LEGITIMACY & LITIGATION: THE RIGHT TO HEALTH CARE

COLLEEN M. FLOOD*

Much ink has been spilt by scholars over how courts should adjudicate socio-economic rights, frequently by scholars in countries that do not expressly include such rights in their constitution. Pedro Felipe de Oliveira Santos describes well the formalist approach that drives many jurists and scholars to argue for minimalism on the part of courts adjudicating socio-economic rights.[1] The separation of power(s) argument is that courts are not democratically elected–governments are–and so the latter should be responsible for the complex trade-offs involved in allocating public funds to social programs.

When I present on litigation of health rights and discuss the volume of cases in countries like Brazil (just shy of 393,000 cases in 2014)[2] or Colombia (113,000 claims in 2012)[3], the usual reaction from legal scholars in high income countries is one of shock and disapprobation: this is not how courts should act. And if courts are to adjudicate socio-economic rights, even progressive scholars seem far more comfortable with the South African jurisprudence where the volume of successful health rights cases is very small. And contentment with this conservative approach persists despite the fact of massive inequalities in access to health care in South Africa, which have only grown larger since the end of apartheid.[4]

In Canada, where section 7 of the Canadian Charter[5] guarantees the right to life, liberty and security of the person, the courts have, so far,

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* Professor & University Research Chair, Director of the University of Ottawa Centre for Health Law, Policy & Ethics

1 Pedro Felipe de Oliveira Santos, *Beyond Minimalism and Usurpation: Designing Judicial Review to Control the* Mis-*Enforcement of Socio-economic Rights*, 18 WASH. U. GLOBAL STUD. L. REV. 493 (2019).

2 CONSELHO NACIONAL DE JUSTIÇA, RELATÓRIOS DE CUMPRIMENTO DA RESOLUÇÃO CNJ N. 107 (National Forum of Health-related Litigation Report), http://www.cnj.jus.br/images/programas/forumdasaude/demandasnostribunais.forumSaude.pdf (cited in Santos, *supra* note 1, at 499 n.22).

3 Everaldo Lamprea, *Colombia's Right-to-Health Litigation in a Context of Health Care Reform*, *in* THE RIGHT TO HEALTH AT THE PUBLIC/PRIVATE DIVIDE: A GLOBAL COMPARATIVE STUDY 131, 145 (Colleen M. Flood & Aeyal Gross eds., 2014).

4 Lisa Forman, *The Role of Rights and Litigation in Assuring More Equitable Access to Health Care in South Africa*, *in* THE RIGHT TO HEALTH AT THE PUBLIC/PRIVATE DIVIDE: A GLOBAL COMPARATIVE STUDY 288 (Colleen M. Flood & Aeyal Gross eds., 2014).

5 *Charter of Rights and Freedoms*, Part 1 of the *Constitution Act*, 1982, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11.

largely dismissed claims for public funding of health care.[6] Canadian courts have been willing to use section 7 to strike down legislation seen as unreasonably intrusive of personal liberties–for example, criminal laws limiting access to abortions,[7] medical-aid-in-dying,[8] and medical marijuana.[9] However, courts have not been willing to employ section 7 to require governments to provide public coverage or to protect against cuts in public coverage, even in the case of claims by refugees cut off from coverage of essential life-saving health care.[10] Even more insidiously,[11] Canadian courts have used the Charter to strike down a law limiting opportunities for privatization of health care on the grounds that wait times in the public system jeopardize security of the person (and possibly one's life) and thus patients have a right to seek out care privately.[12] These same wait times of course impact those without the means to pay for care privately or whom, because of age or disability, are excluded from private insurance plans; however, the court's dismal interpretation of the Canadian Charter fails to protect their interests. Bolstered by the *Chaoulli* decision,[13] litigation is presently underway to employ the Charter to strike down other laws protective of public medicare.[14] The approach of the

6 *See e.g.*, Flora v. Ontario Health Insurance Plan, 2008 ONCA 538 (CanLII); Canadian Doctors for Refugee Care v. Canada (Attorney general), 2014 FC 651 (CanLII). The Canadian Supreme Court has intervened only in isolated cases. For example it was found that hospitals must provide sign language translation services so that the hearing-impaired can access care on equal terms. Eldridge v. British Columbia (Attorney General), [1997] 3 S.C.R. 624. Note, however, that such cases concern ensuring equal access to the basket of established services – the courts are not being asked to *add* anything to the basket.

7 R. v. Morgentaler, [1988] 1 SCR 30.

8 Carter v. Canada (Attorney General), [2015] 1 SCR 331.

9 R. v. Parker, 2000 CanLII 5762 (ON CA).

10 Canadian Doctors for Refugee Care v. Canada (Attorney general), 2014 FC 651 (CanLII).

11 Sujit Choudhry, *Worse than* Lochner*?*, *in* ACCESS TO CARE, ACCESS TO JUSTICE: THE LEGAL DEBATE OVER PRIVATE HEALTH INSURANCE IN CANADA, 75 (Colleen M. Flood, Kent Roach & Lorne Sossin eds., 2005).

12 Chaoulli v. Quebec (Attorney General), [2005] 1 SCR 791. The court justifies its stance on grounds that there is no obvious evidence from other jurisdictions that permitting privatization will undermine the public health care system, wholly failing to understand the unique history, structure and dynamics of the Canadian system. *See* Colleen M. Flood & Bryan Thomas, *A Successful Charter Challenge to Medicare? Policy Options for Canadian Provincial Governments*, 13 J. HEALTH ECON., POL'Y & L. 433 (2018).

13 Chaoulli v. Quebec (Attorney General), [2005] 1 SCR 791.

14 Under Canadian federalism, health care falls largely under provincial jurisdiction, meaning that the *Chaoulli* ruling's direct impact was limited to the province of Quebec. In ongoing litigation, a private for-profit surgical clinic, Cambie Surgeries Corporation, is seeking to build on the *Chaoulli* precedent and overturn laws protective of public medicare in the province of British Columbia. For statements and claims, expert affidavits, and other court filings to date, see *Clinics Case Court Documents*, BC HEALTH COALITION, https://www.bchealthcoalition.ca/what-you-can-do/save-medicare/court-documents (last visited Mar. 3, 2019).

Canadian courts reflects a longstanding liberal conception of rights. In classical liberalism, rights are articulated as restrictions on the state's power that, in Locke's articulation, prohibit it from denying a citizen's life, liberty, or property.[15] In this tradition, rights mostly confer a negative duty on the state not to act, and are not only devoid of any distributional potential, but, to the contrary, may also entrench and exacerbate existing inequalities within society.

But, as I have hinted at, and as Pedro Felipe de Oliveira Santos argues in *Beyond Minimalism and Usurpation*,[16] perhaps the global stance of legal scholars towards a U.S. style of minimal review for socio-economic rights does not have diamond-hard legitimacy. Indeed, let us start with the simple proposition that whilst the doctrine of separation of powers has great constitutional import, so too must the fact that, in a country like Brazil, socio-economic rights are explicitly enshrined in the constitution.[17] A blinkered worldview overlooks the fact that approximately 70% of constitutions worldwide now contain health-related guarantees, while the right to health is justiciable in approximately 40%.[18] Developed-world scholars work within a belief system that socio-economic rights lack legitimacy and that even countries desirous of greater socio-economic rights move in small, incremental steps; but where such rights are explicitly part of a country's constitution, arguments grounded in parliamentary supremacy and separation of powers lose much of their force. Countries that have justiciable socio-economic rights have undertaken constitutional reform often in the wake of massive political upheaval–post communism, post-dictatorship, post- apartheid.[19] Socio-economic rights such as health rights have been made part of the constitutions of a number of middle-income countries following major political upheavals and are justiciable precisely in order to accelerate an

15 *See generally* JOHN LOCKE, SECOND TREATISE ON GOVERNMENT (1690). For a discussion of this understanding of rights, see Daphne Barak-Erez & Aeyal Gross, *Introduction: Do We Need Social Rights? Questions in the Era of Globalisation, Privatisation, and the Diminished Welfare State*, *in* EXPLORING SOCIAL RIGHTS: BETWEEN THEORY AND PRACTICE 1 (Daphne Barak-Erez & Aeyal Gross eds., 2007).

16 Santos, *supra* note 1.

17 CONSTITUIÇÃO FEDERAL [C.F.] [CONSTITUTION] art. 196 (Braz.) ("Health is the right of all and the duty of the National Government and shall be guaranteed by social and economic policies aimed at reducing the risk of illness and other maladies and by universal and equal access to all activities and services for its promotion, protection and recovery.").

18 Courtney Jung, Ran Hirschl & Evan Rosevear, *Economic and Social Rights in National Constitutions*, 62 AM. J. COMP. L. 1043 (2014), http://ssrn.com/abstract=2349680.

19 Colleen M. Flood & Aeyal Gross, *Conclusion: Contexts for the Promise and Peril of the Right to Health*, *in* THE RIGHT TO HEALTH AT THE PUBLIC/PRIVATE DIVIDE: A GLOBAL COMPARATIVE STUDY (Colleen M. Flood & Aeyal Gross eds., 2014).

equality agenda faster than is possible in capitalist democracies relying on trickle-down economics.

And perhaps there is a reasonably straightforward way to think about this: if a constitution explicitly provides for socio-economic rights, then their legitimacy as a class of rights is ipso facto established. Consequently, although there has been a globalization of U.S. ideas in so many domains, including in legal reasoning, this claim that socio-economic rights lack legitimacy should have little impact on legal reasoning in countries where socio-economic rights are clearly part of the constitution and where courts have clearly been given the power to adjudicate. As de Oliveira Santos claims, "[t]he question is not *whether* courts may intervene, but *how* courts may intervene according to constitutional parameters."[20]

However, recognizing the legitimacy of judicial enforcement of health rights is by itself not sufficient. A worry for those aspiring for health rights as a force for positive change is that rights will not be used to improve and save the lives of the most vulnerable, but instead will be co-opted by the middle-class and wealthy,[21] or used by pharmaceutical companies and other industry interests to ensure that their products are prioritized over other, potentially more effective, investments in health or public health. The concern is that, instead of the right to health helping to sustain important values like equality, a focus on rights-based norms will further foster individualism and exacerbate inequalities, as Pedro Felipe de Oliveira Santos demonstrates in his review of the Brazilian health rights jurisprudence.

What becomes clear is that applying the traditional liberal structure of rights to socio-economic rights will not realize the goals motivating the inclusion of those rights within constitutions. A formalist perspective of the enforcement of rights–and a right-as-trumps perspective–operates largely without consideration of the impact on the public fisc. and thus, in health care, without consideration of the impact on the ability to sustain and fairly allocate health resources. Applying such formalism to the health care rights quickly results, as has been the case in jurisdictions like Brazil and Colombia, in significant challenges to the sustainability of public health care systems—jeopardizing not only public programs but also public faith in the courts.[22] Moreover, if legal challenges are exclusively

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20 Santos, *supra* note 1 at 501.

21 Colleen M. Flood & Aeyal Gross, *Introduction: Marrying Health and Human Rights and Health Care Systems*, *in* THE RIGHT TO HEALTH AT THE PUBLIC/PRIVATE DIVIDE: A GLOBAL COMPARATIVE STUDY 452 (Colleen M. Flood & Aeyal Gross eds., 2014).

22 Mariana Mota Prado, *Provision of Health Care Services and the Right to Health in Brazil*, *in*

the purview of industry interests and wealthier individuals, this can, as de Oliveira Santos notes, distort the allocation of public resources away from those most in need.[23]

Complicating the base problem of formalism is also a misunderstanding amongst many, including judges, about how medical need is defined and the economics of health care systems. Frequently judges assume that even if just one physician says a patient needs a certain drug or device or treatment, this must then equate with medical need and in turn a right to health care.[24] In actuality, there are frequently many different treatment options and physicians frequently have zero incentive to consider the cost and relative benefits of different treatments. Thus, for example, as between two drugs of similar effectiveness, the doctor has no incentive to prescribe the drug that costs $1.00 as opposed to the drug that costs $200.00. If judgments are issued equating a physician treatment recommendation with what is required under the right to health care, this also emasculates the ability of public insurers to negotiate a more reasonable price for that drug, device or treatment. Once a right, then the public plan must pay whatever price the manufacturer or service provider demands. Indeed, we have seen examples of industry interests backing health right claims as a way to have their products publicly-funded at the price they demand rather than what would otherwise be negotiated by the public insurer.[25]

This naivety on the part of many judges regarding how health care markets work may, in the minds of some, substantiate the concern that they are out of their depths when adjudicating socio-economic rights, and that these complex policy questions should be left to governments and the policymaking apparatus. However, accepting this largely gives up on the idea of health rights as a means to accelerate better distribution of resources within a society.[26] Moreover, as mentioned earlier, courts in many countries arguably *must improve their approach* as ignoring health right claims is not an option. The only viable path is to get better at *how*

THE RIGHT TO HEALTH AT THE PUBLIC/PRIVATE DIVIDE: A GLOBAL COMPARATIVE STUDY 131, 145 (Colleen M. Flood & Aeyal Gross eds., 2014); Lamprea, *supra* note 3; Santos, *supra* note 1.

23 Santos, *supra* note 1.

24 Lamprea, *supra* note 3, at 144.

25 Lamprea, *supra* note 3, at 150.

26 Kent Roach has argued that the courts can play a positive role in adjudicating socio-economic rights, without overreaching their institutional competency, through the use of creative remedies such as *suspended declarations of invalidity*, which hand the baton back to lawmakers to devise solutions to rights infringements within a set period of time. *See* Kent Roach, *Polycentricity and Queue Jumping in Public Law Remedies: A Two-Track Response*, 66 UNIV. OF TORONTO L.J. 3 (2016). The use of creative remedies is part of the 'how' discussed below.

they adjudicate health rights and other socio-economic rights.[27]

De Oliveira Santos' arguments for how courts can do better in adjudication of health rights and other socio-economic rights builds on what others have argued in the past. He argues first that, in socio-economic rights litigation, courts should be attendant to the impact on the distributive and aggregative effects of their decisions.[28] In essence this is a call to take account of the economics of health care systems and to be alert to the realities that health rights litigation may not be driven by those most in need but from those with the resources and interests to litigate. Being attendant to these issues would suggest, as I have argued with Aeyal Gross, that courts should in general be deferential to decisions by public insurers regarding what services attract public funding but cast a much more searching eye over decisions by public insurers to undercut a fair distribution of health care resources by, for example, privatizing parts of the health care system. [29]

Further de Oliveira Santos argues that courts should "[enrich] the democratic process, especially by pushing issues back to political players with correct incentives to act and institutional adherence wherever possible"[30] This proposal echoes requirements that we see in administrative and constitutional law more generally for a fair process on the part of decision-makers, including participation by those most affected by a decision.[31] It also reflects thinking by philosophers on how best to approach the minefield of determining what services are publicly funded, given the many variables that could be differently weighted by reasonable people.[32] In the face of such heterogeneity of views regarding what should and should not be publicly insured, scholars such as Daniels and Sabin argue this is best determined by insisting upon a fair and accountable

27 Santos, *supra* note 1.

28 Santos, *supra* note 1, at 507.

29 Colleen M. Flood & Aeyal Gross, *Conclusion: Contexts for the Promise and Peril of the Right to Health*, *in* THE RIGHT TO HEALTH AT THE PUBLIC/PRIVATE DIVIDE: A GLOBAL COMPARATIVE STUDY, 452 (Colleen M. Flood & Aeyal Gross eds., 2014).

30 Santos, *supra* note 1, at 501. For a similar argument, see Martha Jackman, *Protecting Rights and Promoting Democracy: Judicial Review Under Section 1 of the Charter*, 34 OSGOODE HALL L.J. 661.

31 *See generally* Kate Glover, *The Principles and Practices of Procedural Fairness*, *in* ADMINISTRATIVE LAW IN CONTEXT (Colleen M. Flood & Lorne Sossin eds., 3d. ed. 2018); Evan Fox-Decent & Alexander Pless, *The Charter and Administrative Law Part I: Procedural Fairness*, *in* ADMINISTRATIVE LAW IN CONTEXT (Colleen M. Flood & Lorne Sossin eds., 3d. ed. 2018).

32 Norman Daniels & James Sabin, SETTING LIMITS FAIRLY: CAN WE LEARN TO SHARE MEDICAL RESOURCES (2002); Jens Byslov et al., *The Need for Global Application of the Accountability for Reasonableness Approach to Support Sustainable Outcomes,* 6 Int J Health Policy Manag 115 (2017).

process, without pretending that these questions can be settled categorically through more theorization about the right to health.[33]

In conclusion, scholars in countries with a clear constitutional right to health and other socio-economic rights should not be paralyzed by views on the legitimacy of such rights by scholars and legal traditions in different constitutional contexts. Instead they should, as de Oliveira Santos argues, look purposively towards why socio-economic rights were included in their respective constitutions and seek to promote those democratic objectives through their judgments. In doing so, they should not force health rights into the formalist mold of traditional civil and political rights, for to do so will undermine the goal of ensuring a fairer distribution of resources and allocating health care on the basis of need and not ability to pay. The most important thing courts can do is to relentlessly insist on a fair and evidence-based decision-making process for determining what is and out of publicly funded the health care basket, including public participation and the right of appeal for individuals adversely affected.[34] Courts can also stand as necessary to ensure that substantive decisions are rational and without undue discrimination in application, and, finally, to conduct a much more searching review of decisions that are antithetical to the goals behind inclusion of socio-economic rights in the constitution, for example, policies permitting privatization or undercutting universality.[35]

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33 *See e.g.*, Norman Daniels & James Sabin, *Fair Procedures, Democratic Deliberation, and the Legitimacy Problem for Insurers*, 26 PHIL. & PUB. AFF. 303 (1997).

34 KEITH SYRETT, LAW, LEGITIMACY AND THE RATIONING OF HEALTH CARE (2007).

35 For further elaboration, see Flood & Gross, *Conclusion: Contexts for the Promise and Peril of the Right to Health*, *supra* note 29.