The Human Rights Framework for Establishing Social Protection Floors and Achieving Universal Health Coverage

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Abstract In its General Comments No. 14 and 19, the Committee on Economic, Social and Cultural Rights has specified the contents of the right to health and the right to social security. The main challenges associated with the implementation of these two human rights have been addressed in several major international policy initiatives and global partnerships: The 2030 Agenda now makes an important contribution to the concretization of the rights to health and social security, because it expressly obliges the international community both to implement the concept of social protection floors and to ensure universal health protection. The extra-territorial obligations deriving from the two human rights are also taken up by the 2030 Agenda.

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1 Introduction

Whenever the media or human rights literature refer to "worst attacks on human rights"[1] or "gross and systematic human rights violations",[2] they usually refer to killings, torture, mass rape, or arbitrary arrests for which states are responsible. It is not surprising that such grave violations of human rights attract the attention of the general public and also have a prominent role in the work of the major human rights NGOs. However, it should not be forgotten that there are other human rights that are to a far greater extent impaired on a daily basis. If the absolute number of people currently affected by human rights violations is taken as a benchmark, it is the rights to health and social security where the gap between what is legally required and what is actually implemented in practice is particularly wide. The International Labour Organization (ILO) assumes that 71% of the global population are not covered by comprehensive social security systems. Only 21.8% of the world's unemployed are entitled to unemployment benefits; only 68% of all people at retirement age receive regular (however mostly only minor) benefits.[3] According to the latest World Health Organization (WHO) estimates, less than half of the world's population has access to full basic medical care; every year, more than 100 million people are driven into poverty because they have to pay health services out of their own pockets.[4] Essential medicines are still inaccessible to a majority of the global population; many, often fatal, diseases could be avoided by adequate health care.[5]

Therefore, the human rights to social security and health—both enshrined in the *Universal Declaration of Human Rights* and in the *International Covenant for Economic, Social and Cultural Rights* (ICESCR)[6] as well as in several other global and regional treaties[7]—are still a long way from being implemented worldwide. At

[1] http://www.independent.co.uk/news/world/politics/amnesty-international-reveals-the-10-worst-attacks-on-human-rights-across-the-world-last-year-a6892911.html (last accessed 27 March 2019).

[2] Damrosch (2011); cf. also Human Rights Watch (2018), pp. 155, 182, 273.

[3] International Labour Office (2017b), pp. xxix–xxxii.

[4] https://www.who.int/en/news-room/fact-sheets/detail/universal-health-coverage-(uhc) (last accessed 27 March 2019).

[5] A good overview of the state of global health care is provided by WHO (2015); WHO (2018), p. 4 et seq.

[6] Art. 9, 12 *International Covenant for Economic, Social and Cultural Rights* (ICESCR), 993 UNTS 3.

[7] Art. 5e iv *International Convention on the Elimination of All Forms of Racial Discrimination* (1966, 660 UNTS 195); Art. 11 Abs. 1 e, f, 12 *Convention on the Elimination of All Forms of Discrimination against Women* (1979, 1249 UNTS 13); Art. 24, 26 *Convention on the Rights of the Child* (1989, 1577 UNTS 3); Art. 27 *International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families* (1990, 2220 UNTS 3); Art. 25, 28 Abs. 2 *Convention on the Rights of Persons with Disabilities* (2006, 2515 UNTS 3); Art. 11, 12, 13 *European Social Charter* (1951, ETS No. 005); Art. 9, 10 *Additional Protocol of San Salvador (to the American Convention on Human Rights) on economic, social and cultural rights* (1988, OASTS 69); Art. 16 of the *African Charter on Human and Peoples' Rights* (1981, OAU Doc. CAB/LEG/67/3 rev. 5, 21 I.L.M. 58 [1982]), Art. 13 f *Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa* (2003, OAU Doc. CAB/LEG/66.6); Art. 36

least, there has been considerable progress in the concretisation of content of the two human rights in recent years. The relevant UN human rights bodies as well as the ILO and the WHO have provided valuable clarification work here (see Sects. 2 and 3 below). Moreover, the *2030 Agenda for Sustainable Development* has given considerable political support both to social protection and to the health care sector (see Sect. 4), which is of great significance for the further implementation of these human rights, in particular in middle- and low-income countries.[8]

2 General Comments No. 14 and 19 of the Committee on Economic, Social and Cultural Rights

At a global level, issues related to the establishment of social protection and health systems have long been debated particularly in development policy contexts, but recently these issues have also been discussed more intensively at the level of human rights. This is partly due to the fact that in the meantime much more attention has been paid to social rights than about twenty years ago. It is hardly contested in jurisprudence that these rights—and thus also the rights to social security and to health—are basically just as legally enforceable as civil rights.[9] In many legal systems (not least in the Global South) the courts are intensively involved in the implementation of international and constitutional guarantees in the area of social rights.[10] This growing importance is further underlined by the *Optional Protocol to the ICESCR*[11] which came into effect in 2013 and provides for a right of appeal for individuals and non-governmental organizations.

The Committee on Economic, Social and Cultural Rights (CESCR) convened by the UN Economic and Social Council (ECOSOC) issued two comments in the years

Arab Charter of Human Rights (2004; 12 Int'l Human Rights Reports 893 [2005]).—At least just as important for the legal specification of the right to social security are the standard setting activities of the ILO. In several conventions the ILO has formulated minimum requirements for various social security branches, which are today the standard for many welfare systems in the world; see ILO (2017a) and also Rodgers et al. (2009), p. 139. Probably the most well-known of these treaties is the *Social Security (Minimum Standards) Convention* of 1952 (210 UNTS 131). Until today, 58 ILO member states have ratified this Convention—which means that they have committed themselves to providing social protection in the event of illness, unemployment, old age, occupational accidents or diseases and in the case of maternity to a specific percentage of the population; survivors and family benefits are also provided for in the Convention. However, governments are allowed, by virtue of flexibility clauses, to limit their implementing obligations to individual social security branches.

[8]The following text is mainly based on Kaltenborn (2017a) and Kaltenborn and Troeppner (2017).

[9]See e.g. Coomans (2008) and Langford (2008).

[10]See the references in Kaltenborn (2017b), p. 259 et seq.; for an analysis of rights-based social policies in South and Southeast Asia see Koehler (2017).

[11]UN Doc. A/RES/63/117.

2000 and 2008—*General Comments No. 14* and *No. 19*—which define what is concretely meant by "health" and "social security" and moreover describe the governmental obligations associated with these rights.[12] Although the *General Comments* of the CESCR are soft law and thus not legally binding under international law,[13] they can be considered as the main source for the interpretation of the Covenant (inter alia as part of the monitoring work of the Committee). In legal literature on social rights they regularly form the starting point for further analysis.[14] Their outstanding position in human rights doctrine is in particular due to the fact that the representatives in the Committee are, on the one hand, independent human rights experts, but on the other hand also gain political and legal legitimation through the selection process—they are appointed to the Committee by the state parties for four years (with the possibility of re-election).

The Right to Health

According to *General Comment No. 14* ICESCR member states—meanwhile 169 in number—are required to fully respect the right to health in all their activities, to protect it from impairments by third parties (e.g. individuals and business enterprises) and last but not least to guarantee the actual conditions for its implementation ("obligations to respect, to protect and to fulfill").[15] The scope of protection set out in Art. 12 ICESCR is very broad.[16] Under Article 12 (1) ICESCR, Member States recognize 'the right of everyone to the enjoyment of the highest attainable standard of physical and mental health'; Article 12 (2) ICESCR sets out a list of those measures which are particularly important in order to realize this right (reduction of infant mortality, environmental and industrial hygiene, control of epidemics and occupational diseases, provision of medical facilities and medical care of everyone). When implementing the right to health, attention must always be paid to the socio-economic context of this human right—mainly factors such as origin, socialization, life, work and age, all of which have an impact on the health of the individual.[17]

[12]Committee on Economic, Social and Cultural Rights (CESCR), *General Comment No. 14 (2000) on the right to the highest attainable standard of health (Art. 12 ICESCR)*, UN-Doc. E/C.12/2000/4; *General Comment No. 19 (2008) on the right to social security (Art. 9 ICESCR)*, UN Doc. E/C.12/GC/19.

[13]See on the importance of soft law instruments both for the development of the human rights architecture and also for the implementation of human rights Forsythe (2018), pp. 15 et seq.; cf. also Lagoutte (2016). See also on the role of 'soft governance' in global social policy from a political-economic perspective see Bender (2016) and Bender et al. (2014).

[14]Cf. Shelton (2014), p. 56; Ssenyonjo (2016), p. 42; Goldblatt (2016), p. 90.

[15]*General Comment No. 14*, para. 33.

[16]Gostin (2014), pp. 20, 251.

[17]*General Comment No. 14*, para. 9; cf. also Braveman (2010) and Chapman (2010).

One of the key obligations arising from Art. 12 ICESCR is the establishment and further enhancement of national health systems.[18] Firstly, States Parties are required to provide facilities, goods and services of public health as well as appropriate government programs which ensure that the basic elements for the maintenance of public health are in place (availability). These include, but are not limited to, the provision of hospitals and other health care facilities as well as adequate medication.[19] In addition, accessibility of the relevant health care facilities, goods and services must be ensured for each person on a non-discriminatory basis, not only physically—problems can arise in particular in rural areas where people have to put up with long distances to health services—, but also in financial terms (affordability). Another important requirement is the acceptability of health programs: Healthcare should be provided in in accordance with medical ethics and cultural habits; the latter aspect in particular has often led the Committee, when reviewing country reports, to elaborate on specific practices, such as the use of traditional medicines and therapies preferred by indigenous peoples.[20] Healthcare must also be of adequate quality: This means that only medically trained staff should be employed and only scientifically tested drugs should be available. Finally, the right to health must also be enforceable for the individual, i.e. he or she must have access to effective judicial or other appropriate remedies in the event of a potential infringement of this right (accountability).[21]

The Right to Social Security

In its *General Comment No. 19* the CESCR first of all clarifies what exactly is meant by "social security". Key areas of a social security system are (similar to *ILO Convention No. 102*) the sectors of health, social benefits for older persons, protection in case of unemployment, employment injuries and occupational diseases, family and maternity benefits, and support for the disabled, survivors and orphans.[22] Social protection schemes covering these life-cycle risks have to be generally available and must be designed in compliance with the principles of human dignity and non-discrimination; in addition, access to social protection schemes must be

[18]See Krennerich (2015), pp. 24 et seq.—For a global survey of recent health policy reforms see Kuhlmann et al. (2015), pp. 135 et seq.; on the influence of global health actors on the development of national health care systems see Kaasch (2015).

[19]The Committee refers to the *WHO Model List of Essential Drugs*, http://www.who.int/medicines/publications/essentialmedicines/en/ (last accessed 27 March 2019).

[20]See the example of Venezuela CESCR, E/C.12/VEN/3, 20.11.2013, Rn. 52, 58, 66; cf. also *General Comment No. 14*, para. 27.

[21]*General Comment No. 14*, para. 59 et seq.; see in this context Gloppen (2008); Yamin (2008); Yamin and Gloppen (2011); cf. also Ferguson (2017) who gives an overview of some mechanisms through which countries' compliance with health-related human rights can be assessed.

[22]*General Comment No. 19*, para. 12–21.

guaranteed for all people in the country, which in particular has consequences for the affordability of social benefits or insurance contributions.[23]

As far as organizational matters are concerned, *General Comment No. 19* leaves the governments a fairly extensive scope of action. They may implement contribution-based social protection systems (following the concept of Bismarck's social insurance legislation) as well as tax-financed programs (e.g. social assistance, public employment programs); but also privately-run schemes or self-help measures (community-based or mutual schemes) can be elements of national social security systems.[24] As a rule, the right to social security is implemented by governmental or state affiliated (semi-public/self-governing) institutions. Insofar as the government does not itself provide social protection in a particular sector, but relies on the services of third parties (e.g. private health or pension insurance companies), it must take appropriate measures to ensure that there are no undue disadvantages for specific groups of the population through restrictions on access to services (this is part of the so-called "obligation to protect").[25] The "obligation to fulfill" requires states parties to recognize the right to social security within their national political and legal system (preferably on a statutory basis), to elaborate a social protection strategy including a plan of action, moreover to establish appropriate protection programs and to provide the population with adequate information about these programs—this obligation is particularly important in view of the large numbers of people living in remote rural areas in the countries of the Global South. Another important aspect of this type of obligation is the provision of social assistance and social services especially to poorer and disadvantaged groups of the population (if necessary on a non-contributory basis).[26]

Progressive Realization, Core Obligations and International Assistance

In *General Comment No. 14*, the members of the CESCR state that

> for millions of people throughout the world, the full enjoyment of the right to health still remains a distant goal. Moreover, in many cases, especially for those living in poverty, this goal is becoming increasingly remote. The Committee recognizes the formidable structural and other obstacles resulting from international and other factors beyond the control of States that impede the full realization of article 12 in many States parties.[27]

Indeed, the claims associated with the broad scope of Art. 12 ICESR, at least at first sight, appear scarcely realistic since even the richer members of the international

[23] *General Comment No. 19*, para. 11, 22–27.

[24] *General Comment No. 19*, para. 4–5.

[25] *General Comment No. 19*, para. 45–46.

[26] *General Comment No. 19*, para. 47–51.

[27] *General Comment No. 14*, para. 5.

community are unlikely to be able to meet all health care requirements listed in *General Comment No. 14*. The same applies to the right to social security: Only a few industrialized countries have so far succeeded in offering their residents comprehensive social protection at an appropriate level.

However, the authors of the ICESCR have been well aware of this problem. Like any other social human right, therefore, the rights to health and social protection are limited by the "progression clause" in Art. 2 (1) ICESCR. According to this provision, states are obliged:

> 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 realization of the rights recognized in the present Covenant by all appropriate means, including particularly the adoption of legislative measures.

This clause, which is important for the understanding of social rights,[28] takes account of the fact that in particular the governments of low-income countries often do not have the financial resources needed to implement their social rights obligations immediately. The Covenant thus differentiates between those states, which, due to their economic strength, can guarantee their citizens a level of protection equivalent to the requirements of the respective social rights, and those which are yet unable to do so.

The obligation of "progressive realization", in turn, is limited by the concept of "core obligations" which each State Party has to comply with—regardless of its economic resources—and which are specified in the respective *General Comments* for the social rights listed in the ICESCR. The core content of the right to health includes, among others, non-discriminatory access to health care, adequate basic food and drinking water supplies, adequate housing, access to key medicines, equitable distribution of all healthcare facilities, goods and services, and the development and implementation of a national health strategy.[29] Likewise, each state has to fulfill certain minimum requirements regarding the right to social security: social protection schemes must be made available to the whole population providing a minimum level of benefits to all persons that will enable them "to acquire at least

[28]For the interpretation of this clause see also CESCR, *General Comment no. 3 on the nature of States parties obligations (Art. 2, par.1), E/1991/23*, para. 9; Alston and Quinn (1987), pp. 172 et seq.; Sepúlveda (2003), pp. 174 et seq.; Young (2012), pp. 101 et seq.; Skogly (2012), advocating for a qualitative approach to the term 'resources' as provided in Article 2(1) of the ICESCR; Kendrick (2017), showing how the tools for measuring efficiency in a microeconomic sense can be applied to measure a duty-bearer's compliance with its obligation to fulfill social rights; cf. also Vandenhole (2016), p. 95, who critically notes that, in the case of the right to social security, the Committee assumes that the core obligations are also qualified by the 'maximum available resources'-clause.

[29]*General Comment No. 14*, para. 43; see also UN Committee on the Rights of the Child, *General Comment No. 15, The Right of the Child to the Enjoyment of the Highest Attainable Standard of Health (Art. 24)*, UN Doc. RC/C/GC/15 (2013), para. 73; for an analysis of the core obligations regarding the right to health see Tobin (2012), pp. 238 et seq.; Forman (2015).

essential healthcare, basic shelter and housing, water and sanitation, foodstuffs, and the most basic forms of education."[30]

But even these basic requirements are not met by many states—as the ILO and WHO figures mentioned above have clearly shown. At this point, the auxiliary obligation of the international community sets in: The so-called "extraterritorial obligation", which also follows from Art. 2 (1) ICESCR, requires that the state parties must also engage outside of their territory to implement the Covenant provisions. As far as their financial resources allow, richer members of the international community have to support poorer states in their efforts to implement, among others, the rights to health and social security.[31] This commitment to international assistance has also been explicitly reaffirmed in the *Maastricht Principles on Extraterritorial Obligations of States in the area of Economic, Social and Cultural Rights*.[32] The *Maastricht Principles* have been published in 2012 by the so-called ETO-Consortium (Extraterritorial Obligations-Consortium), a network of more than 140 human rights researchers and non-governmental organizations. Although the ETO-Consortium is only a civil society initiative, its influence on the interpretation of human rights obligations is by no means low, as reflected, for example, in the repeated reference to the *Maastricht Principles* in the recently published *General Comment No. 24*.[33] It is, however, still not specified to exactly what extent and in which relation between the potential donor states these extraterritorial obligations exist—neither in the *General Comments No. 14* and *19* nor in the *Maastricht Principles.* So far, international law provides only a general obligation to support poorer countries, the details are left to political negotiations.[34]

[30] *General Comment No. 19*, para. 59a.

[31] *General Comment No. 19*, para. 55 (see also para. 52, 58); *General Comment No. 14*, para. 39 (see also para. 45); Tobin (2012), p. 328.

[32] Art. 33 *Maastricht Principles*, http://www.etoconsortium.org/en/main-navigation/library/maastricht-principles/ (last accessed 27 March 2019); see De Schutter et al. (2012) and Langford et al. (2013).

[33] CESCR, *General comment No. 24 (2017) on State obligations under the International Covenant on Economic, Social and Cultural Rights in the context of business activities*, UN Doc. E/C.12/GC/24 (the Maastricht Principles are mentioned in footnote 71 and 78).

[34] Cf. on this Khalfan (2013), pp. 324 et seq.; Vandenhole and Benedek (2013), pp. 340 et seq.; Ssenyonjo (2016), pp. 118 et seq.; see also Vandenhole, in this volume.

3 International Political Initiatives to Improve the Implementation of the Right to Social Security and the Right to Health

The ILO Social-Protection Floor-Recommendation and the Global Partnership for Universal Social Protection to Achieve the Sustainable Development Goals (USP2030)

In 2012, the *International Labour Conference* adopted the *Social Protection Floor Recommendation*,[35] marking a new phase in the history of global social policy. If one compares the recommendation with *General Comment No. 19*, it becomes clear that ILO law (including ILO-soft law) and human rights in the field of social protection are now closely linked.[36] Both documents emphasize the key elements of the so-called "rights-based approach", which must be taken into account when setting up social protection systems.[37] In addition to providing a firm basis for social benefits in the national legal system, the approach includes a special focus on adequate participation of the population at all stages of the implementation process (legislation, program concretization and individual decisions by the authorities) and on monitoring and grievance mechanisms which enable civil society actors and especially persons directly affected to detect implementation deficiencies and, if necessary, defend themselves against them.

These procedural measures, however, will not have any effect for those people being not covered by the social protection systems. The ILO has also recognized this and therefore launched a new initiative to expand global social security at the turn of the millennium.[38] Until then, in its standard-setting activities—not least due to its

[35] *Recommendation concerning National Floors of Social Protection, ILO-Recommendation 102*; cf. Cichon et al. (2011). The ILO Committee of Experts on the Application of Conventions and Recommendations has recently published a report which clarifies the challenges that are associated with the implementation of the recommendation; see ILO (2019).

[36] Philip Alston, Special Rapporteur on extreme poverty and human rights, clearly emphasized this connection: "Implementation of the right to social protection through the adoption by all States of social protection floors is by far the most promising human rights-inspired approach to the global elimination of extreme poverty. In essence, those floors are guarantees of basic income security and access to essential social services for the whole population. No other operational concept has anything like the same potential to ensure that the poorest 15 to 20% of the world's people enjoy at least minimum levels of economic, social and cultural rights."; see *Report of the Special Rapporteur on extreme poverty and human rights to the UN General Assembly* (of 11 August 2014), UN Doc. A/69/297, para. 2, https://www.ohchr.org/EN/Issues/Poverty/Pages/AnnualReports.aspx (last accessed 27 March 2019).

[37] Cf. Kaltenborn (2017b), pp. 250 et seq.; on the rights-based approach to social protection see in detail Sepúlveda and Nyst (2012); for a general introduction to the human rights-based approach to development see Fukuda-Parr (2016), p. 203.

[38] Deacon (2013), pp. 28 et seq.

tripartite structure[39]—the organization had been mainly concerned with the social protection of those people who are in formal employment. However, a large part of the working-age population of the Global South works in the informal sector and is therefore not covered by traditional security systems.[40] The main purpose of the Social Protection Floor-initiative is therefore to provide states with a guideline for eliminating these and other gaps in the implementation of the right to social security.

The recommendation, adopted by consensus,[41] proposes that ILO member states introduce a social protection floor that guarantees access to basic health care and basic income support for all residents; in addition, the states are called upon to continuously raise this basic protection to the level of already existing ILO standards.[42] From a human rights perspective, the obligation to provide for a social protection floor can thus be considered largely equivalent to the core obligations which the ICESCR state parties must observe regarding the right to social security (see Sect. 2). It remains up to their national social policy strategy which instruments governments use to achieve this basic protection—whether they set up social insurance schemes (and, where appropriate, include also private providers) or mainly rely on social assistance programs.[43] The level of social benefits must be regularly reviewed in a legally defined transparent procedure.[44] Social protection programs should primarily be financed from domestic funds; if a country is unable to do so for economic reasons, it may seek temporary international support.[45] The *Social Protection Floor Recommendation* has been endorsed by many other international actors, including G20,[46] the European Union,[47] several other UN institutions[48] and

[39]The decision-making bodies of the ILO are composed of government, employee and employer representatives.

[40]See generally World Bank (2019), pp. 94 et seq.; ILO (2017b), pp. 173 et seq.; UN DESA (2018), p. 19; Alfers et al. (2017); Rutkowski (2018); cf. in this context also the work of the International Social Security Association (2016) which has formulated administrative solutions to improve access to contributory social security programs for populations that are difficult to cover.

[41]http://www.ilo.org/brussels/WCMS_183640/lang%2D%2Den/index.htm (last accessed 27 March 2019).

[42]*ILO-Recommendation 102*, para. 13.

[43]*ILO-Recommendation 102*, para. 9.

[44]*ILO-Recommendation 102*, para. 7 c).

[45]*ILO-Recommendation 102*, para 12.

[46]*G20 Cannes Summit Final Declaration* (of 4 November 2011), para. 4, 77, http://www.mofa.go.jp/policy/economy/g20_summit/2011/declaration.html (last accessed 27 March 2019); see also *G20 2013 St. Petersburg Summit Leaders' Declaration* (of 9 November 2013), para. 30 https://www.g20germany.de/Content/DE/_Anlagen/G7_G20/G20-erklaerung-petersburg-en___blob=publicationFile&v=1.pdf (last accessed 27 March 2019).

[47]*Communication of the EU-Commission on Social Protection in European Union Development Cooperation* (of 20 August 2012), COM(2012) 446 final, S. 6.

[48]WHO (2010), p. 11; UNDP and ILO (2011); UNICEF (2012), p. 32; World Bank (2012), p. 14; HLPE (2012), p. 25; FAO (2017), p. 19.

also civil society,[49] and thus, even though it is only a soft law instrument, it can be regarded—in addition to the ICESCR—as the main international legal document for the global implementation of the right to social security.

In 2016 the World Bank and ILO decided to launch a joint initiative aiming to further develop the idea of the Social Protection Floor and to provide social protection for the entire population of a country. The *Global Partnership for Universal Social Protection to Achieve the Sustainable Development Goals*[50] (since 2017 it has the name "USP2030") provides a platform for joint action on the establishment of comprehensive, integrated social protection systems. At UN level, the USP2030-partnership also involves UNICEF, the United Nations Development Programme (UNDP) and the Food and Agriculture Organization of the United Nations (FAO), other partners are e.g. the African Union, the European Commission, OECD, Helpage International, the International Council on Social Welfare (ICSW), the International Social Security Association (ISSA) and several development agencies.

The International Health Partnership for UHC 2030

In global health policy, the issue of Universal Health Coverage (UHC) has significantly shaped the debates in recent years.[51] Already in 2005 the WHO invited its Member States

> to ensure that health-financing systems include a method for prepayment of financial contributions for health care, with a view to sharing risk among the population and avoiding catastrophic health-care expenditure and impoverishment of individuals as a result of seeking care; to ensure adequate and equitable distribution of good-quality health care infrastructures and human resources for health so that the insurees will receive equitable and good-quality health services according to the benefits package; ... to plan the transition to universal coverage of their citizens so as to contribute to meeting the needs of the population for health care and improving its quality, to reducing poverty, ... and to achieving health for all; ...[52]

Since then, a number of other resolutions have been adopted at the international level specifically addressing UHC. The topic not only concerns the United

[49]For the work of the Global Coalition for Social Protection Floors see http://www.socialprotectionfloorscoalition.org/ (last accessed 27 March 2019).

[50]https://www.usp2030.org/gimi/USP2030.action; see also World Bank Group and ILO (2016); BMZ (2019).

[51]Gentilini (2018) rightly points out that there are many similarities in terms of strategies to achieve universal coverage with regard to the health sector and to social protection.

[52]World Health Assembly, *Sustainable health financing, universal coverage and social health insurance* (of 25 May 2005), WHA58/2005/REC/1; see also World Health Assembly, *Sustainable health financing structures and universal coverage* (of 24 May 2011), WHA64.9/2011/REC/.

Nations,[53] but also increasingly the G7- and G20-summits.[54] According to the definition given by the WHO

> "UHC means that all individuals and communities receive the health services they need without suffering financial hardship. It includes the full spectrum of essential, quality health services, from health promotion to prevention, treatment, rehabilitation, and palliative care. UHC enables everyone to access the services that address the most important causes of disease and death, and ensures that the quality of those services is good enough to improve the health of the people who receive them. . . . UHC is not only about ensuring a minimum package of health services, but also about ensuring a progressive expansion of coverage of health services and financial protection as more resources become available. . . ."; UHC does however "not mean free coverage for all possible health interventions, regardless of the cost, as no country can provide all services free of charge on a sustainable basis".[55]

Here, too, there are partial overlaps with the core obligations which must be observed regarding the right to health (see Sect. 2).[56]

Already in 2007, several stakeholders joined forces to coordinate efforts to develop national health systems as part of a global partnership and to advance the expansion of health protection in the Global South. Among the 26 signatories of the *International Health Partnership (IHP+) Global Compact* were seven states in which the UHC objectives are to be implemented,[57] furthermore bilateral and multilateral donor organizations[58] as well as global Public Private Partnerships[59] and private foundations.[60] Meanwhile, the UHC alliance has grown to 118 participants[61]; additional members (especially middle-income countries and private sector representatives) are recruited. Since 2016, it also has a new name: In order to clarify

[53] UN General Assembly, *Global health and foreign policy* (of 6 December 2012), UN Doc. A/RES/67/81.

[54] *G7 Ise-Shima Vision for Global Health* (of 27 May 2016), para. 2-1-2, http://www.mofa.go.jp/files/000160273.pdf (last accessed 27 March 2019); *Berlin Declaration of the G20 Health Ministers "Together Today for a Healthy Tomorrow"* (of 20 May 2017), para. 17 et seq., http://www.bundesgesundheitsministerium.de/fileadmin/Dateien/3_Downloads/G/G20-Gesundheitsministertreffen/G20_Health_Ministers_Declaration_engl.pdf (last accessed 27 March 2019).

[55] http://www.who.int/mediacentre/factsheets/fs395/en/ (last accessed 27 March 2019). On the multi-dimensional concept of UHC (legal, humanitarian social, health economics, and public health concept) see Abiiro and De Allegri (2015). One of the main questions when introducing UHC is to decide which services are critical to a successful health benefits package; see Glassman et al. (2017).

[56] *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* (of 5 August 2016), UN Doc. A/71/304, para. 28, 74–90; for a detailed comparison of the UHC-concept with the right to health see also Ooms et al. (2014); Forman et al. (2016); Chapman (2016), pp. 283–326.

[57] Burundi, Cambodia, Ethiopia, Kenya, Mozambique, Nepal, Zambia.

[58] Canada, France, Germany, Italy, Netherlands, Norway, Portugal, UK, European Commission (EC), African Development Bank (AfDB), UNAIDS, UNDP, UNFPA, UNICEF, WHO, World Bank.

[59] GAVI Vaccine Alliance (GAVI), Global Fund to Fight AIDS, TB and Malaria (Global Fund).

[60] The Bill & Melinda Gates Foundation.

[61] https://www.uhc2030.org/about-us/uhc2030-partners/ (last accessed 27 March 2019).

the transition to the new development paradigm of the Sustainable Development Goals (SDGs), it is now called *International Health Partnership for UHC 2030 (UHC2030)*.[62] The core goal of the UHC alliance continues to be the effectiveness of health-related development cooperation (based on the *Paris Declaration on Aid Effectiveness*[63]). In addition, however, the effective use of domestic resources has increasingly become the focus of the work of the initiative. The UHC alliance itself does not act as a funding organization, but merely as a "platform for discussions on global health and health system strengthening and as a place for mutual accountability drawing on existing initiatives".[64] The main instruments for the implementation of the UHC-goals are "country compacts which work together more effectively to improve aid effectiveness and deliver priorities in the national health strategy"[65]; furthermore, so-called Joint Assessments of National Health Strategies (JANS) are being undertaken to improve the quality and effectiveness of health strategies at the country level.[66]

Proposal for a Framework Convention on Global Health

Ensuring universal health care delivery is also one of the goals that the initiators of a new legislative project on Global Health Governance seek to achieve. The idea of a *Framework Convention on Global Health* (FCGH)[67] which has been primarily promoted by Lawrence O. Gostin and Eric A. Friedman of the O'Neill Institute of Georgetown University (Washington DC) has the aim of better coordinating international activities in the health sector via a legally binding instrument under international law, of specifying the obligations of states and other transnational actors to implement health-related development goals (in particular SDG 3), and of strengthening the human rights basis of global health law. Key elements of such a framework convention include binding (and verifiable) standards for the implementation and funding of health goals as well as the involvement of civil society in all relevant decision-making processes. Moreover, the extraterritorial human rights obligations

[62]The draft text of the updated *Global Compact* can be downloaded at https://www.uhc2030.org/fileadmin/uploads/ihp/Documents/About_IHP_/mgt_arrangemts___docs/UHC_Alliance/Official_documents_2017/UHC2030_TSC_Global_Compact_Jan_2017_WIP.pdf (last accessed 27 March 2019). For an assessment of IHP+ see Shorten et al. (2012).

[63]http://www.oecd.org/dac/effectiveness/34428351.pdf (last accessed 27 March 2019).

[64]https://www.uhc2030.org/fileadmin/uploads/ihp/Documents/About_IHP_/mgt_arrangemts___docs/Steering_Committee_as_of_2014/SC_VI/IHP__Note_for_the_Record_Sixth_SC_meeting_April_2016.pdf (last accessed 27 March 2019).

[65]https://www.uhc2030.org/what-we-do/coordination-of-health-system-strengthening/country-compact/ (last accessed 27 March 2019).

[66]https://www.uhc2030.org/what-we-do/coordination-of-health-system-strengthening/jans-tool-and-guidelines/ (last accessed 27 March 2019).

[67]https://fcghalliance.org/ (last accessed 27 March 2019).

of states and the links to other policy areas (such as trade, protection of intellectual property) should be addressed in the FCGH.[68]

Undoubtedly, a carefully elaborated framework convention containing, in particular, precisely formulated legal requirements[69] would be a great advantage, not only from the perspective of global health governance. It could also make an important contribution to the debate on the constitutionalization of international law: For global health law—a cross section subject covering several subareas of international law—the standard-setting role of relevant human rights (in this case the rights to health and social protection) could be made much more explicit than it has previously been the case. The project is ambitious—but perhaps too ambitious to have serious chances of being realized in the foreseeable future. It seems rather doubtful whether within the next years a consensus could emerge among governments to move closer to this proposal. So far, neither the G7 group nor any other stakeholders have shown any willingness to establish new international hard law in the field of health financing, exceeding the existing soft law obligations.

4 Social Protection Floors and Universal Health Coverage in the 2030 Sustainable Development Agenda: Financial Responsibilities of the International Community

Since 2015, the global calls for establishing social protection floors and extending health coverage have become an integral part of the *2030 Agenda for Sustainable Development*.[70] Under the heading "End poverty in all its forms everywhere", reference is expressly made to the terminology of the *SPF Recommendation*. According to SDG 1.3 states have agreed to

> (i)mplement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable.[71]

[68]Cf. Friedman and Gostin (2012), p. 4; Buse et al. (2014); Gostin (2014), p. 437 ff.; Friedman (2016); for a critical analysis of the FCGH project see Hoffmann and Rottingen (2013).

[69]See for the advantages of using the framework agreement-model Toebes (2015), p. 19 et seq.

[70]*Transforming our world: The 2030 Agenda for Sustainable Development*, UN Doc. A/RES/70/1, https://sustainabledevelopment.un.org/post2015/transformingourworld (last accessed 27 March 2019).

[71]The indicator for social protection coverage (indicator 1.3.1) is the proportion of population covered by social protection floors/systems, disaggregated by sex, and distinguishing children, unemployed, old age, people with disabilities, pregnant women/new-borns, work injury victims, poor and vulnerable.—The importance of SDG 1.3 has recently been reiterated by the Commission for Social Development (of 20 November 2018), UN Doc. E/CN.5/2019/3.

A group of high-level UN human rights experts had even campaigned to address social protection as an independent new development goal in the new Agenda.[72] Although this was not successful in the end, it is clear that social protection is now one of the key issues of the new catalogue of global goals. It has a kind of "bridging function" between various goals because social protection programs are not only an important tool in fighting poverty (SDG 1.1, 1.2, 1.5), but also the basis for appropriate health care and food security (SDG 1.5, 2.1, 2.2, 3.4, 3.8), for social cohesion (SDG 10.2), for the reduction of inequality (SDG 4.5, 5.1, 5.4, 10.1, 10.4) and for helping people back into work (SDG 8.5, 8.6). Moreover, social protection is a prerequisite for enabling parents to send their children to school instead of encouraging them to contribute to the household income (SDG 8.7).[73]

Universal Health Coverage is also given high priority in the *2030 Agenda*. While some significant progress in global health care has been already made in the period between 2000 and 2015, especially in those sectors explicitly identified as Millennium Development Goals (MDG 4: "reducing child mortality", MDG 5: "improving maternal health", and MDG 6: "combating HIV/AIDS, malaria and other diseases"),[74] there are still severe deficiencies in general health care in many developing and newly industrializing countries. The *2030 Agenda* therefore once more takes up health policy issues—now listed in SDG 3—and calls on states, among other things:

> to "(a)chieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all" (SDG 3.8).

The heading of SDG 3 explicitly clarifies that this ambitious goal should be achieved "for all at all ages".[75] SDG 3.8 is therefore closely related to SDG 1.3, which also includes access for all people to essential health care services as part of the nationwide expansion of social protection programs.

As with most social rights, the right to health and the right to social security, too, can only be achieved by the provision of substantial financial and technical resources. Similar to the *Social Protection Floor Recommendation*, the *2030 Agenda* emphasizes that first and foremost each country for itself has the primary

[72]Press Release of the Office of the United Nations High Commissioner for Human Rights (of 21 May 2013), http://newsarchive.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=13342&LangID=E (last accessed 27 March 2019).

[73]Kaltenborn (2015), p. 3; BMZ (2017), pp. 4, 11; see also Loewe and Strupat (2017).

[74]See *United Nations Millennium Declaration* (of 18.9.2000), UN Doc. A/RES/55/2.

[75]The Special Rapporteur on the right to health critically points out that target 3.8 does "not make explicit commitments to confer priority to the poor and marginalized either in the process of expanding coverage or in developing priorities as to which services to provide. Without those clear commitments, there is a risk that universal health coverage efforts will entrench inequality" and, as a consequence, could be inconsistent with human rights requirements; see *Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health* (of 5 August 2016), UN Doc. A/71/304, para. 76; see also Puras (2016), p. 8.

responsibility for achieving the development goals, including SDGs 1.3 and 3.8.[76] It is the task of the respective government and parliament to implement these goals—and, by this means, also the corresponding human rights obligations—through appropriate legislative acts as well as universal health and social policy programs. In the recent past, a number of countries have shown that they are capable of independently developing their social and health systems to meet basic human rights requirements. Notable advances have been made recently, particularly in some countries which rank as middle-income countries according to the World Bank classification. For instance, Brazil and China have launched ambitious reform programs such as the introduction of cash-transfer schemes[77] or the nationwide expansion of pensions[78]—by this way, both countries played a decisive part in reaching MDG 1 (halving extreme poverty) five years earlier before expiration of the MDG deadline.[79] But in recent years, a range of poorer members of the international community, too, have been successful in combating poverty due to their newly established (partly donor-financed) cash transfer programs.[80] Moreover, some countries have already successfully established nationwide basic health care programs, like, among others, China, Colombia, Rwanda and Thailand.[81]

However, the figures on global social security and health care gaps mentioned above have made it obvious that a large number of states have difficulties in making the necessary funds available from their own financial resources to achieve SDGs 1.3 and 3.8.[82] The *2030 Agenda* therefore emphasizes that

> international public finance plays an important role in complementing the efforts of countries to mobilize public resources domestically, especially in the poorest and most vulnerable countries with limited domestic resources. An important use of international public finance, including official development assistance (ODA), is to catalyse additional resource mobilization from other sources, public and private. ODA providers reaffirm their respective commitments, including the commitment by many developed countries to achieve the target

[76] *2030-Agenda*, para. 41.

[77] The best-known of the Brazilian programs in the area of basic social protection is the program Bolsa Família, see Robles and Mirosevic (2013).

[78] World Bank/ILO (2018), p. 53.

[79] http://www.un.org/millenniumgoals/poverty.shtml (last accessed 27 March 2019).

[80] Cf., inter alia, Garcia and Moore (2012); Barrientos (2013); Bastagli et al. (2016).

[81] ILO (2017b), p. 116; cf. also the comparative study on UHC programs in 24 countries presented by the World Bank (2015); for recent data on the two UHC-indicators (3.8.1: Coverage of essential health services, defined as the average coverage of essential services based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access, among the general and the most disadvantaged population; and 3.8.2: Proportion of population with large household expenditures on health as a share of total household expenditure or income), see WHO and World Bank (2017); for an analysis of the special challenges which African countries face regarding UHC, see Dovlo, in this volume.

[82] However, it is partly the lack of willingness on the part of governments to set corresponding priorities in national budgetary policy. On re-prioritizing strategies aiming at expanding fiscal space for social protection programs see Ortiz et al. (2017), p. 5.

> of 0.7 per cent of gross national income for official development assistance (ODA/GNI) to developing countries and 0.15 per cent to 0.2 per cent of ODA/GNI to least developed countries.[83]

The development of health systems has been supported with financial and technical means of donor organizations and partner countries already for a long time.[84] One reason for the fact that the health sector's proportion of the total budget of development cooperation turns out to be this large might be the strong involvement of some of the largest philanthropic foundations that have invested significantly more than half of their total budget in this sector in recent years.[85] But the governments of several industrialized countries also provide considerable funds for the health sector in developing countries.[86] Just to take an example: the German government provided € 473 million in bilateral development assistance to the health sector in 2017, furthermore € 19.9 million have been directed to the WHO, € 60 million to GAVI and € 230 million to the Global Fund.[87] But it must not be overlooked that these financial commitments are sometimes at least partially guided by self-interest. The outbreak of epidemics and pandemics (e.g. Ebola, Zika) in developing countries also poses a threat to people living in industrialized countries. Therefore, building effective health systems in the South is also in the interest of other countries as it facilitates effective cross-border health protection.[88]

The development and expansion of those parts of social protection systems in the Global South which are not directly health-related is also supported by the donor community with financial and technical means, but to a much lesser extent than the health sector.[89] On the one hand, this is certainly due to the fact that social protection

[83] *2030-Agenda*, para. 43.

[84] For an analysis of the problems currently under discussion see Moon and Omole (2017).

[85] OECD (2017), p. 123. In 2015 the Bill & Melinda Gates Foundation was the third-largest provider in the health and reproductive health sector (with USD 3.3 billion of disbursements; see ibid. p. 155).

[86] OECD (2017), p. 151, cf. also http://www.oecd.org/dac/financing-sustainable-development/development-finance-topics/aidtohealth.htm (last accessed 27 March 2019).

[87] http://www.bmz.de/de/ministerium/zahlen_fakten/oda/leistungen/bilaterale_oda_foerderbereiche_laender_2017/index.html; http://www.bmz.de/de/ministerium/zahlen_fakten/oda/leistungen/deutsche_ODA_EU_2013_2017/index.html (last accessed 17 November 2019).

[88] Cf. in this context the *G 7 Ministerial Declaration "Beyond Ebola: A G7 agenda to help prevent future crises and enhance security in Africa"* of 15 April 2015, p. 2, https://www.auswaertiges-amt.de/en/newsroom/news/150415-g7-beyond-ebola/270868 (last accessed 27 March 2019).

[89] According to a study from 2013, approximately $ 3.4 billion of ODA were invested in social protection programs (excluding food aid); see http://devinit.org/post/financing-social-protection-ldcs/ (last accessed 27 March 2019). In the same year, the health sector was funded with nearly $ 13 billion; see http://www.oecd-ilibrary.org/development/data/oecd-international-development-statistics/official-bilateral-commitments-by-sector_data-00073-en (last accessed 27 March 2019). However, it is difficult to provide reasonably accurate figures for such a comparison, since projects designed to strengthen social protection systems are generally not separately identifiable, but can be allocated to different other parts of the ODA; see http://www.oecd.org/dac/povertyreduction/Evolution%20of%20ODA%20for%20Social%20Protection.pdf (last accessed 27 March 2019).

is an area of development cooperation that has only recently received increased global attention. Another reason for the reluctance of the donor community presumably lies in the fact that social protection programs are, at least in part, investments whose effects are more likely to occur in the medium to long term (the most obvious example are pension insurances) and therefore appear less urgent to donors than other projects financed by development assistance. It should not be forgotten, however, that social protection programs play an important role not only in the fight against poverty but also in the pursuit of many other goals of the *2030 Agenda* (the "bridging function" of SDG 1.3 has already been mentioned). Especially against the background of some global political events of the recent past—on the one hand the various climate-related disasters, on the other hand the refugee crisis—the growing importance of long-term income security programs that cover the entire life cycle of people becomes clear: In countries that are particularly affected by drought, hurricanes or heavy storms due to climate change, social programs that protect people from the sudden loss of livelihoods become more important.[90] And ultimately, the issue is also important in the context of the debate on the refugee crisis: As long as the labour market does not provide sufficient opportunities for income security, people will have (albeit modest) reasons to remain in the country only if they can escape extreme poverty through basic social assistance programs and if they can be confident to be covered by adequate social protection also in old age.[91]

Therefore, the revitalization of the "Global Partnership" in SDG 17[92] is of great significance to global social protection—which means that further substantial efforts will be needed,[93] in addition to the development cooperation programs already existing in this sector. Without the support of foreign partners, many governments in the Global South still have great difficulties to finance basic social protection including essential health services for their citizens. Under international law, as has been shown above (see Sect. 2), there is even a legal (extraterritorial) obligation of the wealthier members of the international community to provide this support and thus contribute to the global implementation of the right to social security and to the right to health.

5 Conclusion

In its General Comments No. 14 and 19, the CESCR has precisely specified the contents of the right to health and the right to social security. The main challenges associated with the implementation of these two human rights have been addressed

[90]Cf. Hallegate et al. (2017), pp. 148 et seq.

[91]However, this topic still requires intensive further research; cf. on this e.g. Gesellschaft für Versicherungswissenschaft und –gestaltung (2017); Adhikari and Gentilini (2018).

[92]See also Martens and Vandenhole, in this volume.

[93]For example, it has been suggested that a Global Fund should be established which could help countries to set up or extend their social protection systems; cf. the references in Kaltenborn (2015), p. 3.

in several major international policy initiatives and global partnerships (the Social Protection Floors Initiative, the Universal Social Protection Partnership and the International Health Partnership for Universal Health Coverage). The 2030 Agenda now makes an important contribution to the concretization of the rights to health and social security, because it expressly obliges the international community both to implement the concept of social protection floors and to ensure universal health protection.

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