

# Litigating the Right to Health: What Can We Learn from a Comparative Law and Health Care Systems Approach

COLLEEN M. FLOOD AND AEYAL GROSS

## Abstract

This article presents research demonstrating that the right to health plays different roles in different types of health systems. In high-income countries with tax-funded health systems, we usually encounter a lack of an enforceable right to health. In contrast, rights play a more significant role in social health insurance/managed competition systems (which are present in a mixture of high-income and middle-income countries). There is concern, for example in Colombia, that a high volume of rights litigation can challenge the very sustainability of a public health care system and distort resources away from those most in need. Finally, in middle-income countries with big gaps between a poor public health system and a rich private one, we are more likely to find an express constitutional right to health care (or one is inferred from, for example, the right to life). In some of these countries, constitutional rights were included as part of the transition to democracy and an attempt to address huge inequities within society. Here the scale of health inequities suggests that courts need to be bolder in their interpretation of health care rights. We conclude that in adjudicating health rights, courts should scrutinize decision-making through the lens of health equity and equality to better achieve the inherent values of health human rights.

---

COLLEEN M. FLOOD is a Professor in the Faculty of Law, University of Ottawa.

AEYAL GROSS is an Associate Professor in Tel Aviv University's Faculty of Law. He is also a Visiting Reader at SOAS, University of London.

Please address correspondence to Colleen M. Flood, Email: cflood@uottawa.ca and Aeyal Gross, Email: agross@post.tau.ac.il.

Competing interests: None declared.

Copyright © 2014 Flood and Gross. This is an open access article distributed under the terms of Creative Commons Attribution Non-Commercial License (<http://creativecommons.org/licenses/by-nc/3.0/>), which permits unrestricted non-commercial use, distribution, and reproduction in any medium, provided the original author and source credited.

## Introduction

THE PAST 20 years has seen a surge of global interest in the right to health, a social right recognized in the post-World War II international human rights order that lay largely dormant for decades. Renewed recognition of the right to health and related litigation has more recently given rise to literature exploring the impact, intended and unintended, of this phenomena: who litigates under the right to health, who benefits, and how does health rights litigation affect the overall equity of health systems?<sup>1</sup>

In this article, we point to the value of a comparative law and health care system approach in assessing this trend, by presenting insights gained from a recent study, the results of which have been published in a book we co-edited, *The Right to Health at the Private/Public Divide: A Global Comparative Study*.<sup>2</sup> Our aim was to understand the role and impact of litigating health-related rights within health care systems made up of different mixes of public and private finance. Does recognition of a right to health help to sustain important values such as equality in systems that are undergoing privatization? Or, to the contrary, does a focus on rights-based norms foster individualism and exacerbate inequalities brought about by privatization? Our comparative study included 16 countries from around the globe, representing a mixture of high- and middle-income countries and a variety of approaches to health rights: some countries with explicit constitutional rights to health care; some where a right to health has been read into more general provisions of the constitution; some where rights to health are created as part of a statute; and others that have not formally recognized a right to health. As distinct from previous comparative studies, we emphasize the intersection of law with health care systems that range in configurations of public and private financing. Specifically, our typology organizes countries by finance model into three baskets—public tax-financed systems, social insurance/managed competition systems, and public/private systems—and draws connections between

these financing models and the role for and impact of health rights litigation.

We first explore some general factors that have driven the increased prominence of the right to health worldwide over the past two decades. We then explain at greater length our motivation, objectives, and methodology in undertaking our 16-country study of this global trend. Next, we outline some findings for each category of our typology and explain why we see disparate roles for health rights litigation and the impact thereof across health care systems with different configurations of public and private finance. We end with some thoughts on how courts should approach the adjudication of health care rights, claiming that courts should firmly keep in mind the overall equity and equality agenda underpinning health human rights. Working with this objective in mind should lead courts to be bolder in overturning governmental policy that is clearly regressive (for example, delisting refugees from health care coverage or imposing co-payments for care on those with low incomes). At the same time, it should lead them to be careful not to review reasonable decisions on the part of governments not to fund new drugs and devices, for to do so may unduly distort the allocation of public funds away from poor and vulnerable populations and towards those who have the resources to litigate.

## Resurgence of the right to health

While the right to health is among the social and economic rights recognized in the post-World War II human rights regime, it remained relatively dormant for approximately the first 50 years of its official recognition. Six factors contributed to the re-emergence of rights to health and health care since the 1990s, at both the national and international levels:

1. To some extent, the end of the Cold War allowed for opportunities to reconceptualize hu-

man rights and thus reduce the ideological divide between civil and political rights and economic and social rights, as apparent in the Vienna Declaration adopted by the Second World Conference on Human Rights in 1993, which refers to the two sets of rights as “universal, indivisible, and interdependent and interrelated.”<sup>3</sup>

2. A growing critique, particularly from post-colonial countries, arguing that deprivations in housing, food, health care, and other material living conditions are no less detrimental than violations of freedom of speech or religion. The human rights movement recognized that it could not remain relevant while ignoring or downplaying social rights.<sup>4</sup>

3. Neoliberal economic policies mandated under the Washington Consensus imposed structural adjustments programs, requiring reduction of government services and privatization, which had a particularly detrimental impact on health care.<sup>5</sup> Subsequent interest in the right to health, particularly in Latin America, may be interpreted as a reaction to these measures.

4. Free-trade agreements, such as the Agreement on Trade-Related Aspects of Intellectual Property Rights, have solidified pharmaceutical patent rights, intensifying the conflict between international trade law and access to medicines.<sup>6</sup> On the patient side of this conflict, HIV/AIDS activism has played a major role, employing human rights to increase access to anti-retrovirals.<sup>7</sup>

5. Health care reforms enacted in many countries since the mid-1980s—internal market reforms, managed competition reforms, and the rise of managed care—have sought to control the cost and volume of health services supplied.<sup>8</sup> Patients facing denial or delays in care as a result of rationing measures often turn to the courts, invoking the right to health.

6. Countries in Latin America and southern Africa have, in recent times, created constitutions inclusive of health and other social rights, as part of a strategy to accelerate an equity and equality agenda in the aftermath of legacies of dictatorship and apartheid resulting in enormous disparities between rich and poor.<sup>9</sup>

These six factors have driven a renewed interest in the right to health from the 1990s and into the 2000s, articulated in numerous international agreements, as well as domestic national constitutions and statutes.<sup>10</sup> A recent study finds that approximately 70% of constitutions worldwide now contain health-related guarantees, while the right to health is justiciable in approximately 40%.<sup>11</sup> But for all these formal declarations, we continue to see extreme inequalities: health care spending per capita for the top 5% of world population is nearly 4,500 times that of the lowest 20%, and 2.5 million people die annually from vaccine-preventable diseases.<sup>12</sup> These sad but familiar statistics force us to take stock: what has the judicialization of health rights achieved, and what promise does it hold for the future?

While proponents believe that health-related human rights will be a force for progressive change, we (along with scholars who conducted earlier comparative research projects in this area, notably the research projects conducted by Alicia Yamin and Siri Gloppen and Varun Gauri and Daniel Brinks) believe that conclusions must be drawn cautiously.<sup>13</sup> It may be that judicial protection of health rights addresses only the “tip of the iceberg,” in a way that obscures the need for other strategies of systemic reform, or worse, may be co-opted in a way that exacerbates access issues.<sup>14</sup> In liberal democracies like the US and Canada, the latter concern relates partly to the individualistic and often negative interpretation given to health rights, meaning that they are interpreted as rights of non-interference, requiring only that the state not act rather than take positive action. In other countries where health-related rights are given a positive interpretation, injustices can arise if limited public resources are diverted to those with the means and ability to litigate their right to health, as has been argued is the case in, for example, Colombia and Brazil.<sup>15</sup>

### Why we look at the role of rights across different health care systems

In our study, our collaborators from the 16 studied countries attempted to explain how their respective health care systems work, particularly the differ-

ential roles of public and private finance and the resulting impact on equity and access. Our collaborators then analyzed the extent to which health care rights, and the litigation thereof, was changing or could change the dynamics of their respective health care systems in terms of access and equity. To better assess what is occurring at a global level, we classified our chosen countries into three groups that, loosely, fall on a spectrum from less to more private. Our typology is as follows:

1. **Public/tax-financed:** Countries where public financing, based on taxation revenues, is a defining feature of the health care system. Representative countries: the UK, New Zealand, Canada, and Sweden, covered, respectively, by Christopher Newdick, Joanna Manning, Colleen M. Flood, and Anna-Sara Lind.

2. **Social health insurance/managed competition:** these systems provide universal coverage like tax-financed systems but are financed either through mandatory contributions from employers and employees or, in cases like the Netherlands, Israel, and Taiwan, by mandating and heavily regulating the purchase of insurance coverage, either through private insurers or non-profit sickness funds. Representative countries: Colombia, Israel, the Netherlands, Hungary, and Taiwan, covered, respectively, by Everaldo Lamprea, Aeyal Gross, André den Exter, Maria Eva Foldes, and Y.Y. Brandon Chen.

3. **Mixed private/public:** Countries where a private health system fulfils a central role alongside a public system. In these countries, health care is either not universal (such as the US) or, alternatively, a universal public scheme exists, but is so impoverished that private finance plays a very significant role (such as India). “Public” in this context includes systems that are partially funded by tax finance as well as those partially funded by mandatory social health insurance or mandatory private insurance (the managed competition model). Representative countries: China, South Africa, Brazil, US, Nigeria, Venezuela, and

India, covered, respectively, by Christina Ho, Lisa Forman and Jerome Amir Singh, Mariana Mota Prado, Allison Hoffman, Remigius Nwabueze, Oscar Cabrera and Fanny Gomez, and Anand Grover, Maitreyi Misra, and Lubhyathi Rangarajan.

We also asked our contributors to explore a number of additional themes as part of their analysis, three of which we discuss below.

First, an important theme concerns the extent to which health rights litigation may serve to undermine a fair allocation of resources within a health care system. Law is often seen as rectifying injustice that results in the most vulnerable in society being allocated an unfair share of resources due to economic inequality, prejudice, discrimination, racism, homophobia, sexism, and other disparities. However, rights litigation that challenges allocation decisions in health care can destabilize the allocation of scarce public resources to the disadvantage of the most vulnerable. Thus, for example, litigation that results in successful claims to access expensive new drug therapies may siphon limited public resources needed for preventative and primary care of greater benefit to poorer patients and communities.

Second, we asked our contributors to explore a closely related theme: how access to justice issues shapes the impact of health rights. Litigation is often expensive, and access to the courts is important in determining whether a right to health serves disadvantaged populations.

Third, we asked our contributors to explore how law and judicial decisions operate within a larger socio-political context. For example, what is the systemic impact of a particular court ruling over time? A health rights ruling that is *prima facie* progressive, ensuring access to health care services of high impact for vulnerable populations, may have little real impact if, for example, it is not systematically enforced. Conversely, a decision that is *prima facie* regressive, perhaps denying access to an essential treatment, may have a positive effect in the long term by, for example, mobilizing political action that results in governments correcting access barriers.<sup>16</sup>

## The impact of health rights litigation

What is the impact of health rights litigation? Here, we discuss some of our findings, at first following the typology of public/private health care systems set out above and then moving into a broader discussion.

### *Public tax-financed health systems*

We begin with some conclusions regarding the tax-financed health systems that were part of our study: Canada, the UK, Sweden, and New Zealand. A puzzle emerges upon examination of these countries: while all have relatively robust public health care systems, they generally do not have a judicially enforceable right to publicly funded health care. These health systems developed as part of the modern welfare state and not within a legal rights framework. However, even without a clear right to health, individuals may, for example, bring claims in anti-discrimination or administrative law challenging decisions not to fund a new drug or device. Courts in response rarely grant substantive positive remedies for fear of overstepping their constitutional mandate. All of these countries are facing increasing pressure to cut costs and ration care, and there are increasing calls for privatization. Thus, the absence of a judicially enforceable right to health may be of concern if reforms in this regard fail to protect the most vulnerable.

The only country in this category with constitutional rights bearing on health is Canada, where concerns regarding wait times are driving a number of constitutional challenges directed at laws protecting the public health care system. To date, general provisions of the Canadian Charter of Rights and Freedoms have not been interpreted to include positive (that is, publicly funded) rights to health care. Instead, the Charter has been interpreted to provide a “negative” right to health care, that is, the right to strike down government restrictions that inhibit a flourishing private system. Such a “right” does not do anything, in our view, to improve access on the part of the most vulnerable in society who cannot afford private health care. For example, in *Chaoulli v. Quebec*, the Supreme Court of Canada struck down Quebec’s ban on private health insur-

ance, holding that, given waiting periods within the public health care system, the ban violated the rights to life and security of the person.<sup>17</sup> This case was only the first in a larger campaign to create opportunities for more private financing of medically necessary care and similar litigation is under way in three other provinces.<sup>18</sup> These Canadian cases point to the risk that the litigation of rights may actually undermine equality and reinforce privatization within established systems of universal health care. Arguably, in the Canadian situation what is needed is a more expansive judicial interpretation of existing constitutional rights to include a positive (that is, publicly funded) right to health care; to date, the Canadian Supreme Court has been steadfast in its reluctance to do this.<sup>19</sup> Interestingly, faced with almost identical constitutional wording, Indian courts have interpreted a (limited) right to publicly funded care.<sup>20</sup>

Within this group of tax-financed systems, the UK shows more hopeful developments in the sense of courts striving to require governments to balance individual “rights” against larger societal interests in public health insurance. There, individualized petitions seeking access to new types of care (mostly new drugs and devices) have resulted in courts developing criteria to inform future decision-makers and judges. Decision-making must adhere to principles of procedural fairness, be consistent, consider relevant factors and exclude irrelevant ones. Allowable considerations include evidence of the treatment’s overall effectiveness, the extent and likelihood that the treatment will work for a particular patient, the extent of improvement a treatment might be expected to provide, the absolute cost of treatment, the number of patients that may benefit, and its relative cost-effectiveness.<sup>21</sup> Further, the UK courts have carved out a means of accommodation for “exceptional” cases, that is, claims for funding on the part of patients who assert that their special circumstances mean they should receive coverage for care that is not generally insured. These cases have provided the impetus for an accountable priority-setting system—one in which hard choices will have to be defended, with especially stringent scrutiny where the decision seriously affects a citizen’s

health. This reasonableness framework perhaps strikes a balance, offering robust protections for individual health-related rights while acknowledging that public decision-makers must weigh priorities within limited resources.

It is important to note that the UK's approach emerged in the context of administrative law rather than in the application of constitutional rights to health care. Arguably, this frame of legal analysis allows a better balance between the overall goals of social solidarity (access to health care for all) and individual patient rights, as administrative law inherently requires a court to consider the degree of deference owed to governmental decision-making.<sup>22</sup> Whether in the context of a system with constitutional rights to health care, statutory rights, or within general administrative law, reasonableness can play a central role as a standard by which to judge decisions concerning access to new services or drugs, and even larger structural decisions, such as the introduction of co-payments that impact vulnerable populations and thereby directly attack the equity goals at the heart of health human rights.

#### *Social health insurance systems (SHIS)*

From this category, our study included Colombia, Israel, the Netherlands, Hungary, and Taiwan. In the comparative literature, both tax-financed systems and SHIS are frequently grouped together as “public,” an approach that misrepresents their real differences and diminishes our ability to understand the impact and interaction with health rights litigation. Tax-financed systems and SHIS both aim for universal coverage and a measure of progressivity. However, financing for SHIS is sourced from employers and employees who contribute to a central fund, who in turn pay competing sickness funds (private non-profit insurers) a premium for each enrolled individual. This added layer in the administration and financing of health care has important implications for how health rights are litigated (for example, the parties to litigation, the scope of remedies, the role of *stare decisis*.)

Although it is not inherent in their design, SHIS do overall seem to allow or generate a greater role for private finance than do tax-financed systems. Fur-

ther, we see from a cross-comparative perspective, a number of SHIS are in transition to a managed competition model, which involves moving from not-for-profit insurers (sickness funds) to a universal mandate and regulated competition between private for-profit health insurers. This is the case, for example, in the Netherlands and Colombia. These recent reforms are difficult to unpack from the perspective of overall equity and the public/private perspective, for while they often represent an expansion to universal health insurance, they may also involve privatization of the management of the insurance function (for example, from non-profit social insurers to regulated for-profit insurers). In some countries, such as Israel, where social insurance operates through non-profit sickness funds, they also include the introduction of co-payments.

SHIS have certain characteristics that lend themselves to a greater role for health rights litigation, in volume of claims if not depth of impact, than is seen in tax-financed countries. First, our research shows that in SHIS countries, not only may health-related rights be embedded in statute, but the insurance contracts between the fund/insurer and an individual may also provide a basis for claiming rights to health care. Second, SHIS have formal decision-making processes to determine the list of goods and services covered for every citizen by the relevant universal insurance plan. Thus, what we see in these countries is that the very structure of the health care system, with its emphasis on a defined package of benefits that are part of a contract of insurance, frequently provides the conditions conducive to litigation. A concern is that the “rights” in SHIS focus primarily upon the patient as a consumer, in the context of exercising his or her private law entitlements. The danger is that the overall objective of ensuring equity and solidarity within and among individuals vis-à-vis health care will be lost.

The case of Colombia illustrates the risk of an undue focus on individual rights. First, it is important to note that Colombia has transitioned to a managed competition system, which, as we noted, provides the preconditions for individual litigation—particularly in private law. In the Colombian case, the private insurers charged with delivering the

universal scheme and a defined basket of services to their enrollees were not meeting these requirements. These problems in access, combined with three further factors, resulted in a tsunami of litigation that eventually threatened the very survival of the universal scheme: first, a constitutional right to health care was inferred from general provisions in the constitution; second, so-called “tutela” hearings offered an inexpensive forum for exercising the constitutional right to health; and third, the court issued a decree that government officials immediately pay for the cost of the treatment ordered as part of a tutela claim or risk being found in contempt of court. Thus, Colombia might at first appear utopian for proponents of health human rights, with easy access to the justice system and reliable enforcement of outcomes. But this is arguably a mirage, for as Everaldo Lamprea discusses in our book, the result is that the government has lost its bargaining power to negotiate prices (with drug companies, hospitals, physicians, and other providers) and galloping public sector costs put the entire universal system at risk.<sup>23</sup>

Here, then, we see a more general problem: if health-related rights are treated as unconditional and not limited by resource capacity, this can put an unsustainable burden on public insurers and undermine their ability to act as wise stewards of public resources through negotiating prices, or resisting patent extensions and so forth. Colombian courts have recently taken steps to achieve greater balance between individual rights and the larger societal interest. These steps are crystallized in the Constitutional Court’s ruling T-760 of 2008, which approached the issue from an overall health system perspective and ordered government to address the systemic factors driving right to health litigation.<sup>24</sup> Time will tell whether the Colombian judiciary’s reforms will chart an effective path forward for the country’s health system to advance overall equity, but clearly, judicial activism vis-à-vis the right to health is cutting a transformative path.

There are also indicators from court judgments in other SHIS countries of the importance of balancing individual rights in the context of ensuring a universal and equitable health care system. In a

series of recent cases, the Israeli Labour Courts have developed criteria, later incorporated into a Ministry of Health directive and upheld by the Israeli Supreme Court, regarding the considerations that “exceptions committees” within the sickness funds must take into account.<sup>25</sup> The courts have thus created a list of factors that insurers (the sickness funds) must at least consider when determining whether to provide insurance coverage for a drug or device that is otherwise not insured, and in doing so sought to strike a balance between individual needs and ensuring a fair distribution from a limited communal pool. The three factors are: (1) objective considerations regarding the requested treatment, such as the international experience with it and its proved efficacy; (2) subjective considerations such as previous treatments given to the patient, and whether there are considerations that bar treatments normally indicated for his or her situation; (3) overall budgetary considerations, for which clear evidence is required.<sup>26</sup> This development is similar to that taking place in the UK, and attests to what we may call a “middle way” between blanket deferral to prioritization and rationing decisions made by the state on one hand, and a tendency to broadly accept any individual petition on the other hand.

#### *Public/private systems*

While our previous two categories are all high-income countries (with the exception of Colombia), those in our final category of public/private systems are all middle-income countries (with the exception of the US). Within this category, our study looked at China, Nigeria, Brazil, the US, South Africa, and India. All have some mixture of public and private finance, but in this category of public/private systems, the private sector role is much more extensive, accounting for 50% or more of health care spending, and the public system is comparatively under-resourced (with the exception of the US, where the public system is relatively well-resourced but only covers the elderly and very poor).<sup>27</sup> Of the three groups of countries in our analysis, this public/private group is the most diverse, both in terms of the wealth of its systems (Nigeria vs. the US) and the justiciability of health care rights (China, with

no justiciable rights, vs. Brazil, with a constitutional right to health). Some countries in this category have enshrined health care as a constitutional right in an attempt to accelerate redistributive and access goals with the dawning of a new constitution. A prime example here is South Africa, which, in its post-apartheid constitution, explicitly entrenched a right to health (as well as other social rights, such as housing) to challenge monumental access gaps between rich and poor.

A few trends are apparent in this category: (a) in some countries (for example, Brazil), courts have opened the door to massive numbers of individualized petitions, with some critics arguing that this leads to “telescopic” judgments that distort the prioritization and rationing processes; (b) in other countries, collective claims have succeeded which challenge unreasonable or irrational public policy, as in the South African TAC case (judicial override of then-President Mbeki’s refusal to expand access to the antiretroviral drug nevirapine to prevent mother-to-child transmission of HIV), demonstrating the potential of public interest litigation as opposed to individualized petitions; (c) in other countries, such as China, Nigeria, and to some extent Venezuela, a lack of justiciability of health rights and/or a lack of judicial independence renders courts ineffectual.<sup>28</sup>

Having heralded the problem of allowing individual health rights to trump larger equity and solidarity concerns, we must acknowledge, of course, the problems that persist in the absence of health rights litigation. Some countries with gross inequalities and nascent health care systems, such as Nigeria, have no rights to health care; in other countries there is no judicial enforcement of health rights (such as they exist), as in China and Hungary, or the approach of the judiciary is very modest and incremental, as in South Africa and India. In this latter regard, the scale of inequity within the system must cause one to consider whether judicial conservatism is the best approach. Recent numbers show that in South Africa, for example, the private health care system continues to receive 60% of total health care funding and 70% of the country’s health care personnel.<sup>29</sup>

## How should courts approach health rights litigation?

What, then, is the best approach to litigating health-related rights? A right to health care is an important feature of any health care system. However, courts in adjudicating health human rights need to frame that right in the context of the larger equity and solidarity goals of a public health care system. There are enormous pressures to fund all health care, all services, and to pay exorbitant prices for drugs and treatments often of very limited effectiveness. One danger with a rights-based approach is that it can reinforce the individual demands for high-priced treatments, thus exacerbating the difficulties governments have in running fair and efficient health care systems. Consequently, courts need to be careful when second-guessing governmental decision-making in this regard. On the other hand, we recommend careful judicial scrutiny of initiatives that are unequivocally reductions in equality and access—for example, measures taken to reduce access on the part of the poor through co-payments, or to de-insure vulnerable groups, such as refugees or other migrant groups.

Our research has shown that in some of the Latin American countries we reviewed, and a number of European countries where EU law prevails, courts tend to be more ready to intervene on an individual application seeking, for example, access to a new drug or therapy.<sup>30</sup> We contend that in this domain, courts should exhibit restraint and be cautious about second-guessing decision-makers who are striving to balance community needs with individuals needs/wants within a universal, public system. On issues of individual application for specific goods and services, we support the middle route of administrative review for procedural fairness and for reasonableness in decision-making. We see this route being favored in the UK, Israel, and South Africa, and in a single New Zealand case; the Brazilian Supreme Court also shows some movement in this direction. This kind of judicial approach resonates with the “accountability for reasonableness” framework that Norman Daniels first put forward, calling for a principled and transparent process for priority setting.<sup>31</sup> The judicial process itself is deliberative

in character and thus can foster accountability for reasonableness on the part of those charged with safeguarding access to health care: it requires the parties to bring evidence and reasoned arguments to the courts; it requires the courts to provide reasoned arguments for its decision; and the record of dissenting arguments fosters public discussion.

Much ink has been spilled trying to determine a fair basket of services in terms of the minimum core, to give content to a “right to health.” In truth, such offerings must change over time as technologies and the health needs of the population change. Thus, for example, it may well be fair to refuse public funding for dialysis treatment in a poor country, yet it will not be considered fair in a country with as many resources as Canada.<sup>32</sup> This means that courts, in adjudicating a right to health, are likely to be most effective in ensuring that public decision-makers follow a fair process in decision making, weighing the interests of individual needs with the importance of fairly distributing limited public resources across the whole population.

In contrast to the appetite on the part of courts (in some countries) to hear individual petitions vis-à-vis health related rights, courts tend to be much more reluctant to intervene in larger policy questions, particularly those directed at the structure of the system such as, for example, a challenge to a policy implementing co-payments or removal of insurance coverage for certain segments of the population, such as migrant workers and refugees.<sup>33</sup> We do see that if governments take progressive measures to, for example, introduce a universal mandate for health insurance (as has happened in Taiwan and the US), then the courts will (even if only just) uphold governmental policy. However, they are much more reluctant to overturn governmental policy that is retrogressive.

We argue that a properly framed right to health could and should embolden courts to take a close look at policy measures that are clearly retrogressive, and push systems towards a commitment to universal, public health care that secures access on the part of those most in need—not because courts can replace policy decisions, but rather because they should scrutinize whether these decisions adhere

to human rights standards. This need is even more apparent in systems with gross inequities between those left in the public system or uninsured and the minority that benefit from a private system; courts should analyze health human rights claims with a view to improving this redistribution problem. We, of course, do not underestimate the difficulties inherent in this endeavor and agree with Paul Farmer that the health and human rights movement cannot pin all its hopes on legal battles, but must also focus on broader solidarity and, pragmatically, the provision of services for those in need.<sup>34</sup> However, wherever possible, courts should both protect and assist the democratic process of establishing universality, equal access, and reasonable coverage for health care. In adjudicating upon health related rights, courts should keep firmly in mind the overall equity and equality agenda underpinning health human rights. Scrutiny of decision-making through the lens of health equity and equality will better achieve the inherent values of health human rights laws.

## Acknowledgements

Aeyal Gross is grateful to the Israel National Institute for Health Policy Research and to the Joseph H. Flom Global Health and Human Rights Fellowship at Harvard Law School for the support of the research for this paper. Both authors wish to acknowledge the superb research and editing assistance of Bryan Thomas, Research Associate at the University of Toronto.

## References

1. See S. Gloppen, “Litigation as a strategy to hold governments accountable for implementing the right to health,” *Health and Human Rights* 10/2 (2008), p. 21; O. A. Cabrera and A. S. Ayala, “Advancing the right to health through litigation,” in J. M. Zuniga, S. Marks, and L. Gostin (eds), *Advancing the human right to health* (Oxford: Oxford University Press, 2013).
2. C. M. Flood and A. Gross, *The right to health at the private/public divide: A global comparative study* (Cambridge: Cambridge University Press, 2014).
3. United Nations, World Conference on Human Rights: Vienna Declaration and Programme of Action, Vienna, June

- 14–25, 1993, UN Doc. No. A/CONF.157/24 (Part I) (1993). On the effect of the end of the Cold War, see also M. J. Roseman and S. Gloppen, “Litigating the right to health: Are transnational actors backseat driving?” in A. E. Yamin and S. Gloppen (eds), *Litigating health rights: Can courts bring more justice to health?* (Cambridge, MA: Human Rights Program at Harvard Law School, 2011), pp. 246 and 249; J. Tobin, *The right to health in international law* (Oxford: Oxford University Press, 2012), p. 1.
4. D. Barak-Erez and A. M. Gross, “Do we need social rights? Questions in the era of globalisation, privatisation and the diminished welfare state,” in D. Barak-Erez and A. M. Gross (eds), *Exploring social rights: Between theory and practice* (Oxford: Hart Publishing, 2007), p.5.
5. Roseman and Gloppen (see note 3), p. 249; S. L. T. McGregor, “Neoliberalism and healthcare,” 25 *International Journal of Consumer Studies* 25/2 (2001), p. 82; P. O’Connell, “The human right to health in an age of market hegemony,” in J. Harrington and M. Stuttaford (eds), *Global health and human rights: Legal and philosophical perspectives* (New York: Routledge, 2010), p. 190.
6. See P. Cullet, “Patents and medicines: The relationship between TRIPS and the human right to health,” in S. Gruskin, M. A. Grodin, George J. Annas, et al. (eds), *Perspectives on health and human rights* (New York: Routledge, 2005), p. 179; E. t Hoen, “TRIPS, pharmaceutical patents, and access to essential medicines: A long way from Seattle to Doha,” in S. Gruskin, M. A. Grodin, George J. Annas, et al. (eds), *Perspectives on health and human rights* (New York: Routledge, 2005), p. 100.
7. A. E. Yamin, “Power, suffering and courts: Reflections on promoting health rights through judicialization,” in *Litigating health rights: Can courts bring more justice to health?* (see note 3), pp. 338–339, 348–350; J. Wolff, *The human right to health* (New York: W. W. Norton & Company, 2012), pp. 39–91; P. Hunt, “The right to health: From the margins to the mainstream,” *Lancet* 360 (2002), p. 1878.
8. C. M. Flood, *International health care reform: A legal, economic and political analysis* (New York: Routledge, 2003), pp. 1–9; Tobin (see note 3), pp. 351–370.
9. Yamin (see note 7), pp. 339–340.
10. See, for example, International Covenant on Economic, Social and Cultural Rights (ICESCR), G.A. Res. 22001 (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc A/6316, 993 U.N.T.D. 3 (1996); Committee on Economic, Social and Cultural Rights, General Comment No. 14, The Right to the Highest Attainable Standard of Health, UN Doc. No. E/C.12/2000/4 (2000). Available at <http://www1.umn.edu/humanrts/gencomm/escgencom14.htm>. Constitution of the World Health Organization, pmbl., 62 Stat. 6349, 14 U.N.T.S. 185. On the right to health in international law, see B. Toebes, *The right to health as a human right in international law* (Amsterdam: Hart/Intersentia, 1999); Tobin (see note 3).
11. C. Jung, R. Hirschl, and E. Rosevear, “Economic and social rights in national constitutions,” (2013), pp. 6–9. Available at SSRN: <http://ssrn.com/abstract=2349680> or <http://dx.doi.org/10.2139/ssrn.2349680>.
12. L. Gostin, “The unconscionable health gap: A global plan for justice,” *Lancet* 375 (2010), p. 1504.
13. A. E. Yamin and S. Gloppen (eds), *Litigating health rights: Can courts bring more justice to health?* (Cambridge, MA: Human Rights Program at Harvard Law School, 2011), pp. 246 and 249. See also V. Gauri and D. M. Brinks (eds), *Courting social justice: Judicial enforcement of social and economic rights in the developing world* (Cambridge: Cambridge University Press, 2010).
14. On rights as dealing with merely the “tip of the iceberg” see D. Kennedy, *The dark side of virtue: Reassessing international humanitarianism* (Princeton: Princeton University Press, 2004), p. 32.
15. See A. Gross, “Is there a human right to private health care,” *Journal of Law, Medicine and Ethics* 41/1 (2013), pp. 138–146. Available at <http://onlinelibrary.wiley.com/doi/10.1111/jlme.12010/pdf>.
16. C.M. Flood and Y. Y. Chen, “Charter rights & health care funding: a typology of Canadian health rights litigation,” *Annals of Health Law* 19/3 (2010), pp. 479–526.
17. *Chaoulli v. Quebec* (Attorney General) (2005), 1 S.C.R. 791.
18. C. M. Flood, “Litigating health rights in Canada: A white knight for equity?” in C. Flood and A. Gross (eds), *The right to health at the private/public divide: A global comparative study* (Cambridge: Cambridge University Press, 2014).
19. Some remain hopeful that positive health-related rights will be recognized under the *Charter*. A recent challenge at the Canadian Federal Court argues that the withdrawal of government funding for some health services for refugee claimants is in violation of *Charter* rights to life, security of the person (s.7), prohibitions against cruel and unusual treatment (s.12), and equality under the law (s.15). See *Canadian Doctors for Refugee Care v. Attorney General of Canada* (Minister of Citizenship and Immigration) Memorandum of the Applicants. Available at <http://jfcy.org/wp-content/uploads/2014/07/Factum-CDRC-CARL-final.pdf>.
20. A. Grover, M. Misra, and L. Rangarajan, “Right to health: Addressing inequities through litigation in India,” in *The right to health at the private/public divide: A global comparative study* (see note 2).
21. C. Newdick, “Promoting access and equity in health – Assessing the National Health Service in England,” in *The right to health at the private/public divide: A global comparative study* (see note 2).
22. C. M. Flood, L. Gable and L. O. Gostin, “Introduction: Legislating and litigating health care rights around the world,” *Journal of Law, Medicine and Ethics* 33/4 (2005), pp.

636-640.

23. See E. Lamprea, "Colombia's right-to-health litigation in a context of health care reform," in *The right to health at the private/public divide: A global comparative study* (see note 2).

24. Corte Constitucional [C.C.] [Constitutional Court], October 21, 2011, Auto 226/11 (Colom.). Available at <http://www.corteconstitucional.gov.co/relatoria/autos/2011/a226-11.htm>.

25. *Macabee v. Minister of Health* (Israel, HCJ 3933/11, March 25, 2014).

26. A. Gross, "The right to health in Israel between solidarity and neoliberalism," in *The right to health at the private/public divide: A global comparative study* (see note 2).

27. Other than China where it is 52.5%, the percentage of public expenditure on health in all the countries in this category is less than 50%, with India being the lowest at 30.3%. In contrast, in the other two categories public expenditure ranges between 57.5% (Taiwan) and 84.1% (UK). See Health expenditures in WHO, World Health Statistics 2012, 134, Table 7. Available at [http://apps.who.int/iris/bitstream/10665/44844/1/9789241564441\\_eng.pdf?ua=1](http://apps.who.int/iris/bitstream/10665/44844/1/9789241564441_eng.pdf?ua=1). For Taiwan, which is not included in the Table, see Taiwan Department of Health, Minguo Jushijiu Nian Guomin Yiliaobaojian Zhichu (January 5, 2012). Available at [http://www.mohw.gov.tw/EN/Ministry/Statistic.aspx?f\\_list\\_no=474&fod\\_list\\_no=4535](http://www.mohw.gov.tw/EN/Ministry/Statistic.aspx?f_list_no=474&fod_list_no=4535).

28. *Minister of Health and Others v. Treatment Action Campaign and Others* (2002) 10 BCLR 1033 (S Afr CC).

29. See L. Forman and J. A. Singh, "The role of rights and litigation in assuring more equitable access to health care in South Africa," in *The right to health at the private/public divide: A global comparative study* (see note 2). See also A. Ntuli, P. Ijumba, D. McCoy, et al., "HIV/AIDS and health sector responses in South Africa treatment access and equity: Balancing the act," in R. Loewenson and C. Thompson (eds), *EQUINET discussion paper number 7* (September 2003). Available at <http://www.hst.org.za/sites/default/files/equinet7.pdf>.

30. A similar finding on Latin America is made in Yamin's and Gloppen's research, see O. Mastad, L. Rakener, and O. L. Motta Ferraz, "Assessing the impact of health rights litigation: A comparative analysis of Argentina, Brazil, Colombia, Costa Rica, India and South Africa," in *Litigating health rights: Can courts bring more justice to health?* (see note 3), pp. 286-288.

31. N. Daniels, *Just health: Meeting health needs fairly* (Cambridge: Cambridge University Press, 2008), p. 14.

32. *Soobramoney v. Minister of Health, KwaZulu-Natal* 1998 (1) SA 765 (CC).

33. See also in Brinks and Gauri's research: D. M. Brinks and V. Gauri, "A new policy landscape: Legalizing social and economic rights in the developing world," in *Courting social justice: Judicial enforcement of social and economic rights in*

*the developing world* (see note 13).

34. P. Farmer, *Pathologies of power: Health, human rights, and the new war on the poor* (Berkeley, CA: University of California, Berkeley, 2003), chapter 9, p. 213.

35. See also Mastad et al. (see note 30), pp. 285-286.