century, common law jurisprudence began erroneously to attribute highly discretional state sovereignty to regulate the entry, stay, and rights of 'foreigners' to the teachings of international law, and this 'rule' has since been legally recognised as a maxim of (contemporary) international law, which includes human rights law.

3. However, the state power to determine the right to entry and the treatment of migrants is not absolute because it has been internationally limited by the development of universal human rights law and refugee law. From the second half of the 20th century on, everyone, including those living outside their state of nationality, has been entitled to the provisions of the human rights law ratified by the state in which they reside. The mutual impact of sovereignty and the idea of human rights has led to a situation where irregular migrants enjoy legal human rights to a lesser extent than country nationals. This trend is reflected in certain treaties and in the findings of some important international and European human rights adjudicators, including in relation to the rights to health.

4. Overall, in relation to irregular migrants, European human rights law tends to be somewhat deferential to states and relies heavily on the concept of sovereign powers in relation to immigration as a 'maxim' of international law to condone detrimental treatment. International and inter-American human rights law provides more generous rights for irregular migrants, and the related case law tends to refer less to control of immigration as a state prerogative required by international law.

1.2. Chapter 2 – 'The Normative Contours of the Right to Health'

This chapter outlined and assessed the development of the right to health in international and regional human rights law, which in operative terms is fairly new. The analysis remained at all times cognizant that health is a technical and intersectional field and one over which states have maintained high levels

of discretion or sovereignty. The field of health, like migration, is extremely sovereignty-sensitive. The state of the art of the multi-layered legal systems regarding health locates states at the centre of health protection. State sovereignty may be referred to as a critical 'political determinant' of health because only where there is a functioning democratic government can health (care) be guaranteed.

To understand whether international and European human rights law can help enhance the protection and promotion of the right to health of irregular migrants, it is essential to clarify what having a right to health means in these legal frameworks.

To summarise:

1. The origins of the right to health, conceived as the right to the highest attainable standard of health, are found in the 20th century, and the development of the right has been strongly inspired by the principles of public health governance. Indeed, its scope extends to both health care and the determinants of health, which can be addressed by intersectoral measures to support health prevention, promotion, and treatment, although to slightly different extents, in both international and European social rights treaties. The PHC approach of the international Declaration of Alma-Ata, the so-called 'Magna Charta of Health',[2] remains a contemporary authoritative reference for what health priorities should be. This was confirmed in 2018 by the Declaration of Astana.

2. International human rights law, from the 1990s on, has developed several conceptual frameworks to operationalise complex state obligations in the area of social rights, including the right to health. All of them, and especially the 'AAAQ' framework and core obligations, revolve around the concepts of non-discrimination and vulnerability. Indeed, social rights are extremely important for people who find themselves in situations of vulnerability or socio-economic precariousness.

3. Against this background of positive developments, socio-economic rights have been traditionally conceptualised as rights or interests to be

[2] Parran (n 18, Chapter 2).

realised progressively. This has led to a situation in which the right to health, among other social rights, has often not been considered a real legal right and has, therefore, been deemed unsuitable for international adjudication. This has enabled states to partially avoid international accountability and has afforded them wide margins for 'manoeuvre' when dealing with resource-demanding public interests or social rights. In such an impasse, which has not been completely resolved to this day, health interests have been addressed in international and European human rights law through a case-based litigation on civil rights. However, as indicated, their resulting jurisprudence on health care does not fully cover the scope of the right to the highest attainable standard of health because it generally frames human health in medical terms and often only offers protection in critical life-saving situations.

4. Today, this gap in international accountability has been partly bridged, at least conceptually, and the provision of the right to health is recognised as being a state obligation of both a progressive and immediate nature. Most notably, the right to the highest attainable standard of health gives rise to an obligation to ensure non-discrimination with immediate normative force. Non-discrimination and vulnerability are solid notions present in all human rights frameworks and are directly or indirectly acknowledged by a series of WHO standards on 'primary health care', the 'social determinants of health', and 'universal health coverage'. The reliance on them in human rights law pushes towards more genuine forms of substantive equality, including positive duties of states that benefit the worst off. However, there is disagreement with regard to the identification of deserving vulnerable people between different international and European legal frameworks and, in particular, on the inclusion of irregular migrants in that category.

1.3. Chapter 3 – 'The Right to Health Care of Irregular Migrants in International and European Human Rights Law'

This chapter showed the different extents to which the right to health care of irregular migrants is guaranteed in European and international human rights law. The analysis uncovered several inconstancies in relation to the legal recognition of irregular migrants' vulnerability and, accordingly, on what discriminatory practices consist of and on how 'thick' their health rights and correlative state obligations should be.

The following points summarise the findings and offer certain recommendations:

1. The European human rights system is generally constrained by the limitations of its personal and material scope in the matter at hand. The ECtHR, which is at the heart of the European system and adjudicates on a treaty that is civil and political in nature, has not provided for the health and well-being of irregular migrants beyond situations of severe material and health deprivation. The ECSR, although it extended the limited personal scope of the ESC to irregular migrants, has proved incapable of affirming the right to health care for this group beyond health care that addresses urgent health needs. These findings reflect the trend in the European region for states to maintain high levels of sovereignty in these areas. Although slightly different conclusions can be drawn from the case law of different bodies, European human rights law draws on the value of 'human dignity', but it does so only to rule out the most severe deprivations of health. With regard to the matter at hand, the European human rights system should incorporate the approach to health of international human rights and global health governance. It must be acknowledged that caring for people's health only in emergency situations coincides with the right to life and the right to freedom from degrading treatment but does not directly relate to the concept of 'health'.

2. In contrast, the international human rights system, by recognising irregular migrants as especially vulnerable people, is more inclined to grant

greater protection of their health needs. In particular, the jurisprudence of the CESCR identifies as a core obligation of an immediate nature the duty 'to ensure the right of access to health facilities, goods, and services on a non-discriminatory basis, especially for vulnerable or marginalised groups'. Elaborating on the test of discrimination and on the substantive concept of 'primary care' within the PHC approach of Alma-Ata, this analysis rejects the notion that irregular migrants should be entitled only to 'urgent' or 'life-saving' treatment.

3. However, international human rights law does not always employ consistent terminology in describing the level of minimum acceptable health care for irregular migrants, and this lack of clarity in monitoring practice may jeopardise the normative positive effects of the Committee's jurisprudence in granting 'priority' to vulnerable people. This is why this research has had to elaborate on an explicit substantive minimum standard of health care, by combining the existing emphasis on the concept of non-discrimination and vulnerability with the substantive notions of primary health care in global health governance.

4. Finally, in its recommendations and prescriptions with regard to standards of health care for irregular migrants, international and European human rights law must propose practicable and non-illusory solutions. An example of one such solution is the recommendation that 'firewalls' be established between public services providers and immigration enforcement, which is a trend that some human rights bodies are beginning to support.

1.4. Chapter 4 – 'The Determinants of Health of Irregular Migrants in International and European Human Rights Law'

This chapter explored how serious the commitment, in European and international human rights law, is to the underlying or social determinants of health of irregular migrants.

The following points summarise the findings and offer recommendations:

1. State measures that address the determinants of health are necessary for the genuine equity-oriented realisation of the right to health. They are understood slightly differently by human rights and public health scholars. The former focus on people's living and working conditions, which can be addressed by the right to health and other social rights, whereas the latter also address underlying structural determinants, such as power, money, and resources, which are structural drivers of health inequity. The determinants of health encompass the interrelatedness and interdependence of all human rights and the multi-layered vulnerability of human beings. To address them, states should adopt measures of substantive equality that target differentiated but universal vulnerability to socio-economic deprivation and ill-health.

2. In the context of human rights law, due consideration of the determinants of health requires, at the bare minimum, a conceptualisation of social rights that is cognisant of their impact on human health and an enforcement of those rights in accordance with such a conceptualisation. As these rights are operationalised by the welfare state, irregular migrants - who do not fit the nationalist and protectionist principles of the welfare system - often find that their health and social needs are unmet. Once again, the institutional sovereign power to exclude and expel irregular migrants runs counter to any real empowering function of indivisible and interrelated human rights.

3. At a more applied level, the second part of the chapter investigated how these concepts feature in the human rights jurisprudence regarding irregular migrants' social rights (which support the determinants of health). In this regard, European and international human rights law offer different approaches. European human rights law encounters similar difficulties to those mentioned in the previous chapter. The ECHR, while it may protect social interests through its civil and political rights, allows states a broad margin of appreciation and sets high thresholds for human rights violations. These circumstances, together with a sovereignty-oriented approach and the clear statement that states 'may have legitimate reasons for curtailing the use

of resource-hungry public services by short-term and illegal immigrants, who, as a rule, do not contribute to their funding',[3] make the ECHR an unsuitable legal framework for the protection of the socio-economic determinants of health of irregular migrants beyond very exceptional circumstances. The ECSR, notwithstanding the significant textual limitation of the ESC, does appear to appreciate the interdependence between health outcomes and the socio-economic determinates of health, although, where irregular migrants are concerned, the recommended measures tend to address people's 'urgent needs'.

4. International human rights law, even though it appears more receptive than the European systems to a concept that is explicitly its own, sets somewhat unclear standards for the promotion of socio-economic conditions that support the determinants of health of irregular migrants. Although there are instances of recommendations for more equality in relation to the level of social benefits granted to nationals and regular and irregular migrant workers, the recommended standards of social rights for irregular migrants are often 'basic', which seems to provide only a subset of the adequate and genuine empowering level of socio-economic conditions.

5. Overall, where irregular migrants are concerned, an 'atomistic' approach that largely ignores the interrelated nature of human rights appears to be preferred as it does not strongly challenge structural inequalities within (and between) countries. To genuinely tackle human and social vulnerability to ill-health and truly commit to the universal empowerment that human rights and health promotion entail would require improving the social rights that support the determinants of health, if not to the extent of equalising irregular migrants' enjoyment of those rights to the level of their enjoyment by vulnerable nationals, then at least beyond survival level, particularly in high- and middle-income countries. The actual and effective enjoyment of these rights, even at basic level, would require holistic and easily accessible service points at local level and the creation of firewalls for service delivery.

[3] *Ponomaryov* (n 75, Chapter 4).

1.5. Chapter 5 – 'The Right to Health of Irregular Migrants in Italy'

This chapter asked whether the Italian legal framework, from its statutes to its constitutional case law, is committed to either a 'thick' or minimalist right to health for everyone, including irregular migrants. Accordingly, it explored whether the Italian experience is consistent with the European or International trends and what role these legal frameworks might play in the domestic legal order.

To summarise:

1. The Italian legal system regards the right to health as one of the most fundamental rights of its Constitution and has operationalised this recognition with a universalist health care system. The Constitution requires that the fundamental rights of 'foreigners' be protected, and the Constitutional Court has built, around the principles of universality of rights, equality, and solidarity, a rich case law on the rights of migrants, including the right to health of irregular migrants These rights, for regular and irregular migrants are also detailed in the CIA.

2. The (statutory) right to health care of irregular migrants is framed as the 'right to urgent and essential treatment' as per Article 35 CIA (and Article 63 LEA). Only the rights to education and health care are prescribed as social rights (which support the determinants of health) that irregular migrants must enjoy. The constitutional case law, although it reaffirms the standards of essential and urgent treatment as per CIA, seems to limit the irreducible core of the right to health, within the inviolable ambit of human dignity, to those health treatments that cannot be postponed without irreparable harm to health.

3. The Constitutional Court has demonstrated a willingness to uphold regional acts that, exercising regional competence in the area of social policy, provide emergency social assistance and shelter to undocumented people, even though it does not have the power to extend these generous standards beyond those regional territories.

4. The Italian legal system appears to partially comply with the PHC approach to the extent that it upholds access to 'essential health care' which includes primary care and chronic care for everyone but falls short of comprehensively addressing the determinants of health – beyond the adoption of measures on health care and primary education – regardless of immigration status.

5. The Constitutional Court currently supports the inclusion of 'essential health care' within the scope of the right to health and the provision of 'firewalls' for the actual enjoyment of that right. However, it appears to do so mainly because statutory laws unambiguously set that standard. International treaties are a source of domestic law, but the jurisprudence of international and European human rights bodies is normatively weak - except for the ECtHR - in the domestic legal system. This is not only due to domestic treaty incorporation but is also a consequence of the uneven treatment of social rights at least at European level. These circumstances make the right to health – beyond urgent care – for irregular migrants particularly fragile vis-à-vis the prospect of regressive domestic legislative reforms. For this reason, it is highly advisable, from a rights-centred position, that international and European human rights bodies make their standards consistent and aligned to the positions and priorities of the PHC approach that global health governance recommends on a universal basis. By doing so, in accordance with the principles of universality and invisibility, they can have a persuasive (although not binding) influence on domestic law- and policy-making.

2. Major Advancements During My Four-Year Ph.D.

The above findings showed that international and European human rights law in this area, while constantly developing, remain inadequate to successfully protect and promote everyone's health. International legal standards, of either soft or hard law, are progressively raising standards towards a genuinely universal human rights law. However, the findings do reveal a number of inconsistencies. First, inconsistency exists between international and

European human rights law, which differ in relation to impermissible grounds for discrimination, the test of proportionality on differentiating measures, and the 'levels of social and health benefits' to which irregular migrants are entitled. Second, there is an inconsistency between what seems to be a value-based right to health care and an urgent needs-based right to the underlying determinants of health for irregular migrants in international human rights law. Finally, the rhetoric surrounding the principles of indivisibility, interrelatedness and universality is inconsistent with human rights practice on irregular migrants. The latter avoids pushing for structural shifts towards solutions that might facilitate real universal enjoyment of social rights and the right to health to their full extent and for every human being, regardless of immigration status.

Since I began my PhD in 2015, in spite of increased anti-immigrant sentiment within the governing parties of several countries, including the US and Italy, new international initiatives, case law, and jurisprudence have made some progress in shaping standards in the area of health and (irregular) immigration.

Global initiatives that have brought renewed attention to migration and health include the above-mentioned Global Compact for Migration and the Declaration of Astana on Primary Health Care, both of which were adopted in late 2018.[4] These political commitments, which are not formally legally binding on state norm-making mechanisms, have involved a broad array of stakeholders in the areas of immigration and health and have set out technical principles and political frameworks according to which the human right to health of irregular migrants should be nationally operationalised and internationally monitored.

As far as European human rights law is concerned, the ECSR's 2018 decision on the merits of *Eurocef* demonstrated that a truly interrelated rights approach with regard to the health of irregular migrant (children) is possible. Indeed, the violation of Article 11 ESC on the right to the protection of health was, in that case, directly due to situations of homelessness and, substantially,

[4] Declaration of Astana (n 153, Chapter 2); GCM (n 86, Chapter 1).

due to the lack of any targeted anti-poverty measures.[5] For its part, the ECtHR, even while upholding a restrictive approach to the protection of the health of irregular migrants, clarified its approach regarding the threshold of health deprivation necessary to prevent deportation in its 2016 judgement in the case of *Paposhvili*, part of which reads as follows:

> Although *not at imminent risk of dying* [the migrant should] […] face a real risk, on account of the absence of appropriate treatment in the receiving country or the lack of access to such treatment, of being exposed to a serious, rapid and irreversible decline in his or her state of health resulting in intense suffering or to a significant reduction in life expectancy.[6]

In international human rights law, a number of relevant advances have been made. For example, in 2017, the CESCR issued a statement, which is quoted throughout this thesis, on the duties of states towards refugees and migrants, which focussed on core obligations and the 'special' vulnerability of undocumented migrants in relation to their enjoyment of socio-economic rights.[7] Second, the two Joint General Comments by the CRC and CMW committees, also issued in 2017, have plainly clarified that migrant children are first of all children and should receive corresponding enhanced human rights protection, which should be equalised with country nationals. Third, there is evidence (in the ECRI, CESCR, CRC, and CMW) of early-stage support among human rights bodies for firewalls between public service providers and immigration authorities.[8] Finally, the first decision on the merits of the CCPR Committee on the right to health and life of irregular migrants was delivered in 2018. This was the decision in the case of *Toussaint*, whereby the Committee held, *inter alia*, that any differentiation on the grounds of irregular status as a consequence of immigration policy that could 'result in the author's loss of life or in irreversible negative

[5] *Eurocef* (n 87, Chapter 4) para 211.
[6] *Paposhvili* (n 36, Chapter 3) 141-142. Emphasis added.
[7] CESCR, Statement (n 153, Chapter 1).
[8] ECRI (n 128, Chapter 3); CESCR, COs Germany (n 90, Chapter 3), CRC and CMW Committees (n 154, Chapter 1).

consequences for the author's health' is unreasonable and thus discriminatory.[9]

These positive developments have had a significant impact on my findings, as is apparent from the several references to them in the previous chapters. They are steps that, to different extents, have contributed to a migrant-centred shaping of international (and sometimes European) human and social rights law in a world of rising populism, racism, and xenophobia.

3. Future Research

The introduction to this thesis clearly sets out research questions, aims, and boundaries in order to exclude from the scope of the study certain legal frameworks, types of literature and subject matters, and to make the thesis scientifically sound and feasible. Some of these excluded elements deserve specific analysis in future research and may significantly contribute to further developing and using the findings of this research.

3.1. The right to mental health of irregular migrants

The right to health embraces both 'physical' and 'mental health', and this research has consciously avoided splitting the analysis into these components due to time constraints and the need to develop further expertise in dealing specifically with mental health.

Against the current background of growing discrimination and xenophobia in migrant-receiving countries, 'immigration status, social exclusion, living and working conditions, communication with family, integration and access to health services' are all factors relevant to the mental health of migrant workers[10]. The right to mental health or the right to support people with mental or psychosocial disabilities is an increasingly important

[9] *Toussaint* (n 172, Chapter 1).
[10] Pūras (n 234, Chapter 2) para 77; Grover (n 234, Chapter 2) para 64.

area of concern for human rights law, especially following the adoption of the Convention on the Rights of Persons with Disabilities in 2006.

However, little human rights scholarship and jurisprudence has specifically addressed the right to mental health for irregular migrants. One exception is the UN SR on the right to (physical and mental) health, who has recommended that health care systems should not focus excessively on the biomedical model and that psychosocial interventions should be embraced in a non-discriminatory way to guarantee access to, and delivery of, community-based mental-health care services and the underlying determinants of health.[11]

For example, some human rights bodies have raised issues of rights violation in relation to dangerous jobs, especially in the agricultural sector,[12] where irregular migrants face 'occupational risk as an additional stress factor, while exposure to pesticides has been linked to anxiety, depression, irritability, and restlessness in agricultural workers'.[13] In the 21st century, mental health should be a global health priority, particularly for people on the move, and this includes establishing 'effective firewalls between service providers and immigration enforcement authorities to ensure that no enforcement operations are carried out in or near mental health-care or support facilities'.[14]

Extending the scope of this research to mental health of irregular migrants would aim at answering the question of whether international and European human rights law are supportive of outpatient mental health care at local level (primary care) or still focussed on emergency and pharmaceutical measures. Accordingly, the international legal frame of reference would inevitably extend to the CRPD.

[11] Dainius Pūras, 'Report of the Special Rapporteur on the right to the highest attainable standard of physical and mental health to the HRC (mental health)' (28 March 2017) UN Doc no A/HRC/35/21, para 20.
[12] *Chowdury* (n 74, Chapter 4); Bhoola (n 137, Chapter 4).
[13] Jack Mearns, John Dunn and Paul R. Lees-Haley, 'Psychological effects of organophosphate pesticides: A review and call for research by psychologists' (1994) *Journal of Clinical Psychology* 50(2) 286; Grover (n 234, Chapter 2) para 65.
[14] Pūras (n 234, Chapter 2) para 83 f).

3.2. Inter-American social rights law

Another significant contribution could be made by extending the geographical scope of this research to the inter-American human rights system and to Latin American constitutionalism under which social rights are constitutionalised and are today largely justiciable. The 2018 judgement of the Inter-American Court of Human Rights in the case of *Poblete Vilches* was the first occasion on which this Court directly adjudicated on the right to health.[15] The Inter-American Court followed its recent case law to declare a violation of Article 26 ACHR in that case, thus integrating 'a new model of direct justiciability of social rights' that 'combines three main sources of Member States' obligations: the inter-American *corpus juris*, national constitutions, and the international plethora of human rights law'.[16] Whereas the *Poblete Vilche*s case demonstrates how regional human rights law was integrated with domestic legal sources in the judges' reasonings, international human rights played a very persuasive role in the ground-breaking judgement T-210/18 of the Constitutional Court of Colombia (CCC) regarding access to health care – beyond life-saving treatment – for Venezuelan irregular migrants in Colombia.[17] The CCC has recently adjudicated on two cases where emergency life-saving health care was not followed by other subsequent necessary and urgent health care interventions because the applicable legislation required regular immigration status for affiliation with the health care system. The CCC qualified the applicants in the two cases as requiring 'urgent medical care' and thus entitled to free and immediate medical care. However, the most interesting parts of the judgement, for the purpose of the current research, concern the extensive references to the applicable international human rights law, including the CESCR's General

[15] *Poblete Vilches and others v Chile* Petition no 339-02 (Inter-Am Ct HR 8 March 2018).
[16] Isaac de Paz González, *The Social Rights Jurisprudence in the Inter-American Court of Human Rights: Shadow and Light in International Human Rights* (Edward Elgar Publishing 2018) 2.
[17] Constitutional Court of Colombia, T-210/18, 1 June 2018, in Spanish, <http://www.corteconstitucional.gov.co/relatoria/2018/t-210-18.htm> accessed 1 March 2019.

Comment no. 14 and its statement on state duties in relation to migrants and refugees. These instruments, together with the constitutional principles of solidarity, minimum core obligations, non-discrimination, and vulnerability, led the Court to establish that the national legal framework must, as quickly and efficiently as possible, mobilise financial resources to progressively and fully realise the right to the highest attainable standard of physical and mental health for Venezuelan irregular migrants. This goal, according to the Court's detailed judgement, must be achieved by intersectoral reform of domestic legal and political frameworks, including regularisation schemes, public health interventions, and the elimination of procedural barriers to affiliation with health care systems. The judicial review of the law, which heavily relied on the findings of international and regional bodies in the area of social rights, is very distant from the approach described in Chapter 5 in relation to the Italian Constitutional Court.

3.3. Using the research findings

The final aim of this thesis was to comprehend the current understanding of the right to health in international and European human rights law and to recommend how these bodies of law can be improved to make the right to health of irregular migrants a meaningful right that genuinely protects and promotes human health. Therefore, the qualified doctrinal analysis of this thesis should, at a later stage, be translated into simpler terms in policy briefs to make it understandable and persuasive for various stakeholders. This operation would also, with the support of legal practitioners and international NGOs, contribute to legal advocacy before international and European social rights bodies.

4. Originality of the Research

Now that the research findings, recommendations, and avenues for future research have been summarised, it is worth pointing out – albeit briefly - the originality of this PhD thesis.

Although, this dissertation is strongly grounded in existing case law, jurisprudence, and authoritative scholarly analysis, each substantive chapter contained certain original ideas, which contribute to existing knowledge. Chapter 1 and 2 not only provided background information but also extensively systematised the root causes of inequality of access to health care and living conditions for irregular migrants in international and European human rights law by testing theory against the actual practice of the major European and international bodies. Chapter 3 dug deep into the relations between primary health care and the concepts of vulnerability and non-discrimination, with the normative intention of building a bridge between the notions of non-discrimination as core obligation and the substantive requirements of the PHC. Chapter 4 sought, for the first time in human rights literature, to unveil the inconsistencies between the underlying principles of human rights law, such as indivisibility and universality, and the jurisprudence on the social rights that protect and promote the determinants of health for this target group. This jurisprudence provides for unclear and often 'basic' social entitlements for irregular migrants. Chapters 3 and 4 compared the international and European standards regarding the right to health, highlighting important differences between them and foregrounding the limits of human rights law vis-à-vis state sovereignty in the areas of immigration and health. Although several Italian scholars have studied the domestic right to health for irregular migrants, Chapter 5 is original insofar as it compared the domestic legal standards with the findings of international social obligations, testing the latter against potential retrogressive trends in the national and regional standard-setting and implementation.

More generally, this thesis contributes to knowledge by extensively unpacking the approaches of international and European human rights

monitoring bodies with regard to the health of irregular migrants. This is useful for evaluating whether these monitoring bodies of this field of law can enhance domestic standard-setting in this area by establishing consistent international obligations. The analysis demonstrates that these legal systems, particularly the European system, are still ideologically more inclined to emphasise civil liberties and focus on members of their polities rather than to genuinely commit to the idea of universal social rights. This thesis demonstrates that agreement on the international social and health standards for irregular migrants is incomplete and that this threatens the normative force of the international jurisprudence in this area. Nonetheless, in the face of neoliberal policies and anti-migrant sentiments, international and European bodies and initiatives are, albeit slowly, moving in the direction of assigning a certain priority to the health and socio-economic conditions of irregular migrants in the international and European human rights project. As recommended, greater consistency with the legacy of Alma-Ata may help to build an international *corpus juris* that 'crystallises' a truly indivisible, interconnected, non-emergency-oriented right to the highest attainable standard of health for everyone.

Bibliography

Scholarly materials / Secondary sources

Achiume Tendayi E, 'Reimagining International Law for Global Migration: Migration as Decolonization?' (2017) 111 American Journal of International Law 142

Alexy R, *A Theory of Constitutional Rights* (first published 1994, OUP 2002)

Alli B, *Fundamental Principles of Occupational Health and Safety* (2nd edn, ILO Publishing 2008)

Alvarez J, 'State Sovereignty in Not Withering Away: A Few Lessons from the Future' in Cassese A (ed) *Realizing Utopia* (OUP 2012) 26

Andreassen B et al, 'Assessing Human Rights Performance in Developing Countries: The Case for a Minimal Threshold Approach to the Economic and Social Rights', in Andreassen B and Eide A (eds) *Human Rights in Developing Countries* (Academic Press 1987) 333

Andreassen B, 'Article 22' in Alfredsson G and Eide A (eds) *The Universal Declaration of Human Rights: A Common Standard of Achievement* (Martinus Nijhoff Publishers 1999) 453

Angeleri S, 'Healthcare of Undocumented Migrants framed as a Right to Emergency Treatment? The State of the Art in European and International Law', in Nesi G (ed) *Migrazioni e Diritto Internazionale: Verso il Superamento dell'Emergenza?* (Editoriale Scientifica 2018) 467

Angeleri S, 'The Impact of the Economic Crisis on the Right to Health of Irregular Migrants, as Reflected in the Jurisprudence of the UN Committee on Economic, Social and Cultural Rights' (2017) 19(2) European Journal of Migration and Law 165

Anghie A and McCormack W, 'The Rights of Aliens: Legal Regimes and Historical Perspectives', in Maloney T and Korinek K (eds) *Migration in the 21st Century: Rights, Outcomes and Policy* (Routledge 2010) 23

Anghie A, 'The Evolution of International Law: Colonial and Postcolonial Realities' (2007) 27(5) Third World Quarterly 739

Arendt H, *On Violence* (Harcourt Brace & Co. 1970)

Arendt H, *The Origins of Totalitarianism* (first published 1950, Harcourt 1968)

Atak I, Nakache D, Guild E and Crépeau F, 'Migrants in Vulnerable Situations' and the Global Compact for Safe Orderly and Regular Migration (Queen Mary School of Law Legal Studies Research Paper No. 273/2018, 15 February 2018) <https://ssrn.com/abstract=3124392> accessed 1 March 2019

Baccelli, 'Welfare, Diritti Sociali, Conflitti. Ci Salveranno i Barbari?' (2014) Ragion Pratica 87

Balduzzi R and Carpani G, *Manuale di Diritto Sanitario* (Il Mulino 2013)

Bales K, 'Asylum Seekers, Social Rights and the Rise of New Nationalism: From an Inclusive to Exclusive British Welfare State?', in Kotkas T and Veitch K (eds) *Social Rights in the Welfare State: Origins and Transformations* (Routledge 2016) 109

Bambara C, 'Going Beyond the Three Worlds of Welfare Capitalism: Regime Theory and Public Health Research' (2007) 61(12) Journal of Epidemiology & Community Health 1098

Barendt, 'Separation of Powers and Constitutional Governments' (1996) Public Law 599

Barsotti V et al., *Italian Constitutional Justice in the Global Context* (OUP 2015)

Bartole S and Bin R, *Commentario Breve alla Costituzione* (Cedam 2008)

Bates E, 'History', in Moeckli D, Shah S and Sivakumaran S. (eds) *International Human Rights Law* (OUP 2018) 3

Bederman D, 'Appraising a Century of Scholarship in the American Journal of International Law' (2006) 100 American Journal of International Law 20

Bell M, 'The Right to Equality and Non-Discrimination' in Hervey T and Kenner J (eds.) *Economic and Social Rights Under the EU Charter of Fundamental Rights – A Legal Perspective* (Hart Publishing 2003) 95

Benhabib S, *The Rights of Others: Aliens, Residents and Citizens* (CUP 2004)

Bergo M, 'I Nuovi Livelli Essenziali di Assistenza. Al Crocevia fra Tutela della Salute e l'Equilibrio di Bilancio' (2017) Rivista AIC 4

Bigo D, 'Criminalisation of "Migrants": The Side Effect of the Will to Control the Frontiers and the Sovereign Illusion', in Bogusz B et al. (eds) *Irregular Migration and Human Rights: Theoretical, European and International Perspectives (Immigration and Asylum Law and Policy in Europe)* (Martinus Nijhoff Publishers 2004) 61

Bilchiz D, *Poverty and Fundamental Rights: The Justification and Enforcement of Socio-Economic Rights* (OUP 2007)

Biondi Dal Monte F, 'Lo Stato Sociale di Fronte alle Migrazioni. Diritti sociali, Appartenenza e Dignità della Persona' (2012) La Rivista del Gruppo di Pisa 3 <www.gruppodipisa.it/rivista/gli-argomenti/2012-03?start=20> accessed 12 March 2019

Biondi Dal Monte F, 'Lo Stato Sociale di Fronte alle Migrazioni. Diritti Sociali, Appartenenza e Dignità della Persona' (2012) 3(12) Rivista del Gruppo di Pisa 1

Biondi Dal Monte F, 'Regioni, immigrazione e diritti fondamentali' (2011) Forum di Quaderni Costituzionali 1

Biondi Dal Monte F, *Dai Diritti Sociali alla Cittadinanza. La Condizione Giuridica dello Straniero tra Ordinamento Italiano e Prospettive Sovranazionali* (Giappichelli 2013)

Björgvinsson D, *The Intersection of International Law and Domestic Law, A Theoretical and Practical Analysis* (Elgar Publishing 2015)

Bodin J, *Les Six Livres de la République* (First published 1579 Alden Press 1955)

Boeles P et al, *European Migration Law* (2nd edn, Intersentia 2014)

Bosniak, L., 'Human Rights, State Sovereignty and the Protection of Undocumented Migrants Under the International Migrant Workers Convention', in Bogusz B et al. (eds) *Irregular Migration and Human Rights: Theoretical, European and International Perspectives (Immigration and Asylum Law and Policy in Europe)* (Martinus Nijhoff Publishers 2004) 311

Boso A and Vancea M, 'Should Irregular Migrants Have the Right to Healthcare? Lessons Learnt from the Spanish Case' (2016) 36(2) Critical Social Policy 225

Braveman P, 'Social Conditions, Health Equity, and Human Rights' (2010) 12(2) Health and Human Rights Journal 31

Brillat R, 'The Supervisory Machinery of the European Social Charter: Recent Developments and their Impact', in De Búrca G and De Witte B (eds) *Social Rights in Europe* (OUP 2005) 31

Brown K, Ecclestone K and Emmel N, 'The Many Faces of Vulnerability' (2017) 16(3) Social Policy and Society 497

Bustamante JA, 'Immigrants' Vulnerability as Subjects of Human Rights' (2002) 36(2) International Migration Review 339

Campiglio C, 'Reciprocity in the Treatment of Aliens in Italy: Good Reasons for its Abolition' (2001) XI Italian Yearbook of International Law 125

Caponio T, 'Governo Locale e Immigrazione in Italia. Tra Servizi di Welfare e Politiche di Sviluppo' (2004) Le Istituzioni del Federalismo 789

Carens J, 'The Rights of Irregular Migrants' (2008) 22(2) Ethics and International Affairs 163

Carozza P G, 'Subsidiarity as a Structural Principle of International Human Rights Law' (2003) 97 American Journal of International Law 38

Carozza P, 'From Conquest to Constitutions: Retrieving a Latin American Tradition of the Idea of Human Rights' (2003) 25(2) Human Rights Quarterly 281

Cassese A, *International Law* (2nd edn, OUP 2003)

Castles S and Schierup C U, 'Migration and Ethnic Minorities', in Castles FG et al. (eds) *The Oxford Handbook of the Welfare State* (Oxford University Press 2010) 278

Chambers R, 'Vulnerability, Coping and Policy' (2006) 37(4) Institute of Development Studies Bulletin 33

Chapman A and Carbonetti B, 'Human Rights Protections for Vulnerable and Disadvantaged Groups: The Contributions of the UN Committee on

Economic, Social and Cultural Rights' (2011) 33 Human Rights Quarterly 682

Chapman A, 'A Violations Approach for Monitoring the International Covenant on Economic, Social and Cultural Rights' (1996) 18 Human Rights Quarterly 23

Chapman A, 'Conceptualizing the Right to Health: A Violation Approach' (1998) 65 Tennessee Law Review 389

Chapman A, 'Core Obligations Related to the Right to Health' in Chapman A and Russell S (eds) *Core Obligations: Building a Framework for Economic, Social and Cultural Rights* (Intersentia 2002) 185

Chapman A, Forman L and Lamprea E, 'Evaluating Essential Health Packages from a Human Rights Perspective' (2017) 16(2) Journal of Human Rights 141

Chapman A, *Global Health, Human Rights, and the Challenge of Neoliberal Policies* (CUP 2016)

Charlesworth H, 'Concepts of Equality in International Law*',* in Huscroft G and Rishworth P (eds) *Litigating Rights: Perspectives from Domestic and International Law* (Hart Publishing 2002) 137

Chetail V, 'The Human Rights of Migrants in General International Law: From Minimum Standards to Fundamental Rights' (2014) 28 Georgetown Immigration Law Journal 225

Chimienti M and Solomos J, 'How Do International Human Rights Influence National Healthcare Provisions for Irregular Migrants? A Case Study in France and the United Kingdom' (2015) Journal of Human Rights 1

Cismas I, 'The Intersection of Economic Social and Cultural Rights and Civil and Political Rights' in Riedel E, Giacca G and Golay C (eds) *Economic Social and Cultural Rights in International Law: Contemporary Issues and Challenges* (OUP 2015) 448

Clifford J, 'Equality', in Shelton D (ed) *The Oxford Handbook of International Human Rights Law* (OUP 2013) 420

Cocco G, 'In Direzione Ostinata e Contraria: Spunti in Tema di Diritto alla Salute e Immigrazione', in Balduzzi R (ed) *Sistemi Costituzionali, Diritto alla Salute e Organizzazione Sanitaria* (Il Mulino 2009) 92

Colleen M. Flood and Aeyal Gross, 'Litigating the Right to Health: What Can We Learn from a Comparative Law and Health Care Systems Approach' (2014) 16(2) Health and Human Rights Journal 62

Coomans F, 'In Search of the Core Content of the Right to Education', in Chapman A and Russell S (eds) *Core Obligations: Building a Framework for Economic, Social and Cultural Rights* (Intersentia 2002) 217

Cornelisse G, 'A New Articulation of Human Rights, or Why the European Court of Human Rights Should Think Beyond Westphalian Sovereignty', in Dembour M and Kelly T, (eds) *Are Human Rights for Migrants? Critical Reflections on the Status of Irregular Migrants in Europe and the United States* (Routledge, 2011) 99

Corsi C, 'Diritti Sociali e Immigrazione nel Contraddittorio tra Stato, Regioni e Corte Costituzionale' (2012) 2 Diritto, Immigrazione e Cittadinanza 43

Crawford J and Koskenniemi M (eds) *The Cambridge Companion to International Law* (CUP 2012)

Crépeau F and Hastie B, 'The Case for "Firewall" Protections for Irregular Migrants: Safeguarding Fundamental Rights' (2015) 17 (2–3) European Journal of Migration and Law 157

Cruft R, Liao S. and Renzo M (eds) 'The Philosophical Foundations of Human Rights (OUP 2015)

Cryer R et al, *Research Methodologies in EU and International Law* (Hart Publishing 2011)

D'Orazio G, *Lo straniero nella Costituzione italiana* (Cedam 1992)

Da Lomba S, 'Immigration Status and Basic Social Human Rights – A Comparative Study of Irregular Migrants' Right to Health Care in France, The UK and Canada' (2010) 28(1) The Netherlands Quarterly of Human Rights 6

Dailler P and Pellet A, *Droit International Public* (7th edn, LGDJ 2002)

Daniels N, *Just Health Care* (CUP 1985)

Daniels N, *Just Health: Meeting Health Needs Fairly* (CUP 2007)

Dauvergne C, 'Sovereignty, Migration and the Rule of Law in Global Times' (2004) 67(4) The Modern Law Review 588

Davy U, 'Social Citizenship Going International: Changes in the Reading of UN-Sponsored Economic and Social Rights' (2013) 22(SUPPL.1) International Journal of Social Welfare S15

De Jesús Butler I, *Unravelling Sovereignty. Human Rights Actors and the Structure of International Law* (Intersentia 2007)

De Vattel E, *The Law of Nations* (first published 1787, Liberty Fund 2009)

De Vitoria F, 'On the American Indians', in Pagden A and Lawrance J (eds) *Vitoria: Political Writings* (CUP 1991) 250

De Wet E, '*Jus Cogens* and Obligations *Erga Omnes',* in Shelton D (ed) *The Oxford Handbook of International Human Rights Law* (OUP 2013) 541

Delanty G, 'Beyond the Nation-State: National Identity and Citizenship in a Multicultural Society – A Response to Rex' (1996) 1(3) Sociological Research Online 1

Dembour M and Kelly T, (eds) *Are Human Rights for Migrants? Critical Reflections on the Status of Irregular Migrants in Europe and the United States* (Routledge, 2011)

Dembour M, *When Humans Become Migrants. Study of the European Court of Human Rights with an Inter-American Counterpoint* (OUP 2015)

Den Heijer M, 'Reflections on *Refoulement* and Collective Expulsion in the *Hirsi* Case' (2013) 25(2) International Journal of Refugee Law 265

Den Heijer M, 'Whose Rights and Which Rights? The Continuing Story of Non-Refoulement under the European Convention on Human Rights' (2008) 10(3) European Journal of Migration and Law 277

Detels R et al., *Oxford Textbook of Public Health* (OUP 2009)

Eide A and Eide W, 'Article 25' in Alfredsson G and Eide A (eds) *The Universal Declaration of Human Rights: A Common Standard of Achievement* (Martinus Nijhoff Publishers 1999) 523

Eide E and Eide A, *A Commentary on the United Nations Convention on the Rights of the Child, Article 24: The Right to Health* (Brill / Nijhoff 2006)

Engbersen G and Broeders D, 'The State versus the Alien: Immigration Control and Strategies of Irregular Immigrants' (2009) 32 West European Politics 867

Entzinger H, 'Open Borders and the Welfare State', in Pécoud A and De Guchteneire P (eds) *Migration without Borders: Essays on the Free Movement of People* (Berghan / UNESCO 2007) 119

Esping-Andersen G, *The Three Worlds of Welfare Capitalism* (Polity Press 1990)

Etzioni A, 'Sovereignty as Responsibility' (2006) 50(1) *Orbis* 71

Evans D and Price M, 'Measure for Measure: Utilizing Legal Norms and Health Data in Measuring the Right to Health', in Coomans F, Grünfeld F and Kamminga M (eds) *Methods of Human Rights Research* (Intersentia 2009) 111

Ferrara M, 'The South European Countries', in Castles FG et al. (eds) *The Oxford Handbook of the Welfare State* (OUP 2010) 616

Ferrara M, 'Towards an "Open" Social Citizenship? The New Boundaries of Welfare in the European Union' in De Búrca G (ed) *EU Law and the Welfare State. In Search of Solidarity* (OUP 2005) 11

Fineman M, 'The Vulnerable Subject: Anchoring Equality in the Human Condition' (2008) 20(1) Yale Journal of Law and Feminism 1

Fineman M, 'The Vulnerable Subject and the Responsive State' (2010) 60 *Emory Law Journal* 251

Finnis J, *Natural Law and Natural Rights* (OUP 1980)

Footer K and Rubenstein L, 'A Human Rights Approach to Health Care in Conflict' (2013) 95(889) International Review of the Red Cross 167

Forman L et al., 'Conceptualizing Minimum Core Obligations under the Right to Health: How Should We Define and Implement the "Morality of the Depths"' (2016) 20(4) The International Journal of Human Rights 531

Forman L et al., 'What Do Core Obligations under the Right to Health Bring to Universal Health Coverage?' (2016) 18(2) Health and Human Rights Journal 23

Francioni F, 'Sovranità Statale e Tutela della Salute come Bene Pubblico Globale' in Pineschi L (ed) *La Tutela della Salute nel Diritto*

Internazionale ed Europeo tra Interessi Globali e Interessi Particolari (Editoriale Scientifica 2017) 51

Fredman S and Campbell M, (eds) *Social and Economic Rights and Constitutional Law* (Edward Elgar 2016)

Fredman S, *Discrimination Law* (2nd edn, OUP 2011)

Freeman GP, 'Migration and the Political Economy of the Welfare State' (1986) 485 Annals of the American Academy of Political and Social Science 51

Gestri M, 'Conclusioni Generali', in Nesi G (ed) *Migrazioni e Diritto Internazionale: Verso il Superamento dell'Emergenza?* (Editoriale Scientifica 2018) 643

Giacca G, *Economic, Social and Cultural Rights in Armed Conflicts* (OUP 2014)

Giannone D, 'Measuring and Monitoring Social Rights in a Neoliberal Age: Between the United Nations' Rhetoric and States' Practice' (2015) 27(2) Global Change, Peace & Security 173

Glendon M, 'The Forgotten Crucible: The Latin American Influence on the Universal Human Rights Idea' (2003) 16 Harvard Human Rights Journal 27

Goodwin-Gill G and McAdam J, *The Refugee in International Law* (OUP 2007)

Greenwood C, 'Sovereignty: A View from the International Bench' in Rawlings R, Leyland P and Young A (eds) *Sovereignty and the Law* (OUP 2013) 251

Griffin J, 'Discrepancies Between the Best Philosophical Account of Human Rights and the International Law of Human Rights' (2001) Proceedings of the Aristotelian Society 7

Griffin J, *On Human Rights* (OUP 2008)

Grosso E, 'Straniero (status costituzionale dello)', in *Digesto delle Discipline Pubblicistiche* XV (Utet 1999) 156

Grotius H, *De Jure Belli ac Pacis Libri Tres* (first published 1646, Clarendon Press 1925)

Grotius H, *De Jure Praedae Commentarius* (first published 1604, Clarendon Press 1950)

Gruskin S and Ferguson L, 'Using Indicators to Determine the Contribution of Human Rights to Public Health Efforts' (2009) 87 Bulletin of the World Health Organization 714

Gruskin S et al. (eds) *Perspective on Health and Human Rights* (Routledge 2005)

Guiglia G, *I Livelli Essenziali delle Prestazioni Sociali alla Luce della Recente Giurisprudenza Costituzionale e dell'Evoluzione Interpretativa* (Cedam 2007)

Guild E, 'Who is an Irregular Migrant?', in Bogusz B et al. (eds) *Irregular Migration and Human Rights: Theoretical, European and International Perspectives (Immigration and Asylum Law and Policy in Europe)* (Martinus Nijhoff Publishers 2004) 3

Guiraudon V, 'The Marshallian Triptych Reordered: The Role of Courts and Bureaucracy in Furthering Migrants' Social Rights', in Bommes M and Geddes A (eds) *Immigration and Welfare: Challenging the Borders of the Welfare State* (Routledge 2000) 72

Habermas J, *Between Facts and Norms* (MIT Press 1997)

Hessler K and Buchanan A, 'Specifying the Content of the Human Right to Health Care' in Rhodes R, Battin M and Silvers A (eds) *Medicine and Social Justice: Essays on the Distribution of Health Care* (OUP 2002) 84

Hiam L and McKee M, 'Making a Fair Contribution: Is Charging Migrants for Healthcare in Line with NHS Principles?' (2016) 109(6) Journal of the Royal Society of Medicine 226

Hobbes T, *Leviathan* (first published 1651, OUP 2008)

Hunt P and MacNaughton G, 'A Human Rights-Based Approach to Health Indicators', in Baderin M and McCorquodale R (eds) *Economic, Social, and Cultural Rights in Action* (OUP 2007) 303

Hunt P, 'Configuring the UN Human Rights System in the 'Era of Implementation': Mainland and Archipelago' (2017) 39 Human Rights Quarterly 489

Ibbetson D, 'Historical Research in Law', in Tushnet M and Cane P (eds) *Oxford Handbook of Legal Studies* (OUP 2003) 863

Ippolito F and Iglesias Sánchez S (eds) *Protecting Vulnerable Groups – The European Human Rights Framework* (Bloomsbury-Hart 2015)

Ippolito F, 'La Vulnerabilità come Criterio Emergente per una Maggiore Tutela del Migrante nel contesto Internazionale', in Nesi G (ed) *Migrazioni e Diritto Internazionale: Verso il Superamento dell'Emergenza?* (Editoriale Scientifica 2018) 447

Jaeger M, 'The Additional Protocol to the ESC Providing for a System of Collective Complaints' (1997) 10(1) Leiden Journal of International Law 69

Jung C, Hirschl R and Rosevear E, 'Economic and Social Rights in National Constitutions' (2014) 62 American Journal of Comparative Law 1043

Kamminga M and Scheinin M (eds) *The Impact of Human Rights Law on General International Law* (OUP 2009)

Katrougalos G, 'The (Dim) Perspectives of the European Social Citizenship' (2012) 5(7) Jean Monnet Working Paper NYU School of Law 1

Keleher H, 'Why Primary Health Care Offers a More Comprehensive Approach for Tackling Health Inequalities than Primary Care' (2001) 7(2) Australian Journal of Primary Health 57

Kelly D, *A Life of One's Own: Individual Rights and the Welfare State* (Cato Institute 1998)

Kendrick A, 'Measuring Compliance: Social Rights and the Maximum Available Resources Dilemma' (2017) 39(3) Human Rights Quarterly 657

Kenyon KH, Forman L and Brolan CE 'Editorial. Deepening the Relationship between Human Rights and the Social Determinants of Health: A Focus on Indivisibility and Power' (2018) 20(2) Health and Human Rights Journal 1

Khan I, *The Unheard Truth: Poverty and Human Rights* (W.W. Norton & Company 2009)

Kinney E and Clark B, 'Provisions for Health and Health Care in the Constitutions of the Countries of the World' (2004) 37(2) Cornell International Law Journal 285

Kirby P, *Vulnerability and Violence* (Pluto Press 2005)

Kostakopoulou D, 'Irregular Migration and Migration Theory: Making State Authorisation Less Relevant', in Bogusz B et al. (eds) *Irregular Migration and Human Rights: Theoretical, European and International Perspectives (Immigration and Asylum Law and Policy in Europe)* (Martinus Nijhoff Publishers 2004) 41

Kotkas T, 'The Short and Insignificant History of Social Rights Discourse in the Nordic Welfare State', in Kotkas T and Veitch K (eds) *Social Rights in the Welfare State: Origins and Transformations* (Routledge 2016) 15

Labman SE, 'At Law's Border: Unsettling Refugee Resettlement' (PhD Thesis, University of British Columbia 2012)

Lauterpacht H, *International Law and Human Rights* (Stevens & Sons, 1950)

Leijten I, *Core Socio-Economic Rights and the European Court of Human Rights* (CUP 2018)

Lester E, *Making Migration Law. The Foreigner, Sovereignty and the Case of Australia* (CUP 2018)

Liebenberg S, 'The Value of Human Dignity in Interpreting Socio-Economic Rights' (2005) 21(1) South African Journal on Human Rights 1

Lindseth P, 'Supranational Organization' in Cogan J, Hurd I and Johnstone I (eds) *The Oxford Handbook of International Organizations* (OUP 2016)

Locke J, *Second Treatise of Government* (first published 1690, Hackett Publishing 1980)

Lougarre C, 'What Does the Right to Health Mean? An Interpretation of Article 11 of the European Social Charter by the European Committee of Social Rights' (2015) 33(3) Netherlands Quarterly of Human Rights 326

Lyon B, 'Inter-American Court of Human Rights Defines Unauthorized Migrant Workers' Rights for the Hemisphere: A Comment on Advisory Opinion 18' (2003) 28 NYU Review of Law & Social Change 547

MacDonald E and Cholewinski R, *The Migrant Workers Convention in Europe: Obstacles to the Ratification of the International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families: EU/EEA Perspectives* (UNESCO Publishing 2007)

Mackenzie C, Rogers W and Dodds S, 'Introduction: What is Vulnerability and Why Does It Matters for Moral Theory?', in Mackenzie C, Rogers W and Dodds S (eds) *Vulnerability. New Essays in Ethics and Feminist Philosophy* (OUP 2014) 1

Macklem P, *The Sovereignty of Human Rights* (OUP 2015)

MacNaughton G, 'Beyond a Minimum Threshold: The Right to Social Equality', in Minkler L (ed) *The State of Economic and Social Human Rights* (CUP 2013) 282

Mann J et al., 'Health and Human Rights' (1994) 1 Journal of Health and Human Rights 6

Mann J, 'Medicine and Public Health, Ethics and Human Rights' (1997) 27 Hasting Centre Report 6

Mann J, *Health and Human Rights: A Reader* (Routledge 1999)

Marshall T H, *Citizenship and Social Class* (CUP 1950)

Martino AD et al., *The Criminalization of Irregular Immigration Law and Practice in Italy* (Pisa University Press 2013)

Mason Meier B and Gostin L (eds) *Human Rights in Global Health: Rights-Based Governance for a Globalizing World* (OUP 2018)

Mason Meier B and Kastler F, 'Development of Human Rights through WHO', in Mason Meier B and Gostin L (eds) *Human Rights in Global Health: Rights-Based Governance for a Globalizing World* (OUP 2018) 111

McAuley A, 'The Challenges to Realising the Right to Health in Ireland', in Toebes et al. (eds) *The Right to Health – A Multi-Country Study of Law, Policy and Practice* (Springer 2014) 375

McCorquodale R, *International Law beyond the State: Essays on Sovereignty, Non-State Actors and Human Rights* (CMP 2011)

McCrudden C, 'Legal Research and Social Science' (2006) Law Quarterly Review 122 632

Mégret F, 'Nature of Obligations', in Moeckli D, Shah S and Sivakumaran S. (eds) *International Human Rights Law* (OUP 2018) 86

Miller D, 'Grounding Human Rights' (2012) 15(4) Critical Review of International Social and Political Philosophy 407

Morana D, *La Salute come Diritto Costituzionale* (Giappichelli 2013)

Moreno-Lax V, 'Dismantling the Dublin System: M.S.S. v Belgium and Greece' (2012) 14 European Journal of Migration and Law 1

Morsink J, *The Universal Declaration of Human Rights: Origins, Drafting, and Intent* (University of Pennsylvania Press 1999)

Murphy T and Müller A, 'The United Nations Special Procedures – Peopling Human Rights, Peopling Global Health' in Mason Meier B and Gostin L (eds) *Human Rights in Global Health: Rights-Based Governance for a Globalizing World* (OUP 2018) 487

Myrdal G, *Beyond the Welfare State: Economic Planning in the Welfare States and its Economic Implications* (Duckworth 1960)

Nafziger J, 'The General Admission of Aliens under International Law' (1983) 77(4) American Journal of International Law 804

Napoletano N, 'Estensione e limiti della dimensione economica e sociale della Convenzione Europea dei Diritti Umani in tempi di crisi economico-finanziaria' (2014) 8(2) Diritti Umani e Diritto Internazionale 389

Neuman G, 'Subsidiarity', Shelton D (ed) *The Oxford Handbook of International Human Rights Law* (OUP 2013) 360

Nifosi-Sutton I, *The Protection of Vulnerable Groups under International Human Rights Law* (Routledge 2017)

Nivard C, 'Précisions sur les droits de la Charte sociale Européenne bénéficiant aux étrangers en situation irrégulière' (2014) La Revue des Droits de L'Homme – Actualité Droits-Libertés 1

Nivard C, La Justiciabilité des Droits Sociaux. Etude de Droit Conventionnel Européen (Bruylant 2012)

Nolan A, Freedman R and Murphy T, *The United Nations Special Procedures System* (Nottingham Studies on Human Rights) (Brill 2017)

Noll G, 'Why Human Rights Fail to Protect Undocumented Migrants' (2010) 12 European Journal of Migration and Law 241

Nowak M, *UN Covenant on Civil and Political Rights – Commentary* (2nd edn, NP Engel Publishing 2005)

Nussbaum M, *Creating Capabilities: The Human Development Approach* (Belknap Press 2011)

Nussbaum M, *Women and Human Development – The Capabilities Approach* (CUP 2000)

O'Cinneide C, 'Austerity and the Faded Dream of "Social Europe"' in Nolan A (ed) *Economic and Social Rights after the Global Financial Crisis* (CUP 2014) 169

O'Connell P, *Vindicating Socio-Economic Rights* (Routledge 2012)

O'Neill O, 'The Dark Side of Human Rights' (2005) 81 International Affairs 427

Oberleitner G, *Global Human Rights Institutions: Between Remedy and Ritual* (Polity Press 2007)

Odello M and Seatzu F, *The UN Committee on Economic, Social and Cultural Rights: The Law, Process and Practice* (Routledge 2013)

O'Flaherty M, 'Towards Integration of United Nations Human Rights Treaty Body Recommendations: The Rights-Based Approach Model', in Baderin M and McCorquodale R (eds) *Economic, Social, and Cultural Rights in Action* (OUP 2007) 27

Onida V, 'Relazione', in VV.AA., *I diritti fondamentali Oggi, Atti del V Convegno dell'Associazione Italiana dei Costituzionalisti* (Cedam 1995) 69

Oppenheimer G, Bayer R and Colgrove J, 'Health and Human Rights: Old Wine in New Bottles?' (2002) 30(4) Journal of Law, Medicine & Ethics 522

Örücü E, 'The Core of Rights and Freedoms: The Limits of Limits', in Campbell T et al. (eds) *Human Rights from Rhetoric to Reality* (Blackwell 1986) 47

Palmisano G, 'L'Obbligo dello Stato di Tutelare il Diritto alla Salute ai sensi della Carta Sociale Europea', in Pineschi L (ed) *La Tutela della Salute nel Diritto Internazionale ed Europeo tra Interessi Globali e Interessi Particolari* (Editoriale Scientifica 2017) 189

Palmisano G, 'Le Norme Pattizie come Parametro di Costituzionalità delle Leggi: Questioni Chiarite e Questioni Aperte a Dieci Anni dalle Sentenze "Gemelle"' (2018) 1 Osservatorio sulle Fonti 7

Parran T, Charter for World Health (1946) 61 Public Health Reports 1265

Pascale AD, 'Italy and Unauthorized Migration: Between State Sovereignty and Human Rights Obligations', in Rubio-Marín R (ed) *Human Rights and Immigration* (Oxford University Press 2014) 278

Passaglia P, 'Immigrazione e Condizione Giuridica degli Stanieri Extracomunitari' (2006) I Foro Italiano 352

Perkowska M, 'Illegal, Legal, Irregular or Regular – Who is the Incoming Foreigner?' (2016) 45(58) Studies in Logic, Grammar and Rhetoric 187

Peroni L and Timmer A, 'Vulnerable Groups: The Promise of an Emerging Concept in European Human Rights Convention Law' (2013) 11(4) International Journal of Constitutional Law 1056

Peters C, 'Equality Revisited' (1997) 110 Harvard Law Review 1211

Posner R, 'Legal Scholarship Today' (2002) 115 Harvard Law Review 1314

Potts H, 'Public Health, Primary Health Care, and the Right to Health', in Backman G (ed) *The Right to Health. Theory and Practice* (Studentlitteratur 2012) 93

Preuss U, 'The Concept of Rights and the Welfare State' in Teubner G (ed) *Dilemmas of Law in the Welfare State* (Walter de Gruyter 1986) 151

Ramji-Nogales J, '"The Right to Have Rights": Undocumented Migrants and State Protection' (2015) 63 Kansas Law Review 1045

Ramji-Nogales J, 'Undocumented Migrants and the Failures of Universal Individualism' (2014) 47 Vanderbilt Journal of Transnational Law 740

Rawls J, 'The Law of People' in Shute S and Hurley S (eds) *On Human Rights – The Oxford Amnesty Lectures 1993* (Basic Books 1983) 41

Raz J, *The Morality of Freedom* (Clarendon Press 1986)

Rosen G, *A History of Public Health* (first published 1958, John Hopkins University Press 1993)

Ross D, *The Nicomachean Ethics / Aristotle* John Loyd Ackrill and James Opie Urmson (eds) (OUP 1980)

Rossi E, 'Da Cittadini vs. Stranieri a Regolari vs. Irregolari. Considerazioni sull'Evoluzione della Disciplina Giuridica dei Non Cittadini nell'Ordinamento Italiano' (2010) Rivista di Diritto Costituzionale 123

Ruger J, 'Towards a Theory of a Right to Health: Capability and Incompletely Theorised Agreements' (2006) 18 Yale Journal of Law & the Humanities 273

Ryan B and Mantouvalou V, 'The Labour and Social Rights of Migrants in International Law', in Rubio-Marín R (ed) *Human Rights and Immigration* (Oxford University Press 2014) 177

Sainsbury D, *Welfare States and Immigrant Rights. The Politics of Inclusion and Exclusion* (OUP 2012)

Salazar C, 'La Carta Sociale Europea nella Sentenza n. 120 del 2018 della Consulta: Ogni Cosa è Illuminata? (2018) 4 Quaderni Costituzionali 905

San Giorgi M, *The Human Right to Equal Access to Health Care* (Intersentia 2012)

Sarkin J, 'The Role of Regional Systems in Enforcing State Human Rights Compliance: Evaluating the African Commission on Human and People's Rights and the New African Court of Justice and Human Rights with Comparative Lessons from the Council of Europe and Organization of American States' (2010) 1(2) Inter-American and European Human Rights Journal 199

Scheinin M, 'Core Rights and Obligations', in Shelton D (ed) *The Oxford Handbook of International Human Rights Law* (OUP 2013) 527

Sciortino G, *Rebus Immigrazione* (Società Editrice Il Mulino 2017)

Scuto F, *I Diritti Fondamentali della Persona quale Limite al Contrasto dell'Immigrazione Irregolare* (Giuffrè Editore 2012)

Sen A, 'Elements of a Theory of Human Rights' (2004) 32(4) Philosophy and Public Affairs 315

Sen A, *Development as Freedom* (OUP 1999)

Sepúlveda Carmona M, 'Alternatives to Austerity: A Human Rights Framework for Economic Recovery', in Nolan A (ed) *Economic and Social Rights after the Global Financial Crisis* (CUP 2014) 23

Serges G, 'I trattati Internazionali Diversi dalla Convenzione Europea dei Diritti dell'Uomo nell'Ordinamento Italiano', in Di Blase A (ed) *Convenzioni sui Diritti Umani e Corti Nazionali* (Roma Tre Press 2014) 196

Shaw, M, *International Law* (7th edn, OUP 2014)

Shue H, *Basic Rights: Subsistence, Affluence, and U.S. Foreign Policy* (first published 1980, Princeton University Press 1996)

Slinckx I, 'Migrants' Rights in UN Human Rights Conventions' in De Guchteneire P, Pécoud A and Cholewinski R (eds) *Migration and Human Rights – The United Nations Convention on Migrant Workers' Rights* (CUP 2009) 122

Smits J, 'Redefining Normative Legal Science: Towards an Argumentative Discipline', in Coomans F, Grünfeld F and Kamminga M (eds) *Methods of Human Rights Research* (Intersentia 2009) 45

Smyth C, 'Towards a Complete Prohibition on the Immigration Detention of Children' (2019) 19(1) Human Rights Law Review 1

Smyth C, 'Why is it so Difficult to Promote Human Rights-Based Approach to Immigration', in O'Connell D (ed) *The Irish Human Rights Law Review 2010* (Clarus Press 2010) 83

Spadaro A, 'I Diritti Sociali di Fronte alla Crisi (Necessità di un Nuovo 'Modello Sociale Europeo': Più Sobrio, Solidale e Sostenibile)' (2011) Rivista AIC 4

Ssenyonjo M, *Economic, Social and Cultural Rights in International Law* (Hart Publishing 2016)

Tamanaha B, *Law as a Means to an End* (CUP 2006)

Tesauro G, *Diritto dell'Unione Europea* (Cedam 2010)

Thakur R, 'The Use of International Force to Prevent or Halt Atrocities: from Humanitarian Intervention to the Responsibility to Protect', in Shelton D (ed) *The Oxford Handbook of International Human Rights Law* (OUP 2013) 815

Tobin J, *The Right to Health in International Law* (OUP 2012)

Toebes B et al, *Health and Human Rights in Europe* (Intersentia 2012)

Toebes B, *The Right to Health as a Human Right in International Law* (Hart Publishing 1999)

Turner B, *Vulnerability and Human Rights* (The Pennsylvania State University Press 2006)

Van Duffel S, 'Moral Philosophy' in Shelton D (ed) *The Oxford Handbook of International Human Rights Law* (OUP 2013) 32

Vermeer-Kunzli A, 'Diplomatic Protection as a Source of Human Rights', in Shelton D (ed) *The Oxford Handbook of International Human Rights Law* (OUP 2013) 250

Wadsworth M and Butterworth S, 'Early Life', in Marmot and Wilkinson R, *Social Determinants of Health* (2nd edn, OUP 2006) 31

Warwick BTC, 'Socio-Economic Rights During Economic Crises: A Changed Approach to Non-Retrogression' (2016) 65(1) International and Comparative Law Quarterly 249

Way S, Lusiani N and Saiz I, 'Economic and Social Rights in the 'Great Recession': Towards a Human Rights-Centred Economic Policy in Times of Crisis' in Eibe Riedel, Gilles Giacca, and Christophe Golay (eds) *Economic, Social, and Cultural Rights in International Law. Contemporary Issues and Challenges* (OUP 2014) 86.

Weber M, *Economy and Society: An Outline of Interpretive Sociology* (University of California Press 1978)

Wentholt K, 'Formal and Substantive Equal Treatment: The Limitations and Potential of the Legal Concept of Equality', in Rodrigues P and Loenen T (eds) *Non- Discrimination Law: Comparative Perspectives* (Kluwer / Brill 1999) 54

Westen P, 'The Empty Idea of Equality' (1980) 95(3) Harvard Law Review 537

Whelan D and Donnelly J, 'The West, Economic and Social Rights, and the Global Human Rights Regime: Setting the Record Straight' (2007) Human Rights Quarterly 29(4) 908

Whelan DJ, *Indivisible Human Rights (*University of Pennsylvania Press 2011)

Wilkinson RG, 'Ourselves and Others – For Better or Worse: Social Vulnerability and Inequality', in Marmot and Wilkinson R, *Social Determinants of Health* (2nd edn, OUP 2006) 341

Winslow C, *The Evolution and Significance of the Modern Public Health Campaign* (Yale University Press 1923) reprinted in (1984) Journal of Public Health Policy 1

Woods J, 'Justiciable Social Rights as a Critique of the Liberal Paradigm' (2003) 38 Texas International Law Journal 763

Yamin A and Cantor R, *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Harvard University Press 2011)

Yamin A and Lander F, 'Implementing a Circle of Accountability: A Proposed Framework for Judiciaries and Other Actors in Enforcing Health-Related Rights' (2015) 14(3) Journal of Human Rights 312

Young K, 'The Minimum Core of Economic and Social Rights: A Concept in Search of Content' (2008) 33 The Yale Journal of International Law 113

Encyclopaedias and dictionaries

'Emergency-related' terms, *Mosby's Dictionary of Medicine, Nursing & Health Professions* (10th edn, Elsevier 2017) 607

'Essential', in *Oxford Dictionaries*, <https://en.oxforddictionaries.com/definition/essential> accessed 1 March 2019

Allen A, 'Feminist Perspectives on Power', in the Stanford Encyclopedia of Philosophy (2005–2016) <https://plato.stanford.edu/entries/feminist-power/> accessed 1 March 2019

Balduzzi R, 'Salute (diritto alla)', in Cassese S (ed) *Dizionario di Diritto Pubblico – Vol. VI* (Giuffrè Editore 2006) 5394

Besson, S, 'Sovereignty' (2011), in the Max Planck Encyclopaedia of Public International Law <http://opil.ouplaw.com/home/EPIL> accessed 1 March 2019

Christine Bell, 'Capitulations' (2009), in the Max Planck Encyclopaedia of Public International Law <://opil.ouplaw.com> accessed 1 March 2019

Feichtner, I., 'Subsidiarity' (2007), in the Max Planck Encyclopaedia of Public International Law <http://opil.ouplaw.com/> accessed 1 March 2019

Grote, R., 'The Westphalian System' (2006), in the Max Planck Encyclopaedia of Public International Law <http://opil.ouplaw.com/home/EPIL> accessed 1 March 2019

Luciani M, 'Salute. I) Diritto alla Salute – Dir. Cost' (1994) *Enciclopedia Giuridica – Vol. XXXII* (Istituto Enciclopedia Italiana Giovanni Treccani) 4

Reports, blogs and online resources

Atak I, 'GCM Commentary: Objective 7: Address and Reduce Vulnerabilities in Migration' (*Refugee Law Initiative Blog*, 30 October 2018) < https://rli.blogs.sas.ac.uk/2018/10/30/gcm-commentary-objective-7/> accessed 15 January 2019

Center for Economic and Social Rights, 'The Universal Periodic Review: A Skewed Agenda? Trends Analysis of the UPR's Coverage of Economic, Social and Cultural Rights' – Report of the CESR – Social Justice Through Human Rights (June 2016) <http://www.cesr.org/universal-periodic-review-skewed-agenda> accessed 1 March 2019

Council of Europe, *Guide on Article 8 of the European Convention on Human Rights* (COE-ECHR 2018)

Council of Europe/European Court of Human Rights, 'Thematic Report – Health-Related Issues in the Case-Law of the European Court of Human Rights' (2015) <https://www.echr.coe.int/Documents/Research_report_health.pdf accessed 1 March 2019> accessed 1 March 2019

Davies AA, Basten A and Frattini C, 'Migration: A Social Determinant of the Health of Migrants' (International Organization for Migration Background Paper, 2006) <http://www.migrant-health-europe.org/files/FINAL%20DRAFT%20-%20IOM%20SDH.pdf> accessed 1 March 2019

European Commission against Racism and Intolerance of the Council of Europe (ECRI) 'ECRI General Policy Recommendation No. 16 on Safeguarding Irregularly Present Migrants from Discrimination' (Ref Doc CRI (2016)16, 16 March 2016) < https://rm.coe.int/ecri-general-policy-recommendation-no-16-on-safeguarding-irregularly-p/16808b5b0b> accessed 1 March 2019

European Network to Reduce Vulnerabilities in Health / Médecins du Monde, '2017 Legal Report – Access to Healthcare in 16 European Countries'

(2017) <https://mdmeuroblog.wordpress.com/resources/publications/> accessed 19 March 2019

European Union Agency for Fundamental Rights, 'Cost of Exclusion from Healthcare: The Case of Migrants in an Irregular Situation' (2015) < https://fra.europa.eu/sites/default/files/fra_uploads/fra-2015-cost-healthcare_en.pdf> accessed 1 March 2019

European Union Agency for Fundamental Rights, 'Migrants in an Irregular Situation: Access to Healthcare in 10 European Union Member States' (2011) <https://fra.europa.eu/en/publication/2012/migrants-irregular-situation-access-healthcare-10-european-union-member-states> accessed 1 March 2019

Fundamental Rights Agency of the European Union, *Migrants in an Irregular Situation: Access to Healthcare in 10 European Union Member States – Comparative Report* (FRA Publishing 2011)

Gubitosi M, Colombera S and Schiaffino C, 'Legal Systems in Italy: Overview', in Thomson Reuters' Practical Law (2018) <https://uk.practicallaw.thomsonreuters.com/w-007-7826?transitionType=Default&contextData=(sc.Default)&firstPage=true&comp=pluk#co_anchor_a496830> accessed 19 March 2019

Guild E and Weatherhead K, 'Tensions as the EU negotiates the Global Compact for Safe, Orderly and Regular Migration' (EU Migration Law Blog, 6 July 2018) <http://eumigrationlawblog.eu/tensions-as-the-eu-negotiates-the-global-compact-for-safe-orderly-and-regular-migration/> accessed 1 March 2019

Hastie B, 'GCM Commentary: Objective 15: Provide access to basic services for migrants' (*Refugee Law Initiative Blog*, 15 October 2018) <https://rli.blogs.sas.ac.uk/2018/10/15/gcm-commentary-objective-15-provide-access-to-basic-services-for-migrants/> accessed 1 March 2019

Ingleby D and Petrova-Benedict R, 'Recommendations on Access to Health Services for Migrants in an Irregular Situation: An Expert Consensus' (International Organization for Migration, 2016) <https://migrationhealthresearch.iom.int/recommendations-access-health-services-migrants-irregular-situation-expert-consensus> accessed 1 March 2019

International Commission of Jurists, 'Report on Courts and the Legal Enforcement of Economic, Social and Cultural Rights: Comparative Experiences of Justiciability' (2009) 6 < https://www.icj.org/courts-and-the-legal-enforcement-of-economic-social-and-cultural-rights/> accessed 1 March 2019

International Law Commission, Yearbook of the International Law Commission (1999 vol. II part 2) A/CN.4/SER.A/1999/Add.l (Part 2) 57

Mason Meier B et al., 'ALMA-ATA at 40: A Milestone in the Evolution of the Right to Health and an Enduring Legacy for Human Rights in Global Health' (Health and Human Rights Journal Blog, 5 September 2018) <https://www.hhrjournal.org/category/blog/> accessed 1 December 2018

NAGA Onlus, 'Curare non è permesso: Indagine sull'accesso alle cure per i cittadini stranieri irregolari negli ospedali milanesi -Report' <www.naga.it> accessed 1 March 2019

OHCHR 'Human Rights Indicators, A Guide to Measurement and Implementation' (2012) HR/PUB/12/5 16

OHCHR and GMG, 'Principles and Guidelines, supported by practical guidance, on the human rights protection of migrants in vulnerable situations' (OHCHR 2008) <https://www.ohchr.org/EN/Issues/Migration/Pages/VulnerableSituations.aspx> accessed 1 March 2019

OHCHR, *The Economic, Social and Cultural Rights of Migrants in an Irregular Situation* (UN Publications 2014)

Platform for International Cooperation on Undocumented Migrants, 'PICUM Quarterly, January–March 2016' (2016) <http://picum.org/en/news/quarterlies/49848/> accessed 1 March 2019

Potts H, 'Accountability and the Right to the Highest Attainable Standard of Health' (2008) University of Essex Human Rights Centre 13 <http://repository.essex.ac.uk/9717/1/accountability-right-highest-attainable-standard-health.pdf> accessed 1 March 2019

Potts H, 'Participation and the Right to the Highest Attainable Standard of Health' (2008) University of Essex Human Rights Centre 16 <http://repository.essex.ac.uk/9714/> accessed 1 March 2019

Romboli R, 'La Influenza della CEDU e della Giurisprudenza della Corte Europea dei Diritti Umani nell'Ordinamento Costituzionale Italiano' (*Consulta Online* 2018) <http://www.giurcost.org/studi/romboli6.pdf> accessed 25 March 2019

Spencer S. and Hughes V., 'Outside and In: Legal Entitlements to Health Care and Education for Migrants with Irregular Status in Europe' (Oxford, COMPAS Report 2015)

Tarimo E and World Health Organization. Division of Analysis, Research and Assessment, 'Essential Health Service Packages: Uses, Abuse and Future Directions' (ARA Paper number 15 1997) WHO/ARA/CC.7

UK Department of Health, 'Making a Fair Contribution. A Consultation on the Extension of Charging Overseas Visitors and Migrants Using the NHS in England' (Visitor and Migrant NHS Cost Recovery Programme, 2015)

UNCHR, 'Note verbale dated 5 December 1986 from the Permanent Mission of the Netherlands to the United Nations Office at Geneva addressed to the Centre for Human Rights ("Limburg Principles")' (8 January 1987) E/CN.4/1987/17

WHO – Commission on Social Determinants of Health (CSDH), *Closing the Gap in a Generation: Health Equity through Action on the Social Determinants of Health: Final Report of the Commission on Social Determinants of Health* (World Health Organization 2008)

WHO European Region / Italian National Institute for Health, Migration and Poverty (INMP), 'Report on the health of refugees and migrants in the WHO European Region' (WHO 2018) <http://www.euro.who.int/en/media-centre/sections/press-releases/2019/migrants-and-refugees-at-higher-risk-of-developing-ill-health-than-host-populations-reveals-first-ever-who-report-on-the-health-of-displaced-people-in-europe> accessed 21 March 2019

WHO, 'Positioning Health in the Post-2015 Development Agenda' – WHO Discussion Paper (October 2012)

World Bank, *World Development Report 1993 – Investing in Health* (OUP 1993)

World Conference on Social Determinants of Health, 'Rio Political Declaration on Social Determinants of Health' (World Health Organotin, 21 October 2011) <https://www.who.int/sdhconference/declaration/en/> accessed 29 March 2019

World Health Organization, 'Emergency Care' for the World Health Organization <http://www.who.int/emergencycare/systems/en> accessed 1 March 2019

World Health Organization, 'Framework of Priorities and Guiding Principles to Promote the Health of Refugees and Migrants' (endorsed by WHA Res 70.15, 31 May 2017) < http://www.who.int/migrants/about/framework_refugees-migrants.pdf> accessed 15 March 2019

Treaties

Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights (adopted 17 November 1988, entry into force 16 November 1999) A-52

Additional Protocol to the European Social Charter Providing for a System of Collective Complaints, (adopted 9 November 1996 entry into force 1 July 1998) ETS. No. 158

American Convention on Human Rights (adopted 22 November 1969 entry into force 18 July 1978)

Charter of the United Nations (Adopted 26 June 1945 entry into force 24 October 1945) 892 UNTS 119

Constitution of the World Health Organization (Adopted 22 July 1946 entry into force 7 April 1948) Off. Rec. WHO 2, 100

Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (adopted 10 December 1984 entry into force 26 June 1987) UNGA Res 49/46

Convention for the Protection of Human Rights and Fundamental Freedoms (adopted 4 November 1950 entry into force 3 September 1953) ETS 5

Convention on the Elimination of All Forms of Discrimination against Women (adopted 18 December 1979 entry into force 3 September 1981) UNGA Res 34/180

Convention on the Rights of Persons with Disabilities (adopted 13 December 2006 entry into force 3 May 2008) UNGA Res 61/106.

Convention on the Rights of the Child (adopted 20 November 1989 entry into force 2 September 1990) UNGA Res 44/25

Convention Relating to the Status of Refugees (adopted 28 July 1951 entry into force 22 April 1954) 189 UNTS 137

Covenant of the League of Nations (28 June 1919 entry into force10 January 1920)

European Social Charter (adopted 18 October 1961 entry into force 26 February 1965) ETS 35

European Social Charter (Revised) (adopted 3 May 1996 entry into force 1 July 1999) ETS 163

International Convention on the Elimination of All Forms of Racial Discrimination (adopted 21 December 1965 entry into force 4 January 1969) UNGA Res 2106 (XX)

International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (adopted 18 December 1990 entry into force 1 July 2003) UNGA Res 45/158

International Covenant on Civil and Political Rights (adopted 16 December 1966 entry into force 23 March 1976) UNGA Res 2200A (XXI)

International Covenant on Economic, Social and Cultural Rights (adopted 16 December 1966 entry into force 3 January 1976) UNGA Res 2200A (XXI)

Optional Protocol to the International Covenant on Economic, Social and Cultural Rights (adopted 10 December 2008 entry into force 5 May 2013) UN Doc A/RES/63/117

Vienna Convention on the Law of Treaties (adopted 23 May 1969 entry into force 27 January 1980) 1155 UNTS 331

Resolutions, declarations and travaux préparatoires

Declaration of Alma-Ata - Health for All, International Conference on Primary Health Care (6-12 September 1978)

Global Compact for Safe, Orderly and Regular Migration (19 December 2018) UNGA Res 73/195

Global Compact on Refugees (17 December 2018) UNGA Res 73/151

Global Conference on Primary Health Care, Declaration of Astana (25–26 October 2018) WHO/HIS/SDS/2018.61

New York Declaration for Refugees and Migrants (16 September 2016) UNGA Res 71.1

PACE (Parliamentary Assembly of the Council of Europe) Res 1509 'Human Rights of Irregular Migrants' (2006)

UNCHR, 'International Bill of Rights Documented Outline' (11 June 1947) UN Doc E/CN.4/AC.1/3/add.1

UNCHR, 'Report of the 3rd Session of the Commission on Human Rights' (24 May –18 June 1948) UN Doc E/800

UNCHR, 'Report of the Drafting Committee [on an International Bill of Rights] to the Commission on Human Rights' (21 May 1948) UN Doc E/CN.4/95

UNCHR, 'Report to the Economic and Social Council on the 2nd Session of the Commission' (2–17 December 1947) UN Doc E/600(SUPP)

UNCHR, 'Revised Suggestions Submitted by the Representative of France for Articles of the International Declaration of Rights' (20 June 1947) UN Doc E/CN.4/AC.1/W.2/REV.2

UNCHR, 'Suggestions Submitted by the Director of the World Health Organisation' (18 April 1951) UN Doc E/CN.4/544 2

UNCHR, 'Summary Record of the 223rd Meeting' (13 June 1951) UN Doc E/CN.4/SR.223

UNCHR, 'United States Revised Suggestions for Redrafts of Certain Articles in the Draft Outline' (1 June 1947) UN Doc E/CN.4/AC.1/8

UNCHR, Draft Outline of International Bill of Rights (4 June 1947) UN Doc E/CN.4/AC.1/3

UNGA Res 3449 'Measures to Ensure the Human Rights and Dignity of All Migrant Workers' (9 December 1975)

UNGA Res 543(VI) 'Preparation of two Draft International Covenants on Human Rights' (5 February 1952)

UNGA Res 67/81 'Global Health and Foreign Policy' (12 December 2012)

UNGA Res 70/1 'Transforming Our World: The 2030 Agenda for Sustainable Development' (25 September 2015)

UNGA, 'Draft International Covenants on Human Rights' (28 January 1957) UN Doc A/C.3/SR.743

Universal Declaration of Human Rights (adopted 10 December 1948) UNGA Res 217 A(III)

WHA Res 62.14 'Reducing Health Inequities through Action on the Social Determinants of Health' (21 May 2009)

WHA Res 65.8 'The Outcome of the World Conference on Social Determinants of Health' (26 May 2012)

WHA Res 69.1. 'Strengthening Essential Public Health Functions in Support of the Achievement of Universal Health Coverage' (27 May 2016)

WHA Res. 64.9 Agenda Item 31.4. 'Sustainable Health Financing Structures and Universal Coverage' (24 May 2011)

World Conference on Human Rights, Vienna Declaration and Programme of Action Vienna (12 July 1993) A/CONF.157/23

Zero Draft of the Global Compact for Safe, Orderly and Regular Migration (5 February 2018) <https://refugeesmigrants.un.org/sites/default/files/180205_gcm_zero_draft_final.pdf> accessed 1 March 2019

UN Treaty Bodies' General Comments and Statements

CAT Committee, 'General Comment No. 4 (2017): The Implementation of Article 3 of the Convention in the Context of Article 22' (4 September 2018) UN Doc CAT/C/GC/4

CEDAW Committee, 'General Recommendation No. 24: Article 12 of the Convention (Women and Health) (1999)

CEDAW Committee, 'General Recommendation No. 26 on Women Migrant Workers' (5 December 2008) UN Doc CEDAW/C/2009/WP.1/R

CERD Committee, 'General Recommendation No. XI: 'Non-Citizens' (1993)

CERD Committee, 'General Recommendation No. XXX: Discrimination against Non-Citizens' (2005)

CESCR (Chairperson), 'Letter to States Parties on Economic, Social and Cultural Rights in the Context of the Economic and Financial Crisis' (16 May 2012)

CESCR 'General Comment No. 14: The Right to the Highest Attainable Standard of Health (article 12 of the International Covenant on Economic, Social and Cultural Rights)' (11 August 2000) UN Doc E/C.12/2000/4

CESCR 'General Comment No. 20: Non-discrimination on Economic, Social and Cultural Rights' (2 July 2009) UN Doc E/C.12/GC/20

CESCR, 'An Evaluation of the Obligation to Take Steps to the 'Maximum Available Resources' under an Optional Protocol to the Covenant – Statement' (21 September 2007) UN Doc E/C.12/2007/1

CESCR, 'General Comment No. 1, Reporting by States parties' (27 July 1981) UN Doc E/1989/22

CESCR, 'General Comment No. 13 (the Right to Education – Article 13 of the Covenant)' (8 December 1999) UN Doc E/C.12/1999/10

CESCR, 'General Comment No. 15 (the Right to Water)' (20 January 2003) UN Doc E/C.12/2002/11

CESCR, 'General Comment No. 16, the Equal Right of Men and Women to the Enjoyment of All Economic, Social and Cultural Rights' (Article 3 of the ICESCR)' (11 August 2005) UN Doc E/C.12/2005/4/Corr.1

CESCR, 'General Comment No. 19, The Right to Social Security (Article 9 ICESCR)' (4 February 2008) UN Doc E/C.12/GC/19

CESCR, ‘General Comment No. 22 on the Right to Sexual and Reproductive Health – Article 12 of the ICESCR (2 May 2016) UN Doc E/C.12/GC/22

CESCR, ‘General Comment No. 23, The Right to Just and Favorable Conditions of Work (Article 7 ICESCR)’ (4 March 2016) UN Doc E/C.12/GC/23

CESCR, ‘General Comment No. 3: The Nature of States Parties’ Obligations (Article 2, para 1, of the Covenant) (14 December 1990) UN Doc E/1991/23

CESCR, ‘General Comment No. 4 (the Right to Adequate Housing – Article 11 (1) of the Covenant) (13 December 1991) UN Doc E/1992/23

CESCR, ‘General Comment No. 9, (the Domestic Application of the Covenant)’ (3 December 1998) UN Doc E/C.12/1998/24

CESCR, ‘Statement on NGO Participation in Activities of the Committee on Economic, Social and Cultural Rights’ (7 July 2000) UN Doc E/C.12/2000/6

CESCR, ‘Statement: The Duties of States Towards Refugees and Migrants under the International Covenant on Economic, Social and Cultural Rights’ (13 March 2017) UN doc E/C.12/2017/1

CESCR, Statement on Poverty and the International Covenant on Economic, Social and Cultural Rights (4 May 2001) UN Doc E/C.12/2001/10

CMW Committee and CRC Committee, ‘Joint General Comment No. 3 / 22 on the General Principles regarding the Human Rights of Children in the Context of International Migration’ (16 November 2017) UN Doc CMW/C/GC/3-CRC/C/GC/22

CMW Committee and CRC Committee, ‘Joint General Comment No. 4 / 23 on State Obligations regarding the Human Rights of Children in the Context of International Migration in Countries of Origin, Transit, Destination and Return’ (16 November 2017) UN Doc CMW/C/GC/4-CRC/C/GC/23

CMW Committee, ‘General Comment No. 2: The Rights of Migrant Workers in an Irregular Situation and Members of their Families’ (23 August 2013) UN Doc CMW/C/GC/2

Committee on the Rights of the Child, ‘General Comment No. 15 on the Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (Article 24)’ (17 April 2013) UN Doc CRC/C/GC/15

Human Rights Committee (CCPR) ‘General Comment No. 15: The Position of Aliens under the Covenant’ (11 April 1986)

Human Rights Committee (CCPR), ‘General Comment No. 18: Non-discrimination’ (1989)

Human Rights Committee (CCPR), ‘General Comment No. 31: The Nature of the General Legal Obligation Imposed on States Parties to the Covenant (26 May 2004) UN Doc CCPR/C/21/Rev.1/Add. 13

CESCR's Concluding Observations

CESCR, Concluding Observations on the reports submitted by:

Albania (18 December 2013) UN Doc E/C.12/ALB/CO/2-3
Argentina (12 October 2018) UN Doc E/C.12/ARG/CO/4
Australia (11 July 2017) UN Doc E/C.12/AUS/CO/5
Austria (13 December 2013) UN Doc E/C.12/AUT/CO/4
Burkina Faso (12 July 2016) UN Doc E/C.12/BFA/CO/1 177)
Canada (22 March 2016) UN Doc E/C.12/CAN/CO/6
Chile (6 July 2015) UN Doc E/C.12/CHL/CO/4
Costa Rica (21 October 2016) UN Doc E/C.12/CRI/CO/5
Cyprus (12 June 2009) UN Doc E/C.12/CYP/CO/5
Cyprus (28 October 2016) UN Doc E/C.12/CYP/CO/6
Denmark (6 June 2013) UN Doc E/C.12/DNK/CO/5
Dominican Republic (7 October 2016) UN Doc E/C.12/DOM/CO/4
Finland (17 December 2014) UN Doc E/C.12/FIN/CO/6
France (12 July 2016) UN Doc E/C.12/FRA/CO/4
France (9 June 2008) UN Doc E/C.12/FRA/CO/3
FYROM (14 July 2016) UN Doc E/C.12/MKD/CO/2–4
Germany (27 November 2018) UN Doc E/C.12/DEU/CO/6
Greece (27 October 2015) UN Doc E/C.12/GRC/CO/2
Honduras (10 July 2016) UN Doc E/C.12/HND/CO/2
Ireland (8 July 2015) UN Doc E/C.12/IRL/CO/3
Italy (28 October 2015) UN Doc E/C.12/ITA/CO/5
Kazakhstan (7 June 2010) UN Doc E/C.12/KAZ/CO/1
Kenya (5 April 2016) UN Doc E/C.12/KEN/CO/2–5
Kyrgyzstan (7 July 2015) UN Doc E/C.12/KGZ/CO/2-3
Lebanon (23 October 2016) UN Doc E/C.12/LBN/CO/2
Lithuania, (24 June 2014) UN Doc E/C.12/LTU/CO/2
Morocco (21 October 2015) UN Doc E/C.12/MAR/CO/4
Nepal (12 December 2014) UN Doc E/C.12/NPL/CO/3
Netherlands (The) (6 July 2017) UN Doc E/C.12/NLD/CO/6
Norway (13 December 2013) UN Doc E/C.12/NOR/CO/5
Pakistan (20 July 2017) UN Doc E/C.12/PAK/CO/1
Paraguay (19 March 2015) UN Doc E/C.12/PRY/CO/4
Philippines (25 October 2016) UN Doc E/C.12/PHL/CO/5–6

Poland (25 October 2016) UN Doc E/C.12/POL/CO/6

South Africa (12 October 2018) UN Doc E/C.12/ZAF/CO/1

Spain (25 April 2018) UN Doc E/C.12/ESP/CO/6

Sri Lanka (4 August 2017) UN Doc E/C.12/LKA/CO/5

Sudan (26 October 2015) UN Doc E/C.12/SDN/CO/2

Sweden (13 June 2016) UN Doc E/C.12/SWE/CO/6

Tajikistan (25 March 2015) UN Doc E/C.12/TJK/CO/2-3

Thailand (12 July 2015) UN Doc E/C.12/THA/CO/1–2

The Russian Federation (6 October 2017) UN Doc E/C.12/RUS/CO/6

Tunisia (14 November 2016) UN Doc E/C.12/TUN/CO/3

Uganda (7 July 2015) UN Doc E/C.12/UGA/CO/1

United Kingdom of Great Britain and Northern Ireland (13 July 2016) UN Doc E/C.12/GBR/CO/6

Uruguay (20 July 2017) UN Doc E/C.12/URY/CO/5

Venezuela (6 June 2015) UN Doc E/C.12/VEN/CO/3

Vietnam (15 December 2014) UN Doc E/C.12/VNM/CO/2-4

CESCR, Country reports and lists of issues:

Belgium - Fourth periodic report (9 July 2010) UN Doc E/C.12/BEL/4

Cyprus - List of issues in relation to the sixth periodic report (12 April 2013) UN Doc E/C.12/CYP/Q/6

Greece - Replies to the List of issues to the second periodic report (6 August 2015) UN Doc E/C.12/GRC/Q/2/Add.1

Ireland - Third Periodic report (8 November 2013) UN Doc E/C.12/IRL/3

Netherlands (The) - List of issues in relation to the combined fourth and fifth periodic report and the fourth periodic report (22 December 2009) UN Docs E/C.12/NLD/4–5, UN Doc E/C.12/NLD/4/Add.1

Sweden - Replies to the list of issues to the sixth periodic report (6 April 2016) UN Doc E/C.12/SWE/Q/6/Add.1

UK - List of issues in relation to the sixth periodic report (3 November 2015) UN Doc E/C.12/GBR/Q/6

Conclusions of the ECSR

ECSR, Conclusions 2013 - Statement of interpretation on Article 30 ESC (2013) Doc no 2013_163_06/Ob/EN

ECSR, Conclusions on Italy regarding the conformity to Articles 11 and 13 ESC (6 December 2013) Doc nos 2013/def/ITA/11/1-3/EN,

2013/def/ITA/13/1-4/EN; (8 December 2017) Doc nos 2017/def/ITA/11/1-3/EN 2017/def/ITA/13/1-4/EN.

ECSR, Conclusions XX–2 Spain on Article 11 and 13 (6 December 2013) Doc nos ESC XX-2/def/ESP/13/1-4/EN; XX-2/def/ESP/11/1-3/EN

ECSR, General Introduction to Conclusions XIX–2 2009

Reports of the UN Special Rapporteurs

Bhoola U, 'End of Mission Statement of the Special Rapporteur on Contemporary Forms of Slavery, including its Causes and Consequences (Country Visit to Italy) (3–12 October 2018)

Crépeau F, 'Report of the Special Rapporteur on the Human Rights of Migrants (Country Visit to Italy)' (2012) UN Doc A/HRC/23/46/Add.3; (2014) UN Doc A/HRC/29/36/Add.2

Eide A, 'Report of the Special Rapporteur on the Right to Adequate Food as a Human Right - The New International Economic Order and the Promotion of Human Rights' (7 July 1987) UN Doc E/CN.4/Sub.2/1987/23

Grover A, 'Report of the Special Rapporteur on the Right to the Highest Attainable Standard of Physical and Mental Health (Main Focus: Migrant Worker's Right to Health' (15 May 2013) UN Doc A/HRC/23/41

Grover A, 'Report of the Special Rapporteur on the Right to the Highest Attainable Standard of Physical and Mental Health (Main Focus: the Right to Health and Criminalization of Same-Sex Conduct and Sexual Orientation, Sex Work and HIV Transmission)' (27 April 2010) UN Doc A/HRC/14/20

Grover A, 'Report of the Special Rapporteur on the Right to the Highest Attainable Standard of Physical and Mental Health (Main Focus: Occupational Health)' (10 April 2012) UN Doc A/HRC/20/15

Hunt P, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (Main Focus: A Human Rights-based Approach to Health Indicators)' (3 March 2006) UN Doc E/CN.4/2006/48

Hunt P, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health' (17 January 2007) UN Doc A/HRC/4/28

Hunt P, Special Rapporteur on the Right of Everyone to the Enjoyment to the Highest Attainable Standard of Physical and Mental Health (12 September 2005) UN Doc No A/60/348

Pūras D, 'Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health (Focus: Agenda 2030)' (5 August 2016) UN Doc. A/71/150

Pūras D, ‘Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health’ (5 August 2016) UN Doc A/71/304

Pūras D, ‘Report of the Special Rapporteur on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health’ (2 April 2015) UN Doc A/HRC/29/33

Pūras D, ‘Report of the Special Rapporteur on the Right to the Highest Attainable Standard of Physical and Mental Health (Main Focus: the Right to Mental Health of People on the Move’ (28 July 2018) UN Doc A/73/216

Pūras D, ‘Report of the Special Rapporteur on the Right to the Highest Attainable Standard of Physical and Mental Health (Main Focus: the Right to Health in Early Childhood’ (30 July 2015) UN Doc A/70/213

CASES

European Court of Human Rights

A.A. v Greece App no 12186/08 (ECHR2010)

A.S. v Switzerland App no 39350/13 (ECHR 2015)

Abdulaziz, Cabales and Balkandali v the United Kigndom App nos 9214/81, 9474/81 (ECHR 1985)

Aden Amhed v Malta App no 55352/12 (ECHR 2013)

Airey v Ireland App no 6289/73 (ECHR 1979)

Alajos Kiss v Hungary App no 38832/06 (ECHR 2010)

Al-Nashif v Bulgaria App 50963/99 (ECHR 2002)

Anakomba Yula v Belgium App no 45413/07 (ECHR 2009)

Aswat v the United Kingdom App no 17299/12 (ECHR 2013)

B. v the United Kingdom App 9840/82 (ECHR 1987)

Bader and Kanbor v Sweden App no 13284/04 (ECHR 2005)

Bah v the United Kingdom App no 56328/07 (ECHR 2011)

Berrehab v the Netherlands App 10730/84 (ECHR 1988)

Biao v Denmark App 38590/10 (ECHR 2014)

Biao v Denmark App 38590/10 (ECHR 2016)

Budina v Russia App no 45603/05 (ECHR 2009)

C.D. and Others v Greece App nos 33441/10, 33468/10 and 33476/10 (ECHR2013)

Calvelli and Ciglio v Italy App no 32967/96 (ECHR 2002)

Carson and Others v the United Kingdom App no 42184/05 (ECHR 2010)

Case 'Relating to Certain Aspects of the Laws on the Use of Languages in Education in Belgium' v Belgium App nos 1474/62, 1677/62, 1691/62, 1769/63, 1994/63, 2126/64 (ECHR 1968)

Centre of Legal Resources on behalf of Valentin Câmpeanu v Romania App no 47848/08 (ECHR 2014)

Chahal v United Kingdom App no 22414/93 (ECHR 1996)

Chapman v the United Kingdom App no 27238/95 (ECHR 2001)

Chowdury and Others v Greece App no 21884/15 (ECHR 2017)

Cyprus v Turkey App no 25781/94 (ECHR 2001)

D. v the United Kingdom App no 30240/96 (ECHR1997)

D.H. and others v the Czech Republic App no 57325/00 (ECHR 2007)

Da Conceição Mateus and Santos Januário v Portugal App nos 62235/12, 57725/12 (ECHR 2013, Decision)

F.H. v Greece App no 78456/11 (ECHR2014)
Fadeyeva v Russia App no 55723/00 (ECHR 2005)
Gaygusuz v Austria App no 17371/90 (ECHR1996)
Guerra and Others v Italy App no 14967/89 (ECHR 1998)
Hirsi Jamaa and Others v Italy App no 27765/09 (ECHR 2012)
Hristozov et al. v Bulgaria App nos 47039/11, 358/12 (ECHR 2012)
Hunde v The Netherlands App no 17931/16 (ECHR 2016, Decision)
Jalloh v Germany App no 54810/00 (ECHR 2006)
James et al v the United Kingdom App no 8793/79 (ECHR1986)
Jeunesse v The Netherlands App no 12738/10 (ECHR 2014)
Johnston and Others v Ireland App 9697/82 (ECHR 1986)
K.H. and Others v Slovakia App no 32881/04 (ECHR 2009)
Khan v France App no 12267/16 (ECHR 2019)
Khlaifia and Others v Italy App no 16483/12 (ECHR 2015) and (ECHR 2016)
Kiyutin v Russia App no 2700/10 (ECHR 2011)
Kudła v Poland App no 30210/96 (ECHR 2000)
L.B. v Belgium App no 22831/2008 (ECHR 2012)
L.L. v France App no 7508/02 (ECHR 2006)
Lopes de Sousa Fernandes v Portugal App no 56080/13(ECHR 2017)
Lopez Ostra v Spain App no 16798/90 (ECHR 1994)
M.S.S. v Belgium and Greece App no 30696/09 (ECHR 2011)
Maaouia v France App no 39652/98 (ECHR 2000)
Marcks v Belgium App no 6833/74 (ECHR 1979)
Maslov v Austria App no 1638/03 (ECHR 2008)
Mehmet Şentürk and Bekir Şentürk v Turkey App no 13423/09 (ECHR 2013)
N. v the United Kingdom App no 26565/05 (ECHR 2008)
Narjis v Italy App 57433/15 (ECHR 2019)
Nasri v France App 19465/92 (ECHR 1995)
Ndikumana v the Netherlands App no 4714/06 (ECHR Decision 2014)
Nencheva and others v Bulgaria App no 48609/06 (ECHR 2013)
Novruc and others v Russia App nos 31039/11, 48511/11, 76810/12, 14618/13 and 13817/14 (ECHR 2016)
Othman (Abu Qatada) v the United Kingdom App no 8139/09 (ECHR 2012).
Oyal v Turkey App no 4864/05(ECHR 2010)
Paposhvili v Belgium App no 41738/10 (ECHR 2016)
Ponomaryov and Others v Bulgaria App no 5335/05 (ECHR 2011)
R.M.S. v Spain App no 28775/12 (ECHR2013)
Rahimi v Greece App no 8687/2008 (ECHR 2011)

Rodrigues da Silva and Hoogkamer v the Netherlands App 50435/99 (ECHR 2006)

S.D. v Greece App no 53541/07 (ECHR 2007)

Saadi v the United Kigndom App no 13229/03 (ECHR 2008)

Soering v the United Kingdom App no 14038/88 (ECHR 1989)

Stec and Others v the United Kingdom App nos 65731/01 and 65900/01 (ECHR 2006)

Tarakhel v Switzerland App no 29217/12 (ECHR 2014)

Villnow v Belgium App no 16938/05 (ECHR Decision 2008)

W.D. v Belgium App no 73548/13 (ECHR 2016)

Wemhoff v Germany App no 2122/64 (ECHR 1968)

X, Y and Z v the United Kingdom App no 21830/93 (ECHR 1997)

Yirdem et al v Turkey App no 72781/12 (ECHR 2018)

Yordanova et al v Bulgaria App no 25446/06 (ECHR 2012)

European Committee of Social Rights

CGIL v Italy Com no 91/2013 (ECSR 2015)

Conference of European Churches (CEC) v the Netherlands Com no 30/2013 (ECSR decision on immediate measures 2013)

Conference of European Churches (CEC) v the Netherlands Com no 30/2013 (ECSR 2014)

Defence for Children International (DCI) v Belgium Com no 69/2011 (ECSR 2012)

Defence for Children International (DCI) v the Netherlands Com no 47/2008 (ECSR 2009)

European Committee for Home-Based Priority Action for the Child and the Family (EUROCEF) v France Com no114/2015 (ECSR 2018)

European Federation of National Organisations working with the Homeless (FEANTSA) v the Netherlands Com no 86/2012 (ECSR decision on immediate measures 2013)

European Federation of National Organisations working with the Homeless (FEANTSA) v the Netherlands Com no 86/2012 (ECSR 2014)

European Roma and Travellers Forum (ERTF) v Czech Republic Com no 104/2014 (ECSR 2016)

European Roma Rights Centre (ERRC) v Bulgaria Com no 46/2007 (ECSR 2008)

Federation of employed pensioners of Greece (IKA-ETAM) v Greece Com no 76/2012 /ECSR 2012)

Federation of Employed Pensioners of Greece (IKA-ETAM) v Greece Com no 76/2012 (ECSR 2012)

International Association Autism-Europe v France Com no13/2002 (ECSR 2003)

International Federation of Human Rights League (FIDH) v France Com no 14/2003 (ECSR 2004)

IPPF EN v Italy Com n 87/2010 (ECSR 2013)

Marangopoulos Foundation for Human Rights v Greece Com no 30/2005 (ECSR 2006)

Médecins du Monde – International v France Com no 67/2011 (ECSR 2012)

UN Treaty Bodies case-based jurisprudence

A.N. v Switzerland Com no 742/2016 (CAT Committee 2018)

Alyne da Silva Pimentel Teixeira v Brazil Com no 17/2008 (CEDAW 2011)

Ben Djazia et al v Spain Com no 15/2015 (CESCR 2017)

Dorothy Kakem Titiahonjo v Cameroon Com no 1186/2003 (CCPR 2007)

E.A. v Sweden Com no 690/2015 (CAT Committee 2017)

F.K.A.G. et al. v Australia Com no 2049/2011 (CCPR 2013)

H.M. v Sweden Com no 3/2011 (CRPD 2012)

I.A.M. v Denmark Com no 3/2016 (CRC Committee 2018)

I.D.G. v Spain Com no 2/2014 (CESCR 2015)

Ibrahima Gueye et al. v France Com no 196/1985 (CCPR1989).

J.B. v Switzerland Com no 721/2015 (CAT Committee 2017)

Joyce Nawila Chiti v Zambia Com no 1303/2004 (CCPR 2012)

Kaba v Canada and Guinea Com no 1465/2006 (CCPR 2010)

L.C. v Peru Com no 22/2009 (CEDAW 2011)

M.A.M.A. et al v Sweden Com 391/2009 (CAT Committee 2012)

M.M.M. v Australia Com no 2136/2012 (CCPR 2013)

M.P. v Denmark Com no 2643/2015 (CCPR 2017)

Madafferi v Australia Com no 1011/2001 (CCPR 2004)

Mansour Leghaei et al v Australia Com no 1937/2010 (CCPR 2015)

McCallum v South Africa Com no 1818/2008 (CCPR 2010)

Miguel Ángel López Rodríguez v Spain Com no 1/2013 (CESCR 2013)

O.A. v Denmark Com no 2770/2016 (CCPR 2017)

Rouba Alhaj Ali v Morocco Com no 682/2015 (CAT Committee 2016)

Stefan Lars Nystrom v Australia Com no 1557/2007 (CCPR 2011)

Tolipkhuzhaev v Uzbekistan Com no 1280/2004 (CCPR 2009)

Toussaint v Canada Com no 2348/2014 (CCPR 2018)

Trujillo Calero v Ecuador Com no 10/2015 (CESCR 2018)

Turdukan Zhumbaeva v Kyrgyzstan Com no 1756/2008 (CCPR 2011)

Warda v Denmark Com no 2360/2014 (CCPR 2015)

X. v Argentina Com no 8/2012 (CRPD 2014)

X. v United Republic of Tanzania Com no 22/2014 (CRPD 2017)

Y.A.A. and F.H.M. v Denmark Com no 2681/2015 (CCPR 2017)

Other international cases

Ahmadou Sadio Diallo (Guinea v Dem. Rep. Congo), (Preliminary Objections) [2007] 599

Barcelona Traction case (Belgium v. Spain) [1970] ICJ

Case C-562/13 *Centre public d'action sociale d'Ottignies-Louvain-la-Neuve v Moussa Abdida* [CJEU 2014] paras 62-64

Customs Régime between Germany and Austria (Advisory Opinion) [1931] PCIJ Series A/B No 41 [Individual Opinion of M. Anzilotti] 57

Island of Palmas Case (*the Netherlands v USA)* (Merits) [1928] 2 UN Reports of International Arbitral Awards 829

Juridical Condition and Rights of the Undocumented Migrants, Advisory Opinion OC-18, IACtHR Series A no 18 (17 September 2003)

Rights and Guarantees of Children in the Context of Migration and/or in Need of International Protection, Advisory Opinion OC-21, IACtHR (19 August 2014)

Domestic legislation and case-law

Constituent Assembly, '(Atti della) Seduta del 24 aprile 1947'

Constitution of the Italian Republic (enacted by the Constituent Assembly 22 December 1947, entered into force 1 January 1948) Official Gazette no 298/1947

D. PCM 29 November 2001, Official Gazette no 33 (08 February 2002)

D. PCM 12 January 2017, Official Gazette no 65 (18 March 2017)

D.P.R (President of the Republic's Decree) no 394 'Rules of Implementation of the Consolidated Immigration Act (31 August 1990)

Italian Civil Code, Royal Decree no 262 (16 March 1942)

Law no 833/1978, 'Istituzione del servizio sanitario nazionale' (National Health Care System) Official Gazette no 360 (28 December 1978) Suppl. Ordinario

Legge Regionale Campania (Campania's Regional Law) no 6 (8 February 2010)

Legge Regionale Puglia (Apulia's Regional Law) no 32 (4 December 2009) Official Bulletin Puglia no 196 (7 December 2009)

Legge Regionale Toscana (Tuscany's Regional Law) no 29 (8 June 2009) Official Bulletin Toscana no 19 (15 June 2009)

Legislative Decree no 286 (25 July 1998) Official Gazette no 191 (18 August 1998) (Consolidated Immigration Act)

Ministerial Circular no 5 (24 March 2000) Official Gazette no 126 (1 June 2000)

Real Decreto-Ley no 7/2018 'Acceso universal al Sistema Nacional de Salud' (27 July 2018) (Spain)

State-Regions Agreement no 255 (Repertorio Atti n.: 255/CSR del 20 December 2012).

Domestic cases

Fong Yue Ting v United States [1893] 149 US 698 (US Supreme Court)

Musgrove v Chun Teong Toy [1891] AC 272 (Privy Council of the United Kingdom)

Nishimura Ekiu v United States [1892] 142 US 651 (US Supreme Court)

Constitutional Court Judgement no 120 (1967)

Constitutional Court Judgement no 244 (1974)

Constitutional Court Judgement no 103 (1977)

Constitutional Court Judgements nos 48, 54, 88 (1979)

Constitutional Court Judgement no 170 (1984)

Constitutional Court Judgement no 404 (1988)

Constitutional Court Judgement no 455 (1990)

Constitutional Court Judgement no 168 (1991)

Constitutional Court Judgement no 62 (1994)

Constitutional Court Judgement no 353 (1997)

Constitutional Court Judgements nos 27, 185 (1998)

Constitutional Court Judgements nos 2, 121, 167, 324, 388, 436 (1999)

Constitutional Court Judgements nos 31, 198, 509 (2000)

Constitutional Court Judgements nos 105, 252 (2001)

Constitutional Court Judgement no 282 (2002)

Constitutional Court Judgement no 88 (2003)

Constitutional Court Judgement no 5 (2004)

Constitutional Court Judgements nos 300, 432 (2005)

Constitutional Court Judgements nos 348, 349 (2007)

Constitutional Court Judgements nos 148, 219 (2008)

Constitutional Court Judgement no 317 (2009)

Constitutional Court Judgements nos 134, 249, 250, 269, 299 (2010)

Constitutional Court Judgements nos 40, 61, 105, 236 (2011)

Constitutional Court Judgements nos 236, 264 (2012)

Constitutional Court Judgements nos 7, 85 (2013)

Constitutional Court Judgement no 275 (2016)

Constitutional Court Judgement no 35 (2017)

Constitutional Court Judgements nos 120, 194 (2018)

Cass (Sez I civ) Judgement 24 January 2008

Cass (SU) Judgement no 796/1973

Cass Civ (Sez I) Judgement no 1531 (2008)

Cass Civ (Sez I) Ordinanza no 7615 (2011)

Cass Civ (Sez VI) Ordinanza no 6000 (2017)

Cass Civ (SU) Judgement no 14500 (2013)

Cass Pen (Sez I) Judgement no 38041 (2017)

Cons Stato (Sez VI) Judgement no 8055 (2010)

T.A.R Veneto Veneza (Sez III) Judgement no 1303 (2008)

T.A.R. Campania (Salerno, Sez II) Judgement no 558 (2014)

T.A.R. Toscana (Firenze, Sez II) Judgement no 695 (2011)

Tribunale di Milano (Fist Instance Court of Milan) (Sez I Civ) Ordinanza no 2380/2008 R.G. (11 February 2008)