Health Justice & Rights

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Abstract: Health is a universal need and good that deserves protection, but there is no agreement about its concept and meaning, nor about the nature and scope of its protection. The aim of this paper is to justify why the protection of health should be considered a public duty of justice and to make a case for a rights-based theory of health care. In order to fulfil that aim the paper answers five questions: 1) what is to be protected, providing a concept of health; 2) who is benefit by this protection, that is, human being, person; 3) where is health protection to be applied, i.e., our political and legal context; 4) why this proposal, by means of a fourfold philosophical foundation; and 5) how is to be implemented health justice through rights.

Keywords: Capabilities, Recognition, Right to health, Secure health capability, Secure functioning.

Not every social or health inequality is unfair. It is not fair or unfair *per se* that *A* is a healthy person and *B* is not; but it is indeed fair or unfair the way a society deals with that situation. This means, firstly, that the rationale for caring health cannot be mercy, solidarity or fraternity but justice; and secondly, that even accepting the compatibility between ontological equality and existential differences, any theory of justice should address the issue of which existential differences are unfair.

The aim of this paper is to justify why the protection of health should be considered a public duty of justice, to explain the relation between justice and rights in the health field, and to make a case for a rights-based theory for health care.

In order to fulfil that aim the paper answers five questions: 1) what is to be protected, providing a concept of health; 2) who is benefit by this protection, that is, human being, person; 3) where is health protection to be applied, i.e., our social and political context; 4) why this proposal, by means of a fourfold philosophical foundation; and 5) how is to be implemented health justice and care through rights.

1. What about? Health

Health is a universal human need; furthermore, it is one of the two basic universal needs, along with autonomy[1]. Although its meaning is disputable and socially relative,

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health constitutes a vital condition for a satisfactory human life and a universal good highly appreciated by individuals and their communities.

Health has a cultural meaning that has changed throughout history. Traditionally, it has been dialectically characterized by its opposed concept, i.e. disease. In the primitive culture, exemplified by the narrative of the great Mediterranean religions, the notion of health was understood as 'grace', while disease was grasped as 'disgrace'. In the Ancient culture, when reality was interpreted in terms of nature, health was conceived as 'order' (gr. κόσμος) and disease as 'disorder' (gr. χάος). In the Modern era, especially since the Eighteenth Century, health ceased to be primarily a matter of fact and became an axiological issue; therefore, health meant 'happiness' or 'fortune', whilst disease denoted 'unhappiness' or 'misfortune'[2]. Amid the Twentieth Century, it stands out the Utopian notion of health endorsed by the World Health Organization (WHO) as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"[3]. Nowadays, more balanced and feasible conceptions move forward. This is the case of the WHO's new biopsychosocial definition of health in terms of functioning and capabilities, and as a result of the interaction of the individual with his or her environment[4]. Currently, health is valuable insofar as it enables us to pursue our vital goals and to interact in society. It means an opportunity, a possibility of life[5] or, even better, a human basic capability[6].

Since health is necessary and valuable for individuals and communities, it is reasonable to conclude that its protection constitutes a matter of justice. This means its enforceability in the traditional sense of perfect duties, and its recognition and protection as a right, specifically as a basic right, essential to the enjoyment of all other rights[7].

As long as health is a consequence of the conditions in which a person lives, health injustice, i.e. unfair and avoidable differences regarding personal state of health, had been explained from the social determinants of health, that is, the conditions in which persons are born, grow up, live, work, and get old, as well as all those systems that shape their daily life, among them economic policies and systems, development agendas, social norms and policies, and political systems[8].

If those determinants are the cause of the causes, i.e. the social, economic and political factors which are in the genesis of health inequality, health justice is neither attainable by itself nor fundamentally through the universal access to high-quality health care services, but mainly through a fair redistribution of the social determinants of health.

Therefore, protecting health becomes a public duty, and not only an individual one, related to the right to health care and other rights. Along with the social dimension of health care, it is also crucial to consider some individual and collective elements other than the social determinants that have influence on people's health. Hence, it seems possible to conclude that personal health is the result of the interaction of four aspects: resources and biological needs, individual behaviour, physical environment, and social conditions[9].

2. Whose health, whose justice? Human beings

Every theory of health justice must acknowledge that human beings get sick, suffer and die; that we are biological frail and finite, but also end-oriented beings, since every

individual tries to overcome his or her vulnerability and limitations transforming his or her needs in opportunities for life.

Human condition combines two features. On the one hand, autonomy, or the free exercise of our capacities in order to become the authors of our lives through our own decisions and actions, to be accountable of them and to deserve moral appreciation. On the other, vulnerability and dependence, which require care and support to deal with such situation. If autonomy expresses the individual character of our decisions and actions, dependence exemplifies how our answers cannot be merely individual since they are based on significant memberships and bonds that define us. Our personality and our identity are partially shaped by our relations in a context of recognition, community and dialogue.

This personal development needs individual capabilities, external conditions and significant memberships. Human action is not independent of the context neither of our bonds, because they determine our opportunities of choice and functioning and define our biography. Achieving a mature and autonomous condition means to become an "independent practical reasoner"[10], defining independence not as autarchy but taking into account our vulnerability, frailty and dependence: a reflective interdependence, that leads to think of autonomy as a relational, contingent and gradual notion.

3. Where? Political and legal context

In order to be fair, any decision on allocating goods and burdens has to consider the context where is implemented. Therefore, a normative theory of justice for health care has to take account of two main transformation processes of our contemporary political systems: constitutionalisation and the overrunning of the State boundaries, mainly as globalisation. In both processes human and fundamental rights play a significant role, as a core element in the Constitutional Rule of Law and international justice.

The first factor is constitutionalisation. After the Second World War, a new ethical, political and legal shaping of our societies arises in Europe: Constitutions appears as an axiological order which imbibes every sphere of social life[11]. The legal–political model in the last centuries, the Legislative Rule of Law, is exhausted and replaced by the Constitutional Rule of Law, which demands another theoretical answer[12].

Constitution is considered a legal, valid and enforceable norm that holds legal supremacy within legal system, and constitutional norms are value-laden norms that often appear as principles demanding thus a practical legal reasoning and balancing. Besides to establish the limits of power, Constitution guarantees its core values through all-pervading basic rights, which have a double dimension: individual or subjective, as individual liberties, and objective or institutional, as architectural elements of legal order, foundations of the political community, and guiding criteria to achieve constitutional goals.

The second factor is the tendency to supersede the boundaries of the State, mainly the globalisation of Law[13]. In the classical model, legal features depend on political

ones and Rule of Law is characterised by legislative norms[14]. Nevertheless, sovereignty is no longer such an absolute power and the domestic legal system is no longer the only one within its territory. An *ad extra* or supra-nationalistic trend and an *ad intra* or infra-nationalistic trend show that sovereignty and territoriality, distinctive factors of the State, are eroded and redefined.

In the end, international consensus around rights and democracy strengthens the relationship of globalisation and constitutionalisation[15], and explains the post-national multilevel constitutionalism[16].

4. Why? Philosophical foundations

A theory of health justice has to show its validity and feasibility and be based in the aforementioned concepts of health and human being. Regarding the former, a rights-based theory with a robust philosophical and political foundations can be the appropriate way for implementing it. Regarding the latter, it should be built upon a redefined concept of medical necessity understood as a social and not individual norm that helps to achieve a full, not endless, life and to avoid inequities[17]. Furthermore, the theory has to use a descriptive-normative concept of need[18], according to which to say we have health needs is not to say that we want health but that we, as end-oriented human beings, will not flourish unless we have it[19].

I show in this section the four-fold philosophical foundations and then move to the legal approach in the next section.

4.1. The theories of recognition

The rights-based approach starts with the theories of recognition[20], that fold out into two dimensions. 1) The subjective or individual recognition, which entails identification or knowledge of one's capacities and attributes, besides the recognition and acceptance by means of self-confidence, self-respect and self-esteem[21]. 2) The intersubjective recognition, that ascertains the aforementioned: being recognized by the others is necessary to complete the own identity and to recognize oneself. There are three levels of mutual recognition: love, legal recognition, and social esteem, whose denial lays out different issues of justice[22].

Healthcare justice does not address all these forms, since rights focus on mutual recognition and thus in its second way -the legal recognition. Individual recognition and the two other ways of intersubjective recognition affect the development and enforcement of legal recognition, but do not reach its level of enforceability.

Recognition based on the status, understanding recognition as a matter of social justice, stands out. Everyone should be placed in a position of fairness and equality to intervene regardless the individual assessment: conditions denying a fair social participation, despite individual acceptance, are unjust and should be ruled out[23]. This social or institutional perspective connects recognition with participatory parity, which operates as a normative criterion for assessing injustice[24].

The most relevant outcome for a theory of health justice is that recognition must be previous to allocation, and such precedence improves the justification of the distribution, since it makes possible to include everybody into the deliberation about the conditions of justice[25].

4.2. The capabilities approach

The capabilities approach[26] asserts that the purpose of any political, ethical, and legal measure on health matters is not based on the level of satisfaction or well-being, nor is defined by the available goods or resources. Moreover, it must neither give priority to functioning over capabilities: the former points out to what a person does and is, whereas the latter leads to what a person can or is able to do and be. The appropriate notion is depicted by the concept of 'capability', aimed to provide people with the necessary means to choose and act among different valuable and real options. In this sense, the capabilities approach is related with the aforementioned notion of medical necessity, but complements it with those of health capability, health functioning and health agency[27].

Capabilities are understood as combined capabilities, i.e. individual's internal capabilities and adequate external conditions, which should be constructed as opportunities that let each individual to freely ascertain his/her own idea of good in order to pursue it within a basic background of equal opportunity – or capability –, and not in one of results – or functioning –.

Central human capabilities have been framed in ten categories, which can be translated into different fundamental or human rights that define the basic social justice: 1) Life. 2) Bodily health. 3) Bodily integrity. 4) Senses, imagination, and thought. 5) Emotions. 6) Practical reason. 7) Affiliation. 8) Other species. 9) Play. 10) Control over one's environment: a) political, and b) material[28].

Health is a prominent capability and also a significant part of other capabilities that should ensure a dignified human life. In this sense, health has been defined as a person's ability to attain or exert a cluster of basic human activities, or the capability to accomplish a cluster of basic or vital capabilities or functionings[29], being the global aim of health protection to ensure the capability to have good health or 'to be healthy'[30].

4.3. The secure functionings approach

A complement of the capabilities approach comes from the secure functionings approach[31]. Since fair health protection must not be reduced to ensure a certain level of functioning at any particular time, this approach underlines the prospects for sustaining that level and guaranteeing the 'capability security'. Furthermore, it aims to prevent either the exposure to extreme risks or the sacrifice of another capability or functioning, and to provide reasonable options for choosing and acting, leading to the 'genuine opportunity for secure functioning'[32].

To have a limited number of genuine opportunities to secure functioning gives rise to social disadvantage, which can be triggered by shortcomings in the internal

resources, the external resources or the social framework. The internal resources are internal capabilities, whereas the external resources and the social framework are equivalent to the external conditions. Instead of policies oriented towards personal enhancements or resources, the intervention here points to improve people's status or social position.

Another contribution of this approach is the addition of new categories to the list of central human capabilities. 11) Doing good to others, or being able to care for others and to express gratitude. 12) Living in a law-abiding fashion, i.e. being able to live within the law; not being forced to break the law, cheat, or to deceive other people or institutions. 13) Understanding the law, its demands, legal rights, duties, powers, and opportunities, which requires an accessible legal system. Thus, the discourse of justice is complemented with the discourse of care, particularly in the 11th category, while categories 12th and 13th highlight the importance of knowledge and the respect for the normative framework of human action[33].

4.4. A political theory of care

Two major premises support the theory of care: all human beings are dependent upon others to develop their basic capabilities, and that in receiving care, individuals tacitly and logically become obliged to care for others[34].

Like health, care is neither a commodity nor a consumption good defined by market criteria and achievable only for people who can afford it. Furthermore, care should not be understood just as an attitude, a motivation, or a virtue, because this conception can reduce care as a matter of gratitude, generosity and placed it only in private or familiar realms[35]. Caring health becomes then a political responsibility that encompasses a set of public practices, even maintaining its private dimension. Since health is a universal need philosophically translated into a capability, care becomes a basic duty of justice, enforceable and deserved by everyone[36].

This political conception means that health care should be understood as an entitlement, enabling us to talk about care rights, namely 1) a right to receive care (everyone is entitled to receive adequate care); 2) a right to care (everyone is entitled to participate in relationships of care that give meaning to their lives; and 3) a right to decide how to care and be cared (everyone is entitled to participate in the public process about how society should ensure the first two premises)[37].

5. How is it implemented? A rights-based theory of health justice

The value of health and its depiction as a duty justifies being acknowledged and protected as a right. Rights ascertain the worth of health and give good arguments for achieving health justice. From a descriptive standpoint, they are a core feature in the Constitutional Rule of Law and express justified claims concerning justice in national and international level. From a prescriptive standpoint, rights' features turn them into the most convincing normative proposal for the protection of health.

Although 'rights' refers mainly to fundamental rights, I also address some matters related to human rights, belonging both to a broader legal category, i.e. subjective rights, understood as legal positions and relations that guarantee individuals some legal goods issued in legal norms[38]. Both categories can be analytically differentiated regarding the normative source of recognition and the right-holder scope[39]. Human rights are subjective rights recognized by international legal instruments to every person whilst fundamental rights are recognized in domestic – or regional, as in Europe – legal systems by Constitutions requiring in some cases to possess some conditions – e.g. citizenship.

5.1. Rights

The first feature of rights is universality. Human rights are bestowed by virtue of being a person, without further requirement, and they universally reflect and ensure values. As they are *universalia iuris materialis*, rights have to be present at any time and in any place for addressing health issues. In addition to the objective universality, i.e. universality of content, rights are also universal from a subjective perspective, both in relation to their holders (every person) and their addressees (*erga omnes* effectiveness, i.e. individuals, groups, and governments)[40].

Further features confirm the suitability of rights: their moral validity, their fundamental character, their enforceability, and their priority. Human and fundamental rights identify, assert, and ensure the basic conditions for a decent life through justified and enforceable claims. From a normative point of view rights express a threefold dimension. 1) A moral category, which expresses the most valuable goods and capabilities in society. 2) A legal category, included in the highest domestic and international legal norms, Constitutions or Covenants, as applicable and binding legal norms to public powers and citizens. 3) A political category, regarding their condition as objective or institutional norms: they conflate the legal order and the political community structure, guide the intervention of public powers and represent the main criteria of legitimacy for power. Therefore, they are not just moral expectations but have a legal and enforceable character.

Another two features are conclusive for health justice. Rights provide social benefits: it is no possible to enjoy them if they are just bestowed; they need positive and active interventions for being granted. Furthermore, they have a twofold dimension, already mentioned. Rights are subjective or individual powers, which ensure the exercise of our freedom, and have an objective or institutional dimension without which the subjective dimension would decline. Fundamental rights are a core element of Rule of Law that settles the foundations of the political community: in a negative sense, rights limit political powers, which must neither infringe theme nor discourage their exercise; and in a positive sense, rights guide policies and political actions.

5.2. A right to health care

In the international field the acknowledgement of health as a right can be already found in the preamble of the WHO's constitution (1946), being confirmed two years later

(1948) in the Universal Declaration of Human Rights (article 25.1). A more accurate legal status for the right to health in international human rights law has been stated by the International Covenant on Economic, Social and Cultural Rights of 1966 (article 12) and confirmed, among others, by the International Convention on the Elimination of All Forms of Racial Discrimination of 1965 (article 5); the Convention on the Elimination of all Forms of Discrimination Against Women of 1979 (articles 12 and 14); the Convention on the Rights of the Child of 1989 (article 24); or the Convention on the Rights of Persons with Disabilities of 2006 (article 25). References to the right to protection of health can also be found in regional human rights, as in the European Social Charter of 1961 (revised in 1996: article 11), as well in recent soft law rules as the UNESCO's Universal Declaration on Bioethics and Human Rights of 2005 (especially article 10 in relation to articles 3, 11, and 14). Furthermore, the right to health care is included in the Charter of Fundamental Rights of the European Union of 2001 (article 35).

In the national field the right to health care is included in Constitutions and domestic legislative norms and case-law tied to human dignity and other fundamental rights. This is the case of Italian Constitution (1947), acknowledging health care as a fundamental right of the individual and a collective interest (article 32, related to articles 2 and 3), or Spanish Constitution (1978), including a right to health protection (article 43.1. related to article 10.1 and 15)[41].

In the light of the aforementioned some conclusions are drawn. Although the expression "right to health" is commonly used both in legal and ordinary language, the legally accurate and correct expression is "right to health care", since this right is not to be understood a right to be healthy but to enjoy some freedoms and entitlements that enable people to be healthy and flourish[42]. In addition, the right to health care has to be considered a fundamental right, connected with other rights and freedoms that shape it[43] and support the constitutional democracy[44]; it is justiciable and enforceable and, despite the social and economic hindrances, cannot be underestimated and unprotected[45]. All human rights are universal, indivisible, and interdependent and interrelated[46], and every right, either liberty or social or political, implies costs and requires provisions[47] in order to be guaranteed.

5.3. Two levels of health justice and rights

Health justice is translated into the language of rights as a *secure health capability*, i.e. what each human being deserves throughout the sustained exercise of his/her basic capabilities[48]. The relational character of rights connects the right to health care with other rights in order to ensure the secure health capability[49].

The rights-based proposal for health justice is supported by a sufficientarian approach, since the goal is not avoiding inequality nor that everyone has the same, but that each should have enough[50]. Health is understood as a non-positional capability[51] that requires a minimum threshold of capabilities and rights for everyone but also admits different or unequal level above this critical threshold.

Therefore, two levels of health justice and rights are to be distinguished[52]:

1. The *core obligations*, which refer to justice as recognition and broaden the scope of health care granting right's subjective universality. Regarding the content, this basic level is even broader than the right to health care. The lack of health does not only harm physical integrity but also entails situations of humiliation and exploitation that erode dignity itself, which is the foundation of rights[53]. In short, it protects basic categorical values and constitutional rights that are morally claimable and legally enforceable, establishing a threshold below which dignity and rights are infringed. In this level the right to health care imposes three types of obligations on the States: to respect, to protect, and to fulfil, ensuring the availability, accessibility, acceptability, and quality of the essential elements of health[54]. A prominent domestic legal example of these core obligations is the fundamental right to the guarantee of a subsistence minimum (*Existenzminimum*), recognized in 2010 by the German Federal Constitutional Court[55], derived from human dignity (article 1(1) of the German Basic Law) in combination with the principle of the social welfare state (article 20(1) of the German Basic Law).
2. A *progressively realized set of goals*, referred to distributive justice and implemented through legally developed rights that are dependent on the socioeconomic background and the distributive choices in political and social deliberation[56]. To attain the highest possible level of health through a fair distribution of health capabilities, as a second step after recognition, requires the inclusion and participation of everybody in deliberation. A rights-based approach should be aware of some issues to guarantee a fair allocation in this level. First, that mere equality of opportunity means that in conditions of scarcity not all rights can be satisfied simultaneously. If one eschews a strictly egalitarian principle whereby all rights are left equally unsatisfied, balancing will be necessary in order to determine which rights are respected in practice; the ranking of rights and the criteria for their satisfaction must be decided in a transparent procedure by democratically legitimized bodies. Secondly, that in a society based on the Rule of Law, rights and their corresponding obligations cannot be set off against each other on an interpersonal basis; the maximization of medical benefits at macrosocial level may infringe the rights of individuals because an inter-individual valuation of life or health could involve an ethically and legally unacceptable consideration of the individual as a fungible entity, incompatible with human dignity. Finally, that even though efficiency is a worthy goal, it can only be achieved in connection with rights and a sound conception of health. Regarding the former, majority or generalization are not enough, since universalization is required; regarding the latter, health benefits must be assessed in terms of individual capabilities and functionings[57].

6. Conclusion

To broaden the progressively realized goals (level 2) and to turn them into core obligations (level 1) reflect the evolution of a society and its legal system towards a fair

health care; and conversely, the legally unacceptable regression or reduction of rights to health illustrates the opposite process[58]. On the basis of a biopsychosocial concept of health and a relational concept of human being I have made a case for a rights-based theory for health care justice underpinned by a political conception of health care and three philosophical supports: the theories of recognition, the capabilities approach, and the secure functioning approach. The result is a finite model of health care, limited in aspirations and thus economically more plausible but at the same time responsive to our need of good health, with affordable, accessible, and sustainable health care goals[59].

Notes

[1] Cf. Doyal & Gough, 1991, pp. 47 ff.
[2] Cf. Gracia, 1998.
[3] Cf. World Health Organization, 1946.
[4] Cf. World Health Organization, 2001.
[5] Cf. Daniels, 2008.
[6] Cf. Nussbaum, 2006; Nussbaum, 2011a. A more detailed explanation in Ruger, 2010, and Venkatapuram, 2011.
[7] Cf. Committee on Economic, Social and Cultural Rights, 2000, point 1; Shue, 1996, pp. 19, 23-34.
[8] Cf. World Health Organization, 2009. A critical appraisal in Preda and Voigt, 2015, pp. 25-36.
[9] Cf. Venkatapuram, 2011, pp. 19, 71.
[10] Cf. MacIntyre, 1999.
[11] Cf. Cruz, 2005.
[12] Cf. Alexy, 1987, pp. 405-408; Ferrajoli, 2008, pp. 33 ff.
[13] Cf. Ferrarese, 2000; Ferrarese, 2012.
[14] Cf. Kelsen, 1960, §§ 36 ff.; Bobbio, 1979.
[15] Cf. Ferrajoli, 2007, pp. 552 ff.
[16] Cf. Pernice, 2006.
[17] Cf. Callahan, 2009, pp. 171-186.
[18] Cf. Wiggins, 1998, p. 25.
[19] Cf. Anscombe, 1958, 7.
[20] Cf. Honneth, 1996; Honneth, 2003; Fraser, 2003; Fraser, 2008; Ricoeur, 2005.
[21] Cfr. Honneth, 1996; Ricoeur, 2005.
[22] Cf. Honneth, 1996, pp. 92 ff.
[23] Cf. Fraser, 2003, pp. 26 ff. and 48 ff.
[24] Cf. Fraser, 2008, pp. 12 ff. and 48 ff.
[25] Cf. Fraser, 2008, pp. 6 ff. and 55 ff., and Alexy 1995, pp. 102 ff., dealing with rights and justice.
[26] Cf. Sen, 1999; Nussbaum, 2006; Nussbaum, 2011b, pp. 23-37; Ruger, 2010; Venkatapuram, 2011, pp. 113-142.
[27] Cf. Ruger, 2010, pp. 83, 141 ff.
[28] Cf. Nussbaum, 2011a, pp. 33 ff.
[29] Cf. Venkatapuram, 2011, pp. 42-43 and 109.
[30] Cf. Venkatapuram, 2011, pp. 143 ff.
[31] Cf. Wolff, 2011, pp. 146-169; Wolff, 2012; Wolff & de-Shalit, 2007.
[32] Cf. Wolff & de-Shalit, 2007, pp. 37, 74.
[33] Cf. Wolff & de-Shalit, 2007, pp. 50 ff.

[34] Cf. Engster, 2007.
[35] Cf. Held, 2006, pp. 51-56, 108 ff.; Tronto, 2013.
[36] CF. Held, 2006; Engster, 2007; Tronto, 2013
[37] Cf. Tronto, 2013, pp. 153 ss.
[38] Cf. Alexy, 2002, pp. 111 ff.; Pariotti, 2013, pp. 3-6.
[39] Cf. Pariotti 2013, pp. 3-6.
[40] Cf. Alexy 1995, pp. 101-110.
[41] Cf. a more detailed explanation in Committee on Economic, Social and Cultural Rights, 2000, point 3.
[42] Cf. Committee on Economic, Social and Cultural Rights, 2000, point 8.
[43] Cf. Committee on Economic, Social and Cultural Rights, 2000, point 8.
[44] Cf. Ferrajoli, 2007, pp. 398 ff., specially 408-412.
[45] Cf. Alexy, 2002, pp. 334-348.
[46] Cf. Vienna Declaration and Programme of Action (1993), point 5.
[47] Cf. Holmes & Sunstein, 1999; Ferrajoli, 2007, pp. 67-71.
[48] Cf. Seoane, 2016.
[49] Cf. Cohen and Ezer, 2013, pp. 7-19.
[50] Cf. Frankfurt, 1987; Frankfurt, 2005.
[51] Cf. Nielsen & Axelsen, 2017, p. 56.
[52] Cf. Committee on Economic, Social and Cultural Rights, 2000, point 43; Eleftheriadis, 2012, pp. 268-285.
[53] Cf. Committee on Economic, Social and Cultural Rights, 2000, points 3 and 11.
[54] Cf. Committee on Economic, Social, and Cultural Rights, 2000, points 33 and 43, and point 11, respectively.
[55] Cf. BVerfGE 125, 175. Cf. also Deutscher Ethikrat, 2011, pp. 78-81.
[56] Cf. Committee on Economic, Social and Cultural Rights, 2000, point 44; Eleftheriadis, 2012, pp. 282-283.
[57] Cf. Deutscher Ethikrat, 2011, pp. 61-72.
[58] Cf. Committee on Economic, Social and Cultural Rights, 2000, point 32: "there is a strong presumption that retrogressive measures taken in relation to the right to health are not permissible".
[59] Cf. Callahan, 2009, 143 ff.

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