A Justiciable Right to Health?

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Abstract: *This article explores the various ways of interpreting a so-called "right to health". In examining these alternative understandings of the right to health, the article seeks to show the right's potential for realistic and effective justiciability. This is done by examining first the arguments of various commentators in support of a justiciable right to health, and secondly the specific approaches of various jurisdictions to the recognition and enforceability of the right to health. Having analysed both these elements, the article concludes that there is, without doubt, potential for alternative notions of the "right to health" to be successfully implemented and enforced.*

I. Introduction

"The right to health is one of the most extensive and complex human rights in the international lexicon."[1] This statement by Paul Hunt, UN Special Rapporteur on the Right to Health, is undoubtedly true. The content, scope and potential for enforcement of the so-called "right to health" is not easily settled and is still hugely contested. Indeed, the very idea of including health as part of a general human rights framework is argued by many to be a fruitless, even dangerous, exercise.

One specific critique of a justiciable right to health is that made by Octavio Ferraz in reviewing the Brazilian model of the "right to health". He states:

The 'Brazilian model,' [...] is characterized by a prevalence of individualized claims demanding curative medical treatment (most often drugs) and an extremely high success rate for the litigant [...] In this interpretation, the right to health is an individual entitlement to the satisfaction of one's health needs with the most advanced treatment available, irrespective of costs [...] This interpretation of the right to health [...] and the model of litigation that it encourages is inadequate and potentially detrimental to health equity.[2]

This model specifically seems to have sprung from the expansive interpretation of the right to health given by the Brazilian Supreme Federal Tribunal in the context of lengthy HIV/AIDS proceedings,[3] and it is arguably this unrestrained interpretation that has caused a subsequent crisis in Brazilian healthcare litigation.

This article looks specifically at Ferraz's particular critique of the "right to health" and will argue that, while his description of Brazil's "epidemics of [health] litigation"[4] is undoubtedly alarming, it is just one example of one country's model of right-to-health litigation, based upon one interpretation of the "right to health". There are, however, other ways of interpreting this right. These alternative understandings of the meaning, scope and methods of enforcing

[1] Paul Hunt, *Report on progress and obstacles to the health and human rights movement, in addition to cases on the right to health and other health-related rights* (submitted to the Human Rights Council on 17 January 2007, A/HRC/4/28) [24].

[2] See Octavio Luiz Motta Ferraz, 'The Right to Health in the Courts of Brazil: Worsening Health Inequalities?" (2009) 11(2) *Health and Human Rights: An International Journal* 33.

[3] ibid 35.

[4] ibid.

the right may pave the way for a more lasting and equitable justiciable right to health, which avoids the pitfalls of the Brazilian approach. Ultimately, Ferraz's example of the "right to health" gone wrong is not a good reason for rejecting entirely the notion of a justiciable right to health.

The article will seek to show the alternative ways of understanding the right to health, and the potential for its realistic and effective justiciability, by examining first the arguments of various commentators in support of a justiciable right to health, and secondly the specific approaches of various jurisdictions to the recognition and enforceability of the right to health. This will show the potential of alternative notions of the "right to health" for successful implementation and enforcement.

II. The Case for a Justiciable Right to Health

Various commentators have argued in favour of adopting a human rights approach to health, creating a justiciable right to health that is equivalent in protections to those more traditional civil-political rights.

Paul Hunt describes the particular benefits of a human rights approach to health as including its ability to give "special attention […] to disadvantaged individuals and communities", its potential for achieving "active and informed participation of individuals and communities in policy decisions that affect them", and its requiring "effective, transparent and accessible monitoring and accountability mechanisms."[5] As regards to actually enforcing the right to health, a system of "indicators and benchmarks" has been recognised as necessary in order to measure the progressive realisation of the right.[6] Hunt also appreciates, however, the concept of accountability and discusses at length the potential of courts (despite their known limitations) to "clarify the meaning of health-related rights and also secure better health-related services for *individuals* and *communities*."[7] Courts can achieve this by using different concepts, such as progressive realisation or the duty to respect, protect and fulfil all rights.[8] Indeed, General Comment 14 of the UN Committee on Economic, Social and Cultural Rights has taken up these very concepts in its attempt to operationalise the right to health,[9] alongside its adoption of the notion of a "minimum core".[10]

Yamin makes the point that modern notions of human rights are inextricably tied up with the courts and judiciary.[11] She seems to think of litigation in this field of socio-economic rights, however, as being about institutional and structural change and she notes that care should be taken not to conflate such an approach with a more individualistic, traditional notion of legal proceedings.[12] Indeed, litigation can often be used as a political tool in the area of social rights, with lobbying and activism working alongside the court in achieving social transformation.[13] Yamin cites examples of

[5] Paul Hunt, *Report on health systems and human rights-based approach to health indicators* (submitted to the Commission on Human Rights on 3 March 2006, E/CN.4/2006/48) [25].

[6] Hunt (n 1) [27].

[7] ibid [58]. Emphasis added. Note that this refers to the courts' potential to generate health benefits for the wider community, as opposed to simply the individual litigant.

[8] ibid [59]–[67], [77]–[85].

[9] General Comment 14: The Right to the Highest Attainable Standard of Health (Article 12) (CESCR, 11 August 2000, E/C.12/2000/4) [30], [33].

[10] ibid [43]–[45].

[11] Alicia Ely Yamin, 'Beyond Compassion: The Central Role of Accountability in Applying a Human Rights Framework to Health' (2008) 10(2) *Health and Human Rights* 1, 5.

[12] ibid 3.

[13] ibid. The *Treatment Action Campaign* case (discussed below) is a good example of this.

how, in the last 15 years or so, courts all over the world have begun to engage with health-related rights, and she argues that "the mere possibility of judicial enforcement" can encourage political shifts and opportunities for negotiation with social movements.[14] This presents a more expansive understanding of the potential for the justiciability of social rights.

Fredman argues that the "right to security" imposes *positive* duties on the state, alongside the more obvious negative duties. These duties include a duty to provide for the basic needs of individuals, based on an understanding of "security" as entailing the right to be free from threats to one's bodily survival[15]—this would include the right to be free from ill-health.[16] She disagrees with the notion that courts should steer clear of adjudicating on those rights imposing positive duties, arguing that this skews the judicial approach in favour of merely *negative* duties whenever a clash arises between the two.[17] Rather, she believes the courts should deepen their understanding of the ways in which positive rights and obligations interact.[18] To this end, she suggests various principles the courts can use in adjudicating such positive duty claims. These include: values and principles enshrined in constitutions (e.g. directive principles contained in the Indian Constitution); the principle of reasonableness; and the notion of equality, when tied to a substantive concept such as the right to security.[19]

Considering specifically the conflict that arises between the right to life and limited public resources, Wicks acknowledges that there is "sound justification for judicial reluctance" to get involved in decisions regarding the allocation of resources.[20] She does not believe, however, that this should stop the courts recognising and enforcing the state's positive duties to protect life whenever an issue of funding also arises.[21] Wicks thus advocates a judicial approach based on "reasonableness" and "proportionality": in other words, an approach based on elements of procedural fairness.[22] This thus avoids the courts getting involved in substantive questions of policy and resource-allocation, but still allows them to review the governing body's decisions to see if it has done all that could "reasonably be expected of it under the right to life."[23] In respect of the right to health (a right arguably subsumed under the right to life) this approach would allow the court to adjudicate claims that the state has failed in its duties to vindicate the right to health, by enabling it to review the reasons underlying the state's policies and assess them as to their fairness.

These various commentaries all present alternative understandings to the Brazilian model as to how a justiciable right to health might operate in practice. The alternatives—to respectively greater and lesser extents—provide an insight into how the right to health can be understood in a more expansive and yet somewhat more nuanced way. These differing conceptions—again, to varying greater and lesser extents—avoid the more individualistic, traditionally legalistic approach of the Brazilian courts. The next section will briefly consider the specific ways in which different courts have

[14] ibid 5–7.
[15] Sandra Fredman, 'The Positive Right to Security' in Goold and Lazarus, *Security and Human Rights* (OUP, 2007).
[16] ibid.
[17] ibid.
[18] ibid.
[19] ibid.
[20] Elizabeth Wicks, *The Right to Life and Conflicting Interests* (OUP, 2010) 223.
[21] ibid.
[22] ibid 232–233.
[23] ibid 237.

dealt with the right to health and its enforceability.

III. A Justiciable Right to Health: Comparative Perspectives

a. South Africa

Section 27(1) of the South African Constitution declares that everyone has the right to have access to health care services. This is subject, however, to the s.27(2) requirement that the state merely take "reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of each of these rights." s.27(3) does not provide such a caveat and simply states: "No one may be refused emergency medical treatment."

In the case of *Soobramoney v Minister for Health*[24] the Constitutional Court interpreted s.27(3) as referring to a person suffering from a "sudden catastrophe which calls for immediate medical attention".[25] It therefore did not apply to the applicant in this case, who was denied dialysis treatment in a state-funded hospital. Moving on to consider the applicant's case under ss.27(1) and 27(2), Chaskalson P noted that the guidelines followed by the hospital as to whom should receive renal dialysis treatment were not suggested to be "unreasonable or […] not applied fairly and rationally".[26] Ultimately, he concluded that the government administrators hold the responsibility of making healthcare funding decisions: such choices "involve difficult decisions to be taken at the political level".[27] Given that this is a governmental function, he ruled that the court would be slow "to interfere with rational decisions taken in good faith by the political organs and medical authorities whose responsibility it is to deal with such matters."[28]

In *Minister of Health v Treatment Action Campaign [No.2]*[29] the Constitutional Court reached the opposite conclusion and found that the state *had* failed to comply with its constitutional duty to "act reasonably to provide access to […] socio-economic rights […] on a progressive basis."[30] The Court therefore ruled that s.27 required the government to "devise and implement within its available resources a comprehensive and co-ordinated programme to realise progressively the rights of pregnant women and their newborn children".[31] In addition to considering this issue of progressive realisation, the court discussed the notion of *accessibility* as regards the drug Nevirapine, ruling that its limited availability to mothers and children was unreasonable.[32]

As seen in these decisions, the Constitutional Court has rejected the idea of a freestanding "minimum core"[33] and has appeared to proceed on the basis of standards such as "reasonableness".[34] Bilchitz suggests that a "principled minimum core", together with his notion of "pragmatic minimum standards", could be used together to evaluate and improve government health programmes, with the ultimate aim of improving the basic standards of South African healthcare over time and

[24] [1998] 1 SALR 765.
[25] ibid [20].
[26] ibid [25].
[27] ibid [29].
[28] ibid.
[29] [2002] 5 SA 721. Hereinafter *TAC*.
[30] ibid [35].
[31] ibid [135].
[32] Hunt (n 1) [72].
[33] See *TAC* (n 29) [34], where the Court cited the decision of Yacoob J in *Republic of South Africa v Grootboom* 2000 (1) SA 46.
[34] Aarthi Belani, 'The South African Constitutional Court's Decision in TAC: A "Reasonable" Choice?' *Center for Human Rights and Global Justice Working Paper, Economic, Social and Cultural Rights Series Number 7* 36. Available at <http://www.chrgj.org/publications/docs/wp/Belani%20The%20South%20African%20Constitutional%20Court's%20Decisions%20in%20TAC.pdf>

progressively realising the right to health in South Africa.[35] While the South African health care system undoubtedly still faces challenges[36] and could possibly benefit from such an approach, the standards applied by the Constitutional Court have arguably been successful thus far in achieving a realistic and meaningful right to health.

b. India

Article 21 of the Indian Constitution states: "No person shall be deprived of his life or personal liberty except according to procedure established by law." This provision was given a rather narrow interpretation until the 1978 case of *Maneka Gandhi v Union of India*, where it was said to cover a variety of rights and thus laid the foundations for the future enlargement of this right to life and liberty.[37]

Throughout the 1980s and 1990s, a number of decisions specifically recognised health-related issues as falling within the Article 21 right to life.[38] It was not until the case of *Paschim Banga Khet Mazdoor Samity v State of West Bengal*[39] however that the right to health was recognised as independently justiciable,[40] inhering in the fundamental right to life under Article 21.[41] Specifically, the Supreme Court stated: "Article 21 imposes an obligation on the State to *safeguard* the right to life of every person [...] The Government hospitals run by the State [...] are duty bound to extend medical assistance for preserving human life."[42] While the Court acknowledged the potential financial constraints on the Government, it reiterated that it is "the constitutional obligation of the State to provide adequate medical services to the people [...] [w]hatever is necessary for this purpose has to be done."[43]

Since then the Court has reaffirmed the right to health as being fundamental under the Constitution.[44] While the Court has engaged in discussions of international standards for adjudicating the right to health and its duties under the UDHR and ICESCR,[45] it has yet to formulate a comprehensive definition of the core content of the right.[46] Several aspects that have thus far been found necessary to guarantee at a minimum include the entitlement to adequate health care, including emergency healthcare, and adequate medical facilities.[47]

In respect of the remedies granted by the Indian courts for health claims, they are both specific and general in nature.[48] These general forms of relief have taken various different forms including: the passing of mandatory orders, delivering detailed directions to public and private respondents to develop requisite policy and regulatory practices, exercising supervising jurisdiction

[35] David Bilchitz, 'The Right to Health Care Services and the Minimum Core: Disentangling the Principled and Pragmatic Strands' (2006) 7(2) *ESR Review* 5–6. Bilchitz describes "pragmatic minimum standards" as being reached by considering the principled minimum core along with other theoretical considerations, as well as resources considerations.

[36] For example, see the Executive Summary of the South African Human Rights Commission, *Public Inquiry: Access to Health Services* (2009).

[37] *Naz Foundation v Delhi* 160 (2009) DLT 27 [25]. Hereinafter *Naz Foundation*.

[38] Sharanjeet Parmar and Namita Wahi, 'India: Citizens, Courts and the Right to Health: Between Promise and Progress?' in Alicia Ely Yamin and Siri Gloppen (eds) *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Harvard Law School, 2011).

[39] (1996) 4 SCC 37. Hereinafter *Paschim Banga*.

[40] Parmar and Wahi (n 38).

[41] *Naz Foundation* (n 37) [61].

[42] *Paschim Banga* (n 39). Emphasis added.

[43] ibid.

[44] Parmar and Wahi (n 38).

[45] ibid. For example, in *Naz Foundation* the Court discussed General Comment 14 along with other UN instruments.

[46] ibid.

[47] ibid.

[48] ibid.

over the matter etc.[49] In assessing the actual success of the Indian courts' approach to health rights litigation, Parmar and Wahi conclude that its effect has been largely positive. While there are some problems with the system—for example, the significant difficulty in actually enforcing courts' orders—the right to health has been extremely useful to citizens in highlighting dire situations and opening up a discourse that forces the Government to justify and explain its policies. This is an especially important tool for those members of minority and vulnerable groups in society.[50]

Empirically, Parmar and Wahi admit it is hard to say conclusively that health rights litigation in India has improved the equitable provision of health care services. What they can say with a degree of certainty, however, is that it does not appear to be *deepening* health inequalities—in marked contrast to the Brazilian model presented by Ferraz.

III. Conclusion

There are many different ways to construe and understand the "right to health": this article has tried to present just some of these alternative interpretations. The highly individualised Brazilian system described by Ferraz arguably lacks nuance and suffers greatly for this. It fails to apply the right to health in a way that takes account of the particular complexities such a right inevitably gives rise to, and it fails to take the more creative and innovative approach explicated by the South African and Indian courts. The various commentaries on the right to health further give arguments that could help a court in developing a shrewder and more workable analysis of the right to health.

It is for these reasons that this article answers the question presented with a resounding no: the pitfalls of the Brazilian model described by Ferraz are not good reasons for rejecting the notion of a justiciable right to health. Rather than simply giving up on the idea of a right to health on the basis of the perceived problems with Brazilian healthcare litigation, inspiration should be taken from the various sources cited in this article. A renewed attempt to understand the right to health could be taken, one that understands the potentially community-orientated nature of the right and the need to move away from the more traditional method of rights enforcement. By doing so, a fairer and more effective right to health for all might just be possible.

[49] ibid.
[50] ibid.

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