Dalhousie Law Journal

Volume 39 | Issue 2 Article 3

10-1-2016

A Goal-Oriented Understanding of the Right to Health Care and its Implications for Future Health Rights Litigation

Michael Da Silva
University of Toronto

Follow this and additional works at: https://digitalcommons.schulichlaw.dal.ca/dlj

Part of the Health Law and Policy Commons

Recommended Citation
Michael Da Silva, "A Goal-Oriented Understanding of the Right to Health Care and its Implications for Future Health Rights Litigation" (2016) 39:2 Dal LJ 377.

This Article is brought to you for free and open access by the Journals at Schulich Law Scholars. It has been accepted for inclusion in Dalhousie Law Journal by an authorized editor of Schulich Law Scholars. For more information, please contact hannah.steeves@dal.ca.

Michael Da Silva*

A Goal-Oriented Understanding of the Right to Health Care and its Implications for Future Health Rights Litigation

International human rights law recognizes a right to health. A majority of domestic constitutions recognize health-related rights. Many citizens believe that they have a moral right to health care. Some theorists agree. Yet the idea of a right to health care remains controversial. Specifying the nature of such a right invites more controversy. Indeed, most models of the right face persistent problems that threaten to undermine the conceptual coherence of a right to health care. This article accordingly sketches preliminary arguments for a new, goal-oriented model of the right to health care. It explains that the model avoids most of the problems facing other models, explains the key insights of those competing models, is consistent with international law, and provides metrics for assessing fulfillment of the right. It then explains the model's potential relevance for future health rights litigation in Canada.

Le droit international en matière de droits de la personne reconnaît le droit à la santé. La majorité des constitutions nationales reconnaissent les droits liés à la santé. De nombreux citoyens croient qu'ils ont un droit moral aux soins de santé. Certains théoriciens sont d'accord. Pourtant, le concept d'un droit aux soins de santé reste controversé. Préciser la nature d'un tel droit amplifie la controverse. En effet, la plupart des modèles du droit moral à la santé se heurtent à des problèmes persistants qui menacent de miner la cohérence conceptuelle d'un droit aux soins de santé. L'auteur esquisse donc les arguments préliminaires pour l'adoption d'un nouveau modèle du droit aux soins de santé, lequel serait axé sur les objectifs. Il explique que le modèle proposé évite la plupart des problèmes qu'éprouvent d'autres modèles et explique les principaux éléments de ces derniers. Il ajoute que le modèle proposé est conforme au droit international et comporte des mesures pour évaluer l'exercice du droit. L'auteur fait ensuite ressortir la pertinence potentielle du modèle pour les futurs litiges relatifs aux droits de la santé au Canada.

* Michael Da Silva is a student in the University of Toronto Faculty of Law's Doctor of Juridical Science (SJD) program and a Canadian Institutes of Health Research (CIHR) Vanier Canada Graduate Scholar. He was a CIHR Training Fellow in Health Law, Policy and Ethics when he wrote this piece. His publications include works in the Canadian Journal of Law and Jurisprudence, Criminal Justice Ethics, Ratio Juris, and Law, Ethics and Philosophy (LEAP).

Introduction
I. *Issues with existing models of the right to health care*
II. *Motivating the goal-oriented right to health care*
III. *Lingering concerns with the goal-oriented model*
IV. *Implications for health rights litigation*
Conclusion

Introduction

Current forms of Canadian health rights litigation must untie jurisprudential knots before achieving mainstream health rights advocates' progressive goals. Whether it is worth untying them in court depends on whether the intended ends are actually laudable and achievable. Litigation is not a tool for merely clearing up conceptual confusion. It is a technical procedure for achieving certain ends. When considering the future of health law in Canada, my desire is to identify the ends that such litigation should achieve. Part of this work is scrutiny of what a health right actually is and what it means to fulfill it. I believe that identifying the intended ends of appeals to health rights could also clear up the aforementioned conceptual confusion by demonstrating that purported health rights are constituted by their intended ends. The right to health care (RTHC) in particular is best understood as a set of goals that are often (perhaps mistakenly) placed under a common rights-based heading. One of my prospective contributions to the future of health law is an argument for this theory of the RTHC and explanation of its implications. My hope is that future health rights litigation will seek to fulfill these goals.

A full argument for this goal-oriented model of the RTHC should identify problems with existing models of the right and explain and motivate the competing model. It should also discuss how the goal-oriented model addresses other models' problem areas. To explore the implications of this model for future health rights litigation, one should then identify the content of the right, measures for how to fulfill the content, how and when health right litigation could fulfill deficiencies in those measures, and why health rights litigation should focus on fulfilling those deficiencies. This complete account is impossible in the space allotted.[1]

1. Indeed, the complete account constitutes much of my doctoral dissertation and other works.

This paper is thus a preliminary effort at explaining what a goal-oriented RTHC might look like and why one may want to adopt the model. I begin by explaining deficiencies with existing views. I then outline arguments for my view, including a claim that it avoids some problems with existing models. As part of this discussion, I address lingering weaknesses with the model. Finally, I present the preliminary case for the claim that future health rights litigation should seek to promote the RTHC's constitutive goals.

I. *Issues with existing models of the right to health care*

There are two major models of the RTHC. Moral theories seek to identify reasons people have a moral RTHC (and explain why it should be fulfilled through the law). Legal theories explain why legal authority must be used to recognize a RTHC. Some look to the law and legal practice to explain the nature of the right.[2] Both model types face a variety of challenges. While some permutations of each avoid the criticisms better than others, the non-goal-oriented variants of both types run into some persistent problems.

Some classic theoretical and practical challenges to the RTHC can be easily met, but others continue to plague most, if not all, of the dominant models of the RTHC. First, the argument from the nature of rights suggests that there can be no RTHC because no one owes a duty to fulfill that right.[3] This challenge can met in ethics with relative ease. But there is reason to question whether a solution to the problem has legal implications. The traditional understanding of rights as claims defines a right as A's entitlement to X from B.[4] A right must be held by an individual and entails specific correlative duties by others. X could be a good, a service, or a freedom. One could have a right to payment for services or to picnic on

2. See, e.g., Joseph Raz, "Human Rights Without Foundations" in Samantha Besson & John Tasioulas, eds, *The Philosophy of International Law* (Oxford: Oxford University Press, 2010) 321; Charles Beitz, *The Idea of Human Rights* (Princeton: Princeton University Press, 2009); Jonathan Wolff, *The Human Right to Health* (New York: WW Norton & Company, 2012).

3. This language appears in Gopal Sreenivasan, "II—A Human Right to Health? Some Inconclusive Scepticism" (2012) 86:1 Aristotelian Society Supplementary Volume 239 to describe an issue with the broader right to health. A similar argument against the RTHC is commonly invoked in debates on that topic. Sreenivasan also presents an argument from the nature of health that highlights the fact that, even in a world of unlimited health-care goods, the right to health can never be fulfilled. While health care is subject to resource constraints, the RTHC does not face an analogous challenge to Sreenivasan's anti-right to health argument from the nature of health.

4. This structure is a standard reading of Wesley Newcomb Hohfeld, "Some Fundamental Legal Conceptions as Applied in Judicial Reasoning" (1913) 23:1 Yale LJ 16 at 31. Some take Hohfeld's observation that in "ordinary legal discourse" rights tend to be viewed as correlative with duties to be a feature of rights. See, e.g., Sreenivasan, *supra* note 3. Hohfeld's work pertained to legal rights, but his structure is commonly invoked in the moral domain.

a public lawn. The service-recipient would then have a duty to give the rights-holder money. Everyone would have a (defeasible) duty not to stop the picnicker from laying down her blanket. The claim-right framework purportedly entails that there cannot be a moral right to health because one cannot identify particular individuals who could fulfill the right and thus cannot identify even candidate duty-bearers.[5] Governments are plausible duty-bearers for health rights, but granting that leaves questions about what the duties entail, raising further problems identified below. Recognizing this fact, health rights advocates highlight the distinction between perfect duties that specify a particular action a duty-bearer must perform and imperfect duties that specify a domain of actions that a duty-bearer must take steps to perform.[6] Yet this distinction may not provide a good model for legal health-care duties. Immanuel Kant, who is commonly cited as the originator of imperfect duties, deemed them ethical "duties of virtue," not legal duties.[7] Non-Kantians too may have reasons not to work towards having the legal reflect the moral. Even if one could identify a moral RTHC, working to ensure that the law reflects the domain of morality in which it is operative is bound to be expensive. These costs are ill-spent where moral boundaries remain fuzzy. Imperfect governmental duties to provide health care may not entail a duty to legally entrench a RTHC. Indeed, attempting to make the law reflect ethics may not count in favor of arguments offered by health rights advocates. For instance, health rights litigants' desire to recognize a positive dimension of constitutional rights leads some to advocate elimination of the positive/negative rights distinction.[8] But that tool is useful in ethics.[9]

Other problems are more persistent for most theories. Consider, second, the problem of scope. At one extreme, an overly expansive set of entitlements threatens to make the RTHC a force for state instability or a hollow aspirational ideal. If the RTHC entails that individuals should be entitled to even a large number of expensive health-care goods, states

5. Hohfeld, *ibid* at 32 states that "claim" could be a synonym for "right" but does not use the term "claim-right."
6. Amartya Sen, "Elements of a Theory of Human Rights" (2004) 32:4 Philosophy & Public Affairs 315 at 346.
7. Immanuel Kant, *The Metaphysics of Morals*, translated by Mary Gregor (New York: Cambridge University Press, 1996) at 153. Imperfect duties are admittedly mentioned in the legal section at 32.
8. Stephen Holmes & Cass Sunstein, *The Costs of Rights* (New York: WW Norton & Co, 1999) provides one leading denial of the positive rights/negative rights distinction at, e.g., 43.
9. Michael Da Silva, Review Essay: Jeff King, *Judging Social Rights*: Cambridge University Press, 2012, ISBN 9781107 400 320, 370 pp. (2015) 9:3 ICL Journal: Vienna J Int'l Constitutional L 463 at 470 n 47.

who attempt to fulfill their RTHC obligations risk economic default.[10] Government budgets are limited. A large number of successful health claims may create debts beyond those limited budgets. This can restrict states' abilities to realize other rights.[11] At the other extreme, a right to a single health-care good is not easily described as a RTHC. Such a right is best described as a right to *that good*. The RTHC is then empty. Identifying where to stop between these extremes is difficult.

This relates to the third problem, which we can call the problem of principles of scope: it is difficult to articulate a *principle* for selecting which goods ought to be covered. Attempts to solve this problem often raise more questions about what to cover than they solve. For instance, identifying the goods necessary to ensure all individuals have equality of opportunity is difficult since the nature of equality of opportunity is itself contested.[12] Likewise, suggesting that "full coverage of 'key' health interventions should be an initial benchmark towards universal coverage"[13] shifts the problem to determining what is "key." Similar problems likely plague most candidate principles.

Finally, the list of goods required to fulfill a right to health will vary over time and space as new goods are developed. Call this the problem of time and space. International human rights law provides some clues about what ought to be covered under the RTHC.[14] Yet it is unlikely that these goods are immutably necessary. Health-care needs also differ between states. Demography and geography make this inevitable. For a geographical example, tropical rainforest climates require more anti-malarial interventions. Economic differences make this problem acute. If

10. E.g., Colombia claimed that their domestic right crippled them financially; Alicia Ely Yamin, Oscar Parra-Vera & Camilla Gianella, "Colombia: Judicial Protection of the Right to Health: An Elusive Promise?" in Alicia Ely Yamin & Siri Gloppen, eds, *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Cambridge: International Human Rights Clinic, Human Rights Program, Harvard Law School, 2011) 103 at 121.

11. Charles Fried, "Positive Rights" in *Right and Wrong* (Cambridge: Harvard University Press, 1978) 108.

12. See, e.g., Gerry Cohen, *Why Not Socialism?* (Princeton: Princeton University Press, 2009) at 14-24.

13. Lawrence O Gostin & Eric A Friedman, "Towards a Framework Convention on Global Health: A Transformative Agenda for Global Health Justice" (2013) 13:1 Yale J Health Pol'y L & Ethics 1 at 40.

14. The international right to health is enshrined in the *International Covenant on Economic, Social and Cultural Rights,* 16 December 1966, 993 UNTS 3, art 12 (entered into force 3 January 1976) [*ICESCR*]. For clues about the content of its health components, see, e.g., *Convention on the Elimination of All Forms of Discrimination Against Women,* 18 December 1979, 1249 UNTS 13, arts 11-12; *Convention on the Rights of the Child*, 20 November 1989, 1577 UNTS 3, arts 24(2)(b),(d),(f); *General Comment No 14 (2000): The right to the highest attainable standard of health (article 12 of the International Covenant on Economic, Social and Cultural Rights)*, UNCESCR, 22nd Sess, UN Doc E/C.12/2000/4 (2000) at para 36 [*GC 14*].

the RTHC only covers essential medicines, it is arguably of little value for the people of well-developed nations who are already entitled to those goods. If it includes more advanced medicines that citizens of such nations may require, it will go unfulfilled in poorer nations. Any RTHC must be sensitive to these variations in needs and circumstances.[15]

There are, then, a variety of challenges with which existing models of the RTHC must contend. I lack sufficient space to explain why each existing model cannot negate all of these criticisms. Again, some versions face the criticisms better than others. I hint at some reasons why above and provide some further detail explaining why the goal-oriented model avoids the bulk of these criticisms below. The goal-oriented model's ability to avoid these criticisms is just one reason why one should prefer it to existing alternatives.

II. *Motivating the goal-oriented right to health care*

The best understanding of the RTHC in both law and ethics suggests that it is not a traditional right but shorthand for a set of goals we can use to assess health-care system performance. The right to health care is best understood as a catch-all for a series of important, related goals rather than a traditional claim-right with clear correlative duties and duty-bearers. More specifically, the RTHC is a plurality of claims to (1) a functioning health-care system, (2) fair allocation of health-care goods, and (3) the goods necessary to live a dignified existence. These goal-based aspects of the RTHC are related. Each is required for persons to live dignified lives and could be grounded in reciprocity for government power over their lives. The three aspects are nonetheless unique. For instance, (1) is a collective right held by persons in concert while the content of (3) more closely resembles the type of goods individuals could claim. The aspects are also severable. One can achieve an aspect without achieving another and each aspect implies different metrics for success. Yet, ultimately, the RTHC is only fully realized when (1) includes (2) and (2) maximizes individuals' access to (3). All of these claims are made in the service of a

15. Part of this problem is avoided in the legal domain by the international right's built-in resource constraint. The right is only to the highest attainable standard of health. Poor nations are not obligated to (immediately) provide seeming luxury goods even as part of the so-called "minimum core" in *General Comment No 3: The nature of States parties' obligations (art. 2, para 1, of the Covenant),* UNCESCR, 5th Sess, UN Doc E/1991/23 (1990) at para 11 [*GC 3*].This fact about resource constraints does not exhaust the question of whether luxury goods are the type of goods we would want the RTHC to guarantee.

broader claim to (4) improved health, though recognizing a right to health as such faces all of the concerns above and some others.[16]

This understanding (1) avoids the brunt of the criticisms discussed above, (2) accounts for many of the insights of the moral and legal understandings of the RTHC, (3) is supported by international human rights law, and (4) suggests measures that one can use to evaluate whether health rights litigation is valuable. In this section, I sketch the arguments for these claims to motivate the goal-oriented model.

To begin, recognizing a procedural aspect of the RTHC helps avoid several problems with existing models of this right. The right to procedural fairness is widely recognized as a right with a clear duty-bearer: government decision-makers. Where fair decision-making procedures exist, there is no need to define an exclusive, eternal basket of goods and services that will serve as the content of the RTHC. The problem of scope is solved by decision-makers in a fair system. Those decision-makers can alter the composition of the basket in light of changes, helping to avoid the problem of time and space. One needs an account about what fairness entails in order to define the set of acceptable principles for identifying those goods, but fairness can allow for a variety of principles for decision making, again avoiding the worst aspects of that concern.

Yet an exclusively procedural RTHC cannot avoid many of the problems with existing models of the right. A RTHC without a minimal floor of goods that must be included seems at odds with the meaning of the phrase "the right to health care." If the RTHC is just a pre-existing, uncontroversial right to procedural fairness, the RTHC is redundant. If the concept is redundant, it is difficult to explain why the controversies above exist. It would be even more difficult to explain why health rights litigants demand more than fair procedures without accusing them of confusion.

A moral RTHC, then, must have unique content and practical versions of the RTHC seek more than fair procedures. The goal-oriented RTHC best avoids the problems identified above by recognizing that it has a procedural component, but the concept of the RTHC only has its intended benefits when it has minimal substantive content. Providing that content likely requires a functioning health-care system. Such a system may also be necessary as the subject of fair decision making. The goal-oriented

16. See, e.g., note 3. Note further that identifying the particular social determinants of health that ought to be covered under a right to health would also arguably run into each of the problems identified above. Problems with identifying candidate duty-bearers are even more acute for some of the social determinants and the costs of fulfilling rights to, e.g., a healthy environment would be astronomical even when compared with the most expensive version of the RTHC.

RTHC ultimately reflects the insights of competing model types and, by recognizing insights of both, avoids criticisms that attach to each.

The goal-oriented model of the RTHC gains further support from its consistency with legal practice. Practice suggests that (at least) (1)-(3) are existing aims of health rights litigants. In the Canadian context, many challenges are framed as claims to essential services.[17] Others address the fairness of allocation decisions.[18] Some focus on attempted cuts to the health-care system.[19] On the goal-oriented model, advocates who invoke the language of the RTHC are not completely misguided. Many seek important ends, including the fulfillment of pre-existing rights like the right to fairness in the distribution of public goods. While discussion of a "right" to health care suggests that it will resemble traditional individual claim-rights, the RTHC in legal practice seems to be a catch-all for a variety of interests, including individual claim-rights, collective claim-rights, and concerns with broader consequential outcomes. Even if the term "RTHC" is philosophically problematic, practice suggests that it is and can be invoked to refer to claims for a series of less controversial, less problematic ends.

There are also moral reasons to support the goal-oriented model. Critics of the philosophical concept grant that their attacks may not apply to advocates who "are happy to use the language of rights in a looser fashion than philosophical strictures require."[20] My pluralist, instrumental approach better reflects the moral status of the RTHC. There are good reasons to suggest that governments already owe (imperfect) duties to ensure all three goals are realized. Governments must provide a functioning health-care system to ensure that all persons have a *de minimus* level of well-being required for a dignified life. Persons have at most few moral reasons to submit to governmental authority if the government cannot provide better security than life outside governmental control. Governmental powers, including the power to regulate health-care provision, are best justified where government can ensure a dignified level of well-being. No one person has a right to a functioning health-care system, but a collective right to such a system follows from the nature of government authority. For the same reasons, the system must ensure that people can access the goods necessary for a dignified existence.

17. E.g., the unsuccessful claim in *Auton v British Columbia (AG)*, 2004 SCC 78, [2004] 3 SCR 657 was criticized as trying to create a freestanding right to all necessary treatments.
18. E.g., fairness arguably motivates section 15 equality claims like *Cameron v Nova Scotia (AG)*, (1999), 204 NSR (2d) 1, 177 DLR (4th) 611 (NSCA).
19. See, e.g., *Canadian Doctors for Refugee Care v Canada (AG)*, 2014 FC 651, [2015] 2 FCR 267.
20. Sreenivasan, *supra* note 3 at 240.

Individuals arguably should be able to take the government account for the provision of these goods. Procedural fairness in the distribution not only of essential goods, but in allocation decisions about non-essential goods, follows from the government's non-controversial duty to recognize that all persons are free and equal and decisions must reflect their equal status. This requires that decisions could theoretically be accepted by equal persons. Transparent use of publicly acceptable reasons and opportunity to challenge allocation decisions based on improper reasons is demanded by political morality regardless of whether we recognize a RTHC.[21] At worst, then, (1)-(3) comprise a mix of pre-existing rights and things we should expect from governments. (4) is a valuable goal from a consequentialist perspective and there may be non-consequential reasons to support it too.

The goal-oriented understanding, then, is supported by practice-based and moral arguments for the RTHC. The goal-oriented RTHC also gains support from its consistency with international human rights law. A full argument for this claim requires an article length manuscript of its own. Yet even a cursory glance at the relevant legal materials makes it clear that the international right to health, which includes an international RTHC, consists of a multiplicity of goals and no one goal exhausts the content of the right. The international right is explicitly not a right to any health care that an individual may require.[22] It is a variety of procedural and substantive rights that fall short of full health-care provision. These rights mirror the goals of the RTHC identified above. International human rights law clearly requires a functioning health-care system.[23] International human rights law's further requirement for a national health-care strategy arguably also requires procedural fairness in deciding how that system will run.[24] Even if that argument fails, international human rights law's foundational commitments to non-discrimination and equality clearly require procedural fairness in decisions about what a national health-care system should cover

21. See the work of Norman Daniels & James E Sabin, including Norman Daniels & James E Sabin "Limits to Health Care: Fair Procedures, Democratic Deliberation, and the Legitimacy Problem for Insurers" (1997) 26:4 Philosophy & Public Affairs 303 and Norman Daniels & James E Sabin *Setting Limits Fairly: Learning to Share Resources for Health*, 2nd ed (Oxford: Oxford University Press, 2008).
22. E.g., *GC 14*, *supra* note 14 at para 7.
23. *Ibid* guarantees "the right to a system of health protection which provides equality of opportunity for people to enjoy the highest attainable level of health."
24. These requirements appear in documents including *ibid* at paras 36, 53 and *Declaration of Alma-Ata*, International Conference on Primary Health Care, 6-12 September 1978 (Geneva: World Health Organization 1978) at art VIII [*Alma-Ata*].

and how care should be provided within it.[25] International human rights law's further foundational commitment to dignity, in turn, suggests that any rights within it ought to promote dignity.[26] This supports a minimal level of content that any RTHC should contain under an international human rights law framework. International human rights law's further commitment to a minimum core of rights,[27] the inclusion of certain goods that are arguably necessary for a dignified existence within that core,[28] and the necessary prioritization of certain goods required by vulnerable persons who may be most apt to be forced below a dignified level of existence[29] also support a minimum floor for the content of the international RTHC and a concern with dignity in identifying the content of that floor. The minimum core's recognition that some aspects of the right do not need to be immediately fulfilled further suggests that international human rights law recognizes that these aspects are best understood as goals, rather than immediate entitlements.[30] The international RTHC, in other words, is not merely a right to particular health-care goods, but a plurality of commitments to achieve certain goals. International human rights law is consistent with the goal-oriented understanding of the RTHC.

Finally, the goal-oriented model of the RTHC suggests measurements one can use to assess whether health-care systems are fulfilling the right.

25. E.g., the *ICESCR*, *supra* note 14's references to "equal and inalienable rights of all" and the rights of "everyone" reflect foundational values of equality and non-discrimination; *General Comment 20: Non-discrimination in economic, social and cultural rights*, UNCESCR, 42nd Sess, UN Doc E/C.12/GC/20 (2009) at para 3. International Human Rights Law, then, requires a fair system for making health-care allocation decisions where fair systems cover goods necessary for a dignified existence. International human rights law also provides guidance for decision-makers in a fair system. Fair decision-making in a system ought to account for these directives. E.g., the so-called "AAAQ" framework requires provision of a sufficient quantity of culturally sensitive, ethically and scientifically appropriate and quality goods in an accessible manner; *GC 14*, *supra* note 14 at para 12.

26. The importance of dignity is recognized in nearly every relevant modern IHRL document, beginning with *Universal Declaration of Human Rights*, GA Res 217A (III), UNGAOR, 3d Sess, Supp No 13, UN Doc A/810, (1948), Preamble, art 1 [*UDHR*].

27. See *GC 3*, *supra* note 15 at paras 1, 10; *GC 14*, *supra* note 14 at para 30.

28. Primary health-care and essential medicines are clearly included within the minimum core. See, e.g., *ibid*; *GC 14*, *ibid* at para 17; *General Comment No 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)*, UNCRC, 62nd Sess, UN Doc CRC/C/GC/15 (2013) at para 94 [*GC 15*]; *Alma-Ata*, *supra* note 24 at V. Definitions of "primary" and "essential" can track "necessary for a dignified existence."

29. See *infra* note 50 for international human rights law passages emphasizing the importance of vulnerable populations in interpreting the right to health. This can include prioritizing them in specifying the right's content. For instance, maternal and infant care is consistently prioritized and infants, at least, are clearly vulnerable as individuals and as a class; see, e.g., *GC 14*, *supra* note 14 at paras 43-44; *General recommendation No. 24: Article 12 of the Convention (women and health)*, UNCEDAW, 22nd Sess, UN Doc A/54/38/Rev.1, ch I (1999) at para 6 [*GR 24*].

30. States only need to progressively realize aspects of rights outside the minimum core; *UDHR*, *supra* note 26, Preamble; *ICESCR*, *supra* note 14, art 2.

The outcomes can be used to assess whether interventions, including legal interventions, are worthwhile. Outcomes that help fulfill the ends of the right are (all-else-being-equal) the best outcomes for fulfilling the ends we mean to discuss when we talk about a RTHC. This suggests that the goal-oriented model of the RTHC has instrumental value. This instrumental value should be unsurprising given that the model is specifically designed around instrumental ends. I discuss these instrumental values in further detail below when exploring the implications of the goal-oriented model for future health rights litigation. But I should first contend with lingering criticisms of the goal-oriented model of the RTHC, including the claim that the instrumental focus of the model undermines the rights-based nature of the claim. I now turn to these criticisms.

III. *Lingering concerns with the goal-oriented model*

Where the proceeding is a mere sketch of the larger argument for the goal-oriented RTHC, it would be surprising if other concerns with the model did not linger. I will now address two of the most immediate concerns. First, one may argue that this understanding of the RTHC means that the RTHC is not a right at all. The goal-oriented model of the RTHC seems to concede the status of the RTHC to the rights skeptic. It suggests that the model is not a model of a right, but a model of a rhetorical placeholder for a variety of important claims, only some of which qualify as stand-alone rights on even expansive models of rights that recognize that there can be imperfect duties to fulfill rights. It is tempting to respond to this criticism by stating "That's the point! Traditional understandings of the RTHC are confused and the goals people talk about when discussing the RTHC are better understood as a variety of severable claims." But that response risks being too flippant and concessive. Instead, it is worth recognizing that the RTHC framework helps to highlight the connections between these important interests, provides rhetorical power for claims to fulfillment of the important interests, and fits with the (sometimes confused) language of international human rights law. I may concede that the RTHC is not a stand-alone right on any traditional or even standard understanding of rights. But to say that the RTHC is not a traditional claim-right is not to say that it is useless. If this model forces me to abandon the rights framework for these claims, it does not undermine the fact that the (now improperly named) RTHC models important moral interests and their relations and provides a rhetorically valuable language for discussing those interests. It also does not change the fact that such a right exists in international law.

Second, one may charge that the goal-oriented model of the RTHC does not actually avoid the problem of scope and the problem of time and space.

While a strictly procedural model of the right can avoid these concerns, the problems threaten to recur when one requires a floor for the content of the right. Invoking the concept of dignity to set the minimum floor seems particularly problematic. Dignity is a famously contentious concept. The Supreme Court of Canada accordingly recognized the limitations of the concept in the equality context.[31] Many are dubious that dignity can help solve the problem of scope or the problem of time and space if arguably less contentious concepts such as equality of opportunity failed.[32]

Dignity is not, however, a necessarily problematic concept. One should not take debates about how to understand the concept as dispositive proof that the concept cannot be coherently interpreted in a way that can guide both moral and legal decision-making. Recent works provide ample insight into the moral and legal concepts of human dignity.[33] It is hard to see why human dignity should be any more difficult to interpret than equality, autonomy, or other contentious moral concepts that many are happy to accept as bases for ethical and legal posits. Moreover, there is no reason to suggest that dignity would be any less capable as a guidepost for identifying a discrete list of goods that should serve as the floor for any RTHC. Whatever dignity might mean, failing to provide goods necessary for people to even be able to manage their chronic pain fails to meet the dignity standard. At worst, then, dignity is on a par with alternatives in its ability to meet the problems of scope and time and space. At best, dignity can help identify a discrete set of goods that constitute the floor of the right. A full argument to that effect must wait for another day. Until then, heuristics can be valuable.[34] Even if this and other defenses of dignity ultimately fail, the fact that alternatives encounter the same issues suggests that a strictly content-focused right will be problematic. This supports the

31. *R v Kapp*, 2008 SCC 41, [2008] 2 SCR 483 [*Kapp*] accordingly removed the dignity analysis from analyses of potential violations of section 15 of the *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c 11. *Kapp* was subsequently superseded by *Withler v Canada (AG)*, 2011 SCC 12, [2011] 1 SCR 396.

32. This criticism is a health rights-specific variant of a general argument that dignity is a context-specific concept that cannot ground a universal human rights claim that appears in, e.g., Christopher McCrudden, "Human Dignity and Judicial Interpretation of Human Rights" (2008) 19:4 European J of Int'l L 655 (though even McCrudden recognizes it may have some value in the minimum core context) and arguably underlies the pleadings in *Kapp, ibid.*

33. See Jeremy Waldron, "Dignity, Ranks, and Rights: Lecture 1: Dignity and Rank" in Meir Dan-Cohen, ed, *Dignity, Rank, and Rights* (Oxford: Oxford University Press, 2012) 13 for a good moral argument. Several interesting responses appear in the same volume. Michael Rosen expands his view in *Dignity: Its History and Meaning* (Cambridge and London: Harvard University Press, 2012). See Aharon Barak, *Human Dignity: The Constitutional Value and the Constitutional Right* (Cambridge: Cambridge University Press, 2015) for an account of a strictly legal right to dignity.

34. As noted below, international human rights law provides a list of goods that must be prioritized and that could be used as heuristics for the goods necessary to live a dignified life.

goal-oriented model. Other aspects of the goal-oriented RTHC avoid these problems, minimizing their threat, but other aspects require *some* minimal content for the right to account for all intuitions about the purpose of health rights. Any goal-oriented model must thus set a minimal floor. Dignity is no worse than alternatives in its ability to set that floor. The foundational role of dignity in ethics and law suggests it could be better.[35]

IV. *Implications for health rights litigation*

If the RTHC is not a traditional right, but a catch-all for a variety of independent claims, then fulfilling the right as such may not be the proper aim of health rights litigation. One should take an instrumental rather than conceptual approach to health rights litigation. Health rights litigants should pursue the goals inherent in its claims. Identifying deficiencies in Canada's fulfillment of the constitutive goals of the RTHC could be important groundwork for further claims. Health rights litigation will better accord with its purported commitment to the RTHC when it fulfills the goals the RTHC language is invoked to further. Yet simply stating that a given intervention should improve procedural fairness or improve access to the goods necessary to live a dignified life is likely too vague to guide future health rights litigation. Canadian law, at least, is likely unable to secure a functioning health-care system on its own. Further metrics of how to fulfill these goals are accordingly necessary to guide future litigation.

In this section, I accordingly examine metrics for fulfilling the goal-oriented RTHC that are suggested by the model and international human rights law that is consistent with it. In so doing, I articulate a research project for analyzing whether nations are realizing the constitutive goals of the RTHC.[36] A complete account of how nations fare on these metrics could provide a good base for analyzing how different health-

35. One may also argue that I fail to highlight the importance of improved health outcomes above and below. Few would be interested in the goals listed above if they did not bear *some* relation to health outcomes. While health rights litigation will not always improve health outcomes improving *some* health outcomes must be a goal the RTHC is designed to achieve. It may even be the primary purpose of the RTHC. Improved health outcomes are a constitutive goal of the RTHC, but I strategically do not emphasize them here. Health is an amorphous concept and even less apt to be the proper object of a right. The problem of scope for a right to health is even more acute than the problem of scope for a RTHC. Fulfilling a large number of even the imperfect duties such a right would imply is potentially astronomically expensive. It is also more difficult to measure health and the extent to which interventions, including legal interventions, affect health outcomes. My hope is that future scholars will be able to make these causal claims. In the meantime, I can focus on three other aspects of the RTHC.

36. I recently began publishing research on this topic in the Canadian context elsewhere. In addition to my forthcoming doctoral dissertation, see Michael Da Silva, "Medicare and the Non-Insured Health Benefits and Interim Federal Health Programs: A Procedural Justice Analysis" (2016) 10:2 McGill J L & Health [Da Silva, "Procedural"], which focuses on the procedural elements of the right.

care systems, cultural structures, and other possible causes help realize the RTHC. At minimum, it would help identify deficiencies in individual nations' realization of the RTHC's constitutive goals. Future litigation could help remedy these deficiencies. Further research on whether and how different types of litigation actually remedy them would provide insight into law's ability to help realize the RTHC. Setting out the proper metrics for realizing the goal-oriented RTHC motivated above is thus just the beginning of what could be a lengthy future research agenda.

The three goals of the RTHC suggest at least six metrics for assessing RTHC fulfillment. First, bare facts about the existence of a health-care system provide metrics for determining the extent to which claims to a functioning health-care system are being fulfilled. At international law, a state must have a legally protected health-care system to count as fulfilling its RTHC obligations.[37] The presence thereof is a RTHC implementation metric. Fairness and international law suggest that it should include a national health-care policy with indicators and benchmarks for success.[38] Both also suggest that people should have the opportunity to participate in the creation of that policy.[39] The presence of a national health-care policy alone and the presence of fora for participation in the administration of that policy (through, e.g., public debates on what to cover at a given time) are clear metrics for fulfillment of the international RTHC and good metrics for the fulfillment of the goals of its goal-oriented moral RTHC.

Second, the indicators and benchmarks within the policy serve as self-defined metrics. One can easily identify the bare presence of a national policy and participation therein. Whether one can identify the extent to which a state is meeting its indicators and benchmarks will be a case-by-case determination. Much will depend on a state's transparency. Where one can apply these metrics, they help overcome concerns that the RTHC can be inattentive to states' differing health-care needs by ensuring one set of metrics is tailored to states' self-identified needs.

37. See note 23. *General Comment No 15 (2013) on the right of the child to the enjoyment of the highest attainable standard of health (art. 24)*, UN Committee on the Rights of the Child (CRC), 62nd Sess, UN Doc CRC/C/GC/15 (2013) at para 94 [*GC 15*] suggests statutory protection of the RTHC may be required. This could include the national health-care system requirement.

38. The argument from fairness could stem from the problem of time and space and a recognition that states will need to realize the RTHC differently. It could also stem from criticisms of the RTHC that suggest that it is a Western construct that is insufficiently attendant to cultural difference. As noted in the following paragraph, if states can set their own benchmarks and indicators for success, this builds culture-specific metrics into a broader metric of universal standards. The international law requirement is in *GC 14*, *supra* note 14 at paras 36, 53.

39. The argument from fairness builds on the treatment of reciprocity for authority above. For relevant international human rights law, see, e.g., *Alma-Ata*, *supra* note 24, arts III, art VII(5).

Third, essential good coverage within the system and rates of access thereto serve as good metrics for assessing the extent to which states fulfill RTHC claims to the provision of goods necessary for a dignified existence. If the RTHC leaves a large number of persons below a dignity level, it does not fulfill its aims. Where we cannot identify the dignity level and thus cannot identify the number of persons below it in any given state, we can only measure whether a process aims at ensuring people access to the goods needed to live at the dignity level. While a full list of goods required for a dignified existence is unavailable, acknowledged essential goods, including primary health care, are plausible examples. The World Health Organization offers a Model List of Essential Medicines, which forms part of the aforementioned minimum core.[40] This list is the result of a fair process for identifying the goods to which one ought to be entitled. It also provides a working understanding of what counts as essential. The list is constantly updated, which ensures that it addresses changes over time. It is also sufficiently broad to address problems concerning differences between states.[41] This metric thus helps avoid the problem of time and space. While the focus on medicines rather than other health-care goods makes the list incomplete, access to goods on the list could serve as a heuristic for achieving the medicine-based components of the RTHC. Whether a system covers these goods is an indicator of its success. In the absence of agreement on their precise meaning, the paradigm examples of primary health-care can serve as similar metrics. Non-medicinal health-care goods, including maternal and infant care, are similarly recognized as being universally required.[42] These goods may not perfectly mirror the goods required to meet the dignity level, but provide a reasonable approximation. Rates of access thereto are metrics for assessing RTHC fulfillment.

Fourth, RTHC claims to fairness in health-care allocation decisions can be measured in part by the presence of a fair process of good distribution. The bare existence of a process serves in a state's favor. Yet the fairness of a process admits of degrees. National RTHC assessments should be tied to the relative fairness of the proceedings. Norman Daniels

---

40. Particular goods are added and removed over time. World Health Organization, "WHO Model List of Essential Medicines: 19th List (April 2015) (Final Amendments—November 2015)" (2015), online: World Health Organization <who.int/medicines/publications/essentialmedicines/en/> is the 19th list.

41. While the present essential drugs list is expansive, it is difficult to get a firm grasp on the underlying principles of what is currently listed. I hope that it is a reasonable approximation of the goods needed for a dignified life.

42. See note 29.

and James Sabin's accountability for reasonableness is a good (and, I would argue, the best) framework for doing so.[43] After all, it reflects of recognized requirements of political morality.[44] The framework's markers, including the presence of public display of reasons for decision making, the use of publicly accepted rationales in those decisions, and the presence of challenge or appeal procedures, can serve as metrics for the fairness of health-care entitlement selection procedures.[45] Some of Daniels and Sabin's metrics have been fruitfully applied to the Canadian health-care system already.[46] This provides a baseline for future research, which should help track whether Canada is improving fulfillment of (or, in the language of international human rights law, "progressively realizing"[47]) the RTHC's procedural elements.

Fifth, measuring the RTHC requires metrics for determining whether individuals receive their fair share of the goods selected by the fair process. Where a fair system must cover essential goods, this metric will partly mirror the essential goods metric above in the ideal case. It will also address non-essential goods selected through a fair process. A health-care system must present all persons with an equal opportunity of accessing the goods selected through fair procedures to fulfill the universality requirements of the RTHC. One cannot, however, directly measure opportunities and should instead focus on the extent to which persons are accounted for in a process and the extent to which they are free from barriers to their fair share of the selected goods, such as user charges and misapplications of eligibility criteria. The relevant metrics will include the proportion of the population qualified to receive goods in the process and the number of barriers to one's share of goods in a state. Actual rates of access to selected goods will be relevant where available.

Sixth, recognizing that the RTHC is not static (per the problem of time and space) requires measuring how states fare over time. Progressive realization indicators help measure this temporal shift. Progressive

43. See the work of Daniels & Sabin, *supra* note 21.

44. Colleen M Flood, "Conclusion" in Colleen M Flood, ed, *Just Medicare: What's In, What's Out, How We Decide* (Toronto: University Toronto Press, 2006) 449 at 452.

45. For a summary of Daniels & Sabin, *supra* note 21 that makes these requirements explicit, see Norman Daniels, "Accountability for Reasonableness: Establishing a Fair Process for Priority Setting is Easier than Agreeing on Principles" (2000) 321:7272 Brit Med J 1300. For more details of how these can be metrics for analyzing the procedural fairness of health-care systems, see Da Silva, "Procedural," *supra* note 36.

46. See, e.g., Colleen M Flood & Michelle Zimmerman, "Judicious Choices: Health Care Resource Decisions and the Supreme Court" in Jocelyn Downie & Elaine Gibson, eds, *Health Law at the Supreme Court of Canada* (Toronto: Irwin Law 2007) 25 at 27. For an update, see Da Silva, "Procedural," *supra* note 36.

47. See note 30.

realization is a core component of all international social rights.[48] In the absence of an uncontroversial stopping point for the content of the RTHC, international human rights law invokes progressive realization to suggest that states ought to continue expanding their RTHC coverage unless they are in danger of reaching the extreme end of the continuum of possible scopes where additional coverage would lead to severe economic problems.[49] This suggests that complete fulfillment of RTHC obligations cannot be measured by looking at the selection of goods and access thereto at a given time. This is also a plausible moral position. Progressive realization requires comparative assessments to take account of changes over time. Where a state does not score well on other metrics the extent to which it takes steps to improve counts in its favor. Deliberately retrogressive removals of required features then will count against states. Removal of procedural markers of fairness or failure to add these safeguards in a reasonable timeframe counts against states. Likewise, removing people from coverage or failing to cover a wide breadth of the population or prioritize the vulnerable members of that population counts against them. Failure to increase coverage of goods can also be problematic in certain circumstances. One should assess whether a state allocates more resources over time, but some goods will be removed for good reasons. This justifies focusing on the rate at which goods are removed without warrant or being replaced by other goods.

International human rights law, in turn, suggests that these metrics should be applied at two levels: to the general population and to vulnerable groups. Contemporary international human rights law is consistently concerned with the protection and assistance of vulnerable populations.[50] The goal-oriented understanding of the RTHC could account for this concern. Prioritizing the vulnerable could be justified to maximize the number of persons above the dignity level. Fairness and dignity also require metrics for determining the extent to which states prioritize the needs of vulnerable populations in the health-care allocation process and its design. The extent to which processes select goods that vulnerable populations identify as needs and goods that we reasonably believe

48. Again, see note 30.

49. For more on its content, see *GC 3*, *supra* note 15 at para 2; *GC 14*, *supra* note 14 at para 31.

50. See, e.g., *UDHR*, *supra* note 26, s 25(2); *GC 14*, *supra* note 14 at paras 14, 18, 21; *GC 15*, *supra* note 37 at para 98; *General Comment No 3 (2003): HIV/AIDs and the rights of the child*, UNCRC, 32nd Sess, UN Doc CRC/GC/2003/3 (2003) at paras 1, 3; *General Recommendation No 15: Avoidance of discrimination against women in national strategies for the prevention and control of acquired immunodeficiency syndrome (AIDS)*, UNCEDAW, 9th Sess, UN Doc A/45/38 (1990); *Beijing Declaration and Platform for Action*, 17 October 1995, UN Docs A/CONF.177/20 (1995) and A/CONF.177/20/Add.1 (1995) art 93; *GR 24*, *supra* note 29 at para 6.

vulnerable populations need should be useful metrics. There are limits on the extent to which this ideal comparison can be conducted.[51] At minimum, the requirement to prioritize the vulnerable suggests that the metrics above must be studied with respect not only to the general population, but also to vulnerable populations. Low rates of access to essential goods for vulnerable populations suggest room for better RTHC fulfillment.

There are, then, six sets of metrics assessing fulfillment of a goal-oriented RTHC: the presence of legal protection of a health-care system, of a national health policy and of participation fora in the development and administration of the policy, a state's self-defined benchmarks and indicators of success, the extent to which essential goods are covered by a system, Daniels and Sabin's fairness metrics, rates of access to essential goods and the goods selected in the process, and progressive realization indicators. International human rights law, fairness, and dignity require vulnerable population-specific variants of some of these metrics.

Research applying the metrics should identify societies' gaps in rights to health-care coverage. These gaps provide a prima facie case for health rights litigation. Using the law in the health-care context to fill other goals when these gaps remain misplaces priorities at best and may undermine realization of the RTHC at worst. For instance, claims for non-essential goods can be understood as undermining potential access to essential goods in a world of scarce resources.[52] A failure in RTHC coverage is, then, a good starting point for future health rights litigation. The question then becomes whether health rights litigation is the best way to fill these gaps in coverage. There may be reason to use non-legal means to fill gaps in RTHC realization. Further research will be necessary to assess whether legal or non-legal means are more likely to be successful. If legal means are more successful, then future health rights litigation in Canada should be primarily concerned with filling identified gaps in Canada's RTHC realization.

51. For instance, it can be hard to know what goods vulnerable populations require in some circumstances. It is far from impossible in most contexts.

52. Indeed, health rights in Latin America may have been co-opted by the middle class to improve their access to non-essential goods, to the detriment of vulnerable populations' access to essential goods. The data in Latin America are contested, but there is some evidence in support of the co-option thesis. Mariana Mota Prado, "Provision of Health Care Services and the Right to Health in Brazil: The Long, Winding and Uncertain Road to Equality" in Colleen M Flood & Aeyal Gross, eds, *The Right to Health at the Public-Private Divide: A Global Comparative Study* (Cambridge: Cambridge University Press, 2014) 319 provides a good summary of the debate. See Octavio Luiz Motta Ferraz, "The Right to Health in the Courts of Brazil: Worsening Health Inequities?" (2009) 11:2 Health & Hum Rts 33 and César Rodríguez-Garavito, "Beyond the Courtroom: The Impact of Judicial Activism on Socioeconomic Rights in Latin America" (2011) 89:7 Texas LR 1669 for contrasting positions.

Conclusion

Existing models of the RTHC face several challenges. The goal-oriented model of the RTHC avoids the brunt of many challenges while accounting for the insights of competing models. The goal-oriented model also provides metrics for assessing the extent to which nations fulfill the RTHC. My current and future research applies these metrics and analyzes the extent to which legal interventions can remedy deficiencies in fulfillment. My hope is that future litigation will aim to remedy such deficiencies and will provide more data for further research on the extent to which law can help realize the aims of the RTHC. Yet much remains to be done. The account of the goal-oriented model of the RTHC and potential implications above is strictly preliminary; it is a mere sketch of a much larger work. Fully exploring how nations fare on these metrics and whether law can help them fare even better will require further work still. Regardless of whether others ultimately accept the goal-oriented model of the RTHC, I hope the future of health law will include interventions to improve the goals of the RTHC and research on how best to do it in particular nations.