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# The Right to Health in a multi-level perspective

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A fundamental right of every human being is the right to health, which implies the right to life and as such, it is fundamental, unavailable, non-erodible and practically enforceable. The right to health is a universal principle that emerges in the Preamble of the Constitution of the World Health Organization (WHO); it is universally recognized by the human person, and directly ascribable to the supreme value of life, which constitutes the capacity for immanent action (Sgreccia, Spagnolo 1999).

In accomplished democracies, the right to health has an absolute value. This absoluteness is due to the principle of being recognized by everybody as well as from the fact that it guarantees an *erga omnes* value, meaning that nobody can assume facts or behaviors that could harm such a right.

For instance, article 32 of the Italian Constitution defines the Right to health as a fundamental[1] and absolute right, protected by the Constitution in a full and unconditional way with respect to everyone, without distinction of race, religion, political belief, economic and social conditions, therefore a "precondition" for the exercise of all other rights (Luciani 2003).

In accordance with the Italian Constitution, in fact, the need to protect physical health is emphasized as much as the psychical one. In particular, the Constitutional Court focuses on *health care*[2], i. e. all the "*positive interventions for the protection and promotion of human health*", which requires not only care but also an affective and relational support. It is then clear that an exhaustive analysis of the dynamics and problems connected with the "right to health" issue cannot be separated from the existing European legislation in this field, given the complementary role that this legislation has in the Member States' legal systems (Cuocolo 2005).

Since from the initial foundation of the Community, it is not possible to elicit a comprehensive discipline of social rights. The failure to include a comprehensive set of social rights in the Community texts is due to the historical post-war situation in Europe, characterized by the government control of monetary policy, which is crucial for the construction of the State system. However, it is possible to find a track of social measures from the founding Treaties and, above all, relating to health care. In particular, article 100A of the treaty establishing the European Community provided that the Commission should pursue a high level of public health protection when adopting measures aimed at reconciling Member States' legislation.

An important step forward was made in 1986, with the Single European Act, which combines the three Communities with the European political cooperation and extends the Community's competences concerning the subject under discussion (Cartabia, Weiler 2000). The Single Act adds a Title on economic and social cohesion to the EC Treaty (article 130); it also highlights the importance of the European Community to pursuing social justice objectives in the Preamble, recalling the principles of the Social Charter of the Council of Europe approved in 1961 (D'Intino *et alii* 2006, 7-9).

However, these predictions cannot be translated into a catalogue of fundamental social rights. If, therefore, emphasis must be focused on launching the development of Community social policies, it is not possible to identify a real breakthrough in the Single European Act in terms of protecting the rights of individuals and

[1] In article 32, the Constituent stated that «*Republic protects health as a fundamental right of the individual and in the interest of the community, and guarantees free treatment for the needy. No one can be obliged to take any particular medical treatment except by legal provision. Under no circumstances can the law violate the limits imposed by respect for the human person*».

[2] Constitutional Court, judgment of 30th September 1999, n. 382, in *Giurisprudenza Costiuzionale*, 1999.

explicitly in health protection, which must be pursued in all Community development policies.

In 1992, the Treaty on European Union (TEU) known as Maastricht Treaty amended the TEC by identifying the achievement of a high level of health protection as one of the Union's main aims. Title X of the TEU is dedicated to *"Public Health"* and it is composed of a single article 129; it underlines the need for Community intervention to complement State action in order to achieve a high level of protection of human health (Pitino 2003, D'Intino *et alii* 2006 , 162).

Finally, article 6 of the TEU, in line with the approach developed by the Court of Justice, affirms the Union's obligation to respect fundamental rights guaranteed by the European Convention on Human Rights as they result from the traditions common to the Member States as general principles of Community law (Ferrari 2001, 4).

However, this provision does not seem to be extendable to social rights: the reference made by article 6 in fact, it is apparently restricted to the fundamental rights of freedoms, which are effectively governed by the above-mentioned Convention. The rights set out in the European Social Charter and, therefore the right to health are thus excluded.

In the framework set out in the Maastricht Treaty, it should be pointed out that the principle of harmonization of national policies has been tending to be replaced by the open method of coordination, which aims to share information between Member States in order to identify best practice in individual areas, without imposing minimum requirements for individual states

The real breakthrough in the protection of social rights came in 1997 with the Amsterdam Treaty, which entered into force on 1st May 1999 (Zanetta 2003, 48).

Article 3 (p) requires Community action to contribute to the attainment of a high level of health protection. The most relevant aspect consists in the introduction of the article 152 TEC, replacing the former Article 129 TEU, which enshrines the basic principles of Community action on the protection of human health. More exhaustively, article 152 (1) provides that a high level of health protection is to be ensured in the definition and implementation of all Community policies and activities. This Article provides that Community action is to be directed primarily towards the prevention of diseases by encouraging research to their causes and transmission, as well as health information and education. It is clear that the provision introduced by the Treaty of Amsterdam differs from Article 129, which provided for a very marginal role for the Community institutions, merely as a subsidy for the action of the Member States. On the contrary, article 152 places health protection as a general criterion to be followed in the implementation of all Community policies. The protection of health is therefore not a material matter, but a criterion, a Community principle in the light of which the action of the Community bodies can be read. It is of fundamental importance to clarify that in Community law, after Amsterdam, the protection of human health is almost an obligatory result, which cannot be sacrificed in balance with the other guiding principles of Community action.

Moreover, Article 152 (1) takes into consideration not only the "healing" aspect of health protection, but also the preventive aspect; this is, in particular, a profile that considers the Community provisions more advanced than those of the national Constitutions, including the provision of Article 32 of the Italian Constitution and that requires new standards of protection in member states, also with respect to prevention aspects.

Article 152 (2) provides that "Community shall encourage cooperation between Member States in the areas covered by this article and, where necessary, support their action. The Member States in liaison with the Commission shall coordinate among themselves their policies and programs in the areas referred to in paragraph 1. The Commission, in strict contact with the Member States, may take any useful initiative to promote such coordination". The provision incorporates some of the principles contained in above-mentioned article 129, that reiterates the necessary harmonization of Member States' policies.

Article 152 (3), supplementing the principle of harmonization set out in the second subparagraph, provides that "The Community and its Member States foster the cooperation with third countries and the competent international

organizations in the field of public health". The achievement of the objectives set out in Article 152 may require Community measures to complement the actions of Member States, but it mainly involves encouraging cooperation between States, in accordance with the principle of subsidiarity.
At institutional level, defined in Article 152, incentive actions shall be adopted by the Council acting in accordance with the co-decision procedure, while recommendations shall be adopted by qualified majority on a proposal from the Commission. The Council, therefore, becomes one of the main players in achieving health protection standards. Nevertheless, the provisions contained in the fourth subparagraph are not exhaustive of Community action in the field of health, but are only part of Community competence; this is also confirmed in the open clause of point (c), which requires the Council to adopt any incentive measure, provided that it does not involve forced harmonization of national legislation (Pitino 2003, 306).
One of the most important forecasts introduced by the Amsterdam Treaty is that of Article 152 (5), according to which: "Community action in the field of public health fully respects the responsibilities of the Member States for the organization and delivery of health services and medical care"; direct Community intervention in the provision of health services is therefore excluded. The fifth subparagraph, combined with the impossibility for the Council to adopt harmonization measures, leads to the conclusion that there is still a lack of instruments for regulating the public health service at Community level, the definition of which is left to the legislation of individual Member States, which often differ widely from one another (Cilione 2003, 75).
It is not easy to balance the actual scope of the statements of principle contained in the original Community law: while the guarantee of high levels of health protection is a fundamental principle of all Community policies, on the other hand, the community lacks the means to regulate the forms of health protection in practice, that must be guaranteed to all European citizens (Sciullo 2004).
These considerations raise a few questions about the content of European citizenship, which does not seem to identify itself with a set of Community social rights yet.
The final step on the road to European social rights before reaching the Constitutional Treaty is the Charter of Fundamental Rights of the European Union, which was adopted in Nice in December 2000. One of the characteristics of the Nice Charter is the particular system, which, although it acknowledges social rights, does not divide them according to traditional generations.
In this regard, it should also be pointed out that the Nice Charter, although it has a high symbolic value as a result of a solemn proclamation, has no binding force in terms of positive law. The principles of the Nice Charter are useful mainly as interpretative arguments and that has a particular significance in consideration of what it is expressed by the article 6 of the Maastricht Treaty, which sets out a circular dynamic of fundamental rights (Azzena 2001, 135).
However, it is not possible to compare the extent of a legally binding act with that of an interpretative instrument, particularly in relation to social rights, which, although largely governed by the Charter, are not covered by the article 6 TCE.
The Charter's Preamble strengthens the weight of fundamental rights in the Community system as they derive from constitutional traditions and international obligations common to the Member States, the TEU, the Community Treaties, the European Convention for the Protection of Human Rights and Fundamental Freedoms, and the Social Charters adopted by the Community as well as the Council of Europe. In addition, the rights recognized by the jurisprudence of the European Court of Justice and the European Court of Human Rights are reaffirmed. The provisions concerning the right to health protection are the first three articles included in Chapter I, "*Dignity*".
In particular, Article 1 recognizes human dignity as inviolable, prescribing the necessary respect and protection; Article 2 guarantees the right to life for every individual; Article 3, finally, affirms the right to physical integrity, dictating specific prescriptions for medical activities. These provisions are undoubtedly important and clearly demonstrate the protection afforded by Community law to aspects of the negative right to health, i. e. the right not to receive

harm to one's own health. As far as the positive aspects of health protection are concerned, the analysis must focus on Article 35 dedicated to the" Protection of health" in Chapter IV dedicated to" Solidarity".
Article 35 provides that" Everyone has the right of access to health prevention and medical treatment under the conditions laid down by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities". While the second period of the provision reproduces Article 152 of the Treaty of Amsterdam, the first period introduces even more explicitly the right to preventive and rehabilitative treatment to protect individual health.
Despite the limited legal scope of the Nice Charter, it is essential to note the definitive separation between the concept of the protection of human health and the pursuit of other Community objectives and the qualification of the right to health protection as a right of the individual. On the other hand, the wording used in the Nice Charter does not serve as a basis for Community competence in regulating the public health service; The Charter states that the right to prevention and treatment is guaranteed within the limits of national laws and practices.
In a certain sense, this provision is the result of an obligatory line of action since, from the Preamble onwards, it is detected the scope of the rights set out above all in Article 51, which states that the Charter" does not introduce new powers or tasks for the Community and the Union, nor does it modify the powers and tasks defined in the Treaties".
It is crucial at this point to reflect on the effective protection of the law at Community level. In this sense, first of all, a negative limit can be identified, which consists in the choice to refer to the laws of the member states the organization and the concrete regulation of the public health service; a consideration resulting from the application of the principle of vertical subsidiarity that requires to allocate functions to the level of government as close as possible to the citizens (Arena 2006; Albanese, Marzuoli 2003; Moscarini 2003; D'Intino 2006).
This choice is due, on the one hand, to the different traditions of social rights in the various European experiences, and, on the other hand, to the numerous and fragmented forms of regulation which are based on different models and which provide for different forms of division of competences between the state and decentralized levels of government (Cuocolo 2005).
It can be said, therefore, that the competences of the health service are still destined to be placed at state or sub-state level for a long time, as it is indirectly confirmed in the *Green Paper on services of general interest* (COM-2003-270), which attracts only those public services of economic importance to the Community competition rules. However, this does not detract from the fact that the Community institutions can also play a leading role in terms of health protection.
In order to understand the extent to which this is happening, it is necessary to wonder what instruments and techniques for regulating the right to health are permitted by the Treaty that establishes a Constitution for Europe, approved by the Intergovernmental Conference on 18 June 2004 in Brussels and signed on 29 October 2004 in Rome (Letta 2006, 14-15). The Constitutional Treaty in Part II includes the Charter of Fundamental Rights and, in particular, in article II-35 it takes over article 35 of the Charter, which deals with the protection of human health.
On the other hand, article 152 TEC, introduced by the Treaty of Amsterdam, is reproduced in article III-179 within Section I" Public Health" where Chapter V is dedicated to "Sectors in which the Union may decide to demonstrate coordination, integration and support action".
In the adopted perspective, it is relevant the wording of the seventh paragraph corresponding to article 152 (5) TEC. In fact, it is well affirmed the competence of each member state to define public health policies and the organization and delivery of the public health service; it specifies that "the responsibilities of member states include the management of health services and medical care as well as the allocation of resources destined to them".
It is evident that Community action in the healthcare sector would never lead to the creation of a European health system. It can be assumed that human health is not a competence of the Union, but only a criterion to be followed in regulating subjects. In support of this

argument, it could be emphasized that the Nice Charter did not recognize a subjective right to health protection. If this were the case, health protection would be a sort of" filter" through which to read every Community act, but not a competence of the Union that would legitimize the development of autonomous policies.
On the contrary, it can be assumed that health protection, even with all the limitations highlighted, is a proper subject that should belong to the shared competence of the Union (Pitino 2003).
This reconstruction is confirmed by article I-13 of the Constitutional Treaty that identifies the areas of shared competence of the Union in point (b) of the second paragraph; it makes express reference to social policy, as regards the aspects defined in Part III. Where this is true, the guarantee of a high level of human health protection can also be the subject of specific policies and, in this context, the provision of specific" essential Community levels" of health care could even be envisaged.
Community protection could thus absorb the constitutional principles of the state and, as far as Italian law is concerned, the essential levels of benefits relating to civil and social rights that must be guaranteed throughout Italy. The scenario is certainly stimulating and it is not excluded that it may have significant developments in the future (Morbidelli 2004, Cuocolo 2005).

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