Private Actors in Health Services

Towards A Human Rights Impact Assessment Framework

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ISER
Facilitating Social Justice

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HUMAN RIGHTS CENTRE
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List of Abbreviations

AAAQ Availability, Accessibility, Acceptability and Quality
BITs Bilateral Investment Treaties
CEDAW United Nations Committee on the Elimination of Discrimination Against Women
CESCR United Nations Committee on Economic, Social and Cultural Rights
CRC United Nations Committee on the Rights of the Child
ECtHR European Court of Human Rights
ETOs Extraterritorial Obligations
FET Fair and Equitable Treatment
GNP Gross National Product
HRC UN Human Rights Committee
IACmHR Inter-American Commission of Human Rights
IACtHR Inter-American Court of Human Rights
ICCPR International Covenant on Civil and Political Rights
ICESCR International Covenant on Economic, Social and Cultural Rights
IMF International Monetary Fund
ODA Official Development Assistance
OHCHR UN Office of the High Commissioner for Human Rights
PPPs Public-Private Partnerships
UDHR Universal Declaration of Human Rights
UN United Nations
WHO World Health Organisation

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Executive Summary

This report presents a preliminary outline of how the existing human rights framework applies in the context of increasing involvement of the private sector in the delivery and financing of health care. It seeks to provide a starting point for a more nuanced reflection upon the obligations of States under international law in light of this phenomenon.

Private actor involvement in health care is understood as activities conducted by non-state actors in this sector that impact on the realisation of the right to health. While this report primarily reflects upon the role and impact of national and transnational corporations, the intention is for researchers and practitioners to be able to use and draw from this report to further unpack the distinctions across the different types of private actors and the nature of their involvement, and to refine the impact assessment framework.

Privatisation in the health sector is a process within the framework of health-related activities, where the control of an undertaking shifts from the public sector to non-state actors.[1] For the purposes of this report, privatisation refers to the growth of the share of private sector involvement in health systems. In many contexts, such increased involvement poses particular challenges and risks to the enjoyment of the right to health.[2]

This report first explains the definition and selected forms of private involvement in the financing and provision of health care. It details State obligations under international human rights law for the right to health, including when its delivery or financing is carried out by private actors. These obligations include: the duty to "respect, protect, fulfil" the right to health; to progressively realise the right to health through maximum available resources; immediate obligations including minimum core obligations; non-discrimination; participation; and the obligation to make healthcare services, goods and facilities available, accessible, acceptable and good quality. They include extraterritorial obligations. The report then moves on to discuss the establishment of accountability for private actors and its promotion, by the State, through various mechanisms, including a discussion of regulation, transparency, participation, monitoring, review, and remedies.

[1] Committee of Ministers of the Council of Europe, ***Privatization of public undertakings and activities***, Recommendation No. R (93) 7, 18 October 1993, 1.

[2] UN Office of the High Commissioner for Human Rights (OHCHR), ***The corporate responsibility to respect human rights: An imperative guide,*** OHCHR Publication UN/PUB/12/02, 2012.

A study of the current international human rights framework in this report shows that recent progress has been made in recognising the importance of reaffirming State obligations when non-state actors become involved. At the same time, international human rights mechanisms, including treaty bodies and the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (hereafter: Special Rapporteur on the right to health), have recognised that private involvement can have negative consequences on the right to health if robust and effective rights-based safeguards are not in place. This requires the implementation of solid regulatory processes and accountability for the right to health, and an understanding from the State that the involvement of private actors in sectors of public importance, such as health care, is accompanied by the preservation of State obligations in these sectors.

The report is accompanied by an annexed human rights impact assessment framework, which proposes a methodology of questions to draw upon when evaluating the influence and consequences of private actor involvement in the financing and delivery of health care while considering States' human rights obligations.

1. Introduction

In recent decades, the involvement of private actors in essential services has increased significantly in many countries around the world,[3] including sectors such as health, education, and water and sanitation, amongst others. The backdrop to this trend includes the shrinking of the welfare state, particularly over the last thirty years, and a shift towards liberal economics, which has been accompanied by reductions in public expenditure, trade liberalisation, privatisation of State companies and market deregulation.[4] International organisations, such as the International Monetary Fund (IMF) and the World Bank, have at times conditioned loans on such policies.[5] At the same time, some donors, including the World Bank Group, in particular the International Finance Corporation, have promoted privatisation through the support of public-private partnerships in healthcare.[6]

Private actor involvement in these sectors has attracted criticism from human rights actors for a range of reasons, including a perceived failure to improve and address resulting inequalities in the access to various services. For example, in their Concluding Observations on States' periodic reports, various UN human rights treaty bodies have voiced apprehensions about privatisation, mostly in relation to concerns over insufficient budget allocation and decreasing affordability and quality of services, particularly for vulnerable groups.[7] On the other hand, proponents of private involvement have argued that it can provide the improvement of basic services.[8]

The far-reaching effects of private involvement in health are of special interest in the context of human rights – and international human rights law – where States are obligated to ensure access to, and enjoyment of, minimum levels of certain goods and services, and to take targeted,

[3] Chapman A. R., ***Global health, human rights and the challenge of neoliberal policies,*** Cambridge University Press, United Kingdom, 2016, 115.
[4] Ibid, 79.
[5] Ibid, 101.
[6] Independent Evaluation Group, ***Public-private partnerships in health: World Bank Group engagement in health PPPs,*** 2016.
[7] See CRC, ***Concluding Observations: Lebanon,*** 21 March 2002, 42; CESCR, ***Concluding Observations: El Salvador,*** 27 June 2007, 24; CRC, ***Concluding Observations, The consolidated third and fourth periodic reports of India,*** 13 June 2014,63; CESCR, ***Concluding Observations: India,*** 8 August 2008, 38 and 78; CESCR, ***Concluding Observations: Pakistan,*** 23 June 2017,75; CESCR, ***Concluding Observations: Vietnam,*** 15 December 2014, 22; CESCR, ***Concluding Observations: Republic of Korea,***17 December 2009, 22 and 30; CRC, ***Concluding Observations: Bahrain,*** 11 March 2002, 13; CESCR, ***Concluding Observations: Lebanon***, 24 October 2016, 11; CESCR, ***Concluding Observations: Poland,*** 2 December 2009, 29; CESCR, ***Concluding Observations: Croatia***, 5 December 2001, 34; CEDAW, ***Concluding Observations: Hungary***, 26 March 2013, 8; CESCR, ***Concluding Observations: Zambia***, 23 June 2005, 48.
[8] Kikeri S and Nellis J, ***Privatization in competitive sectors: The record to date,*** The World Bank Private Sector Advisory Services Department, Policy Research, Working Paper Number 2860, 2018, --< http://documents.worldbank.org/curated/en/737881468761945796/117517322_20041117181542/additional/multi0page.pdf > on 17 December 2019.

concrete and deliberate steps towards the full realisation of rights[9] including the right to the highest attainable standard of physical and mental health. This report seeks to explore the parameters and implications of the States' obligations under international human rights law, concerning the involvement of private actors in the health sector. The analysis focuses on the role of the State. The important and evolving debate around the responsibilities and/or obligations of non-state actors lies beyond the scope of this project.

This report begins by explaining the definition and the different forms of private involvement in the provision of health goods and services and financing. It then turns to the legal framework for this private involvement under international human rights law. It analyses the different State obligations, including extraterritorial obligations, under the right to health, setting out general standards and applying them to private involvement. Finally, the report establishes the aspects of accountability that States need to put in place for the enjoyment of the right to health, including regulation, transparency, participation, monitoring, review, and remedies.

[9] CESCR, *General Comment No. 3, The nature of states parties' obligations (article 2, para. 1, of the Covenant),* 14 December 1990, 2.

2. Definition and Forms of Private Involvement in Healthcare and Healthcare Financing

Private actor involvement in healthcare is understood as activities conducted by non-state actors in this sector that impact on the realisation of the right to health. This may be underpinned by the notion that private market incentives, including competition, should be a means of delivering social services.[10] While appreciating the diversity of private actors involved in health financing and provision, this report primarily reflects upon the role and impact of national and transnational corporations. Furthermore, for the purposes of this report, the increase in the share of private actors in the health system is referred to as privatisation.

The involvement of the private sector in health care poses particular challenges and risks to the realisation of the right to health and other human rights.[11] Therefore, private actor involvement requires careful planning, regulation and accountability in order to protect human rights.

2.1 Private actor involvement in healthcare service provision

Private sector actors may become involved in healthcare in a variety of ways, ranging from the direct provision of healthcare services, to manufacturing goods, building infrastructure, or the financing of all of the previous examples. While in most countries the State is the largest provider of healthcare, there are some instances where private actors are the main players in certain sections of the health system.

Private actor involvement can take various forms. In some cases, while the government remains responsible for providing the service, the functioning of the service is managed by the private sector.[12] Specific health services may also be contracted out to private providers, wherein the State retains direct accountability for human rights and the responsibility to oversee service provision, but (at least in theory) contracts out the financial risk to the private sector.[13] For instance, contract management of public hospitals involves the provision of certain services within healthcare facilities by private companies, while the State remains responsible for the facility.[14] These forms fall under the broader category of public-private partnerships (PPPs),

[10] Fevzi A, ***Privatization in Health Care: Theoretical Considerations and Real Outcomes,*** Journal of Economics and Economic Education Research, Volume 3, Number 2, 2002.
[11] OHCHR, ***The corporate responsibility to respect human rights: An imperative guide,*** OHCHR Publication UN/PUB/12/02, 2012.
[12] Kukunda EB, ***Privatisation of service delivery and its impact on Uganda's attainment of the 7th MDG,*** 10(2) The African Symposium, 2010, 39.
[13] Forde K and Malley A, ***Privatisation in health care: theoretical considerations, current trends and future options,*** Aust Health Rev. 1992;15(3):269-77, https://www.ncbi.nlm.nih.gov/pubmed/10121779.
[14] Ibid.

where the distribution of ownership and the control and use of services, facilities and resources, between the State and the private organisation, can vary. "Load shedding", on the other hand, represents a greater level of private actor involvement, where responsibility for service delivery is transferred entirely to private actors.[15]

Private actors take various forms, such as businesses or organisations, and could range from pharmacies to "high end" hospitals. They can be for profit, or not-for-profit. Within the international human rights legal framework, there has been no distinction made between the different types of private actors and the regulation required with respect to each of them. They may provide a range of types of healthcare: in addition to allopathic medicine, private actors may also provide traditional or alternative medicines.

2.2 Private actor involvement in healthcare financing

The World Health Organisation (WHO) defines health financing as the 'function of a health system concerned with the mobilisation, accumulation and allocation of money to cover the health needs of the people, individually and collectively, in the health system'.[16] Its purpose 'is to make funding available, as well as to set the right financial incentives to providers, to ensure that all individuals have access to effective public health and personal health care'.[17]

There are four main mechanisms of health financing: taxation; social security; private insurance, which may be operated on a non-profit or for-profit basis; and out-of-pocket expenditure.[18] Healthcare financing arrangements have a strong bearing on access to healthcare, a key concern for the right to health. Particularly where out-of-pocket payments are required, access to healthcare services is often determined by income level. A reliance on private health insurance can also result in limited access to health services. Without adequate regulation, private financing schemes may exclude older persons or those with particular health conditions. Inequitable financing arrangements are one factor that contributes towards a coverage gap between the rich and poor worldwide. It is estimated that addressing this coverage gap would save the lives of over 16 million children.[19]

In his 2012 report on financing in health,[20] the Special Rapporteur on the right to health, Anand Grover, stressed that 'the right to health approach to health financing recognises that an appropriate balance must be achieved between public and private financing for health, as well as between public and private administration of health facilities, goods and services.' [21]

15 Ibid.
16 World Health Organization, ***The World Health Report 2000: Health systems: Improving performance,*** 2000.
17 Ibid.
18 Savedoff W, ***Tax-based financing for health systems: Option and experiences,*** World Health Organisation, Discussion Paper Number 4, --< https://www.who.int/health_financing/taxed_based_financing_dp_04_4.pdf > on 17 December 2019.
19 World Health Organisation, ***Health systems financing: The path to universal coverage***, 2010.
20 Chapman AR, ***Global health, human rights and the challenge of neoliberal policies,*** Cambridge University Press, United Kingdom, 2016, 116.
21 Grover A, ***Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health***, UN A/67/302, 13 August 2012, 3.

The United Nations Committee on Economic, Social and Cultural Rights (CESCR) has expressed concerns regarding equal access to national insurance programmes, calling on States to ensure the availability and affordability of health insurance.[22] The impact of private insurance on the public system, as well as questions of equitable access, have been considered in two domestic cases from Canada, in provinces where private health insurance was prohibited. In ***Chaoulli v. Quebec,*** the prohibition of private insurance in a scenario where public healthcare involves a significant delay in access to health services was considered unjustified.[23] In the subsequent case of ***Allen v. Alberta***, the Appeal Court found that the constitutionality of the prohibition on private insurance would depend on the facts of the case.[24]

[22] CESCR, ***Concluding Observations: Vietnam;*** CESCR, ***Concluding Observations: Republic of Korea.***
[23] ***Chaoulli v. Quebec*** (2005) 1 SCR 791, Supreme Court of Canada.
[24] ***Allen v. Alberta*** (2015) ABCA 277, Alberta Court of Appeal.

3. The Legal Framework For Private Involvement in Healthcare and Healthcare Financing

3.1 BACKGROUND

3.1.1 The right to healthcare and underlying determinants of health

The right to health should be understood as 'a right to the enjoyment of a variety of facilities, goods, services and conditions necessary for the realisation of the highest attainable standard of health'.[25] In terms of healthcare, the right to health includes entitlements to preventive and curative health care. It represents the right to have access to services, facilities, diagnosis, treatment, care and prevention of diseases.[26]

Inasmuch as our analysis focuses on health financing and delivery, it is important to note that the right to health extends beyond healthcare services to encompass:[27]

> A wide range of socio-economic factors that promote conditions in which people can lead a healthy life, and extends to the underlying determinants of health, such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions, and a healthy environment.[28]

3.1.2 The right to health in international human rights law

The right to health has been widely recognised internationally as a fundamental human right, [29] and codified in various legally binding international human rights treaties. The first instrument to mention it is the Constitution of the World Health Organisation (1946), which acknowledges in its preamble that the highest attainable standard of health is a fundamental human right.[30] The Universal Declaration of Human Rights (1948) declares that everyone has the right to health, which includes medical care and necessary social services. The Declaration also protects motherhood and childhood, ensuring special care and assistance for vulnerable parties.[31]

[25] CESCR, ***General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant)***, 11 August 2000,9.

[26] Ibid, 17; Ssenyonjo M, ***Economic, social and cultural rights in international law,*** 2nd ed, Bloomsbury Publishing, 2016, 519.

[27] CESCR, ***General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant),*** 11 August 2000, 4; OHCHR, ***The right to health, Fact Sheet Number 31,*** 2008, --< https://www.refworld.org/docid/48625a742.html > on 17 December 2019.

[28] CESCR, ***General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant)***, 11 August 2000, 4.

[29] ***International Covenant on Economic, Social and Cultural Rights,*** 16 December 1966, 993 UNTS 3, article 12; ***Constitution of the World Health Organisation,*** 1947, article 1; Hunt P, ***Report of the Special Rapporteur on the right of everyone to enjoyment of the highest attainable standard of physical and mental health,*** E/CN.4/2003/58, 13 February 2003.

[30] Toebes B, ***Human rights and health sector corruption,*** in Harrington J and Stuttaford M (eds) Global health and human rights, Routledge, New York, 2010, 173-174.

[31] ***Universal Declaration of Human Rights,*** 10 December 1948, 217 A (III), article 25(1) and 25(2).

Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR) recognises that everyone has the right to the enjoyment of the highest attainable standard of physical and mental health and State Parties must take steps to improve hygiene, prevent diseases, assure medical service and reduce infant mortality in order to achieve the full realisation of this right.[32] Other international human rights treaties also contain provisions regarding the right to health, namely:

- the International Convention on the Elimination of All Forms of Racial Discrimination (1969);[33]
- the Convention on the Elimination of All Forms of Discrimination against Women (1979);[34]
- the Convention on the Rights of Child (1989);[35]
- the Convention on the Protection of the Rights of All Migrant Workers and Members of their Families (1990);[36] and
- the Convention on the Rights of Persons with Disabilities (2006).[37]

The treaty bodies which oversee the implementation of these treaties have clarified the normative content and obligations of the right to health through General Comments, which are authoritative, non-binding interpretations of international human rights standards, as well as in Concluding Observations on States Parties' periodic reports submitted under these treaties, and decisions on cases.

Within the regional systems of human rights protection, core treaties recognising the right to health include:

- the African Charter on Human Rights and Peoples' Rights (1981);[38]
- the Additional Protocol to the American Convention on Human Rights 'Protocol of San Salvador' (1988);[39]
- the Revised European Social Charter (1996);[40] and
- the Arab Charter on Human Rights (2004).[41]

Until recently, the role of private actors has been addressed as a cross-cutting concern in the work of the CESCR.[42] However, in 2017, it adopted General Comment 24 on State Obligations under the International Covenant on Economic, Social and Cultural Rights in the Context of Business Activities, in which it devotes greater attention and analysis to the challenge of privatisation.

[32] I*nternational Covenant on Economic, Social and Cultural Rights,* 16 December 1966, 993 UNTS 3, article 12.
[33] *International Convention on the Elimination of All Forms of Racial Discrimination,* 21 December 1965, 660 UNTS 195, article 5(e) (iv).
[34] *Convention on the Elimination of All Forms of Discrimination Against Women,* 18 December 1979, 1249 UNTS 13, article 12.
[35] *Convention on the Rights of the Child,* 20 November 1989,1577 UNTS 3, article 24.
[36] *International Convention on the Protection of the Rights of All Migrant Workers and Members of their Families,* 18 December 1990, A/RES/45/158, articles 25, 28, 43 and 45.
[37] *Convention on the Rights of Persons with Disabilities,* 24 January 2007, A/RES/61/106, article 25.
[38] *African Charter on Human and Peoples' Rights*, 27 June 1981, CAB/LEG/67/3 rev. 5, article 16.
[39] *Additional Protocol to the American Convention on Human Rights in the Area of Economic, Social and Cultural Rights ("Protocol of San Salvador"),* 16 November 1999, A-52, article 10.
[40] *European Social Charter (Revised),* 3 May 1996, ETS 163, article 11.
[41] *Arab Charter on Human Rights (Revised),* 15 September 1994,12 IHRR 893, article 39(1).
[42] CESCR, *General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant),* 11 August 2000

This General Comment states that 'Privatisation is not per se prohibited by the Covenant, even in areas such as the provision of water or electricity, education or health care where the role of the public sector has traditionally been strong.'[43] However, it establishes certain requirements for private actor involvement that will be referred to throughout this report.

Concerns over the participation of private actors have been expressed in the General Recommendation on women and health, adopted by the United Nations Committee on the Elimination of Discrimination Against Women (CEDAW),[44] in United Nations Committee on the Rights of the Child (CRC) General Comment 15 on the Right of the Child to the enjoyment of the highest attainable standard of health,[45] and in the CRC General Comment No 16 on State obligations regarding the impact of the business sector on children's rights.[46] Most recently, the African Commission on Human and Peoples' Rights adopted a Resolution on States' obligations to regulate private actors in health service provision, calling on States to 'Ensure, through effective regulatory systems, the protection of access to health care and needed medicines, from the negative actions of third parties and in particular, actions that would affect access for vulnerable groups and marginalised communities.'[47]

Legal instruments and case law have established that the ultimate responsibility for violations of the right to health (as well as violations of all other human rights) remains with the State, even if private entities are involved in the violation to varying degrees. This is despite growing consensus that businesses have the responsibility to respect human rights.[48] This stems from the fact that relevant legally binding instruments directly bind States as the primary subjects of international law, and has been confirmed through cases in which the State has been found responsible for violations happening in private hospitals, or through the policies of private insurance providers.[49]

In several countries, the right to health is also protected through constitutional provisions.[50] Where the State is legally or factually unable to compel private providers to ensure all aspects of the right to health, it must provide public alternatives. For example, in the case ***Policlínica Privada de Medicina y Cirugía S.A. v. Municipalidad de la Ciudad de Buenos Aires,*** the Argentine Supreme Court of Justice held that authorities could not force private hospitals to keep a patient hospitalised after their term of coverage had ended. It stated that, in such cases,

[43] CESCR, ***General Comment No. 24, State obligations under the ICESCR in the context of business activities,*** 10 August 2017, 21.

[44] CEDAW, ***General Recommendation No. 24, article 12 of the Convention (Women and Health),*** 2 February 1999,17.

[45] CRC, ***General Comment No. 15 (2013), The right of the child to the enjoyment of the highest attainable standard of health (article 24),*** 17 April 2013, 75-85.

[46] CRC, ***General Comment No. 16 (2013), State obligations regarding the impact of the business sector on children's rights,*** 17 April 2013, 1 and 33-34.

[47] African Commission on Human and Peoples' Rights, ***Resolution on States' Obligation to Regulate Private Actors Involved in the Provision of Health and Education Services,*** 14 May 2019, Res. 420 (LXIV).

[48] ***Guiding principles on business and human rights***, adopted by the UN Human Rights Council (HRC) in its Resolution 17/4, HR/PUB/11/04, 2011.

[49] See ***Mehmet Şentürk and Bekir Şentürk v Turkey,*** ECtHR Judgement of 9 April 2013, 96-97; ***Elisabeth de Blok et al. v The Netherlands,*** CEDAW Comm. No. 36/2012 (24 March 2014), 8.7-8.9; ***Maria de Lourdes da Silva Pimentel (on behalf of Alyne da Silva Pimentel Teixeira) v Brazil,*** CEDAW Comm. No.17/2008 (27 September 2011), 7.5-7.7; ***Suárez Peralta v Ecuador,*** IACtHR Judgement of 21 May 2013 (Preliminary Objections, Merits, Reparations and Costs), 132-133; See also CEDAW, G***eneral Recommendation No. 19, Violence against women,*** 1992, 9.

[50] See World Policy Center, ***Health***, on https://worldpolicycenter.org/topics/health/policies for a world panorama of which countries have constitutional guarantees for health, on 17 December 2019.

the State had an obligation to provide public health care to the patient after they were no longer able to access private care.[51]

As stated in General Comment 14 of the CESCR, which provides an authoritative analysis of the norms and obligations deriving from the right to health, States should take 'whatever steps are necessary to ensure that everyone has access to health facilities, goods, and services so that they can enjoy, as soon as possible, the highest attainable standard of physical and mental health'.[52]

3.2 STATE OBLIGATIONS

3.2.1 State obligations to respect, protect and fulfill

The CESCR General Comment 14 identifies three levels of obligations on States concerning the right to health, extending to healthcare and to the underlying determinants of health.[53]

The obligation to respect requires States to avoid acting in a way that negatively impacts the right to heath.[54] It means preventing interference of the State in the enjoyment of the right to health and includes not denying access to healthcare and not enforcing discriminatory policies.

The State's obligation to protect means that it is obligated to protect the right to health even when healthcare is provided by a third party, and to ensure that privatisation of health is not detrimental to its availability, and accessibility, and the accessibility and quality of health facilities.[55] This obligation requires States to:

> adopt legislation and take other measures to ensure equal access to health care and health-related services provided by third parties; to control the marketing of medical equipment and medicines by third parties; to ensure that medical practitioners and other health professionals meet appropriate standards of education, skill and ethical codes of conduct; to ensure that harmful social or traditional practices do not interfere with access to pre- and post-natal care and family planning; to ensure that third parties do not limit people's access to health-related information and services; to prevent third parties from coercing women to undergo traditional practices, e.g. female genital mutilation; and to take measures to protect all vulnerable or marginalised groups of society, in particular women, children, adolescents and older persons, in the light of gender-based expressions of violence.[56]

The obligation to fulfill includes the components of promotion, provision and facilitation, where the government must take positive measures to ensure enjoyment of the right to health and

[51] ***Policlínica Privada de Medicina y Cirugía S.A. v. Municipalidad de la Ciudad de Buenos Aires,*** (1998), Supreme Court of Justice of Argentina, 169.
[52] CESCR, General Comment No. 14, ***The right to the highest attainable standard of health (article 12 of the Covenant),*** 11 August 2000, 53.
[53] Ssenyonjo M, E***conomic, social and cultural rights in international law,*** 2nd ed, Bloomsbury Publishing, 2016, 532.
[54] Ibid.
[55] CESCR, ***General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant),*** 11 August 2000, 35.
[56] Ibid, 35.

'create, restore and maintain the health of the population.'[57] The obligation to fulfil also entails the use of maximum available resources in an efficient manner and requires States to:

> give sufficient recognition to the right to health in the national political and legal systems, with a detailed plan for realising the right to health; ensure provision of health care, including immunisation programmes against the major infectious diseases, and ensure equal access for all to the underlying determinants of health, such as nutritiously safe food and potable drinking water, basic sanitation and adequate housing and living conditions; ensure sexual and reproductive and mental health services; ensure the appropriate training of doctors and other medical personnel.[58]

A different, but partially overlapping, tripartite framework has been developed by the former Special Representative of the Secretary-General on the issue of human rights and transnational corporations and other business enterprises, John Ruggie, and adopted by the Human Rights Council in 2011 (see figure 1).[59]

Figure 1. The UN Guiding Principles on Business and Human Rights

The "Respect, Protect and Remedy" Framework, fleshed out in a set of Guiding Principles on Business and Human Rights, developed by the Special Representative of the Secretary-General on the issue of human rights and transnational corporations and other business enterprises, is not meant to create new legal obligations, but to 'elaborate the implications of existing standards and practices for states and businesses'.[60] The "Protect" principle addresses the State, reiterating its duty to protect everyone from human rights abuses by third parties. Guiding Principle 5 provides:

> States should exercise adequate oversight in order to meet their international human rights obligations when they contract with, or legislate for, business enterprises to provide services that may impact upon the enjoyment of human rights.

The "Respect" part of the framework addresses business enterprises themselves. Their responsibility to respect human rights entails, inter alia, the need to avoid causing or contributing to adverse human rights consequences and addressing their impact when they occur.[61]

Lastly, both States and corporations are required to ensure access to remedy for human rights abuses by business enterprises,[62] with the primary responsibility incumbent on the State.[63]

[57] Ibid, 37.
[58] Ibid, 36.
[59] UN HRC, ***Human rights and transnational corporations and other business enterprises,*** A/HRC/RES/17/4, 2001, 1.
[60] Ruggie J, ***Final report of the Special Representative of the Secretary-General on the issue of human rights and transnational corporations and other business enterprises,*** A/HRC/17/31, 21 March 2011,14.
[61] ***Guiding principles on business and human rights,*** UN Human Rights Council (HRC), Resolution 17/4, HR/PUB/11/04, 2011, principles 11 and 13(a).
[62] Ibid, principles 22 and 25.
[63] Ibid, principle 22. This becomes obvious from the language used in the Guiding Principles, while states 'must take appropriate steps to ensure [...] access to remedy' (Principle 25), businesses 'should provide for or cooperate in [...] remediation' (Principle 22).

While the CESCR and Ruggie frameworks emphasise the obligation to protect,[64] the CRC and the CEDAW have adopted a broader approach, linking privatisation to the full tripartite framework.[65] Taking into account that the obligation to protect stresses the protection of the status quo, while the obligation to fulfil entails progressive improvements, Nolan has argued that the focus on protection from interference by third actors is too narrow and attention must also be paid to the State decisions before and during privatisation, which must be measured against the standards of the obligation to fulfil.[66]

3.2.2 Progressive realisation and prohibition of retrogression

Article 2.1 of the ICESCR stipulates that:

Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and co-operation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

The ICESCR, in article 2, requires that States take positive measures, adopting appropriate legislative, administrative and other measures, in order to progressively achieve the full realisation of their human rights obligations, including health.[67] It means that States shall continue advancing, by concrete, deliberate and targeted steps, in a continuous and increasing way, towards the realisation of the right to health.[68]

The CESCR observes in General Comment 14 that 'progressive realisation means that States Parties have a specific and continuing obligation to move as expeditiously and effectively as possible towards the full realisation of article 12'.[69] In ***Cuscul Pivaral et al v. Guatemala,*** the Inter-American Court of Human Rights affirmed the obligation of States to progressively realise the right to health. In this case, the Court determined that Guatemala breached the principle of progressivity by failing to take steps towards protecting the right to health for persons living with HIV/AIDS.[70]

States are required to monitor the realisation of human rights through appropriate and clear strategies and programmes aimed at their implementation,[71] underscoring the importance of the development of indicators and benchmarks for the progressive realisation of rights.[72]

[64] Nolan A, ***Privatisation and economic and social rights,*** 40 (4) Human Rights, Quarterly, 2018, 24.
[65] Ibid, 28 and 34
[66] Ibid, 25.
[67] De Schutter O, ***International human rights law***, 2nd ed, Cambridge University Press, United Kingdom, 2014, 527.
[68] Nolan A, Lusiani NJ and Courtis C, ***Two steps forward, no steps back? Evolving criteria on the prohibition of retrogression in economic and social rights,*** in Nolan A, (ed), ***Economic and social rights after the global financial crisis,*** Cambridge University Press, United Kingdom, 2014,123.
[69] CESCR, General Comment No. 14, ***The right to the highest attainable standard of health (article 12 of the Covenant)***, 11 August 2000, 31.
[70] ***Cuscul Pivaral et al v. Guatemala,*** Inter-American Court of Human Rights, Series C No. 359, 23 August 2018.
[71] Ssenyonjo M, ***Economic, social and cultural rights in international law,*** 2nd ed, Bloomsbury Publishing, 2016, 90.
[72] De Schutter O, I***nternational human rights law,*** 2nd ed, Cambridge University Press, United Kingdom, 2014, 531

However, progressive realisation does not absolve the State from certain immediate obligations, which they are obligated to implement without delay, regardless of resource availability.[73] This includes equality and non-discrimination, as well as core obligations, both of which are discussed below.

The emphasis on progressive realisation precludes retrogression, or measures that negatively affect the enjoyment of rights previously enjoyed by individuals.[74] The duty to provide the advancement of economic, social and cultural rights demands a negative obligation: the prohibition of adopting measures that reduce the enjoyment of the right.[75] This negative obligation involves a normative dimension (regarding relevant legal norms) and an empirical understanding (referring to the effective, de facto, enjoyment). [76]

The CESCR General Comment 14 clarifies that:

If any deliberately retrogressive measures are taken, the State Party has the burden of proving that they have been introduced after the most careful consideration of all alternatives and that they are duly justified by reference to the totality of the rights provided for in the Covenant in the context of the full use of the State Party's maximum available resources. [77]

Decreased quality of health services, cutting of subsidies, and lower budget allocations to health, could thus be considered violations of the principle of non-retrogression. [78]

The move from State provisioned health care or financing towards private actors can be a retrogressive step if it leads to negative outcomes, either in terms of substantive health outcomes or in terms of procedural obligations, such as transparency, participation, and accountability. Privatisation, therefore, is only permissible under the strict safeguards for retrogressive measures set out above. As for private actor involvement in areas that previously were not under direct State provision, or privatisation that does not lead to retrogression, the State is still obliged to ensure that the most suitable option - whether public, private or a mixed system - for progressive realisation is chosen. [79]

[73] CESCR, ***General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant)***, 11 August 2000, 30.

[74] Ibid, 32.

[75] Nolan A, Lusiani NJ and Courtis C, ***Two steps forward, no steps back? Evolving criteria on the prohibition of retrogression in economic and social rights,*** in Nolan A, (ed), ***Economic and social rights after the global financial crisis,*** Cambridge University Press, United Kingdom, 2014, 123.

[76] Ibid, 123.

[77] CESCR, ***General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant),*** 11 August 2000, 32.

[78] CESCR, ***Concluding Observations: Egypt,*** 13 December 2013, 6.

[79] CESCR, ***Concluding Observations; Lebanon,***11, in which the CESCR recommends that the State should 'review whether the practice of contracting out the delivery of basic services to private actors constitutes an optimal use of available resources to ensuring Covenant rights without discrimination'.

3.2.3 Core obligations

The concept that human rights possess an essential core, which is inviolable and not subject to limitations, creates the idea that States must satisfy the minimum core obligations regarding each one of these rights.[80] The CESCR has emphasised that States must ensure the satisfaction of minimum levels of each right.[81] Thus, for example, a State Party in which any significant number of individuals are deprived of essential food, essential primary health care, basic shelter and housing, or of the most basic forms of education is, ***prima facie***, failing to discharge its obligations under the Covenant.[82]

These core obligations are non-derogable, not conditioned by lack of resources, and are directly applicable.[83] If a State attributes its failure to provide the minimum core obligations to a lack of resources, 'it must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations'.[84] The CESCR also elaborates on the minimum core obligations with regard to health in General Comment 14,[85] and enumerates other obligations of comparable priority.[86]

The core obligations are a minimum "floor", whether in a public, private, or mixed system. The core obligation to ensure access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups, is of particular importance in a privatised context. In 2012 the Special Rapporteur on the right to health, Anand Grover, found that in many cases privatisation leads to 'disproportionate investment in secondary and tertiary care sectors at the expense of primary health care and increased disparity in the availability of health facilities, goods and services among rural, remote and urban areas'.[87]

[80] Ssenyonjo M, ***Economic, social and cultural rights in international law***, 2nd ed, Bloomsbury Publishing, 2016,105.

[81] CESCR, ***General Comment No. 3, The nature of states parties' obligations (article 2, para. 1, of the Covenant)***, 14 December 1990, 10.

[82] Ibid, 10.

[83] Scheinin M, ***Core rights and obligations,*** in Shelton D (ed), ***The Oxford handbook of international human rights law***, Oxford University Press, United Kingdom, 2013, 538. See also CESCR, ***General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant),*** 11 August 2000, 47.

[84] CESCR, ***General Comment No. 3, The nature of states parties' obligations (article 2, para. 1, of the Covenant),*** 14 December 1990, 10.

[85] CESCR, ***General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant),*** 11 August 2000, 43:

(a) To ensure the right of access to health facilities, goods and services on a non-discriminatory basis, especially for vulnerable or marginalised groups;
(b) To ensure access to the minimum essential food, which is nutritionally adequate and safe, to ensure freedom from hunger to everyone;
(c) To ensure access to basic shelter, housing and sanitation, and an adequate supply of safe and potable water;
(d) To provide essential drugs, as from time to time defined under the WHO Action Programme on Essential Drugs;
(e) To ensure equitable distribution of all health facilities, goods and services; and
(f) To adopt and implement a national public health strategy and plan of action, on the basis of epidemiological evidence, addressing the health concerns of the whole population; the strategy and plan of action...

[86] Ibid, 44:

(a) To ensure reproductive, maternal (prenatal as well as post-natal) and child health care;
(b) To provide immunization against the major infectious diseases occurring in the community;
(c) To take measures to prevent, treat and control epidemic and endemic diseases;
(d) To provide education and access to information concerning the main health problems in the community, including methods of preventing and controlling them; and
(e) To provide appropriate training for health personnel, including education on health and human rights.

[87] Grover A, ***Interim report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health***, UN A/67/302, 13 August 2012.

Moreover, there is a core obligation to adopt and implement a national public health strategy and plan of action. This obligation, read together with the obligation to regulate, elaborated upon below, arguably implies that spontaneous processes of privatisation arising from the State ceding formerly publicly provided services or financing, should be avoided. If privatisation does occur, it should be part of the national strategy which should specify the role(s) of the private sector and be carefully managed.[88] This also requires the process of privatisation to be participatory and transparent, and the impact of privatisation to be reviewed regularly.

3.2.4 Maximum available resources and efficiency

Article 2(1) of the ICESCR directs States to use the maximum available resources towards the realisation of economic, social and cultural rights. The maximum available resources refer to those within a State as well as those available from the international community. [89]

Various UN bodies have made statements about the use of maximum available resources[90] and have occasionally suggested changes in resource allocation, tax policy, or stronger measures against corruption.[91] The CEDAW suggests that States should 'balance the roles of public and private health providers in order to maximise resources and the reach of health services'. [92] The CESCR has in several instances commented on insufficient resource allocation for health and recommended that States increase funds for this sector.[93] It has also remarked, in the case of Lebanon, that 'the budgeting process lacks democratic approval and oversight and that the current sectoral allocations no longer correspond to the needs and priorities in the State Party' and recommended to ensure accountability for budgeting and 'adequate allocation to priority needs and sectors.' [94]

Case law suggests that while courts recognise resource constraints of States, funding allocation and priorities must be reasonable and made in good faith. The "reasonableness" criterion has been established by the South African Constitutional Court in ***Soobramoney v. Minister of Health (Kwazulu-Natal)***[95] and applied in subsequent cases by the same court, as well as others.[96]

At the regional level, in the case of ***Jorge Odir Miranda Cortez v El Salvador,*** the 26 petitioners alleged a breach of the right to health and the right to life because of a failure to provide them

[88] See CRC, ***General Comment No. 19 (2016), Public budgeting for the realisation of children's rights (article 4),*** 20 July 2016, 85, which states, 'In their budget proposals, parties should specify any child-related programmes that they propose to outsource, or have already outsourced, to the private sector'.

[89] CESCR, ***Statement by the Committee: An evaluation of the obligation to take steps to the 'Maximum of available resources' under an optional protocol to the Covenant,*** E/C.12/2007/1, 21 September 2007, 5.

[90] Ibid; CRC, ***General Comment No. 5 (2003): General measures of implementation of the Convention on the Rights of the Child,*** 27 November 2003.

[91] De Schutter O, ***Report of the Special Rapporteur on the right to food, mission to Brazil,*** A/HRC/13/33/Add.6,36; CESCR, ***Concluding Observations: Canada,*** 4 March 2016, 9; CESCR, ***Concluding Observations: Sudan,*** 22 October 2015,15.

[92] CEDAW, ***Concluding Comments: India,*** 2 February 2007, 41.

[93] CESCR, ***Concluding Observations: El Salvador,*** 27 June 2007, 24; CESCR, ***Concluding Observations: India,*** 8 August 2008, 38 and 78; CESCR, ***Concluding Observations: Pakistan,*** 23 June 2017, 75-76; CESCR, ***Concluding Observations: Poland,*** 2 December 2009, 9.

[94] CESCR, ***Concluding Observations: Lebanon,*** 24 October 2016, 10-11.

[95] ***Soobramoney v. Minister of Health KwaZulu Natal*** (1997), Constitutional Court of South Africa.

[96] ***Government of the Republic of South Africa. & Ors v. Grootboom & Others*** (2000), Constitutional Court of South Africa; ***L.N. and 21 Others v. Ministry of Health et al*** (2015), High Court of Kenya at Nairobi.

with free antiretroviral treatment for their HIV infections. The Inter-American Commission on Human Rights held:

> In the instant case, the State demonstrated - to the satisfaction of the Inter-American Commission - that it took ***what steps it reasonably could to provide medical treatment to the persons included in the record.*** The IACHR finds that, in the circumstances, the measures of the State were sufficiently expeditious to accomplish that aim effectively. It is not possible, therefore, to speak of any direct violation of the right to health of Jorge Odir Miranda Cortez or the other 26 persons [...], as would have been the case if, for instance, it were shown that the State refused to provide care to any of them. Moreover, during the processing of the instant case the Salvadoran health services ***progressively broadened free coverage*** to other persons infected with HIV/AIDS, subject to medical screening. Furthermore, the petitioners have not alleged any backtracking in the sense of suspension of benefits that any of them were already receiving.[97]

In the seminal case ***Minister of Health et al v. Treatment Action Campaign et al,*** the Constitutional Court of South Africa, applied the concept of reasonableness to find that the government has an obligation to expand the availability of antiretroviral treatment for HIV more quickly than it was doing, which was denied in ***Jorge Odir Miranda Cortez.***[98] This seeming contradiction demonstrates that reasonableness has to be established on a case-by-case basis, taking into account the circumstances of each case.

In sum, States have an element of discretion over the raising and spending of resources. Scholarship suggests that when assessing whether a State is using its maximum available resources, attention should be paid to five areas: government expenditure, government revenue, development assistance, debt and deficit financing, and monetary policy and financial regulation.[99]

In the context of government expenditure, States are obliged to use resources as efficiently as possible.[100] One of the main arguments put forward in favour of privatisation is that it supposedly increases efficiency in two aspects: (1) through the injection of private capital, the State needs to spend less on the same outcome, and (2) thanks to market forces and competition, unnecessary costs will be cut, leading to greater overall efficiency (i.e. with the same amount of resources spent, regardless of their origin, a greater outcome can be achieved).[101]

However, evidence suggests that in some contexts, intended efficiency savings are not, in fact, made through private sector involvement. An Oxfam case study on a public private partnership in Lesotho reveals how costs for governments can end up being much higher than originally planned, largely due to the high negotiation power of the private company which allows it to establish contractual conditions that are profitable for itself, but costly for the government.[102]

[97] ***Jorge Odir Miranda Cortez v. El Salvador,*** Inter-American Commission on Human Rights (IACmHR) Case 12.249, (2009), 108.
[98] ***Minister for Health et al v. Treatment Action Campaign et al*** (2002), Constitutional Court of South Africa.
[99] Balakrishnan R, Elson D, Heintz J and Lusiani N, ***Maximum available resources and human rights: Analytical report,*** Center for Women's Global Leadership, 2011, 5.
[100] Sepúlveda M, ***The nature of the obligations under the International Covenant on Economic, Social and Cultural Rights,*** Intersentia, Antwerpen, 2003, 335.
[101] Chapman AR, ***Global health, human rights and the challenge of neoliberal policies,*** Cambridge University Press, United Kingdom, 2016, 115 and121-122.
[102] Marriott A, ***A dangerous diversion: Will the IFC's flagship health PPP bankrupt Lesotho's Ministry of Health?,*** Oxfam International, Lesotho Consumer's Protection Association, 2014, 7-9.

Similar issues have been observed in the UK, the US, Australia, Spain, and Portugal.[103] Efficiency "savings" may actually bring about additional costs through corruption and the pursuit of profit.[104] Efficiency in the economic sense could also be artificially improved through pay cuts for health workers and/or worsening working conditions, which can in turn translate into poorer quality of care (and potentially violate the health workers' labour rights).[105]

Other arguments undermining the claim that private, particularly for-profit, provision is more efficient include that the pursuit of profit often reduces the share of revenue that can be reinvested by the private provider.[106] Furthermore, loans are generally cheaper for governments than for the private sector, thus private providers need to dedicate a greater share of their budget to debt repayment.[107]

3.2.5 The duty to regulate the private sector

The State duty to regulate private actors, particularly when they provide essential services, is well established in international law.[108] Provision of health services and regulation of service providers should be undertaken by separate authorities.[109] Insufficient regulation includes the failure to regulate, as well as the revocation of existing regulations to the detriment of the enjoyment of the right to health.[110] The CESCR has stated in its General Comment 24 that private providers in areas where the role of the public sector has traditionally been strong (e.g. health care):

> should be subject to strict regulations that impose on them so-called "public service obligations": [...] private health-care providers should be prohibited from denying access to affordable and adequate services, treatments or information. For instance, where health practitioners are allowed to invoke conscientious objection to refuse to provide certain sexual and reproductive health care services, including abortion, they should refer women or girls seeking such services to another practitioner within reasonable geographic reach who is willing to provide such services.[111]

[103] Ibid, 7-18.

[104] Marriott A, ***Blind optimism: Challenging the myths about private health care in poor countries,*** Oxfam International, 2009, https://policy-practice.oxfam.org.uk/publications/blind-optimism-challenging-the-myths-about-private-health-care-in-poor-countries-114093 on 17 December 2019.

[105] Balakrishnan R, Elson D, Heintz J and Lusiani N, ***Maximum available resources and human rights: Analytical report,*** 8.

[106] Marriott A, ***A dangerous diversion: Will the IFC's flagship health PPP bankrupt Lesotho's Ministry of Health?***, Oxfam International, Lesotho Consumer's Protection Association, 2014, 7-9.

[107] Ibid, 10.

[108] CESCR, ***General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant),*** 11 August 2000, 51; CESCR, ***General Comment No. 24, State obligations under the ICESCR in the context of business activities,*** 10 August 2017, 16; CRC, ***General Comment No. 15 (2013), The right of the child to the enjoyment of the highest attainable standard of health*** (article 24), 17 April 2013, 80; ***Maria de Lourdes da Silva Pimentel (on behalf of Alyne da Silva Pimentel Teixeira v. Brazil,*** CEDAW Comm. No.17/2008 (27 September 2011), 7.5; ***Ximenes Lopez v. Brazil*** IACtHR Judgement of 4 July 2006, (Merits, Reparations and Costs), 141; ***Mehmet Şentürk and Bekir Şentürk v. Turkey,*** ECtHR Judgement of 9 April 2013, 81; Hunt P, Special Rapporteur on the right to health, A/HRC/7/11/Add.4, 29 February 2008. ***Note on mission to India,*** 21.

[109] Hunt P, Special Rapporteur on the right to health, A/HRC/7/11/Add.4, 29 February 2008. ***Note on mission to India,*** paras. 18 and 22.

[110] CESCR, ***General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant),*** 11 August 2000, 48-49.

[111] CESCR, ***General Comment No. 24, State obligations under the ICESCR in the context of business activities,*** 10 August 2017, 21.

> ***The Inter-American Court of Human Rights has held that:***
>
> ***In order to comply with the obligation to guarantee the right to personal integrity and in the context of health, States must establish an adequate normative framework that regulates the provision of health care services, establishing quality standards for public and private institutions that allow any risk of the violation of personal integrity during the provision of these services to be avoided.***[113]

The CESCR also emphasises that privatisation 'should not lead the enjoyment of Covenant rights to be made conditional on the ability to pay' or 'result in excluding certain groups that historically have been marginalised, such as persons with disabilities.'[112]

In ***Senturk v. Turkey,*** the European Court of Human Rights held that the State was responsible for a violation of the right to life because it had not ensured that the provision of life-saving treatment in a private hospital was independent of prior payment.[114] Similarly, in ***Elisabeth Blok et al v. Netherlands,*** the CEDAW found the State responsible for a gap in the provision of insurance for paid maternity leave, one that arose after privatising a public insurance scheme, resulting in some women being unable to afford insurance.[115]

In ***Alyne da Silva Pimentel v. Brazil,*** the CEDAW condemned the State for the multi-dimensional discrimination based on sex, race and socio-economic background that the victim suffered, which in part stemmed from inadequate medical practices at the hands of a private health-care institution. Holding that 'the State is directly responsible for the action of private institutions when it outsources its medical services, and that furthermore, the State always maintains the duty to regulate and monitor private health-care institutions', the CEDAW recommended the State to 'ensure that private health care facilities comply with national and international standards on reproductive health care'[116] The ***Pimentel case*** demonstrates the need for government regulations and standards to be in place as pre-emptive measures, in order to protect individuals from violations.

Both the CESCR and the CRC have clarified that States should require businesses to undertake due diligence, in order to identify, prevent and mitigate the risks of violations of Covenant rights, to avoid such rights being abused, and to account for the negative impacts caused or contributed to by their decisions and operations and those of entities they control on the enjoyment of Covenant rights.[117]

[112] Ibid, 22.
[113] ***Suarez Peralta v. Ecuador*** (Preliminary Objections, merits, reparations and costs), Inter-American Court of Human Rights, Series C No 261, 21 May 2013,132.
[114] ***Mehmet Şentürk and Bekir Şentürk v. Turkey***, ECtHR Judgement of 9 April 2013, 96-97.
[115] ***Elisabeth de Blok et al. v. The Netherlands,*** CEDAW Comm. No. 36/2012 (24 March 2014), 8.7-8.9.
[116] ***Maria de Lourdes da Silva Pimentel (on behalf of Alyne da Silva Pimentel Teixeira v. Brazil***, CEDAW Comm. No.17/2008 (27 September 2011), 7.5-7.7 and 8.2.
[117] CESCR, ***General Comment No. 24, State obligations under the ICESCR in the context of business activities,*** 10 August 2017, 16; See also CRC, ***General Comment No. 15 (2013), The right of the child to the enjoyment of the highest attainable standard of health*** (article 24), 17 April 2013, 80.

The CRC additionally states that 'large business enterprises should be encouraged and, where appropriate, required to make public their efforts to address their impact on children's rights'.[118] Moreover, it requires States to integrate the principle of the best interest of the child into legislation and policies influencing business activity,[119] and even goes as far as to assert that the principle is 'directly applicable to business enterprises that function as private or public social welfare bodies by providing any form of direct services for children, including [...], health'.[120] The CEDAW has also clarified that States are obliged to regulate private actors in order to ensure that they do not discriminate against women.[121]

In addition, States should impose administrative or criminal sanctions and penalties on businesses where their activities or their lack of due diligence result in abuses of human rights, enable civil suits to allow victims to claim reparations,[122] and take appropriate measures to effectively combat corruption.[123]

Further guidance on the State duty to regulate can also be found in the UN Guiding Principles on Business and Human Rights.[124] According to these Principles, States should, inter alia:

- Enforce laws that are aimed at, or have the effect of, requiring business enterprises to respect human rights, and periodically to assess the adequacy of such laws and address any gaps;
- Provide effective guidance to business enterprises on how to respect human rights throughout their operations;
- Encourage, and where appropriate require, business enterprises to communicate how they address their human rights impacts.[125]

The issue of enforcement of existing standards has also been dealt with in case law. For example, in two cases concerning abortion in Peru, the UN Human Rights Committee (HRC) and the CEDAW have held the State responsible for not enforcing the legally established right to a therapeutic abortion, thus causing physical, mental and financial harm to the victims and their families.[126] While both of these cases took place in public hospitals, they provide useful illustration of the principle that having laws in place is not, as such, sufficient; States must also act to ensure that the laws are implemented, in order to support the right to health.

However, some uncertainty as to what exactly States must regulate remains. For example, while it is well established that private hospitals cannot deny access to life-saving treatment on the

[118] CRC, ***General Comment No. 15 (2013), The right of the child to the enjoyment of the highest attainable standard of health*** (article 24), 17 April 2013, 80.
[119] Ibid, 15.
[120] CRC, ***General Comment No. 16 (2013), State obligations regarding the impact of the business sector on children's rights***, 16.
[121] CEDAW, ***General Recommendation No. 28, The core obligations of states parties under article 2 of the Convention on the Elimination of All Forms of Discrimination against Women***, 16 December 2010, 13.
[122] CESCR, ***General Comment No. 24, State obligations under the ICESCR in the context of business activities,*** 10 August 2017, 15.
[123] Ibid, 20.
[124] The guiding principles are not legally binding, but they stem from existing obligations as opposed to creating new obligations, as set out in the document in the section titled "General Principles".
[125] ***Guiding principles on business and human rights,*** HRC, Resolution 17/4, HR/PUB/11/04, 2011, principle 3.
[126] ***Karen Noelia Llantoy Huamán v. Peru,*** CCPR Comm. No. 1153/2003 (22 November 2005) 6.6; ***L.C. v. Peru,*** Comm. No. 22/2009 (4 November 2011), 8.17.

grounds of the inability of the patient to pay,[127] it is unclear whether, and under which conditions, prices for other treatment may be higher in private facilities than in public facilities. According to the Belgian Constitutional Court, it is not always appropriate to regulate private and public institutions in exactly the same fashion, as this can have negative impacts which have to be weighed against the positive impacts of the regulation.[128]

Regulation of private actors can be particularly challenging if the actors at play are for-profit actors from other countries, as their investments may be protected under international investment law which can conflict with human rights law (see figure 2).

Figure 2. Regulation in the context of investment treaties and contracts

Another pressing issue to be addressed in the context of regulation is the interplay with investment law, both bilateral investment treaties (BITs) and investor-state contracts. The duty to regulate presupposes a duty to maintain conditions in which the State is able to regulate. States are required to refrain from entering into treaties or contracts if they conflict with their human rights obligations.[129]

Investment law can, in different ways, conflict with human rights obligations, particularly the obligation to progressively realise economic, social and cultural rights. Most BITs contain a provision requiring "fair and equitable treatment" (FET) of investors. This protects the legitimate expectations of the investor. These expectations have, in some cases, been characterised in an extremely broad manner, and without taking the protection of human rights into account. In ***Tecmed v. Mexico***, the arbitration tribunal stated that:

> The foreign investor expects the host State to act in a consistent manner, free from ambiguity and totally transparently in its relations with the foreign investor, so that it may know beforehand any and all rules and regulations that will govern its investments, as well as the goals of the relevant policies and administrative practices or directives, to be able to plan its investment and comply with such regulations. Any and all State actions conforming to such criteria should relate not only to the guidelines, directives or requirements issued, or the resolutions approved thereunder, but also to the goals underlying such regulations. The foreign investor also expects the host State to act consistently, i.e. without arbitrarily revoking any pre-existing decisions or permits issued by the State that were relied upon by the investor to assume its commitments as well as to plan and launch its commercial and business activities.[130]

[127] CESCR, ***General Comment No. 24, State obligations under the ICESCR in the context of business activities,*** 10 August 2017, 21; ***Mehmet Şentürk and Bekir Şentürk v Turkey,*** ECtHR Judgement of 9 April 2013, 96-97.

[128] Constitutional Court of Belgium, No. 4607. C. C., n°2009-170, 29 October 2009. The case concerned the regulation establishing the limits on claiming supplementary fees from patients staying in individual hospital rooms, which were the same for the public and private sector. Two physicians from the private sector complained about the inadequacy of this regulation. The Court found that while such similar treatment was not always appropriate, in this case it was. The detrimental impact treating authorised and non-authorised doctors in the same manner was not disproportionate to the positive outcome of ensuring that patients could affordably access healthcare.

[129] CESCR, ***General Comment No. 24, State obligations under the ICESCR in the context of business activities,*** 10 August 2017, 13; ***Guiding principles on business and human rights,*** HRC, Resolution 17/4, HR/PUB/11/04, 2011, principle 9.

[130] ***Técnicas Medioambientales Tecmed, S.A. v. The United Mexican States,*** ICSID Case No. ARB (AF)/00/2 (2003), 154. Tecmed was operating a hazardous waste landfill. The license was originally indefinite, but later replaced by a two-year license which was subsequently not renewed after protests by the local community against the landfill. Tecmed argued this refusal was arbitrary and violated their right to fair and equitable treatment.

Against this background, while the CESCR has encouraged States to ensure that mechanisms for the settlement of investor State disputes take human rights into account,[131] this goal is difficult to achieve. For example, in ***Suez and Vivendi v Argentina,*** the State had imposed a limit on charges for water provision by the investor during the 1998 – 2002 Argentine economic crisis, which made the project less profitable but, arguably, was necessary to ensure the affordability of water. The tribunal found that Argentina had violated the fair and equitable treatment provision[132] and that the State must adhere to obligations arising from both investment law and human rights law but did not specify how this could be achieved.

The conflict between investment law and human rights law is exacerbated by the power difference between their enforcement mechanisms. Investor-State Dispute Settlement, contained in most BITs and contracts, allows investors to resort to international arbitration if they feel States have violated their rights, and obtain an enforceable award on compensation. Therefore, States experience the so-called "regulatory chill", leading to their avoidance of implementing regulations which might make them vulnerable to arbitration. Stabilisation clauses, which are often part of investor-state contracts, have an even broader effect as they preclude any future regulation that negatively affects profits from applying to the project. [133] The regulatory chill can prevent States from adopting or enforcing regulation that is required by international human rights law in the context of the right to health or from correcting mistakes made in the process of privatisation. For example, a State could be prevented, by international investment law, from introducing caps on user fees or from increasing minimum quality standards if a foreign investor had reason to believe that, under their contract, such steps would not be taken. Moreover, participation can be rendered meaningless if the State unduly restricts its own discretion from the outset.

The recent case of ***Urbaser v. Argentina*** sheds some light on the options that States have in order to comply with human rights requirements when contracting out services. The tribunal confirmed that States can confer human rights obligations on investors by way of investor-states-contracts.[134] Similarly, in India, in the case of a joint venture by the government and a private provider, the High Court of Delhi has found that:

> By agreeing to be a partner with the State in the matter of health care, with stipulations about free health care to the specified extent, [the consortium] had taken onto itself the mantle of State instrumentality. The discourse on 'right to health' would show that it hardly lies in the mouth of the private player to turn around and abdicate its responsibility, after having offered its services for establishing a multi-disciplinary super-specialty hospital on the terms inclusive of benevolent arrangements for the poor and indigent and in the bargain having secured State largesse in the form of prime parcel of public land and monetary contribution.135

[131] CESCR, ***General Comment No. 24, State obligations under the ICESCR in the context of business activities,*** 10 August 2017, 13.
[132] ***Suez, Sociedad General de Aguas de Barcelona S.A., and Vivendi Universal S.A. v. Argentina,*** ICSID Case No. ARB/03/19 (2010), Decision on Liability, 247.
[133] Leader S, ***Human rights, risks, and new strategies for global investment,*** 9(3) Journal of International Economic Law, 2006, 657 and 672.
[134] ***Urbaser SA and Consorcio de Aguas Bilbao Bizkaia, Bilbao Biskaia Ur Partzuergoa v. Argentina,*** ICSID Case No. ARB/07/26 (2016), 1210. The case concerned similar facts as Suez Vivendi, namely regulations introduced by Argentina to ensure the affordability of water (which was provided by private actors) during the economic crisis.
[135] ***All India Lawyers Union v. Government of NCT of Delhi and Others*** (2009), High Court of Delhi, 30.

As a consequence of human rights obligations being included in investor-state contracts, an investor breaching these obligations would no longer be entitled to compensation for regulations that affect the profitability of the project if they are undertaken to safeguard human rights. To the contrary, the State could even bring a claim before an investment tribunal against an investor that fails to comply with its contractual obligations.

To avoid entering into agreements that unduly restrict policy space, States are required to conduct human rights impact assessments prior to the adoption of agreements.[136] To this end, the former Special Rapporteur on the right to food, Olivier de Schutter, developed a set of "Guiding Principles on human rights impact assessments of trade and investment agreements". Key elements of these principles are, that impact should be assessed ex ante and periodically ex post; [137] that the procedure of preparing the assessment should itself follow a human rights based approach including principles of non-discrimination, inclusive participation, transparency, and accountability;[138] that the group or body tasked with preparing the assessment must possess sufficient expertise and funding;[139] and that explicit reference to the normative content of human rights should be made and human rights indicators should be incorporated.[140]

[136] CESCR, ***General Comment No. 24, State obligations under the ICESCR in the context of business activities,*** 10 August 2017, 13; De Schutter O, R***eport of the Special Rapporteur on the right to food: Guiding principles on human rights impact assessments of trade and investment agreements,*** A/HRC/19/59/Add.5, 19 December 2011, 2; CESCR, ***Concluding Observations: Ecuador,*** E/C.12/1/Add.100, 7 June 2004, 56; CRC, ***Concluding Observations: El Salvador,*** CRC/C/15/Add.232, 30 June 2004, 48; CEDAW***, Concluding Observations: Colombia,*** CEDAW/C/COL/CO/6, 2 February 2007, 29; CEDAW, ***Concluding Observations: Philippines***, CEDAW/C/PHI/CO/6, 25 August 2006, 26; CEDAW, ***Concluding Observations: Guatemala,*** CEDAW/C/GUA/CO/6, 2 June 2006, 32; De Schutter O, ***Report of the Special Rapporteur on the right to food on his mission to the World Trade Organisation,*** A/HRC/10/5/Add.2,37-38.

[137] De Schutter O, ***Report of the Special Rapporteur on the right to food: Guiding Principles on human rights impact assessments of trade and investment agreements,*** A/HRC/19/59/Add.5, 19 December 2011, principle 3 (3).

[138] Ibid, principle 4.

[139] Ibid, principle 4.

[140] Ibid, principle 5.

3.2.6 Extraterritorial obligations

Under international human rights treaties such as the ICESCR, the Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities, States have an obligation to engage in international cooperation and assistance for economic, social and cultural rights, including the right to health.[141]

With regard to the right to health, the CESCR has established that:

> States parties have to respect the enjoyment of the right to health in other countries, and to prevent third parties from violating the right in other countries, if they are able to influence these third parties by way of legal or political means, in accordance with the Charter of the United Nations and applicable international law. Depending on the availability of resources, States should facilitate access to essential health facilities, goods and services in other countries, wherever possible, and provide the necessary aid when required. [142]

The obligations to respect, protect and fulfil the right to health thus extend beyond state borders. These extraterritorial obligations are fleshed out by the UN treaty bodies and summarised in the Maastricht Principles on Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights (see figure 3).

Figure 3. The Maastricht Principles on Extraterritorial Obligations of States in the Area of Economic, Social and Cultural Rights

In light of the realisation that globalisation and international interdependencies create significant challenges for the universal realisation of human rights, the ETO Consortium, a network of over 140 academics and civil society organisations, developed the Maastricht Principles on Extraterritorial Obligations (ETOs) of States in the Area of Economic, Social and Cultural Rights. While the Principles are not themselves legally binding, they are based on extensive research and analysis of international law and have influenced the practice of international human rights bodies. The Principles adopt the tripartite framework of obligations to "respect, protect and fulfil" and flesh out the meaning of these obligations in an extraterritorial context.

3.2.6.1 Development cooperation

Based on the above, it can be concluded that, insofar as private actor involvement in health care services and health financing harms the right to health, donor States should abstain from funding such an endeavour or from requiring privatisation as a condition for the continued provision of financial assistance. This is supported by the latest Concluding Observations by both the CESCR and the CRC on the United Kingdom, which welcome the spending of 0.7% Gross National Product (GNP) on Official Development Assistance (ODA) but express concern over

[141] Article 2(2), ICESCR; article 4; CRC, article 4(2).
[142] CESCR, *General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant)*, 11 August 2000, 39.

the use of this assistance for activities in contravention to human rights, particularly for support to private actors providing education in developing countries in a way which may undermine the quality of free public education and create discrimination among students (see figure 4).[143]

Figure 4. The UN treaty bodies on international assistance and privatisation of education

CESCR:

While welcoming the achievement by the State Party of the international target of allocating 0.7 per cent of gross national product for official development assistance in the framework of international cooperation, the Committee is concerned that in some cases the assistance provided has reportedly been used for activities in contravention of economic, social and cultural rights in the receiving countries. The Committee is particularly concerned about the financial support provided by the State Party to private actors for low-cost and private education projects in developing countries, which may have contributed to undermining the quality of free public education and created segregation and discrimination among pupils and students (articles. 2, 13 and 14)

…

The Committee calls upon the State Party to adopt a human rights-based approach in its international development cooperation by: (a) Undertaking a systematic and independent human rights impact assessment prior to decision-making on development cooperation projects; (b) Establishing an effective monitoring mechanism to regularly assess the human rights impact of its policies and projects in the receiving countries and to take remedial measures when required; (c) Ensuring that there is an accessible complaint mechanism for violations of economic, social and cultural rights in the receiving countries embedded in the framework for development cooperation projects.[144]

CRC:

In the context of international development cooperation, the Committee is concerned about the State Party's funding of low-fee, private and informal schools run by for-profit business enterprises in recipient States. Rapid increase in the number of such schools may contribute to substandard education, less investment in free and quality public schools and deepened inequalities in the recipient countries, leaving behind children who cannot afford even low-fee schools.

…

The Committee recommends that the State Party ensure that its international development cooperation supports the recipient States in guaranteeing the right to free compulsory primary education for all, by prioritising free and quality primary education in public schools, refraining from funding for-profit private schools and facilitating registration and regulation of private schools.[145]

[143] CESCR, ***Concluding Observations: United Kingdom,*** 24 June 2016,14; CRC, ***Concluding Observations: United Kingdom***, 3 June 2016, 17.

[144] CESCR, ***Concluding Observations: United Kingdom,*** 14-15.

[145] CRC, ***Concluding Observations: United Kingdom,*** CRC/C/GBR/C O/5, 3 June 2016, 17-18.

This does not undermine the obligation to provide international assistance, which is firmly established in the practice of the UN treaty bodies and special procedures.[146] Rather, it is about the way this assistance is spent. The CRC has stated that 'The Convention should guide all international activities and programmes of donor and recipient States related directly or indirectly to children's health.'[147] The CESCR asserts that in times of emergency and humanitarian actions, 'Priority in the provision of […] financial aid should be given to the most vulnerable or marginalised groups of the population'.[148] To avoid breaching their extraterritorial obligations, States must exercise due diligence,[149] e.g. through conducting human rights impact assessments.[150]

These obligations extend to aid channelled through international organisations, including international financial institutions. In this case, States are required to use their influence in the institution to safeguard the right to health in its activities.[151]

3.2.6.2 Obligations concerning activities of corporations and other private entities

The UN treaty bodies, as well as the above-mentioned Maastricht Principles, also recognise an obligation to regulate or influence, within the limits of international law, the conduct of entities that are acting, and are potentially violating human rights abroad, where there is a sufficient nexus to the regulating State.[152]

This obligation, according to the CESCR, comprises administrative, legislative, investigative, adjudicative and other measures, including setting incentives through economic or political and diplomatic activities. Corporations should be required to exercise due diligence to identify, prevent and address human rights violations, not only in their own operations abroad, but also by their subsidiaries and business partners.[153]

[146] CESCR, ***General Comment No. 3, The nature of states parties' obligations (article 2, para. 1, of the Covenant),*** 14 December 1990, 14; CESCR, ***General Comment No. 24, State obligations under the ICESCR in the context of business activities,*** 10 August 2017, 45; Hunt P, ***Report of the Special Rapporteur on the right to the highest attainable standard of health, Mission to Sweden,*** A/HRC/4/28/Add.2, 28 February 2007, 110; CRC, ***General Comment No. 15 (2013), The right of the child to the enjoyment of the highest attainable standard of health (article 24),*** 17 April 2013, 89. The Concluding Observations in which the CESCR has criticised States for not meeting the international target of spending 0.7% of their GNP on official development assistance, e.g., CESCR, ***Concluding Observations: Spain,*** 2012, 10; CESCR, ***Concluding Observations: Canada,*** 2016, 11; CESCR, ***Concluding Observations: Italy***, 2015, 8 and 12; CESCR, ***Concluding Observations: Ireland,*** 2015, 36.

[147] CRC, ***General Comment No. 15 (2013), The right of the child to the enjoyment of the highest attainable standard of health (article 24),*** 17 April 2013, 87.

[148] CESCR, ***General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant)***, 11 August 2000, 40.

[149] CESCR, ***Concluding Observations: France,*** 2016, 7.

[150] ***Maastricht principles on extraterritorial obligations of states in the area of economic, social and cultural rights,*** 2011, principle 14. Further explanation in De Schutter O et al, ***Commentary to the Maastricht principles on extraterritorial obligations of states in the area of economic, social and cultural rights,*** 34 Human Rights Quarterly, 2012, 1084.

[151] CESCR, ***General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant)***, 11 August 2000, 39; Hunt P, ***Report of the Special Rapporteur on the right to the highest attainable standard of health, Mission to Sweden,*** A/HRC/4/28/Add.2, 28 February 2007, 108.

[152] ***Maastricht principles on extraterritorial obligations of states in the area of economic, social and cultural rights,*** 2011, principles 24 and 26; CESCR, ***General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant),*** 11 August 2000, 39; CESCR, ***General Comment No. 24, State obligations under the ICESCR in the context of business activities***, 10 August 2017, 26 and 28; CRC, ***General Comment 16,*** 43 and 46.

[153] CESCR, ***General Comment No. 24, State obligations under the ICESCR in the context of business activities***, 10 August 2017, 33.

The right to a remedy and reparation also applies to extraterritorial violations. The CESCR in General Comment 24 provides that:

> States parties have the duty to take necessary steps to address these challenges [to the access of remedies in transnational cases] in order to prevent a denial of justice and ensure the right to effective remedy and reparation. This requires States Parties to remove substantive, procedural and practical barriers to remedies, including by establishing parent company or group liability regimes, providing legal aid and other funding schemes to claimants, enabling human rights-related class actions and public interest litigation, facilitating access to relevant information and the collection of evidence abroad, including witness testimony, and allowing such evidence to be presented in judicial proceedings. The extent to which an effective remedy is available and realistic in the alternative jurisdiction should be an overriding consideration in judicial decisions relying on ***forum non conveniens*** considerations.[154]

Additionally, the Maastricht Principles state that the obligation to regulate extends to situations where:

a) the harm or threat of harm originates or occurs on its territory;
b) where the non-State actor has the nationality of the State concerned;
c) as regards business enterprises, where the corporation, or its parent or controlling company, has its centre of activity, is registered or domiciled, or has its main place of business or substantial business activities, in the State concerned;
d) where there is a reasonable link between the State concerned and the conduct it seeks to regulate, including where relevant aspects of a non-State actor's activities are carried out in that State's territory;
e) where any conduct impairing economic, social and cultural rights constitutes a violation of a peremptory norm of international law, where such a violation also constitutes a crime under international law, States must exercise universal jurisdiction over those bearing responsibility or lawfully transfer them to an appropriate jurisdiction.[155]

The Maastricht Principles further emphasise that States must cooperate with each other to prevent human rights violations by private actors, and to provide remedies where a violation has occurred,[156] and on the subject of remedies in transnational cases, elaborate that States should:

a) seek cooperation and assistance from other concerned States where necessary to ensure a remedy;
b) ensure remedies are available for groups as well as individuals;
c) ensure the participation of victims in the determination of appropriate remedies;
d) ensure access to remedies, both judicial and non-judicial, at the national and international levels; and
e) accept the right of individual complaints and develop judicial remedies at the international level.[157]

As part of the provision of remedies, States must also ensure adequate reparation for victims for extraterritorial violations.[158]

[154] Ibid, 44.
[155] *Maastricht principles on extraterritorial obligations of states in the area of economic, social and cultural rights,* 2011, principle 25.
[156] Ibid, principle 27.
[157] Ibid, principle 37.
[158] Ibid, principle 38.

3.3 Normative content and cross cutting rights and principles

3.3.1 The AAAQ Framework: availability, accessibility, acceptability and quality

Under the obligation to protect, the CESCR requires States to ensure that 'privatisation of the health sector does not constitute a threat to the availability, accessibility, acceptability and quality of health facilities, goods and services'.[159] The framework of availability, accessibility, acceptability and quality, also called the AAAQ framework, has been established in General Comment 14 and widely used in context of the right to health. Within the 2030 Sustainable Development Agenda, availability and accessibility are key pillars under the drive for Universal Health Coverage, which is a central element of Sustainable Development Goal 3 (see figure 7).

Availability refers to the provision of a sufficient amount of health services for the entire population of a territory. [160] This involves the provision of an adequate quantity of 'functioning public health and health-care facilities, goods and services, as well as programmes'.[161] The involvement of private actors in health care could impact the availability of health services as evidenced in the case described in figure 5. These include infrastructural aspects such as clinics, hospitals and sanitation facilities, as well as trained medical professional and essential treatments. Regarding the latter, it may be the case that better working conditions in the private sector lead to a loss of a health workforce from the public to the private sector, decreasing the availability of (potentially free or low-cost) public services.[162]

Figure 5. For-profit private actors and availability

In the case of ***Mariela Viceconte v. Ministry of Health and Social Welfare***,[163] the private sector found it unprofitable to manufacture a particular vaccine for Argentine haemorrhagic fever. However, since the disease threatened over 3.5 million people, the court ruled that it was the Government's responsibility to ensure access to the drug. In this case, the private system was clearly failing to ensure a higher level of availability of healthcare services and facilities.

Accessibility of health services has four different dimensions: non-discrimination, physical accessibility, economic accessibility, and the accessibility of information.[164]

(i) Accessibility of healthcare has to be ensured for everyone without discrimination. As such, healthcare service provision must be ensured without discrimination, especially with reference to vulnerable and marginalised groups.

[159] CESCR, ***General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant),*** 11 August 2000, 35.

[160] Toebes B, ***Human rights and health sector corruption,*** in Harrington J and Stuttaford M (eds) ***Global health and human rights,*** Routledge, New York, 2010, 177 –178.

[161] CESCR, ***General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant),*** 11 August 2000,12 (a).

[162] Hunt P, Special Rapporteur on the right to health, A/HRC/7/11/Add.4, 29 February 2008. ***Note on mission to India,*** paras. 18 and 22 in which the Special Rapporteur comments on the low percentage of health professionals in the public sector and the lack of availability of (free) public services, particularly those that are lifesaving, forcing patients to access private services which may impoverish them.

[163] ***Viceconte, Mariela Cecilia v. State of Argentina (Health Department)*** (1998), Federal Administrative Court, Argentina.

[164] CESCR, ***General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant),*** 11 August 2000,12 (b). This framework also applies to the underlying determinants of health, in addition to healthcare.

(ii) Economic accessibility means that services must be affordable or economically accessible to all. Here, the CESCR emphasises that payment for healthcare must be based on the principle of equity;[165] States must protect socially disadvantaged groups and health care costs must not disproportionately burden poorer households.
(iii) Physical accessibility requires ensuring that health facilities are within safe physical reach to all, especially vulnerable groups.
(iv) Information accessibility involves ensuring the right to request, gain access to and impart information relating to health.[166]

The UN treaty bodies have many times pointed to how private involvement can hinder accessibility on the basis of equality and non-discrimination (see figure 6), as there can be a disproportionate impact on vulnerable, disadvantaged and marginalised groups,[167] including particularly, but not limited to, women,[168] the rural population,[169] the unemployed and underemployed, the homeless and those living in poverty.[170]

Figure 6. Selected UN treaty bodies' statements on privatisation of healthcare services and its impact on vulnerable groups

CEDAW:

Concluding comments for India

… In addition, the Committee is concerned that the privatisation of health services has an adverse impact on women's capacity to access such services.
…
It calls upon the State Party to balance the roles of public and private health providers in order to maximise resources and the reach of health services. It calls upon the State Party to monitor the privatisation of health care and its impact on the health of poor women and provide such information in its next periodic report.[171]

Concluding observations for Pakistan

The Committee is […] further concerned at the wide privatisation of the health system and the inadequate budget allocated to the health sector, in particular with regard to sexual and reproductive health-care services, especially in rural remote areas.[172]

CESCR:

Concluding observations for El Salvador

The Committee considers that the budget allocated for the health sector is insufficient in order to provide adequate coverage for the population, in particular for vulnerable groups. It notes that access to health services is limited owing to the lack of financial means allocated

[165] Ibid, 12 (b)(ii).
[166] Ibid, 12 (b) (i) – (iv).
[167] CESCR, ***Concluding Observations: El Salvador,*** 27 June 2007, 24; CESCR, ***Concluding Observations: India,*** 8 August 2008, 38; CESCR, ***Concluding Observations: Republic of Korea***, 17 December 2009, 22.
[168] CEDAW, ***Concluding Comments: India***, 2 February 2007, 40.
[169] CEDAW, ***Concluding Observations: Pakistan***, 27 March 2013, 31.
[170] CESCR, ***Concluding Observations: Croatia***, 5 December 2001, 34.
[171] CEDAW, ***Concluding Comments: India***, 2 February 2007, 40-41.
[172] CEDAW, ***Concluding Observations: Pakistan,*** 27 March 2013, 31.

by the State Party to the public sector, and by the preference for a private-sector approach to the management, financing and provision of services, to the detriment of those who are unable to pay for such services.[173]

Concluding observations for India

The Committee notes with concern that the universal health-care scheme in the State Party falls short of providing for universal coverage, excluding a considerable portion of the population. The Committee is also concerned that the quality and the availability of the health services provided under the scheme have been adversely affected by the large-scale privatisation of the health service in the State Party, impacting in particular on the poorest sections of the population.

…

The Committee recommends that the State Party substantially increase funds allocated to public health and to provide additional incentives in order to prevent further loss of medical professionals from the public health services. The Committee also urges the State Party to take all necessary measures to ensure universal access to affordable primary health care. The Committee also requests the State Party to provide information on the measures to regulate the private health-care sector.[174]

Concluding observations for Republic of Korea

The Committee is therefore concerned at inadequate public social expenditure and the high level of privatisation of social services, including health care, education, water and electricity supplies, which has led to greater difficulties in the access and use of such services by the most disadvantaged and marginalised individuals and groups. [175]

Concluding observation for Croatia

The Committee recommends that the State Party carefully review the probable effects of its plans to privatise portions of the national health-care system on the most disadvantaged and marginalised sectors of society, including, in particular, the unemployed and underemployed, the homeless and those living in poverty.[176]

An increase in private sector provision of health services may increase inequity in access to medical services as it excludes people who are unable to pay for treatment.[177] In 2012, the Special Rapporteur on the Right to Health also found that 'In many cases, privatisation has led to increased out-of-pocket payments for health goods and services, [...] and increased disparity in the availability of health facilities, goods and services among rural, remote and urban areas.'[178] This implies a decrease of affordability, which has also been criticised by the CESCR,[179] and a negative impact of private involvement on physical accessibility.

[173] CESCR, ***Concluding Observations: El Salvador,*** 27 June 2007, 24.
[174] CESCR, ***Concluding Observations: India***, 8 August 2008, 38 and 78.
[175] CESCR, ***Concluding Observations: Republic of Korea,*** 17 December 2009, 22.
[176] CESCR, ***Concluding Observations: Croatia,*** 5 December 2001, 34.
[177] Marriott A, ***Blind optimism: Challenging the myths about private health care in poor countries,*** Oxfam International, 2009, https://policy-practice.oxfam.org.uk/publications/blind-optimism-challenging-the-myths-about-private-health-care-in-poor-countries-114093 on 17 December 2019 .
[178] Hunt P, ***Report of the Special Rapporteur on the right of everyone to enjoyment of the highest attainable standard of physical and mental healt***h, E/CN.4/2003/58, 13 February 2003.
[179] CESCR, ***Concluding Observations, Vietnam***, 15 December 2014, 22.

The asymmetry of information between health care providers and health service users can also be compounded by a multiplicity of actors, making it difficult to access information and make informed choices.[180]

Figure 7. Universal Health Coverage

Universal health coverage (UHC), one of the targets for the 2030 Agenda for Sustainable Development, aims to ensure access to health services for all, without negative and lasting financial consequences.[181] This is closely linked to the fulfilment of States' right to health obligations and is an important benchmark from a human rights perspective, as it covers a minimum standard of availability and accessibility to health care.

There is a trend on the part of a number of donors and developing countries to favour privatisation, particularly in the provision of health insurance and through public-private partnerships, in order to achieve UHC.[182]

Health care services, goods and facilities must be acceptable in their delivery. Under this provision 'all health facilities, goods and services must be respectful of medical ethics and culturally appropriate.'[183] Health facilities must, therefore, be respectful and sensitive to cultural differences and requirements.

Quality of healthcare must be of adequate and appropriate service standard[184] including by ensuring 'skilled medical personnel, scientifically approved and unexpired drugs and hospital equipment, safe and potable water, and adequate sanitation.'[185]

UN human rights bodies have voiced concern about quality in relation to private actor involvement in three aspects: firstly, where there is a lack of regulation of private actors regarding the quality of their services, secondly, where there are disparities in quality depending on patients' ability to pay, and thirdly and relatedly, dissatisfaction with the quality of public services leading patients to prefer private services even if they are impoverished by the fees.[186]

In sum, private involvement in healthcare and financing can impact all aspects of the AAAQ framework. The most cited concerns are equality and non-discrimination or the impact of private involvement on vulnerable groups, affordability, and quality, but availability, physical and information accessibility can also be impacted.

[180] Arrow K.J., ***Uncertainty and the welfare economics of medical care,*** 53(5) The American Economic Review, 1963, 941
[181] World Health Organisation, ***Universal Health Coverage (UHC) Fact Sheet Number 395,*** updated December 2016, --< https://www.who.int/news-room/fact-sheets/detail/universal-health-coverage-(uhc) > on 17 December 2019.
[182] Chapman AR, ***Global health, human rights and the challenge of neoliberal policies,*** Cambridge University Press, United Kingdom, 2016, 297.
[183] CESCR, ***General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant),*** 11 August 2000, 12 (c).
[184] Ibid, 12 (b) (iii).
[185] Ibid,12(d).
[186] CRC, ***Concluding Observations on the consolidated third and fourth periodic reports of India***, 63; Hunt P, Special Rapporteur on the right to health, A/HRC/7/11/Add.4, 29 February 2008. ***Note on mission to India,*** 23; Grover A, ***Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health***, A/HRC/20/15/Add.2, 4 June 2012; CRC, ***Concluding Observations: Lebanon,*** 21 March 2002, 42; ***Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health on his visit to Algeria***, A/HRC/35/21/Add.1, 20 April 2017, 34.

3.3.2 Equality and non-discrimination

The principle of equality and non-discrimination is an immediate obligation under the ICESCR. States must realise the right to health without discrimination on any grounds, including race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, and civil, political, social or other status.[187] The International Convention on the Elimination of All Forms of Racial Discrimination,[188] the Convention on the Elimination of All Forms of Discrimination Against Women,[189] and the Convention on the Rights of Persons with Disabilities[190] also reference the need to eliminate racial, disability and gender-based discrimination in the provision and financing of health.

As stated above, within the AAAQ framework, non-discrimination is also reflected in acceptability, as the CESCR states that 'all health facilities, goods and services must be respectful of medical ethics and culturally appropriate, i.e. respectful of the culture of individuals, minorities, peoples and communities, sensitive to gender and life-cycle requirements'.[191] The AAAQ framework covers accessibility on the basis of non-discrimination, in law and in fact.[192]

In General Comment 16, the CESCR defines discrimination as:

> differential treatment of a person or a group of persons based on their particular status or situation, such as race, colour, sex, language, religion, political, and other opinion, national or social origin, property, birth or other status, such as age, ethnicity, disability, marital or refugee or migrant status.[193]

Ensuring non-discrimination requires an equitable system and affirmative action where necessary.[194] This includes protecting vulnerable groups by adopting 'relatively low-cost targeted programmes' and adopting strategies to eliminate health-related discrimination.[195]

International law places special emphasis on the rights of vulnerable groups. The CESCR's General Comment No. 14 devotes specific sections to elaborating the right to health of older persons, persons with disabilities and indigenous peoples emphasising that the State must ensure that private providers do not discriminate against persons with disabilities.[196] There is a general recognition that vulnerable groups may not only require additional care or treatment, they may also be more at risk of negative impact due to their particular circumstances. This also applies in health care financing.

[187] I*nternational Covenant on Economic, Social and Cultural Rights,* 1966, article 2(2).
[188] I*nternational Convention on the Elimination of All Forms of Racial Discrimination,* 1965, article 5.
[189] *Convention on the Elimination of All Forms of Discrimination Against Women,* 1979, article 12.
[190] *Convention on the Rights of Persons with Disabilities,* 2006, article 3.
[191] CESCR, *General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant),* 11 August 2000, 12(c).
[192] Ibid, 12(b).
[193] CESCR, *General Comment No. 16, The equal right of men and women to the enjoyment of all economic, social and cultural rights (article 3 of the Covenant)*, 11 August 2005,10.
[194] CESCR, *General Comment No. 18, The right to work (article 6 of the Covenant),* 6 February 2006, 7-8.
[195] CESCR, *General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant)*, 11 August 2000, 8.
[196] Ibid, 26.

> ***The Committee on the Rights of the Child (CRC) has emphasised that:***
>
> ***Private health insurance companies should ensure that they do not discriminate against pregnant women, children or mothers on any prohibited grounds and that they promote equality through partnerships with State health insurance schemes based on the principle of solidarity and ensuring that inability to pay does not restrict access to services.*** [197]

The CESCR General Comment 14 restates the importance of ensuring equality of access to health care,[198] specifying that non-discrimination in the application of the right to health and the equitable distribution of health services are core obligations.[199] The CESCR stresses that inappropriate resource allocation can have indirect discriminatory effects.[200] In the context of a competitive market open to private actors, several problems may arise. Certain types of health risks may be non-marketable, and markets may not always provide insurance for all conditions and groups of patients[201] without some form of regulation. In addition, the multiplicity of providers can make the integration of facilities and services difficult, which particularly impacts health service users who have multiple needs requiring the cooperation of different services. Such services include, for example, elderly care as a combination of neurological, cardiac, and various other health services.[202] This may be a point of issue for the equal treatment of vulnerable groups, especially when they have needs that require specific accommodation. While competition can encourage equity through more opportunity for choice, and the effect of a "public vote of confidence", it is unclear and difficult to measure what type of competition can positively impact equitable distribution.[203]

3.3.3 Participation

Participation includes involvement of health service users in decision making in terms of their own health and healthcare. It also includes participation in decision-making related to policy development, implementation and review at the national, regional and local levels.[204]

The CESCR emphasises that 'effective provision of services can only be assured if people's participation is secured by States' [205] and calls for:

> the improvement and furtherance of participation of the population in the provision of preventive and curative health services, such as the organisation of the health sector, the insurance system and, in particular, participation in political decisions relating to the right to health taken at both the community and national levels.[206]

[197] CRC, *General Comment No. 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (article 24)*, 83.
[198] CESCR, *General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant),* 11 August 2000, 12(a) and 18-19.
[199] Ibid, 43 (a) and (e).
[200] Ibid, 19.
[201] Stirton L, *Back to the Future? Lessons on the pro-competitive regulation of health services,* 22(2) Medical Law Review, 2014, 180-199.
[202] Newdick C, *From Hippocrates to commodities: Three models of NHS governance: NHS governance, regulation, Mid Staffordshire inquiry, health care as a commodity,* 22(2) Medical Law Review, 2014, 162–179.
[203] Hunter DJ, *The case against choice and competition,* 4(4) Health, Economics, Policy and Law, 2009, 489.
[204] CESCR, *General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant),* 11 August 2000, 54.
[205] Ibid, 54.
[206] Ibid, 17.

The State has a legal obligation to refrain from preventing people's participation in health-related matters.[207]

As the ability and willingness of health system users to effectively participate is directly linked to the information accessible to them, there is a need for transparency in all matters relating to the private actor involvement.[208]

Furthermore, the need for private healthcare providers to maintain transparency becomes increasingly important, since there is a need to keep health service users and rights holders more generally informed in order to ensure participation.

3.3.4 Accountability

Accountability is a fundamental part of the human rights obligations. Private actor involvement can represent a potential risk if States do not take into consideration their human rights obligations, properly regulate the private actors in the health system, and ensure robust systems of accountability.[209]

The fundamental features of accountability from a human rights perspective are monitoring, review, and remedies.[210] Regulation and transparency are essential for accountability including for the private sector.[211] The following sections elaborate on these features, linking them with private involvement in the health sector.

3.3.4.1 Monitoring

Monitoring the compliance of States with their human rights obligations is essential in maintaining accountability.[212] Monitoring can reveal where progress has been made and identify difficulties in the implementation of State obligations with regard to the right to health.[213]

The collection and evaluation of data in a systematic, regular manner is essential in monitoring the realisation of the right to health. The realisation of the right to health requires the use of appropriate indicators and benchmarks, in order to measure the accomplishment of the obligations related to article 12 of the ICESCR. General Comment No. 14 elaborates that: 'National health strategies should identify appropriate right to health indicators and benchmarks. The indicators should be designed to monitor, at the national and international levels, the State Party's obligations under article 12.'[214]

[207] Ibid, 34.
[208] Vahdat S, Hamzehgardeshi L, Hessam S and Hamzehgardeshi Z, ***Patient involvement in health care decision making: A review***, 16(1) Iran Red Crescent Medical Journal, 2014, 1.
[209] Chapman AR, ***Global health, human rights and the challenge of neoliberal policies,*** Cambridge University Press, United Kingdom, 2016, 131.
[210] The Partnership for Maternal, Newborn and Child Health, ***A review of global accountability mechanisms for women's and children's health***, in Hunt P and Gray T (eds) ***Maternal mortality, human rights and accountability,*** Routledge, 2013, 161.
[211] OHCHR and Center for Economic and Social Rights, ***Who will be accountable? human rights and the post-2015 development agenda,*** HR/PUB/13/1, New York and Geneva, 2013, 22.
[212] Chapman AR, ***Global health, human rights and the challenge of neoliberal policies,*** Cambridge University Press, United Kingdom, 2016, 59.
[213] CESCR, ***General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant),*** 11 August 2000, 56.
[214] Ibid, 57.

> ***Similarly, the CRC states that:***
>
> ***States Parties should monitor and analyse the revenue collection, reach and outputs of actual expenditures for different groups of children during the budget year and from year to year, for example in terms of the availability, quality, accessibility and equitable distribution of services. States Parties are urged to ensure that resources and capacity are in place to conduct such monitoring and analyses, including of services outsourced to the private sector.*** [215]

Right to health indicators have been developed to assess structural, procedural and outcome aspects of the implementation of the right. The CESCR General Comment No 14 also focuses on the need for plans of action with specific targets and time frames for their fulfilment.[216] The data and evidence gathered through the indicators must be disaggregated and used for assessment. Indicators must measure and include various aspects of the right to health,[217] including underlying determinants of health. Furthermore, benchmarks must be set by individual States, in order to commit the State to a particular performance standard.[218]

The role of monitoring is crucial to the fulfilment of the State's obligations with regard to the human right to health, particularly the obligation to protect persons from infringements by third parties.[219] States must, therefore, set up regular reporting or alternative monitoring procedures to ensure that private actors meet the benchmarks set by the State with regard to the right to health. The State also has a duty to monitor the overall systemic impact of private actor involvement, particularly privatisation, on the enjoyment of this right.[220]

3.3.4.2 Review

Review is a process of analysing whether human rights commitments and obligations are being accomplished by States. The process can happen on the national, regional and global level[221] and involves the identification of good practices or shortcomings, and recommendations for action, when applicable.[222] Health policies and strategies should be accompanied by accountability,[223] for example States are 'required to periodically review their national policies'.[224] Review procedures may be independent, non-independent or peer review.[225]

[215] CRC, ***General Comment No. 19, public budgeting for the realisation of children's rights (article 4)***, 20 July 2016, 86.
[216] CESCR, ***General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant)***, 11 August 2000, 56
[218] Bantekas I and Oette L***, International human rights law and practice,*** Cambridge University Press, United Kingdom, 2017, 387.
[219] Ibid, 387.
[220] CESCR, ***General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant),*** 11 August 2000, 51.
[221] CEDAW, ***Concluding Comments: India,*** 2 February 2007, 41; Hunt P, Special Rapporteur on the right to health, A/HRC/7/11/Add.4, 29 February 2008, ***Note on mission to India,*** 23; CEDAW, ***Concluding Observations: Lebanon,*** 24 November 2015, 41-42.
[222] Commission on Information and Accountability for Women's and Children's Health, ***Keeping promises, measuring results,*** in Hunt P and Gray T (eds) ***Maternal mortality, human rights and accountability,*** Routledge, 2013, 176.
[223] OHCHR, ***The right to health, Fact Sheet Number 31, 2008,*** --< https://www.refworld.org/docid/48625a742.html > on 17 December 2019.
[224] CESCR, ***General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant),*** 11 August 2000, 36 and 43.
[225] The Partnership for Maternal, Newborn and Child Health, ***A review of global accountability mechanisms for women's and children's health,*** in Hunt P and Gray T (eds) ***Maternal mortality, human rights and accountability,*** Routledge, 2013, 161-162.

Independent review is made by a 'body composed by individuals, usually experts, that act in an independent capacity', in the sense that they do not accept external influence.[226] It is important to note that the independent body is not necessarily the judiciary, although in many countries separation of powers links the idea of independence to judges.[227] A health ombudsperson is an alternative way to increase the independence of the review.[228] The independent review can also be carried out by national human rights institutions, commissioners, independent oversight bodies of health services, etc. [229]

On the other hand, non-independent review bodies are composed of members who act as representatives or delegates of a stakeholder. Finally, the peer review is a form of reciprocal evaluation, sometimes involving other stakeholders like civil society organisations.[230]

For the review to be effective, the reviewers should make use of indicators disaggregated by sex, origin, social and economic status, geographic and other variables in order to identify inequalities in the distribution of health care.[231] The review should also be participatory and transparent.[232] Policy makers and legislators should ensure the results from the review process are taken into consideration when future national health policies and plans are drawn up.[233]

3.3.4.3 Provision of remedies

Accountability goes beyond justiciability and encompasses the entire legal process, aiming to provide a platform for redress. State obligations in international law include the implementation of mechanisms that ensure human rights are respected, and offer legal redress when they are not. Without appropriate remedial mechanisms in place, the protection of the right to health is weakened and rendered meaningless. States have the obligation, and private actors have the responsibility, to provide for, facilitate, and contribute to remediation. Notably, businesses have the responsibility to identify when they cause or contribute to adverse impacts, and to provide for and cooperate with legitimate remediation processes.[234]

[226] Ibid, 163.
[227] Hunt P, ***SDG series: SDGs and the importance of formal independent review: An opportunity for health to lead the way,*** Health and Human Rights Journal, 2015, --< http://www.hhrjournal.org/2015/09/02/sdg-series-sdgs-and-the-importance-of-formal-independent-review-an-opportunity-for-health-to-lead-the-way/ > on 17 December 2019.
[228] Commission on Information and Accountability for Women's and Children's Health, ***Keeping promises, measuring results,*** in Hunt P and Gray T (eds) ***Maternal mortality, human rights and accountability***, Routledge, 2013, 187.
[229] Hunt P, ***SDG series: SDGs and the importance of formal independent review: An opportunity for health to lead the way,*** Health and Human Rights Journal, 2015, --< http://www.hhrjournal.org/2015/09/02/sdg-series-sdgs-and-the-importance-of-formal-independent-review-an-opportunity-for-health-to-lead-the-way/ > on 17 December 2019, 225.
[230] The Partnership for Maternal, Newborn and Child Health, ***A review of global accountability mechanisms for women's and children's health,*** in Hunt P and Gray T (eds) ***Maternal mortality, human rights and accountability,*** Routledge, 2013, 163
[231] UNGA, ***Transforming our world: The 2030 agenda for sustainable development,*** 21 October 2015, A/RES/70/1, 74 (g).
[232] CESCR, ***General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant),*** 11 August 2000, 43 (f).
[233] Commission on Information and Accountability for Women's and Children's Health, ***Keeping promises, measuring results,*** in Hunt P and Gray T (eds) Maternal mortality, human rights and accountability, Routledge, 2013, 187.
[234] ***Guiding principles on business and human rights,*** HRC, Resolution 17/4, HR/PUB/11/04, 2011.

The right to an effective remedy is inscribed in article 2(3) of the International Covenant on Civil and Political Rights (ICCPR),[235] and article 8 of the Universal Declaration of Human Rights (UDHR).[236] In particular, the CESCR General Comment No. 14 sets out that 'any person or group victim of a violation of the right to health should have access to effective judicial or other appropriate remedies at both national and international levels.'[237]

However, there are inherent difficulties in attempts to ensure the provision of remedies for business-related human rights violations. If a private actor is considered a third-party, an entity that does not belong to the State or operate under its supervision, this challenges the ability of victims to seek effective remedies.[238] The adjunction of private entities reveals a problem of access to justice. In addition, the form taken by businesses, such as parent-subsidiary entities, may complicate access and delivery of remedy still further. Judgments against local subsidiaries are dependent on the willingness or ability of the State to enforce remedies.[239] These may lack effectiveness if the company has transferred profits to its parent and has limited funds as a result.[240] There may also be little actual enforceability if the parent and subsidiary companies are separate legal entities and they have limited liability from one to the other, resulting in no material basis for claims against the parent company.[241] When claims are brought against parent companies in the home states, this brings an added challenge from transnational jurisdiction issues, which not all courts accept,[242] and the difficulty of obtaining applicable legal counsel.[243]

The Ruggie Principles extend and apply the right to an effective remedy to business-related human rights abuses within a State's domestic jurisdiction, according to the foundational principle that:

> As part of their duty to protect against business-related human rights abuse, States must take appropriate steps to ensure, through judicial, administrative, legislative or other appropriate means, that when such abuses occur within their territory and/or jurisdiction those affected have access to effective remedy.[244]

Implementing the right to an effective remedy is not limited to ensuring there is access to a remedy, which can take different substantive forms, but extends to establishing a transparent, impartial process, which must be free from external influences and, in the case of international cases, include cross-border cooperation.

[235] ***International Covenant on Civil and Political Rights,*** 16 December 1966, 999 UNTS 171, article 2(3).
[236] ***Universal Declaration of Human Rights,*** 10 December 1948, 217 A (III), article 8.
[237] CESCR, ***General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant),*** 11 August 2000, 59.
[238] De Feyter K and Isa FG (eds), ***Privatisation and human rights in the age of globalisation,*** Intersentia, Antwerp, 2005, 254.
[239] McBeth A, ***Human rights in economic globalisation,*** in Joseph S and McBeth A (eds), ***Research handbook on international human rights law,*** Edward Elgar Publishing Limited, United Kingdom, 2010, 150.
[240] Rott P and Ulfbeck V, ***Supply chain liability of multinational corporations?***, 23(3) European Review of Private Law, 2015, 415- 416.
[241] Bilchitz D, ***The necessity for a business and human rights treaty,*** University of Johannesburg, 2014 --<https://ssrn.com/abstract=2562760 > on 17 December 2019.
[242] Joseph S, ***Liability of multinational corporations,*** in Langford M (ed), Social rights jurisprudence, Cambridge University Press, United Kingdom, 2008, 624.
[243] Bilchitz D, ***The necessity for a business and human rights treaty,*** University of Johannesburg, 2014 --<https://ssrn.com/abstract=2562760 > on 17 December 2019,18
[244] ***Guiding principles on business and human rights***, HRC, Resolution 17/4, HR/PUB/11/04, 2011, principle 25.

Recent efforts from the UN Office of the High Commissioner for Human Rights (OHCHR) have expounded the provision of effective remedy to include alternative non-judicial recourse.[245] States must provide not only an effective judicial process, but also secure alternate avenues of recourse, including administrative, legislative, or mediation-based mechanisms. The Ruggie Principles outline eight criteria for assessing the effectiveness of these non-judicial mechanisms, they must be: (a) Legitimate; (b) Accessible; (c) Predictable, to provide certainty; (d) Equitable; (e) Transparent; (f) Rights-compatible; (g) Evolving through continuous learning; and (h) Based on engagement and dialogue, to promote participation.[246]

The principles affirm a duty of the State to provide, facilitate, protect and supplement operative processes to offer victims of human rights violations adequate and sufficient compensation for their grievances. It is a duty that must take into account practical and procedural barriers to access to justice, and provide operational solutions within a comprehensive system. However, victims of human rights abuses continue to face legal, financial and practical barriers to accessing judicial and non-judicial mechanisms when seeking remedy, especially when they belong to vulnerable or marginalised categories of the population.[247] In addition, there have been reports that, in the case of business-related human rights violations, victims, witnesses, and legal representatives, have been subject to intimidation.[248]

3.3.4.4 Transparency

Transparency is defined as 'the availability of information about an actor allowing other actors to monitor the workings or performance of this actor.'[249] Considering that availability of information is fundamental to the accountability process, transparency facilitates accountability.[250] Besides that, transparency and accountability processes reinforces each other,[251] in the sense that accountability can demonstrate that more transparency is necessary for a specific issue.

In the context of health, States are required to ensure that third parties do not limit people's access to health-related information and services.[252] Indeed, access to information generally (such as budgets) and access to health information, represent an essential characteristic of the right to the highest attainable standard of health and, therefore, is part of an effective health system.[253]

Information related to prices, services free of charge, and the conditions to access certain

[245] OHCHR, ***Protect, Respect and Remedy: A Framework for Business and Human Rights.*** Report of the Special Representative of the Secretary-General on the issue of human rights and transnational corporations and other business enterprises, John Ruggie, 7 April 2008.
[246] ***Guiding principles on business and human rights,*** HRC, Resolution 17/4, HR/PUB/11/04, 2011, principle 31.
[247] OHCHR, ***Access to remedy for business-related human rights abuses: A scoping paper on State-based non-judicial mechanisms relevant for the respect by business enterprises for human rights: Current issues, practices and challenges,*** 17 February 2017.
[248] HRC, ***Business and human rights: Improving accountability and access to remedy,*** A/HRC/RES/32/10, 30 June 2016.
[249] Meijer A, ***Transparency,*** in Bovens M, Goodin RE and Schillemans T (eds) The Oxford handbook of public accountability, Oxford University Press, United Kingdom, 2014, 510-511.
[250] Ibid, 510-511.
[251] Ibid.
[252] CESCR, ***General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant),*** 11 August 2000, 35.
[253] Hunt P and Backman G, ***Health systems and the right to the highest attainable standard of health,*** in Grodin MA, Tarantola D, Annas GJ and Gruskin S (eds) ***Health and human rights in a changing world,*** Routledge, New York, 2013, 64.
[254] Toebes B, ***Human rights and health sector corruption,*** in Harrington J and Stuttaford M (eds) ***Global health and human rights,*** Routledge, New York, 2010, 110.

> ***The CESCR General Comment 14:***
>
> ***The national health strategy and plan of action should also be based on the principles of accountability, transparency and independence of the judiciary, since good governance is essential to the effective implementation of all human rights, including the realisation of the right to health. In order to create a favourable climate for the realisation of the right, States parties should take appropriate steps to ensure that the private business sector and civil society are aware of, and consider the importance of, the right to health in pursuing their activities.*** [258]

treatments [254] provide a better basis for a decision to the users of the health system. The access to information in health also facilitates better quality of services and public participation in the decision-making process regarding health policies and strategies.[255] Transparency and participation are fundamental before the adoption of privatisation in the health sector and for all decisions relating to the role and involvement of private actors.[256]

Transparency also helps in exposing corruption in the health system, as noted by the UN Special Rapporteur on the right to health, Dainius Puras, in his report on corruption and the right to health, presented in July 2017. He stresses several ways to improve transparency in health: public access to procurement bidding results, monitoring of the prices paid and analysis of bids; publication of criteria; the promotion of information that sets out the services and treatments to which individuals are entitled and how these services are reimbursed, and publication of transparent waiting lists.[257]

The requirement of transparency applies to all who work in the health sector, including States, international organisations, businesses and civil society organisations, whether independently or in partnerships.

Regarding privatisation, transparency is essential before, during and after decisions regarding the increased involvement of the private sector in the health system. Transparency should also be required in the conduct of the private actors in all matters, especially in relation to prices, types of services available, and quality of services, but always ensuring that personal medical information remains protected.

[255] Hunt P and Backman G, ***Health systems and the right to the highest attainable standard of health***, in Grodin MA, Tarantola D, Annas GJ and Gruskin S (eds) ***Health and human rights in a changing world,*** Routledge, New York, 2013, 64.
[256] Toebes B, ***Human rights and health sector corruption,*** in Harrington J and Stuttaford M (eds) ***Global health and human rights***, Routledge, New York, 2010, 111.
[257] UNGA, ***Globalisation and its impact on the full enjoyment of all human rights,*** A/72/137 14 July 2017.
[258] CESCR, ***General Comment No. 14, The right to the highest attainable standard of health (article 12 of the Covenant)***, 11August 2000, 55.

4. CONCLUSION

This report collates the existing legal framework regarding State obligations under international human rights law in the context of private actor involvement in the health sector. It further highlights some key issues for right to health norms and specific concerns and difficulties depending on the level and functioning of private involvement in the health system.

However, with particular reference to private involvement in health, there is insufficient empirical evidence on the impact of corporate actors in health services, and a lack of indicators and frameworks to assess the effects of increasing private involvement on the health system and the way different groups are affected. The development and application of such a framework must also take into account the variations in the functioning of privatisation, and the diversity in levels of private involvement.

This report also highlights a need for more empirical research and impact assessment. The development of specific methodologies for assessing the impact of the increasing involvement of the private sector in health systems would involve identifying the various factors, causes and effects, of private actor involvement, and the specific impacts on human rights. Such a process would aid and allow for monitoring of privatisation, which is necessary to fulfil States' obligations to citizens under international human rights law.

Studies suggest that an impact assessment on the right to health must be based on the principles of availability, accessibility, acceptability and quality of healthcare services.[259] There are few comprehensive studies of the systemic impact at a national level, or comparisons of a State's health system and its success before and after private sector involvement.[260]

This report, therefore, puts forth a preliminary human rights impact assessment framework (see Annex 1), with the intention of supporting on-going efforts by researchers and practitioners to determine the human rights impact of the increasing activity by private actors. Feedback from researchers and practitioners who utilised the framework will contribute towards further reflecting upon the most helpful framing for an impact assessment on this issue.

[259] Toebes B, ***The right to health and the privatisation of national health systems: A case study of the Netherlands,*** 9(1) Health and Human Rights, 2006, 120.

[260] de Wolf AH and Toebes B, ***Assessing private sector involvement in health care and universal health coverage in light of the right to health,*** 18(2) Health and Human Rights Journal, 2016.

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Annex 1:

Impact Assessment Framework

While assessment tools are often used in the context of environmental and social impact, human rights impact assessment can be defined as 'the process of predicting the potential consequences of a proposed policy, programme or project on the enjoyment of human rights.'[261] The purpose of impact assessment, therefore, is to keep both decision-makers and stakeholders informed, allowing for mitigation of potential negative effects and maximisation of positive effects of policies.[262]

The following impact assessment framework can be used to anticipate the potential effects that private involvement and the process of privatisation could have on the enjoyment of the right to health. The questions are based on the legal framework of the right to health, taking into consideration the notions of AAAQ, core obligations, maximum available resources, regulation and non-discrimination, as detailed earlier in this report. These considerations provide an outline for a rights-based approach to assessing the possible impact of an increase in private involvement in health service delivery and financing.

[261] Hunt P and MacNaughton G, ***Impact assessment, poverty and human rights: A case study using the right to the highest attainable standard of health,*** World Health Organisation, Health and Human Rights Working Paper Series Number 6, 200 -- < http://www.who.int/hhr/Series_6_Impact%20Assessments_Hunt_MacNaughton1.pdf > on 17 December 2019.

[262] Ibid.

Core Questions [263]

ISSUE (KEYWORD)	QUESTION	SUB-QUESTIONS/INDICATORS
IMPACT OF PRIVATE ACTOR INVOLVEMENT ON HEALTH SERVICES		
Availability	Are health goods, facilities and services available in sufficient quantity everywhere in the country?	How does private actor involvement affect the availability of: • health care to promote and protect physical and mental health, including primary healthcare? • good quality operational hospitals and clinics? • trained health professionals receiving domestically competitive salaries? In particular, are health professionals for the public sector lost to the private sector? • essential medicines as defined by the World Health Organisation? In particular, are medicines produced based on need rather than profitability? • programmes for prevention, treatment and control of epidemic and endemic diseases? • primary, secondary and tertiary care facilities?
Accessibility	Is there discrimination or inequality in the accessibility of health goods, facilities and services?	Does the health system ensure access without discrimination on any of the prohibited grounds, including race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status, including physical, sensory or mental disabilities and age? (see also impact on vulnerable groups)
	Are health goods, facilities and services physically accessible, particularly in poor and rural areas?	Does private actor involvement influence the distribution of facilities between urban and rural areas? Is public transportation available to safely access facilities?
	Are health goods, facilities and services affordable?	Does private actor involvement increase the cost of health insurance or health care? Are there instances where more expensive private facilities are crowding out free or low-cost public facilities? Are there measures in place to ensure that life-saving treatment is provided regardless of the ability to pay?
	Is health information and education accessible?	Is information available about which services and insurance options are available, whether public or private? Do individuals in private health facilities and in the private insurance system receive quality health information and education?

[263] Questions or sub-questions are partially taken from Hunt P and MacNaughton G, ***Impact assessment, poverty and human rights: A case study using the right to the highest attainable standard of health,*** World Health Organisation, Health and Human Rights Working Paper Series Number 6, 200 and de Wolf AH and Toebes B, ***Assessing private sector involvement in health care and universal health coverage in light of the right to health,*** 18(2) Health and Human Rights Journal, 2016 79-92.

ISSUE (KEYWORD)	QUESTION	SUB-QUESTIONS/INDICATORS
IMPACT OF PRIVATE ACTOR INVOLVEMENT ON HEALTH SERVICES		
Acceptability	Are health goods, facilities and services acceptable to everyone? Do health services respect medical ethics and are they sensitive to cultures and gender?	Do private actors in health respect: • the cultures of individuals, minorities, peoples and communities? • the perspectives and needs of women, men, older persons and adolescents • confidentiality and the need for privacy at home, school and work for various aspects of daily living. Are private insurance providers accepting all patients or selecting patients on the basis of their health or financial status? Are there measures in place to safeguard the autonomy of individuals in making decisions about their health and in the use of healthcare services?
Quality	Are health goods, facilities and services of good quality?	Are privately provided goods, facilities and services of adequate quality? Are there disparities in quality between the public and private sector? If so, are the better quality goods, facilities and services equally accessible to all?
Core Obligations	Are core obligations negatively affected by private actor involvement or privatisation?	How does private actor involvement or privatisation affect: • equitable distribution of all health goods, facilities and services, including for vulnerable groups? • provision of health facilities, goods and services on a non-discriminatory basis? • essential medicines and primary health care? • health strategies and plans of action, including in relation to immunisations for all? • reproductive, prenatal and maternal, and child health care? • education process concerning health and access to services • provision of adequate training for health personnel, including on human rights?

ISSUE (KEYWORD)	QUESTION	SUB-QUESTIONS/INDICATORS
IMPACT OF PRIVATE ACTOR INVOLVEMENT ON HEALTH SERVICES		
Maximum Available Resources	What are the trends in State spending on health and how do they relate to processes of privatisation?	Has health spending by the State increased or decreased? How has the allocation of resources within the health budget changed, and how does this affect different groups, particularly vulnerable groups? Are there any examples where health spending can be seen to have been more or less efficient than before? Are there any linkages to the role of the for-profit healthcare sector? Have there been examples of individuals, particularly those belonging to vulnerable groups, taking on greater cost, including through unpaid care, pay cuts for health workers, or increased costs for patients? How has the relation of State spending to available services changed?
Impact on Vulnerable, Marginalised or Disadvantaged Groups	Are there measures in place to measure disproportionate impact, mitigate it and take into account specific issues on the provision of health by private actors for vulnerable groups, including women, children, older persons, persons with disabilities or chronic health conditions, including those living with HIV, indigenous peoples, ethnic, linguistic and religious minorities, the rural population, the unemployed and underemployed, the homeless, those living in poverty, and members of the LGBTI+ community? Specific to women	How are vulnerable or disadvantaged groups being impacted by private actor involvement? Is it disproportionate in relation to other categories of the population? What are the compounding factors? Are there effective measures to mitigate this: • with impartial, transparent and participative processes? • with safeguards for the protection of each vulnerable or disadvantaged group? Are there effective measures in place to ensure that vulnerable or disadvantaged groups are not discriminated against by private health care and insurance providers? Do safeguards for the protection of women reflect the standards afforded by the Convention on the Elimination of all Forms of Discrimination Against Women and the work of the UN Committee on the Elimination of Discrimination against Women?

ISSUE (KEYWORD)	QUESTION	SUB-QUESTIONS/INDICATORS
IMPACT OF PRIVATE ACTOR INVOLVEMENT ON HEALTH SERVICES		
	Specific to children	Are there resources dedicated to maternal and reproductive health? Does private actor involvement influence the availability, accessibility, acceptability or quality of maternal and reproductive health services? Do safeguards for the protection of children reflect the standards afforded by the Convention on the Rights of the Child and the work of the UN Committee on the Rights of the Child? Is the principle of the best interest of the child integrated in regulation affecting children and their right to health?
Participation	Des the State regularly consult with a wide range of organisations and groups of people, including those people most likely to be affected by private actor involvement, in designing (and/or implementing) relevant policies and making relevant decisions, including the selection of partners for public-private partnerships? Have steps been taken to incorporate the feedback and decisions of primary stakeholders in the process of privatisation?	Are stakeholders regularly informed about latest developments and impending decisions related to private actor involvement? Are policy proposals explained, including the need for a policy, the issues to be addressed, and the forums for stakeholder participation? Is the free exchange of ideas concerning private actor involvement promoted? Is participation by vulnerable and disadvantaged groups enabled and encouraged? Have primary stakeholders been given a say in determining accountability standards for private healthcare providers?

ISSUE (KEYWORD)	QUESTION	SUB-QUESTIONS/INDICATORS
IMPACT OF PRIVATE ACTOR INVOLVEMENT ON HEALTH SERVICES		
Regulation	Is there adequate regulation of private actors?	Does the regulation in place cover each aspect of the availability, accessibility, acceptability and quality framework? Is there regulation prohibiting the denial of access to affordable and adequate services, treatments and information? Is there regulation that prohibits the denial of access to life-saving treatment in the case of inability to pay? Are alternatives to private healthcare and financing made available for those who cannot afford it? Are private providers required by law to exercise human rights due diligence? Are private providers encouraged or required to publish their measures taken to prevent and address negative human rights impact? Is the State taking measures to combat corruption? Is the State offering guidance to private actors on how to respect human rights throughout their operations? Is the existing regulation enforced in practice? Has the State entered into bilateral investment treaties or investor-State contracts that affect its ability to regulate effectively, for example by providing extensive protection for the 'legitimate expectations' of the investor and allowing the investor access to international arbitration? Is the State regularly assessing the human rights impact of such an agreement, including before and after entering into it? If yes, is the State taking measures to counterbalance any negative impact, e.g. through inserting explicit human rights obligations for the investor in the investor-State contract?

ISSUE (KEYWORD)	QUESTION	SUB-QUESTIONS/INDICATORS
ACCOUNTABILITY OF PRIVATE ACTORS		
Monitoring	Are there procedural provisions to assess the impact and role of private actors in healthcare?	Have indicators and benchmarks been determined to measure the effects of privatisation? Are these indicators and benchmarks adequate to capture the full range of the right to health, including availability, accessibility, acceptability, quality, non-discrimination, progressive realisation and accountability? Are the data on these indicators collected in a systematic, regular manner? Are the data disaggregated for all the vulnerable groups identified above?
Review		Are independent review mechanisms regularly reviewing the impact of laws and policies regarding private involvement in health? Is the review process transparent and participatory? Are mechanisms in place to ensure the results of the review are taken into account in future laws and policies?
Access to Remedies	Is there access to remedies against right to health abuses by private actors?	Has the State put mechanisms in place to settle grievances suffered from private actors? Do rights-holders have information about remedies? Can rights-holders access legal counsel? Does the State promote the support of NGO actors for victims? Are there alternatives to judicial processes, e.g. legislative, administrative, mediation-based? Are there judicial and non-judicial avenues of recourse against human rights abuses by private actors • with impartial and transparent processes? • with safeguards for the protection of witnesses, victims and their legal representatives?

ISSUE (KEYWORD)	QUESTION	SUB-QUESTIONS/INDICATORS
ACCOUNTABILITY OF PRIVATE ACTORS		
Transparency	Is the right to receive and impart health-related information respected, including for vulnerable and disadvantaged groups?	Is information provided in relation to budget, the way the services are run, price to the population, services available for free, and the conditions to access certain treatments? Is health information accessible to all, including in regional languages and alternative formats, such as large print, Braille or audio recording?
EXTRATERRITORIAL OBLIGATIONS		
Development cooperation		Are foreign States, including through their participation in multilateral organisations, funding private actor involvement that is harmful to the right to health? Are foreign States, including through their participation in multilateral organisations, requiring privatisation as a precondition for the provision of funds? Are development programmes guided by human rights standards? Are vulnerable groups being prioritised in development programs? Are donor States exercising due diligence, including by conducting human rights impact assessments?
Obligations concerning activities of corporations and other private entities	Are States regulating the extraterritorial activities of their corporations and other private entities?	Where private providers have the nationality of a foreign State or have their main centre of activity in a foreign state, does this State have regulation in place to require the provider to exercise human rights due diligence covering its own activities and those of subsidiaries and business partners? Where such regulation is not legally feasible, is the foreign State exercising influence over the private entity through other means, e.g. financial incentives or diplomatic measures? Are States cooperating in the provision of remedies? Are remedies available for groups as well as individuals? Are victims participating in the determination of appropriate remedies?

ISSUE (KEYWORD)	QUESTION	SUB-QUESTIONS/INDICATORS
EXTRATERRITORIAL OBLIGATIONS		
	Are States putting in place remedies that are adequate for transnational cases?	Are States removing substantive, procedural and practical barriers to remedies in transnational cases, including by establishing parent company or group liability regimes, providing legal aid and other funding schemes to claimants, enabling human rights-related class actions and public interest litigation, facilitating access to relevant information and the collection of evidence abroad, including witness testimony, and allowing such evidence to be presented in judicial proceedings?

Annex 2: Methodology

The research was conducted in two phases:

(1) The first phase was a literature review on privatisation in the health sector and its connection to the right to health which was compiled on the basis of international human rights legal and academic sources. Particularly, we reviewed how different international human rights law instruments codify the right to health, and how it has been unpacked in the General Comments/Recommendations by the UN Committee on Economic, Social and Cultural Rights (CESCR), the UN Committee on the Rights of the Child (CRC), and the UN Committee on the Elimination of Discrimination against Women (CEDAW). Time limitations meant that we did not have resources to explore the output and approach of other UN treaty bodies through their jurisprudence. Secondary sources by academics from the fields of human rights and public health were also used to explore the main concerns that arise when evaluating privatisation from a human rights point of view. These reports and articles were selected topically, using official databases from the OHCHR and partner organisations in the project, and taken from the works of authorities on private sector involvement in health care and financing.[264]

(2) We carried out a comprehensive review of reports issued by the mandate of the UN Special Rapporteur on the right to the highest attainable standard of health, Concluding Observations on country reports issued by the above-mentioned treaty bodies, and case law from the UN treaty bodies, regional human rights courts and domestic courts. Selected sources from other UN Special Procedures were also included, e.g. the former Special Rapporteur on the Right to Food, Olivier de Schutter, and the Special Representative of the Secretary General on human rights and transnational corporations and other business enterprises, John Ruggie. The human rights-based legal framework for privatisation in health care was established by drawing on these authoritative sources. While these are not themselves legally binding, they are tools for interpretation in accordance with article 32 of the Vienna Convention of the Law of Treaties and article 38 of the Statute of the International Court of Justice.[265]

In addition, we used empirical observations quoted in academic literature and by other reports to point out which State obligations require special attention in the current context. Our work in this phase was guided by several expert interviews with academics at universities in the UK and the US.

Drawing on the findings from our research on the State obligations in relation to privatisation in the health sector, we developed the annexed impact assessment tool drawn from a framework proposed in a WHO Working Paper by the then Special Rapporteur on the right to health, Paul Hunt, and the academic Gillian MacNaughton,[266] and from the work of human rights organisations assessing private actors in education.[267]

[264] For a list of reviewed sources, see Bibliography.

[265] For a detailed analysis, see Scheinin M, ***The art and science of interpretation in human rights law,*** in Andreassen B and McInerney-Lankford S (eds) ***Research methods in human rights: a handbook***, Edward Elgar Publishing Limited, United Kingdom, 2017, 21.

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