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The right to health: a model for determining the contents of the minimum core and the periphery

Derecho a la salud: un modelo para la determinación de los contenidos mínimos y periféricos

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ABSTRACT The right to health has been widely recognized in the Argentine courts, however only those who have the ability to access the justice system are able to fully enjoy that right. Therefore traditionally excluded groups, who for different reasons have not been able to make their demands heard in a judicial court, do not benefit from the recognition gained up to this point in the different judicial resolutions. Taking into account these institutionalized unequal practices, this article suggests a model for understanding the right to health truly as a right. A distinction is made between the right to health as a rule (understood as the minimum or essential core of that right) and the right to health as a principle (understood as the periphery of the right). In this way, it is shown how considering the right to health as both a rule and as a principle could offer greater equality in recognition of that right for disadvantaged groups that lack access to the justice system.
KEY WORDS Right to Health; Social Justice; Redistributive Justice; Social Group.

RESUMEN El derecho a la salud ha sido fuertemente reconocido por los tribunales argentinos, pero lo cierto es que solo goza de dicho derecho quien tiene posibilidad de acceder a la justicia. Por lo tanto, los grupos tradicionalmente excluidos, que por diferentes motivos no pueden hacer oír sus reclamos en sede judicial, no se benefician con el reconocimiento logrado hasta ahora en las diferentes resoluciones judiciales. Teniendo en cuenta estas prácticas desigualitarias institucionalizadas se plantea aquí un modelo que implica entender el derecho a la salud como verdadero derecho. Para esto se realiza una distinción entre el derecho a la salud como regla (en lo que se refiere al contenido mínimo o esencial de dicho derecho) y el derecho a la salud como principio (respecto del contenido periférico), demostrándose así cómo el derecho a la salud considerado como regla y como principio podría llegar a otorgar mayor igualdad en el reconocimiento de este derecho respecto de los grupos desaventajados, que carecen de acceso a la justicia.
PALABRAS CLAVES Derecho a la Salud; Justicia Social; Justicia Redistributiva; Grupo Social.

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INTRODUCTION

The World Health Organization defines health as a state of complete physical, mental and social well-being, that at its core constitutes an essential right of every individual (1). According to the Argentine Constitution as well as several international treaties on human rights, the right to health cannot be understood in isolation given that it coexists with other rights and the mandate of equality. Therefore, this paper will examine the thesis that the right to health must be enjoyed under conditions of *structural equality of opportunities* (2-11).

But, how can a structural equality of opportunities guarantee the effective exercise of the right to health within contexts of social exclusion? This question pertains to the problematic nature of the specification of the content of social rights in general, and in particular of the right to health. Accordingly, it is possible to argue that one way of guaranteeing such equality is to establish clear methods to determine a "minimum core" and other content beyond this threshold that could be called "peripheral content." That being said, it is widely accepted that social rights demand State action; nevertheless, one argument commonly raised against the full enforcement of these rights is the difficulty in determining the extent of these positive obligations (12-13). Although this difficulty is taken on by a large body of literature, it seems that there is still a need to develop a more thorough, founded approach to social rights (14).

The aim of this paper is to contribute to some extent to this objective, through a contemplation of the nature of the rules or principles of State obligations to provide healthcare services implied by social rights. For this purpose, the discussion will be informed by the distinction between rules and principles found in Alexy's *A Theory of Constitutional Rights* (12). Special reference will be made to the right to health as part of the body of social rights recognized by the Argentine Constitution and other documents.

This paper is divided into three sections: the first will briefly elaborate on the tensions that emerge when dealing with social rights, emphasizing the problem of (in)equality characteristic of the development of social rights through judicial decisions. The second section will consider the implications of the model of rules and principles through an analysis of the principle of proportionality or weighing, employing the concept of a "rule-oriented weighing model" (*ein reger orientiertes Abwägungsmodell*) developed by Clérico as a distinction between mere weighing and *ad hoc balancing* (15,16). Thus, the purpose of this paper is to establish which of these models should be applied in the resolution of cases that involve social rights (more precisely, the right to health) or whether they can be taken together as a single model, wherein the application of the right to health as a rule or as a principle varies depending on the case in question. In the third section, some conclusions will be presented regarding the need to achieve a more egalitarian acknowledgment of the right to health, and how the proposed model represents a driving force in this direction.

SOCIAL RIGHTS: 'PROBLEMS' ASSOCIATED WITH SOCIAL RIGHTS

Mere mandates or true rights?

Although much has been written in this field about the scope of social rights, the debate still remains open. It should be mentioned that this paper will only take into account a few of the critiques of the concept of 'social rights' (17-20). In this regard, some legal scholars posit that social rights develop progressively – that is to say, they are mere mandates that should be gradually developed by legislators. Consequently, the progress of social rights would result from the creation and planning of public policies, and therefore entirely in the hands of lawmakers. From this perspective, social rights are by nature incomplete rights, and as such cannot be invoked in courts of law.

Two significant characteristics would result from this interpretation: generality and dependence on budgetary resources. On the one hand, it is argued that the generality of statements establishing social rights require a regulatory framework in order to determine the extent of the benefits involved – in order words, the aim of the right in question. This feature affects claims made in the courts given that the content of the right is not specified.

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On the other hand, the connection between social rights and budgetary resources should also be mentioned. These resources are managed exclusively by political actors and not by the justice system. As has been noted elsewhere:

> ... when the compensation resulting from the violation of economic, social and cultural rights entails positive State action and the mobilization of budgetary resources, or that said compensation affects in any way the design or implementation of public policies, or implies making a decision to determine which social sectors or groups will be prioritized for State assistance, courts tend to consider these issues to be the jurisdiction of the political system. (13 p.127) [Own translation]

Thus, many courts contend that it is largely impossible for them to influence policies that may affect budgetary resources.

It is widely accepted that the field of social rights is governed by the principles of progressive realization and non-regression. The principle of non-regression compels States to fully uphold the status of a right, and to ensure compliance once its scope and content have been fully determined.

> If any deliberately retrogressive measures are taken, the State party has the burden of proving that such measures have been introduced after the most careful consideration of all alternatives and that they are fully justified by reference to the totality of the rights provided for in the Covenant and within the framework of full use of the State party's maximum available resources. (21)

Similarly, the principle of progressive realization involves:

> ...the adoption of measures, especially those of an economic and technical nature insofar as there are available resources – by legislation or other appropriate means – with a view to achieving progressively the full realization of certain economic, social and cultural rights. (22 p.34)

Thus, both principles imply not only the obligation of the State to adopt policies that improve the status of the rights and to further define their scope, but also to avoid decisions that could lead to a reduction in their degree of realization (23).

In other words, States have the duty to move as expeditiously and effectively as possible towards full compliance – in the case of the right to heath – with Article 12 of the International Covenant on Economic, Social and Cultural Rights (24).

However, States may not limit their actions to the mere establishment of a baseline of rights given that the provision of the social benefits derived must be progressive, meaning that they must gradually develop and cannot remain static in relation to other social benefits. Therefore, the principles of progressive realization and non-regression are essential to strengthen the standards of enforceability since the State is required to demonstrate that all possible resources have been made available in order to fulfill the right in question. Hence, any regressive measure must be grounded on sufficiently strong reasons (22).

These principles – progressive realization and non-regression – have been used by legal scholars and applied in jurisprudence to reinforce the legal standing of economic, social and cultural rights (ESCR) (25). Consequently, prior consensus that social rights were mere mandates addressed to legislators has eroded. Nowadays, ESCR are *considered genuine rights that must be guaranteed to the fullest extent possible, making possible their claim before courts, and at the same time, it must be ensured that individuals have adequate resources for the protection of these rights*. Therefore, although States have a certain degree of discretion in terms of the strategies chosen to ensure that these rights are fulfilled, they have the obligation to act progressively. Accordingly, not only must the State avoid interfering with the exercise of individual rights, but it also has the obligation to produce positive actions in order to prevent them from becoming ineffectual. This is evidenced by the ruling of the Argentine Supreme Court in the case of "Asociación Benghalensis" (26). Similarly, United Nations General Assembly Resolution 32/130 sets forth that:

> 1. a) All human rights and fundamental freedoms are indivisible and interdependent;

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> equal attention and urgent consideration should be given to the implementation, promotion and protection of both civil and political and economic, social and cultural rights; b) the full realization of the civil and political rights without the enjoyment of economic, social and cultural rights is impossible... (27 p.160-161)

In conclusion, the right to health acknowledged as a true right has been broadened by both legal scholarship and individual judicial decisions. Therefore, the State is now under the obligation to guarantee this right. Undoubtedly all progress in this matter is significant, but other problems may also arise, which will be taken up in the next section.

Effects on equality when issuing rulings in cases involving the right to health

Courts have certainly made progress in the acknowledgement of social rights, consistently providing arguments in support of the position that these rights are enforceable (a), especially in the context of the right to health (b). In recent years there has been an increase in both individual and collective litigation aimed at ensuring the effective fulfillment of the right to health despite non-compliance by either national or local governments (c), and in some cases even by individuals, in addition to important cases of judicial activism oriented towards ensuring greater guarantees of these rights (34). For example, in the "Comunidad Toba del Chaco" case, the Ombudsman filed a class action lawsuit against both the provincial government of Chaco and the federal government after 19 people died of malnutrition, a legal maneuver that intended to compel the provincial and federal governments to take all necessary actions to modify the present living conditions of the indigenous communities of the region that have been repeatedly and systematically deprived of adequate humanitarian and social assistance, leading to a situation of silent, progressive, and systematic annihilation. The Ombudsman also petitioned the court to order both the provincial and federal governments to guarantee these communities a dignified quality of life such that they may effectively enjoy the rights to life, health, medical and social assistance, food, drinking water, and education as well as to housing, general welfare, work, social inclusion, and so on, and to see that these rights are continuously and permanently satisfied. Other examples illustrating this point are the case of "Asociación Benghalesis y otros c/ Ministerio de Salud y Acción Social, Estado Nacional s/amparo ley 16.986" dated June 1, 2000; and the case of "Ministerio de Salud y/o Gobernación s/acción de amparo" dated October 31, 2006.

However, this issue must be approached cautiously. When dealing with social rights, although a judicial resolution might benefit one individual or group, this situation could be regarded as unequal treatment if all individuals and groups do not benefit in a similar fashion. Thus, it is necessary to take into account the inequalities imposed by this system, given that some social groups (especially those most vulnerable) do not see their rights protected, even though they do not bring claims before the State. On the other hand, although "the Supreme Court assumes the role of protector of rights in particular cases, this does not solve the larger problem arising from inaction or omission in regards to the functions that correspond to the other two branches"(35). In other words, there are a large number of conflicts that for different reasons (lack of legal knowledge, economic difficulties, lack of time, distrust in the government or the legal system, dependence of families' income on discretional social welfare) will never be brought before the courts (36,37 p.315). This situation becomes even more complex when the affected social groups suffer from structural inequalities (economically disadvantaged groups, women, indigenous peoples, etc.). A good example of this is the Ramos case (38), in which a claim was brought before the court by an unemployed, single mother living in "conditions of extreme poverty" with her eight children, aged between nine months and fifteen years old, in a modest home that had been lent to her free of charge. One of her daughters, Mariana S. Ramos, had to undergo an operation because of a congenital heart disease. The girl, who suffered from malnutrition, could not be operated on even once she got an appointment at Garrahan Hospital, due to her mother's lack of economic means to transport her to the hospital and difficulties in finding someone who could care for her other children. Furthermore, the plaintiff argued that

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in addition to the conditions of extreme poverty she faced, she had deficiencies in education and consequently she and her children were immerse in conditions of structural poverty that would be impossible to overcome without the assistance of the State. It was argued that her children would not be able to complete schooling and that they suffered from malnutrition – some even exhibiting developmental disabilities – due to the inadequate intake of quality food. Therefore, she requested that the court order the federal and provincial governments to: a) respect their rights (hers and her children's) ensuring that they had access to food, healthcare, education, and adequate housing, all of which would result in the provision of an "adequate, effective and continuous food aid on a monthly basis" and which would enable them to meet their basic needs and to attain a decent standard of living; b) provide her daughter, Mariana S. Ramos, with the medical care necessitated by her condition and to remove the obstacles which had made it impossible for her to fully and effectively exercise the right to health; and c) provide her six school-aged children with the necessary elements (clothing, shoes, books, school supplies and transportation costs) to attend school. The Argentine Supreme Court ruled that the State cannot be sentenced to grant additional benefits or social services to the filing party – who was head of a household of eight and living in conditions of extreme poverty – given the prior availability of a similar social program (for single mothers with more than seven children) and in light of the fact that access to education and healthcare is already guaranteed. Consequently, it is possible to conclude that "the social groups who suffer from structural inequality and social exclusion are the primary victims of this institutional deficit that affects their political, social and civil rights" (36 p.300, 39). Furthermore, it is worth mentioning that although promising progress has been made in particular cases regarding the acknowledgement of social rights (especially the right to health), the efficiency of the system should be called into question.

As a result, in Argentina only those who can afford it effectively exercise the right to health; that is, those who receive healthcare coverage through the social security sector, private health insurance companies, or those whose right has been acknowledged by an administrative or court order. Unfortunately, not everyone has enough money to afford healthcare, even fewer have employer-provided health insurance coverage, and only a limited number of people manage to access the justice system.

In Argentina, between 3 and 5 million individuals hold private health insurance (coverage purchased on the private market) and approximately 15 million are covered by the social security sector (40). Therefore, we can argue that almost half the population (of over 40 million people) lacks coverage and relies on public hospitals:

> ...the absence of integration among the different subsectors – the public, social security and private sectors – is characteristic of the [healthcare] system, and it is further exacerbated by the fact that each subsector is highly fragmented. The overall picture gets more complicated since the public sector is divided into jurisdictions – national, provincial and municipal – among which the degree of coordination is not adequate. (41 p.62) [Own translation]

Thus, only those able to access to the legal system are guaranteed to have their right to health respected, which in turn requires not only an awareness of the possibility of bringing claims before the court, but also an investment of the money and time necessary for initiating and carrying out legal proceedings. Although free counseling services exist in many districts of the country they are generally located in large cities, and people who live in underserved areas are unable to access these services. Indeed, free counseling services have been available at public universities since the beginning of the 20th century (for example, at the Universidad de Buenos Aires), and through NGOs working with these issues, but unfortunately they are far from meeting the societal demand. Thus, it becomes clear that a minimum core of the right to health must be determined, essential not only for the Judiciary, but also for the other principal actors involved in the process of acknowledging the right to health (legislators, national and provincial executives acting as administrators of the

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national and provincial public health systems, respectively, and the different subsectors of the healthcare system). Accordingly, it is stated in subsection 47 of General Comment No. 14 "that a State Party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations set out in paragraph 43 above, which are non-derogable" (42). This brings us to the second issue: the establishment of a "minimum core" of the right to health accessible to all citizens.

RULES, PRINCIPLES AND THE "RULE-ORIENTED WEIGHING MODEL"

As indicated at the beginning of this paper, the difficulties arising from cases involving social rights, especially the right to health, include: 1) determining when medical treatment is necessary (therefore obligating the healthcare system to provide coverage), given that the right involved might otherwise be affected; 2) issues of structural equality implied by the development of social rights through court orders, considering that disadvantaged groups still remain largely affected. Thus, this paper suggests making a distinction between the interpretation of the right to health as a rule and as a principle. There are undoubtedly treatments that are urgent and necessary and as such should not be denied to any person: namely, those cases in which the life of the patient is at risk (d). These cases are characterized by "the obligation of the State to take immediate action, as otherwise not only is the right to health violated, but also the right to life" (44). Furthermore, it should be noted that "the denial of a minimum level of medical assistance and treatment would enter into conflict with the assurance of a dignified standard of living [...] and as such incompatible with the right to life" (45 p.218). The obligation to comply with this right is undeniable. In these cases, following Robert Alexy, it can be argued that *the right to health acts as a rule* (12). German scholars have extensively taken up theories concerned with outlining the content of rights (relative, absolute, spatial theories, etc.) (12,15,17,46,47). However, it should be noted that the intent of this paper is not to construct a philosophical argument concerning the content of social rights, but rather to promote the equal recognition of these rights in social and legal practices.

It is widely accepted that a rule "is a limitation to a fundamental right whenever, once in effect, [...] a permanent non-freedom or non-right of equal content appears" (12 p.274). Rules have a definitive character in that they may be complied with or not; that is, the solution is implicit in the rule itself: for example, when driving a car it is mandatory to stop at stoplights, this is a definitive obligation. In such cases, the subsumption model applies and not the weighing of rights: "norms regarding the minimum core of social rights apply as rules (subsumption model). The minimum core of the right cannot be weighed or ranked against other principles" (44).

It is for this reason that a theory of the core content of rights is adopted (e). This implies complying with the terms of General Comment No. 14 (42) concerning the existence of certain basic non-derogable obligations. These obligations are included in the core content (f) of the right to health, which is *inalienable*. That is, in the cases of certain conditions or diseases (this will be further discussed later), the State must provide treatment and cannot under any circumstances justify a failure to do so (claiming, for instance, that resources were allocated to attend to other problems) since, in such cases the right to health includes this core content, an essential minimum that cannot be neglected by the State or by individuals. An example of this would be the right of HIV-positive people to receive treatment (properly administered and under adequate conditions) provided by the healthcare system. Such treatment cannot be denied on the grounds that resources are limited or that complying with this obligation would compromise the financial resources of the entire system.

Having said that, it should be noted that the existence a minimum core of rights does not equate to a denial of the possibility of broadening the scope of these rights, given that this broader scope may also be enforceable in a court of law (44 p.494, 49 p.57). Nonetheless, there are some circumstances in which the need for treatment is more questionable, primarily because the health of the individual would not be at risk as in previously mentioned cases, but rather cases in which the condition in question does not pose a threat

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to the life (existence) of the individual. Such cases fall outside the scope of what has been defined as the minimum core, even though other rights may be affected, such as the right to health – as defined by the WHO (1) in a general sense – to dignity, and to integrity. Nevertheless, these cases undoubtedly affect the right of the individual in question to live a dignified life, a right that is ultimately protected in all democratic societies.

Legal scholars have designated these cases as "difficult cases" (17). To illustrate this point, the following questions arise when considering this definition of difficult cases: Should the State provide assistance for fertility treatment or breast implants? Should private insurance companies be required to cover the cost of plastic surgeries (50,51)? This is where the right to health acts as principle. In this regard, the doctrine of fundamental rights has established that "principles require that something must be realized to the greatest extent possible, bearing in mind the legal and real possibilities" (52 p.20). Thus, principles are considered *prima facie* obligations, and not definitive mandates as in the case of rules. Alexy posits that "principles lack resolution within their content with respect to opposing principles and real possibilities" (12 p.99). That is to say, he understands principles as optimization mandates. Hence, in the event of a conflict between a "part" of a particular right with other fundamental rights, the solution is provided by weighing the magnitude of the principles in question (g).

> A collision between two principles is resolved by establishing a conditional relation of precedence between the principles taking into account the circumstances. The circumstances under which one principle takes precedence over another constitute the establishment of a conditional relation of precedence. Under other circumstances, the issue of precedence can be resolved inversely. (12 p.92) (italics in original) [Own translation]

This implies that a principle may be disregarded when it enters into conflict with a more significant principle because:

> ...as opposed to the minimum core, the periphery [the realm in which the right to health acts as a principle] may be restricted, according to the needs derived from other rights, benefits or interests that are acknowledged in the Constitution or that are relevant to social life. (17 p.411) [Own translation]

However, some important clarifications regarding the proposed model must be mentioned.

How is the core content established when the right to health is considered a rule?

Although an exhaustive casuistic analysis of these issues is beyond the scope of this article, an attempt will be made to provide some guidelines to contribute to the construction of a more comprehensive model of the right to health both as a rule and as a principle. Accordingly, it has been stated that "setting adequate parameters or indicators [...] can contribute to the task of determining when economic, social and cultural rights have been violated" (54). Therefore, some basic guidelines will be set forth below in order to establish the core content of the right to health. In this sense, Victor Abramovich and Cristian Courtis state that:

> ...even without regulation, some criteria must be followed to determine the scope of these rights. Thus, the concept of minimum core or core content – developed both in scholarship and jurisprudence – provides a good starting point for doing so [...] This means that when the other branches of government fail to define the core content of social rights, the courts can rule on this neglect based on these – or some other – criteria. (55 p.31) [Own translation]

Therefore, the minimum core is defined as follows:

1. *All medical treatments and/or drugs necessary to ensure human life*. That is, all treatments and/or drugs that must be given when a human life is at stake (44 p.1-34). In this regard, as the Committee on Economic, Social and Cultural Rights stated, "General Comment No. 3 [...] confirms that States parties have a core obligation to ensure, at the very least [...] essential

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primary health care" (56). This, in turn, implies providing access to basic foodstuffs and potable water, supplying necessary drugs (for example, to people suffering from cancer), setting up healthcare centers adequate in terms of structure and accessibility, etc.

2. *Medical treatment related to individuals requiring special protections*. As per Article 75, Section 23 of the Argentine National Constitution as well as the doctrine created by the Constitutional Court of Colombia (57), all cases related to the health of children (h), women (regarding sexual and reproductive health), the elderly, people with disabilities, patients with terminal conditions (for example, some HIV patients) (i), and indigenous peoples fall under this category. Thus, the protection of the health and well-being of these individuals is within the scope of the minimum core that the State must comply with.
3. *All cases deemed by the legislature to be cases of mandatory compliance*. In Argentina, the minimum core that the national healthcare system must comply with is set in the Compulsory Medical Plan (CMP) [*Programa Médico Obligatorio*] (j). In this respect, Alexy points out that "fundamental rights [...] can only be restricted through, or on the basis of, constitutional laws. Thus, restrictions of fundamental rights are always either constitutional laws or laws of lower hierarchy which allow for the enactment of constitutional laws" (12 p.277). As a result, legislators – or in some cases the courts – have the authority to set the content of fundamental rights.
4. *All circumstances in which the repetition of rules occurs as a result of a weighing process*. In this regard, the rule-oriented weighing model proposed by Clérico (15) is worth mentioning, given that rules permit the universalization of the results of a given weighing process. Furthermore, subsequent collisions of principles may not need to be submitted to the weighing process, provided that the case in question can be subsumed under a prior rule produced by a weighing process. Under such circumstances no weighing is carried out in practice (15). In this sense, it is important to discuss the concept of a network of rules resulting from weighing processes, in conjunction with the principle of progressive realization already mentioned. Rules resulting from weighing processes play an essential role in determining the minimum core of social rights, since by virtue of the principle of non-regression, once the scope of a right has been asserted it cannot be turned back. It should be noted that this "superior" recognition may be either general (for example, when a certain treatment is acknowledged by the legislature) or individual (when this is done, for example, through a court decision). The fact that repeated court decisions grant access to a given treatment after applying a weighing process demonstrates that the society considers and demands that said treatment should be included as part of the minimum core. Conversely, after a number of similar court decisions, the legislature or the executive may guarantee the treatment of all cases by way of a law or an executive order, respectively. Recent cases include the incorporation of gastric bypass surgery into the CMP (Law 26,396 of 2008) and assisted reproductive treatments in the context of the Province of Buenos Aires (Provincial Law 14,208 of 2011). Hence, in accordance with the repetition of judicial decisions, when dealing with cases in which an individual's health is at stake, all subsectors of the healthcare system must acknowledge that right. Therefore, consistent with rules resulting from weighing processes, if a new case of similar tenor is presented, the individual should not be forced to file a claim in court to guarantee the protection of that right (that is, a judge should consider the right to treatment by applying the principle of proportionality). Rather, the healthcare provider is expected to go beyond the wording of the law (in this case, the CMP) and provide an adequate solution to the patient. For instance, if an employer-based insurance provider has repeatedly been ordered to cover the costs of gastric bypass treatment for patients with morbid obesity and a new request for treatment is presented by a morbidly obese patient (in accordance with the diagnosis of the attending physician), it is inconsistent with the law that this patient should be forced to file a similar claim. Thus, rules that have taken shape through jurisprudence become a part of the minimum core.
5. *The opinion of specialists*. The judgment of specialists plays an important role due to its

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crucial impact when prescribing treatment that is medically necessary for the patient and not purely for aesthetic reasons (for example, in the case of a gastric bypass). Consequently, Alegre posits that "any omission on the part of healthcare professionals is morally tantamount to an action – in this case, an obstruction of the realization of the right to health" (59). In such instances, the healthcare provider (that is, the hospital director, insurance company, etc.) must consider and act in accordance with the specialist's indications. Other specialists' opinions may be requested, where relevant, in order to assess whether the treatment is necessary or not. Following these criteria, in the event that a patient needs urgent medical attention, services or treatments not included in the CMP must be provided, and after the fact health insurance institutions may take legal action against the State, as the ultimate guarantor of the right to health. When dealing with situations related to the right to health, financial considerations (profits) should not prevail over this right or the life of the person. The level of urgency may be assessed by a healthcare team working independently from the patient's healthcare provider. The State will establish in each case whether the costs are to be reimbursed or not, taking into account that neither private health insurance companies nor the institutions of the social security sector should operate solely from a business logic (by evaluating all revenues garnered by the healthcare provider during the time that the beneficiary – client – has been paying for their services). Under no circumstances can the costs be passed on to the patient when what has been previously identified as the minimum core is at stake.

In light of these considerations, and taking into account the principle of progressive realization included in the realm of social rights, the objection that the minimum core would become solidified cannot be raised (15). This minimum core merely establishes a baseline, given that States are required to make progress toward fuller acknowledgment of social rights. Similarly, the core content should not be taken as a fixed and unmovable object, but rather as a flexible one open to the inclusion of other contents into the minimum core (by widening the spectrum of the right to health taken as a rule).

Finally, in the event that the minimum core is not satisfied, penalties to healthcare agents (insurance providers, hospital directors, health ministers, etc.) should be established that would compel them to provide the required services (15). Such penalties could include fiscal or tax-related measures, removal from office, or any other action that may make the access to the right to health effective and available to citizens.

How is the weighing process put into practice?

In a previous paper I analyzed at length the implementation of a proportionality test applied to a specific instance of the right to health (access to assisted reproductive treatments) (50). Therefore, it is worth mentioning that when a proportionality analysis leads to the conclusion that this treatment is appropriate and relevant, a "proportionality test strictly speaking" should be applied. To do so, the abstract and specific weight of every competing principle must be taken into account. A wide variety of arguments may be put forth in order to determine the weight of these principles. However, it is important to take into account the significance of the right to health given its close relationship with other rights (integrity, dignity). In cases where the right to health as a principle is compromised, its weight will be significant and strong arguments against it must be provided. In turn, the greater relative importance attributed to the right to health is a consequence of the obligation that States have to act progressively in its realization.

It should be noted that utilitarian arguments cannot form the basis of rulings. Therefore, questions pertaining to the number of people that will benefit from or be affected by a given measure, or to the number of people that could potentially be helped if this treatment were not afforded by the State should not be posed. Nevertheless, a cost-benefit analysis is often implicit in the reasoning behind rulings. A utilitarian approach violates the rights of groups since it ignores or minimizes the particular characteristics of minority groups in the

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name of general welfare (60). In this respect, it has been argued that:

> ...utilitarian criteria violate persons' rights. Not only is the access to certain treatments which are strictly necessary from the medical point of view denied, but also [...] the right to equal opportunities is disregarded: people suffer from discrimination due to circumstances beyond their control. (61) [Own translation]

As a result, utilitarian criteria must not be employed in cases involving the minimum core of the right to health (k). Although these criteria may be included among the arguments put forth in any particular case, their weight is not significant or decisive (62).

Thus, the right to health is composed of a minimum irrevocable core and a "peripheral" content. Although it may be weighed against other rights, the arguments invoked to justify the exclusion or failure to develop the content of the right to health must be sufficiently well-founded.

Resources: implications of considering the right to health both as a rule and as a principle

As has been argued above, the right to health has a certain minimum content that the State must comply with and a peripheral content that is subject to a weighing process. However, the argument most frequently cited to justify the non-fulfillment of social rights is the lack of resources (with reference to both the core and peripheral contents) (l). It has been observed that the State cannot meet all demands, and thus some rights will not be fully realized (63 p.105). This line of argument is evident in the ruling of the South African Constitutional Court in the case of Soobramoney vs. Minister of Health (Kwazulu-Natal) (64). The appellant, a 41-year-old unemployed man, suffered from diabetes, ischemic heart disease, and cerebrovascular disease that caused him to have a stroke. Unfortunately, his condition was irreversible and by the time he brought his case to court he was in the final stages of chronic renal failure. His life could have been prolonged by means of standard renal dialysis, treatment that he sought from the Renal Unit of Addington Hospital located in Durban. However, the hospital could only provide dialysis treatment to a limited number of patients (the renal unit had 20 dialysis machines available). Thus, only patients eligible for kidney transplants gained admission to the dialysis program. The appellant was not eligible and, therefore, he did not meet this requirement. The Court found that a decision could not be reached regarding the acceptability of these criteria, but concluded that if all people in South Africa who suffered from chronic renal failure were to be provided with dialysis treatment – many of them require it three times a week, as would have been the case of the appellant – the cost of providing treatment would produce substantial increases in the health spending. Additionally, if this principle were to be applied to all patients claiming access to costly medical treatments or drugs, the health budget would have to be dramatically augmented at the expense of other areas to which the State must attend. Therefore, it should be noted that the availability of resources creates serious difficulties for the exercise of Economic, Social and Cultural Rights (ESCR).

In this manner, the scarcity of resources can be a pernicious argument used to justify a wide range of situations. It is generally agreed that the resources the State has to ensure the fulfillment of social rights are limited but not scarce, at least when it comes to the minimum core that the State is obligated to guarantee. Regarding the distinction between a limitation and a scarcity of resources, the former term is preferred since it makes reference to the fact that these resources are finite – they have a limit, an end point. Scarcity, however, seems to imply that there are less resources than necessary. Similarly, it could be argued that a scarcity of resources would also affect civil rights, since the protection of private property, freedom of speech, etc., require resources – as is the case for social rights. It is clear, then, that the concept of scarcity actually refers to the lack of public policies that prioritize social issues.

While my intention is not to open a debate on how the State should invest limited resources, it is important to note that this argument has frequently been used to circumvent compliance with what has been established as the minimum core of given

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right. Paragraph 9 of the Maastricht Guidelines on Violations of Economic, Social and Cultural Rights establishes that minimum core obligations "apply irrespective of the availability of resources" (65). Although the availability of resources is limited, this does not justify non-compliance on the part of the State, or more specifically a lack of structured planning intended to take on the problems implicit in ESCR. That being said, "it is important to distinguish inability from unwillingness of a State to comply with its obligations" (65).

It is possible to identify an example that emerges from customary practice in this field. A 2009 report by the Civil Association for Equality and Justice [*Asociación Civil por la Igualdad y la Justicia*] (66) detailed the poor conditions of the education system in the southern area of the City of Buenos Aires (an area mainly inhabited by low-income people), in comparison with the superior conditions present in the northern area of the city. Thus, this raises the question: if resources are limited, why do so many differences exist among schools within the same city? Shouldn't schools from these two areas show similar conditions? Therefore, it is clear that the argument of a shortage of resources is unsatisfactory. Often, rather than a limitation of resources, governments lack a systematic approach to the allocation of these limited resources (67), with this omission disproportionately affecting those suffering from structural inequalities and who, as previously mentioned, effectively lack access to the justice system in order to ensure their rights are protected.

Although it is widely accepted that resources should be utilized rationally, the core content of rights must be preserved. In this sense, a systematic approach is necessary in order to effectively address problems related to the *right to receive health services under structural equality of opportunities*.

The significance of the proposed model

The significance of this proposal which distinguishes between rules and principles pertains mainly to the situation of rights-bearing individuals, especially individuals or groups that lack access to the justice system. This lack of access results in institutionalized discriminatory practices (68, 69), since higher income sectors are better equipped to access the justice system, file claims in court, and have their rights acknowledged. However, this is not the case for poor and marginalized sectors, since in most cases they do not even have access to the above-mentioned minimum core. This suggests that the distinction made between the right to health considered as a rule and as a principle would not be as relevant if it were not for the fact that, in practice, the right to health is systematically denied to disadvantaged groups.

Thus, if the right to health is taken as a principle, and a person must petition the executive or the justice system in order assess the scope of their rights, this should not be necessary with regards to the minimum core since the person's life would be at stake. The proposal outlined here is that the minimum core must be respected at the administrative level (by healthcare providers) without the need for a court decision in order to guarantee this right. It is important to emphasize that although a large number of variables (political, economic, scientific, etc.) influence the health sector, healthcare providers must act in compliance with the right to health and "secondary" factors should not be considered as relevant as rights. So, when a claim to access a certain treatment is presented, common practice among healthcare providers should not be the denial of treatment but rather the compliance with that right and, at most, the discussion of the best way to facilitate access to the treatment in question. Certainly, the definition of the core content of the right is a step in the right direction since healthcare providers would have prior awareness of what is expected in this sense.

In this respect, once a physician or an administrative authority has evaluated a situation included as part of the minimum core, the State has the obligation to act urgently without requiring any further assessment of the circumstances. To illustrate this point, for example, in the case of a group of malnourished children in the province of Chaco (m), once the situation has been confirmed the State (provincial, national, or both) must act regardless of which one of them must fulfill that obligation (a question of jurisdiction). Similarly, in the event that a certain medical condition has already been demonstrated, health insurance providers (both in the social security and private subsectors),

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must act accordingly and cannot argue that the treatment is not included in the Compulsory Medical Plan or claim other administrative issues. All secondary factors related to the right to health and the right to life may be further discussed after the provision of treatment.

The distinction between the right to health as a rule and as a principle exists because imminent risk to a patient's life (existence) differs from a situation that may broadly affect the right to health. This argument is contrary to the position held by numerous scholars that consider it possible to limit social rights, despite only allowing restrictions that have passed the strict scrutiny of reasoning (70 p.124). The Inter-American Court of Human Rights stated that:

> The right to life is a fundamental human right, and the exercise of this right is essential for the exercise of all other human rights. If it is not respected, all rights lack meaning. Owing to the fundamental nature of the right to life, restrictive approaches to it are inadmissible. In essence, the fundamental right to life includes not only the right of every human being not to be deprived of his life arbitrarily, but also the right that he will not be prevented from having access to the conditions that guarantee a dignified existence. States have the obligation to guarantee the creation of the conditions required so that the violations of this basic right do not occur and, in particular, the duty to prevent the agents from violating it. (71 p.40)

Therefore, in the cases falling under the scope of the first model (rule), the healthcare provider or legislator cannot carry out a weighing process, but rather has the obligation to act urgently in order to effectively ensure access to the claimed right. Nonetheless, in cases related to the second model (principles), which are equally important and distressing from the patient's perspective, the weighing of principles is required.

Similarly, the determination of the core content is useful in the definition of indicators of progressive realization (49 p.55). Under Article 19 of the Protocol of San Salvador, the States parties must submit periodic reports on the progressive measures they have taken to ensure due respect for the rights set forth in the Protocol. In this respect, it is essential to have a minimum core in order to measure a country's improvements and setbacks in terms of social rights, particularly the right to health. Without this minimum core, it is not possible to evaluate the implementation of progressive measures taken to guarantee the right to health.

CONCLUSIONS

Although progress must still be made in the acknowledgement of social rights, specifically the right to health, it is necessary to bear in mind that the current system is insufficient given that some groups lack access to justice. Thus, the State, as guarantor of last resort of the right to health, must adopt effective and consistent measures that take into account power asymmetries within society to ensure the effective exercise of the right to health. Accordingly, a socially mindful interpretation of the principle of equality necessitates a non-neutral State, capable of recognizing social and cultural differences and of taking positive or corrective measures in order to compensate for disadvantages or imbalances experienced by certain marginalized groups or sectors of the society (as put forth in Article 75, Section 23 of the Argentine National Constitution) (34 p.268).

Along these lines, it should be pointed out that the dilemma is not whether to expand access to justice or to improve the healthcare system . An expanded access to justice is necessary to allow marginalized groups to present claims regarding their rights, but this is insufficient when the life of a person or even a group of people is at stake. Therefore, the acknowledgement of social rights solely by the justice system should not be regarded as satisfactory. Although the Judiciary can be a decisive actor in safeguarding the rights of marginalized groups, the resolution of such cases rarely has universal or structural implications, but rather these judicial decisions in general benefit the petitioner or petitioners. Moreover, the costs borne by the State must be also taken into consideration (costs that could be reduced if people were not forced to file claims for the protection of their rights). In this respect, as has been noted:

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"only through universal policies is the inalienable minimum core guaranteed, which in turn fosters further guarantees of equality and non-discrimination" (37 p. 307).

Consequently, the right to health should be regarded both as a rule and as a principle. Although this model is open for debate, particularly regarding the core content of the right, this proposal is generally preferred to the idea which suggests that all rights and contents can be weighed, given that this can exacerbate the inequalities described above. It has become evident that the core content is difficult to establish with clarity and legal vigor (taking into account, for example, that the right to health is in constant tension with technological development and the healthcare industry). Therefore, although this model may not completely eliminate the practical difficulties related to healthcare, it constitutes an effective tool that can help healthcare providers act in the interest of constructing a more egalitarian access to the right to health.

In this respect, the concept of the right to health as a rule and as a principle must not only be applied in courts, but perhaps more importantly by legislators and healthcare providers. In conclusion, following Dworkin (73): *if rights are to be taken seriously,* it must be asserted that social rights have an inviolable core that should be respected by both governmental bodies (the legislature, the judiciary and the executive) and by individuals. This means that the minimum core should not be disregarded, and more importantly that it must be developed under conditions of structural equality.

ACKNOWLEDGEMENTS

This paper was written as part of a research fellowship on the right to health financed by a grant from the ALEARG (DAAD/ME) Program, sponsored by Deutscher Akademischer Austausch Dienst and the Argentine Ministry of Education and developed at the Max Planck Institute of Foreign and International Criminal Law in Heidelberg, Germany. I would like to thank Leticia Vita for her invaluable inputs for this paper.

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ENDNOTES

a. In Argentina, works can be consulted from the Civil Rights Association [*Asociación de Derechos Civiles*] (28), The Center for Legal and Social Studies [*Centro de Estudios Legales y Sociales*], and at the Economic, Social and Cultural Rights Case Law Database (ESCR-Net).

b. In this sense, the pioneering judicial decisions made by the Argentine Supreme Court are: "Campodónico de Beviascque, Ana Carina c/ Ministerio de Salud y Acción Social – Secretaría de Programas de Salud y Banco de Drogas Neoplásticas" dated October 24, 2000; "Monteserín, Marcelino O. c/ Estado Nacional" dated October 16, 2001; "Etcheverry, Roberto E. c/ Omint Sociedad Anónima de Servicios" dated March 3, 2001; "Hospital Británico de Buenos Aires c /Estado Nacional (Ministerio de Salud y Acción Social)" dated March 31, 2001. Precedents set by these judicial decisions have been quoted in several occasions by both the Supreme Court and lower courts, which in turn have broadened the scope of protection. Regarding jurisprudence in this field, refer to Clérico (31), Clérico y Scioscioli (32), and others.

c. For information on the distribution of obligations among the national and provincial governments relative to the right to health as well as the Argentine Constitutional Reform of 1994, see Clérico (33).

d. According to the classification of Herbert Lionel Adolphus Hart, these can be considered as "easy cases" since, at first glance, it can be assessed whether it falls within the scope of the regulation intended to be applied (17 p.140). The following authors explicitly apply the concept of easy cases: Clérico (39 p.30), Clérico and Scioscioli (45)

e. In this regard, Article 19 Subsection 2 of German Federal Law establishes that under no circumstances can a fundamental right be affected in its core content (19.2 *In keinem Falle darf ein Grundrecht in seinem Wesensgehalt angetastet werden*). In Argentina, the concept of core content of rights is provided in Articles 14, 28 and 99 (Section 2) of the Argentine National Constitution, related to the rules and regulations of rights and the spirit of the laws. A right is altered or modified when its core is compromised. It should be noted that the term "core content" is preferred to "minimum core," since at first sight the latter suggests something small whereas the former indicates something more important (substantial) that may not be minimum.

f. Rodolfo Arango, referencing the social rights in general and quoting the jurisprudence of the German Constitutional Court, refers to vital minimum rights. He states that these "ensure the satisfaction of basic needs of all human beings..." (45 p.212). Similarly, it has been pointed out that "this minimum core might not be easy to define, but includes at least the minimum decencies of life consistent with human dignity. No one should be condemned to a life below the basic level of dignified human existence. The very notion of individual rights presupposes that anyone in that position should be able to obtain relief from a court" (48 p.22-23).

g. "The principle of proportionality is applied when a regulation supporting a fundamental right shall be fulfilled and validated" (12). Other additional references are Clérico (15) and Bernal Pulido (17 p. 138). Cases of omission or inadequate action are called prohibition of insufficient protection (*Untermassverbot*). Regarding the prohibition of insufficiency in the field of health, see Clérico's application and development of this concept (38,53).

h. These were the criteria of the Argentine Supreme Court in the cases of Lifschitz (June 15, 2004) and Maldonado (November 23, 2004), among others.

i. These were the criteria adopted by the Argentine Supreme Court in the cases of Hospital Británico and Asociación Benghalensis.

j. The Compulsory Medical Plan (CMP) consists of "a set of mandatory and basic health services which under no circumstances should people be deprived of" (as set forth by National Ministry of Health Resolution 939/2000 and Resolution 201/02, related to the extension of the Emergency Compulsory Medical Plan (ECMP) [*Plan Médico Obligatorio de Emergencia*] resulting from the National Declaration of Health Emergency (Federal Executive Order 486/2002) and its modifications by the National Ministry of Health and Environment (Resolution 1991/2005), among others. The CMP has been constantly updated either by means of the enactment of laws, passing of resolutions or judicial decisions (58). It is worth mentioning that, although the CMP unified the healthcare services that providers should comply with, its implementation brought about several problems that were taken to court; for example, regarding the disease-free period (preexisting conditions) set by health insurance companies both in the social security and private subsectors (for instance, as set forth in the case of "Unión de Usuarios y Consumidores c/ Compañía Euromédica de Salud S.A.," by the Argentine Supreme Court decision dated April 8, 2008); also, regarding ceilings on healthcare services not affected by subsequent modifications (for instance, as provided in the case of "Cambiaso Péres de Nealón Celia M. A. y otros c/ Centro de

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Educación Médica e Investigaciones Médicas," by the Argentine Supreme Court decision dated October 28, 2007), etc.

k. This is the case with the precautionary measure issued by Civil and Commercial Court No. 2 dated October 2, 2010 by which the Ministry of Health was ordered to bear all costs of Aquiles Víctor Hugo Misiti's cancer treatment since he did not have health insurance and whose treatment was worth ARS 45,000 per session. The patient was given conventional chemotherapy treatment with no positive results. The patient was then advised to be treated with "hepatic arterial chemoembolization using drug-eluting beads." The court stated that "due to the plaintiff's condition treatment must be administered without delay" (Statement of reasons reference IV). Thus, the court ordered to "administer immediately, fully and continuously the treatment and medication prescribed by the physician." Therefore, the court set aside utilitarian considerations and rejected arguments related to the shortage of resources (although the costs of the treatment were high). Faced with the possibility of affecting what we have described as the minimum core, the court ruled in favor of the plaintiff.

l. The National Supreme Court concluded that an eventual financial deficit does not constitute sufficient grounds for not fulfilling a core obligation. See the cases of "Hospital Británico de Buenos Aires c/ Estado Nacional" dated March 31, 2001 and "Unión de Usuarios y Consumidores c/ Compañía Euromédica de Salud S.A." dated April 8,2008.

m. Legal proceedings were brought against the Argentine province of Chaco and the Federal Government by the Ombudsman before the National Supreme Court due to the severe malnutrition, lack of access to drinking water and insufficient access to healthcare services suffered by the indigenous Toba community. Refer to the Argentine National Supreme Court of Justice case "Defensor del Pueblo de la Nación c/ Estado Nacional y otra (Provincia del Chaco) s/ Proceso de Conocimiento," decision dated September 18, 2007.

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CITATION
Ronconi LM. The right to health: a model for determining the contents of the minimum core and the periphery. Salud Colectiva. 2012;8(2):131-149.

Received:13 December 2011 | Revised: 19 April 2012 | Accepted: 25 April 2012

The translation of this article is part of an interdepartmental collaboration between the Undergraduate Program in Sworn Translation Studies (English < > Spanish) and the Institute of Collective Health at the Universidad Nacional de Lanús. This article was translated by Romina Lago and Mónica Valenciano, reviewed by Mariela Santoro and modified for publication by Joseph Palumbo.