Individual and 'National' Healthcare Rights: Analyzing the Potential Conflicts

[Note: This is an author's accepted manuscript for a work in Bioethics.]

An Acadian in Eastern Quebec receives public funding for insulin shots they require to manage their chronic illness that is unavailable in other provinces. Now, the Acadian community seeks control over healthcare policy in his area as their priorities differ from the rest of Quebec. Should the Acadian have a *right* to funding for insulin under that regime? Do your intuitions differ if the Acadian is an Indigenous Quebecer or is in New Brunswick? Were the rights of their Scottish cousin with another illness who voted for Scottish independence violated when the cousin lost access to another WHO-recognized essential medicine post-Brexit? Resurgent nationalisms and political shocks like COVID challenge traditional views on how authority over healthcare policy should be divided. They will likely force communities to address similar cases head-on. Doing so provides opportunities to better understand the relevant 'rights' at issue.

Legal recognition of rights to healthcare (RTHCs) is increasingly common.[1] Claimed moral analogues abound.[2] Both usually present as 'individual' rights. So-understood, they raise tensions with group 'rights' claims. Whether and when different entities (central/federal governments, provinces, cities, etc.) should possess final decision-making authority over healthcare policy is debatable.[3] In multinational states, some who share characteristically 'national' features (e.g., language, culture, myths, history) claim *rights* to such authority. Sub-state nations (henceforth simply 'nations,' bracketing nation-states) possess international legal internal self-determination rights that many view as entailing rights to set healthcare policy.[4] Michel Seymour thus suggests that it is "natural for a people to be able to conduct its own policies in matters related to … health" and federal governments should not interfere with

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[1] Evan Rosevear et al., "Justiciable and Aspirational Economic and Social Rights in National Constitutions" in Katharine G Young, ed, *The Future of Economic and Social Rights* (Cambridge UP, 2019) 37. While international law recognizes a 'right to health' with healthcare components, most domestic rights focus on healthcare.

[2] See healthcare-related parts of excellent summaries in Benedict E Rumbold, "The Moral Right to Health" (2017) 20(4) CRISPP 508; Nicole Hassoun, "The Human Right to Health: A Defense" (2020) 51(2) J Social Phil 158.

[3] Keith G Banting & Stan Corbett, eds, *Health Policy and Federalism A Comparative Perspective* (McGill-Queens UP, 2002) is a classic study. Many more recent texts are country-specific; e.g., Katherine Fierlbeck & William Lahey, eds, *Health Care Federalism in Canada* (McGill-Queens UP, 2013); Jamila Michener, *Fragmented Democracy* (Cambridge UP, 2018). Douglas McKay & Marion Danis, "Federalism and Responsibility for Health Care" (2016) 30(1) Public Affairs Quarterly 1 provides rare philosophical scrutiny. 'Policy' here encompasses 'law.'

[4] Examples from numerous jurisdictions appear below. Many Indigenous claims also/alternatively invoke "inherent sovereignty" over healthcare; John J Borrows, "A Genealogy of Law: Inherent Sovereignty and First Nations Self-Government" (1992) 30(2) Osgoode Hall LJ 291. These claims differ from those at issue. Some findings below suggest Indigenous cases differ from 'national' ones. I cannot assume this ex-ante.

Quebecois healthcare-related decisions.[5] A 'right' to control healthcare policy is a group right to make its own choices and realize its values. Many Quebecois and Scottish 'nationalists' believe such authority is necessary to realize their uniquely strong commitments to solidarity.[6] Others believe legitimate health-related authority entails rights to decide using group-specific understandings of health. Consider internationally-recognized Indigenous rights to traditional medicines.[7] Such national authority claims recur and remain contested. To wit, COVID-19 produced new national claims to control healthcare policy as centralized decision-making in Canada and the U.S.A. impacted Quebec and some Indigenous groups more than other groups.[8]

International individual RTHCs and 'national' group self-determination rights are supposed to be interdependent,[9] but the respective 'rights' at least present tensions. Authority over healthcare policy could help one create institutions necessary to fulfill RTHCs but may instead challenge RTHC realization. It likely entails powers to decide what healthcare goods will be available to or funded for those subject to such authority. While non-Indigenous rights claims are often framed in terms of solidarity, even Quebec or Scotland may not always fund goods recognized as part of individual RTHCs. For instance, Quebec initially funded in vitro fertilization [IVF] even though other provinces did not, but then stopped doing so.[10] While IVF is not part of every RTHC conception, the *possibility* of its inclusion in individual RTHCs highlights potential tensions. Authority allocations have tracked national cleavages, producing coverage differences.[11] So, authority allocation impacting individual entitlements is not a mere theoretical possibility. Other groups desire funding for group-specific services. For instance, the

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[5] Michel Seymour, "Quebec and Canada at the Crossroads: A Nation Within a Nation" (2000) 6(2) Nations and Nationalism 227 at 246.

[6] 'Solidarity'-based arguments for sub-state national control over social policy are common. Whether such control promotes solidarity is empirically contestable. See Daniel Béland & André Lecours, *Nationalism and Social Policy* (Oxford UP, 2008). Scottish 'nationalists' even said that insufficiently equitable U.K. health policy supported independence; *Scotland's Future: Your Guide to Independent Scotland* (Scottish Government, 2014).

[7] Indigenous groups share 'national' characteristics even if they are not best-understood as 'nations.' The *United Nations Declaration on the Rights of Indigenous Peoples*, GA Res 61/295, UNGAOR, 107th Sess, UN Doc A/RES/61/295, (2007), art 24 [UNDRIP] provides Indigenous-specific health rights whose contours and domestic applications remain contested. Consider the literature on Canada's *Hamilton Health Sciences Corp v DH*, 2014 ONCJ 603/*Hamilton Health Sciences Corp v DH*, 2015 ONCJ 229 [*DH*].

[8] Michael Da Silva, "COVID-19 and Health-Related Authority Allocation Puzzles" (2021) 30(1) Cambridge Quarterly Journal of Healthcare Ethics 25.

[9] Relevant international law appears above and below. Its recognition of "inherent sovereignty" is much less clear. Daniel J Whelan, *Indivisible Human Rights* (U Penn P, 2010) summarizes indivisibility claims.

[10] Some coverage restoration recently occurred; CBC News, "In-vitro fertilization will once again be free for Quebec couples, but only for one cycle" (11 November 2020), <https://www.cbc.ca/news/canada/montreal/quebec-public-ivf-1.5798240>.

[11] E.g., Béland & Lecours, *supra* note 6.

Indigenous right to traditional medicines recognized in international law could be operationalized through Indigenous healthcare governance that funds them.[12] Given scarce resources, this could limit the ability to fund other individual healthcare goods. Stronger group rights could even permit prioritizing those medicines in individual treatment plans, as in a famous case where a family sought to choose traditional medicines over a Western plan.[13]

This work scrutinizes the relationship between individual RTHCs and self-determination rights-based arguments for national control over healthcare. Contextual features of contentious circumstances where such claims arise blur intuitions. Stylizations help abstract from controversy to focus on a narrower issue about the nature and scope of rights. Consider the following scenarios, based on real cases, in which sub-state 'nations' possess authority to make healthcare policy decisions for their members within larger encompassing states:

> *National Solidarity:* The group chooses to publicly fund a wide range of essential healthcare goods and services, increasing access to those services relative to others in the state. Access to more expensive treatments in a state-wide program, some of which could substantially improve some individuals' well-being, is consequently minimized.[14]
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> *Free-Market Nation:* The group chooses not to publicly fund a wide range of essential healthcare goods and services due to national commitments to free-market principles. Some individuals secure access to a wider range of services, but access to essential services guaranteed to those in state-wide programs is now difficult for others.[15]
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> *National Morality:* The group does not allow drugs for sexually transmitted diseases into its territory, appealing to a different national morality to justify its decision.[16]
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> *Different Values, Different Care:* The group chooses not to fund cancer medications or require cancer treatments for pediatric individuals with proven effectiveness due to national beliefs that an alternative is more effective according to national standards. It funds the alternative, which the state did not previously provide.[17]

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[12] Recall note 7, recognizing caveats in note 4.
[13] *DH*, *supra* note 7.
[14] Concerns in notes 4-7 can combine with scarce resources to raise the possibility of differential coverage, even if 'healthcare federalism' rarely presents a choice between distinct federal and provincial programs.
[15] As discussed in [redacted for review], this possibility is conceptually possible and has empirical support.
[16] This scenario modifies the state-focused facts in *Minister of Health and Another v Treatment Action Campaign and Others*, 2002 (5) SA 721 (CC) (S Afr) [*TAC*].
[17] Note 7 cases inspire this scenario.

Pluralist bioethics provide guidance on how to address various moral concerns in each scenario. This requires clarity on the *types* of operative concerns. Even pluralists acknowledge that moral phenomena relate in different ways: conflicts of rights are not conflicts between right and internal supererogatory impulses. The complex conflicts of rights literature is unnecessary if the contrasts concern different phenomena.[18] For instance, rights 'trump' supererogatory desires by definition.[19] Case type identification is thus prerequisite to moral guidance/resolution.

The following thus analyzes the possibility of genuine conflicts between individual RTHCs and health-related sub-state national self-determination rights. Consistent with much of the "health rights" and health justice literatures, it uses healthcare resource allocations as its paradigm of control.[20] It concludes that genuine conflicts between individual RTHC and national control over healthcare are rare. The strongest cases for sub-state national self-determination rights do not implicate healthcare or provide reasons to override individual RTHCs. Most 'conflicts' between individual rights and 'nationalist' policies thus do not raise 'conflicts of rights' considerations. Moreover, even in rare cases where genuine conflicts arise and favour sub-state nations, a RTHC should be used to evaluate sub-state national actions.

The arguments for these conclusions likely generalize – the same considerations likely justify any right to control healthcare policy, including at the state level, and any such rights likely relate to individual rights in similar ways – but my modest claim concerns a small set of politically salient cases where sub-state national control could undermine individual RTHCs. I examine them by identifying the RTHC's forms and examining if and when it conflicts with sub-state national control over healthcare policy. While other health rights or arguments for sub-state national control may be more important,[21] a narrower focus on RTHCs and arguments for sub-state national control over healthcare policy helps identify and focus on cases that present a unique kind of at least apparent conflict. If successful, my analysis should help resolve cases like

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[18] Leif Wenar, "Rights" *Stanford Encyclopedia of Philosophy* (2015), <https://plato.stanford.edu/entries/rights/> summarizes this literature.

[19] My use of 'trumps' language does not invoke Ronald Dworkin, *Taking Rights Seriously* (Harvard UP, 1977). Right have strong normative force and are prioritized over the supererogatory on any account in *ibid.*

[20] Rumbold, *supra* note 2. For representative examples, consider Jennifer Prah Ruger "Toward a Theory of a Right to Health" (2006) 18(2) Yale JL & Hum 273 [PR, "Towards"]; Norman Daniels & James E Sabin, *Setting Limits Fairly*, 2nd ed (Oxford UP, 2008); Norman Daniels, *Just Health* (Cambridge UP, 2008); Jennifer Prah Ruger, *Health and Social Justice* (Oxford UP, 2009).

[21] For a representative explanation of the primacy of the social determinants of health, see Sridhar Venkatapuram, *Health Justice* (Cambridge: Polity, 2011). For a representative defense of the continued (if lesser) importance of healthcare, see Michael Da Silva, "The International Right to Health Care" (2018) 39(3) Mich J Int'l L 343 ["Int'l"].

those above while providing new insights into the nature of rights, content of national self-determination rights, and their interaction with individual rights and guidance on how to establish and evaluate powers over healthcare policy and approach competing moral concerns.

Definitions

Definitions clarify analysis. 'Rights' here refers to entitlements to X from Y where Y's failure to provide the entitlements triggers X's second-order right to demand explanation and (at least potentially) compensation. While potentially controversial, this approach is common in health rights texts[22] and reflects two uncontroversial features of rights: (1) they are 'correlative' with duties such that 'rights' only exist where we can identify someone who is bound to fulfill them (Y) and something someone must do to fulfill them (X) and (2) special relationships between rights-holders and duty-bearers can shift normative powers (e.g., create second-order duties), a point often described in terms of the creation of 'directed duties.'[23] We can understand governments as the relevant duty-bearers here. Even those who posit corporate, non-governmental organizational, or individual duties to realize health rights recognize governments *as* primary duty-bearers.[24] So, a 'RTHC' is, minimally, an entitlement to some healthcare goods from the government. Conceptions of health rights below determine the content of the entitlements and, consequently, the duties governments must fulfill to realize the rights.

'Conflicts of rights' refers here to instances where two entities possess entitlements that cannot both be fulfilled and otherwise appear to have the same normative status. Our genuine conflict thus requires an individual right to X and a collective right to decide not X.[25] If, for instance, individuals have a right to funding for a traditional medicine and Quebec does not fund it, perhaps due to commitment to secularisms or prioritization of other Quebecois interests, that is a genuine conflict of rights. The relevant contrast with a 'RTHC' is a 'sub-state national self-determination right.' Conflicts are unlikely to arise in cases where 'national' control is equivalent

[22] Michael Da Silva, "The Complex Structure of Health Rights" (2020) 13(1) Public Health Ethics 99 uses a similar schema, drawing on sources in note 2. This use also appears consistent with Nicole Hassoun, *Global Health Impact: Extending Access to Essential Medicines* (Oxford UP, 2020) [*GHI*]'s framework.

[23] Wenar, *supra* note 18 summarizes debates about the meanings of 'correlativity' and 'directedness.' Questions remain about the justification of rights (interest v. will theories), how precise correlative duties must be, or whether multiple duty-bearers or set of duties can exist, but no mere definition will resolve those issues and analyzing different conceptions of RTHCs can help resolve them. Note 2 sources summarize (and Gopal Sreenivasan, "A Human Right to Health? Some Inconclusive Scepticism" (2012) 86 Proceedings of the Aristotelian Society Supp Vol 239 argues for) the non-correlativity (and thus non-existence) of moral health rights.

[24] E.g., *GHI*, *supra* note 22.

[25] See also FM Kamm, "Conflicts of Rights" (2001) 7(3) Legal Theory 239.

to state control. Existing legal RTHC already purportedly constrain state action. But conflicts may arise where sub-state nations possess internal 'self-determination' rights that similarly constrain states. 'National control' thus refers to sub-state national control over healthcare policy free from interference with another decision-making body. A 'sub-state nation' merely refers to a group that shares traditional indicia of 'nationhood' and exists within the confines of a larger encompassing state.[26] This includes 'nations' with their own provinces (e.g., Quebec) and those lacking territory (Roma in some countries), though control over policy will be easier where a nation constitutes a majority in a territory.[27] 'National self-determination rights' are sub-state nation's entitlements to make certain political decisions. These can take numerous forms. Our primary focus is a national 'right' to control healthcare policy free from interference such that Scotland, for example, cannot have its decisions replaced by those made in London.

RTHC Conceptions

Health rights come in various forms.[28] Brief overviews help determine whether *any* component of any RTHC conflicts with sub-state national control over healthcare policy and identify sources of potential tensions between individual RTHCs and other values/rights. Moral RTHCs admit substantive, procedural, and systemic conceptions.[29] While many accounts feature substantive, procedural, and/or systemic guarantees, most focus predominantly, if not exclusively, on one element. Duties to realize the guarantees then 'correlate' with each moral RTHC conception. Legal health rights adopt different versions (and combinations) of each.[30]

Substantive accounts seek to identify set healthcare goods to which one is entitled or (more often) principles for identifying same. Exemplary principles cover care "necessary for a 'decent' or 'tolerable' life … the essentials of life … basic security … [or] normal species-

[26] This describes phenomena in André Lecours, "Sub-state Nationalism in the Western World: Explaining Continued Appeal' (2012) 11(3) Ethnopolitics 268.
[27] Rainer Bauböck, "Multinational Federalism: Territorial or Cultural Autonomy?" (2001) Willy Brandt Working Paper 2/01.
[28] Jeff King, *Judging Social Rights* (Cambridge UP, 2012) at 18-19 (on 'social rights.')
[29] Full analyses of all possibilities are impossible here. Rumbold, *supra* note 2 devotes many pages to *describing* dominant accounts. Per "Int'l," *supra* note 21, the healthcare-related components of the international right to health include substantive rights to particular goods, procedural rights to fair processes in healthcare decisions, *and* systemic rights to the processes needed to secure substantive and procedural guarantees. Moral cases sometimes require elements of both. Yet many accounts of moral RTHCs focus primarily, if not exclusively, on substantive *or* procedural content. For instance, PR, "Toward", *supra* note 20 focuses on substantive entitlements while Daniels, *supra* note 20 focuses primarily on procedural concerns. Rumbold provides more examples.
[30] "Int'l," *ibid*; Brigit Toebes, *The Right to Health as a Human Right in International Law* (Oxford: Hart, 1999).

typical functioning."[31] Procedural accounts see no non-arbitrary way to determine scope and view health rights as a species of less controversial procedural rights guaranteeing just decision-making in health-related contexts.[32] Systemic accounts view the RTHC as a right to the political institutions necessary to secure health justice. In a representative account, the RTHC is a right to fair democratic institutions that select the healthcare goods to which persons are entitled.[33]

Each RTHC is paradigmatically individual. 'Collective' health rights are often self-determination rights or instrumental to or specifications of individual RTHCs.[34] They are not group-exclusive rights to *healthcare* but rights to make healthcare-related decisions or assurances that members' general rights will be protected.[35] National rights to control healthcare policy are accordingly better contrast cases for individual RTHCs; they are more clearly distinct from individual RTHCs and more likely to present genuine conflicts.[36]

Sub-State National Control and RTHCs

The case for national rights to control healthcare policy takes at least three forms. None require that nations control territory,[37] but each requires 'national' autonomy to make some ultimate decisions for national group members. Each also produces the same result here: strong moral reasons to recognize forms of national healthcare-related autonomy that can frequently conflict with individual RTHCs are lacking.[38] The first, 'empirical' case for national control over healthcare policy holds that national control is justified by its ability to fulfill morally valuable

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[31] Rumbold, *supra* note 2 at 517.
[32] *Ibid*. See the literature on how Daniels & Sabin, *supra* note 20's accountability for reasonableness could be made into a rights-based framework for examples of this approach.
[33] Kristen Hessler & Allen Buchanan, "Specifying the Content of the Human Right to Health Care" in Rosamund Rhodes et al., eds., *Medicine and Social Justice* (Oxford UP, 2012) 84.
[34] International law recognizes a right to protect cultural practices, including healthcare practices, and consistently emphasizes "marginalized" and "vulnerable" groups as key to rights realization. Yet group rights usually amount to general self-determination rights that are not specific to the healthcare context (and do not require national control over healthcare policy as a matter of law) or specific entitlements to goods that vary general substantive approaches to the RTHC. They do not require full control over healthcare policy; UNDRIP, *supra* note 5; *International Covenant on Economic, Social and Cultural Rights*, 16 December 1966, 993 UNTS 3; U.N.C.E.S.C.R., *General Comment 14: The Right to the Highest Attainable Standard of Health*, 22d Sess, UN Doc E/C.12/2000/4, (2000).
[35] Exceptions in law and morality are claimed collective rights to perform specific healthcare practices and/or particular kinds of practitioners. Whether the right in UNDRIP, *ibid* entails a right to Indigenous healthcare providers, whether anyone has a moral right to a healthcare practitioner that shares relevant characteristics, and whether groups have moral rights to group member practitioners remains contested.
[36] This contrast is particularly intriguing where even strictly individualist approaches to health rights necessarily implicate collective considerations. The rights above can only be realized where a functioning system exists. Any individual RTHC is bound to implicate collective concerns even if the right is not 'systemic.'
[37] Programs for diffuse nations analogous to programs for veterans are conceptually possible.
[38] I accordingly do not discuss their merits in detail here, but I canvass them in [redacted]. Some forms do not focus on features of nations as such to ground authority claims. Others cannot justify healthcare-specific authority.

ends. The ends chosen may vary. They could include RTHC realization. Recall Quebec and Scotland's claimed commitments to more solidaristic policies.[39] Solidarity may demonstrably improve access to healthcare, if not procedural or systemic rights realization.[40] Alternatively, nations may be better attuned and able to tailor healthcare programs to co-nationals' unique needs and thus better able to fulfill important moral ends, plausibly including health rights.[41]

The second, 'self-determination' case states that self-determination rights require that national groups control social policy within encompassing states. Moral self-determination rights could require national control over healthcare policy absent analogous legal requirements.[42] Powers to make decisions for group members unfettered by state involvement may be necessary for the individual or collective exercise of any self-determination rights such that authority over some domains is constitutive of national self-determination.[43] This would explain Seymour's aforementioned claim about Quebecois self-determination and healthcare.[44]

The third, 'remedial' case states that national control is necessary to remedy past wrongs.[45] Encompassing states wronged many nations. Some wrongs occurred in healthcare settings or had profound repercussions for sub-state nationals' health. Social policy powers that are exercisable free from regular state government interference may be necessary to remedy those wrongs. National control *over healthcare policy* is necessary (at least) where the wrongs implicate health/healthcare. Consider health disparities between Canada's Indigenous and non-Indigenous populations, the extent to which Canadian healthcare policies contributed to them, and other ways in which Canada's healthcare sector actively wronged Indigenous Canadians.

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[39] E.g., Alisa Henderson & Nicola McEwan, "Do Shared Values Underpin National Identity? Examining the Role of Values in National Identity in Canada and the United Kingdom" (2005) 7(2) National Identities 173.
[40] The empirics on this issue are, again, contestable; e.g., Béland & Lecours, *supra* note 6.
[41] This applies the concept of subsidiarity discussed in James E Fleming & Jacob T Levy, eds, *Federalism and Subsidiarity* (New York: NYU P, 2014). *Cf.* NW Barber, *The Principles of Constitutionalism* (Oxford UP, 2018), c 7 (contrasting subsidiarity and self-determination principles).
[42] International law recognizes a national right to internal self-determination whose violation may trigger a secession right. Neither right clearly requires full control over healthcare policy. International law is supposed to be consistent with all forms of government. This should include federal arrangements that allocates powers at different levels. Where most federal states allocate healthcare powers to federal governments, stating that self-determination requires national control likely requires too great a deviation from the status quo. On self-determination rights/secession law, see Christian Walter et al., *Self-Determination and Secession in International Law* (Oxford UP, 2014).
[43] These claims are central to arguments in Seymour, *supra* note 5, Anna Moltchanova, "Nationhood and Political Culture" (2007) 38(2) J Social Phil 255, and others.
[44] Of course, Seymour, *ibid*'s account of 'nations' is value-based and linked to solidaristic concerns.
[45] Allen Buchanan, "What's So Special About Nations?" (1997) 26(Sup1) Can J Phil 283 ["What's'"].

Those wrongs violated Indigenous Canadians' individual rights. At least some wronged the collective. Note suppression of Indigenous healthcare practices central to collective identity.[46]

Individual RTHCs and any sub-state national rights to control healthcare policy present potential conflicts. Health rights and self-determination rights rarely intersect at international law. International self-determination rights do not require a form of national control over healthcare that could conflict with individual rights realization.[47] Neither state failure to realize internal self-determination rights nor failure to realize health rights justifies secession.[48] Yet considerations underlying relevant rights and cases for a moral RTHC and moral self-determination rights raise understandable concerns. What is good for the individual and what is good for the collective can clearly differ. So can decisions about whether the individual or collective good is more important. Cases where group members claim rights to particular healthcare goods but national entities do not provide that good are non-imaginary.

The scenarios above have real-world analogues. Individual RTHCs may create entitlements to healthcare goods that make it difficult for a national entity to provide other healthcare goods they find more valuable. These are prima facie conflicts about what goods should be provided in an area and in the values to be promoted in a jurisdiction. Regardless of how one views national self-determination, being able to make unfettered decisions about healthcare policy could also constitute what it means to be a *sovereign*.[49] Sovereignty could allow policies contrary to RTHC realization. Suggestions that substantive, procedural, and systemic RTHCs adopt universal conceptions of the good and identify content that may not be appropriate to particular contexts also fit uneasily with the localized, particularistic impetus behind sub-state national control.[50] Concerns about conflicts between individual and collective 'rights' at issue here thus cannot be avoided by simply adopting particular conceptions of each.

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[46] E.g., Truth and Reconciliation Commission of Canada (TRCC), *Honouring the Truth, Reconciling for the Future* (TRCC, 2015) and vast literatures on related issues.

[47] Recall e.g., note 34.

[48] *Ibid.*

[49] Recall Seymour, Moltchanova, and like-minded philosophers.

[50] While a claim to universality is likely just a feature of human rights, the RTHC is criticized for adopting an "imperialism" about the good and thus an adoption of a standard of entitlement that is inadequately sensitive to cultural needs. This concern is distinct from the concern that health rights can be "imperial" by making all subject matters health concerns such that health is a supreme value (PR, "Towards", *supra* note 20 at 315n166), but both forms of imperialism stem from concerns about prioritizing a conception of the good. Similar critiques could apply to fair processes or systems. Leading accounts of procedural fairness are developed by looking at Western systems and grounded in liberal-democratic values; e.g., Daniels & Sabin, *supra* note 20. Those inspired by 'political' accounts should consider work (e.g., John Borrows, *Freedom and Indigenous Constitutionalism* (U Toronto P,

The Rarity of Genuine Conflicts of These 'Rights' in Healthcare Settings

Genuine conflicts are, however, rare on plausible combinations of RTHC conceptions and cases for sub-state national control over healthcare policy. Attending to the cases for sub-state national control makes this clear. First, the empirical case for sub-state national control over healthcare policy is under-determined by a dearth of supporting data. Indigenous control is presently incomplete and empirically unanalyzable.[51] Some examples, like the one inspiring Difference Values, Different Care, at least fit uneasily with RTHC realization.[52] Evidence on sub-state national rights realization is at best mixed.[53] Even if Scottish and Quebecois solidarity-based control furthered some moral goods, those nations alone provide little insight into the moral goods one should expect from providing authority to 'nations' that are not formally recognized by their encompassing states.[54] It is, for instance, unclear whether an Acadian-led healthcare system in Canada would secure better access to healthcare goods required for de minimus well-being or greater transparency in healthcare allocation decisions for Acadians.[55] One cannot assume that there will be more real-world variants of National Solidarity than of Free Market Nation. Indeed, the sociology/economy of cultural difference may produce cases like National Morality or Different Values, Different Care that could undermine realization of plausible access to essential goods and services or outcomes-based RTHC specifications.[56]

Even if future evidence strengthens the empirical case, it cannot justify governance rights that genuinely conflict with individual RTHCs. Empirical cases make national control instrumental to rights realization. Absent realization, the case for national control falters. National control that does not fulfill a RTHC conception is non-justified, so conflict is impossible regardless of the RTHC is substantive, procedural, and/or systemic. If other empirical reasons to adopt national control create conflicts, they are not conflicts of *rights*. Consider moral reasons supporting national policy based on unique understandings of health or morality. A

2016); Catherine Lu, *Justice and Reconciliation in World Politics* (Cambridge UP, 2017)) on how decisions from negotiations between groups can bias towards dominant groups. Systemic conditions could be similarly constrained.

[51] [Redacted].

[52] *Ibid.* The case in 7 could be read that way,

[53] Note variations in Béland & Lecours, *supra* note 6; Henderson & McEwan, *supra* note 39; etc.

[54] Adding other recognized nations, like Flanders (Béland & Lecours, *ibid*; André Lecours, "Political Institutions, Elites, and Territorial Identity Formation in Belgium" (2001) 3(1) National Identities 51) cannot alter this.

[55] As Seymour, *supra* note 5 at 239 notes, Acadians plausibly qualify as nations.

[56] Recall note 53.

'right' to govern according to local norms is hard to ground in empirics alone if such governance undermines existing rights. A *right* to govern must be grounded in other moral concerns.

Self-determination offers better prospects for at least justifying forms of national control over policy areas, but the self-determination-based case for national control over healthcare is weak and likely cannot create collective 'rights' capable of overriding individual RTHCs. 'Self-determination' refers to multiple claimed rights.[57] The right to self-determination in the healthcare context requires elaboration.[58] How plausible national self-determination arguments implicate *healthcare* is hard to parse. National self-determination cannot require full control over all areas of governance. Otherwise, sub-state nations are by definition problematic.

The most promising route for identifying when self-determination grounds plausible claims to national control likely does not require national healthcare powers. It selects domains where control is necessary for nations to exist.[59] Self-determination rights could require providing some authority to a group to provide a context for choice in which rights can be realized. [60] Nations are good candidate vessels for exercising individual self-determination rights. They may require authority over policy areas to provide contexts for choice. Yet unfettered power over healthcare allocation or other healthcare powers is unnecessary for national groups to exist or be viable political entities. If nations are constituted by their values and solidarity is a characteristic value,[61] this may require providing healthcare authority to nations. Empirics on healthcare as a means of building national identity could favour such power-sharing.[62] Whether they do so frequently, let alone uniformly, is questionable. Free Market Nation and National Morality linger. Narrower understandings of national 'constitution' that identify nations with fundamental sociological characteristics (e.g., language, ethnicity, shared history) do not, in turn, clearly implicate healthcare.[63] Systemic failures to ensure basic healthcare necessary to protect those goods can be avoided without national control. Nations may require some social policy

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[57] Allen Buchanan, "Self Determination, Secession, and the Rule of Law" in Robert McKim & Jeff McMahan, eds, *The Morality of Nationalism* (Oxford UP, 1997) 301 at 306 ["Rule"].
[58] Recall note 42.
[59] [Redacted] has details.
[60] One can, for instance, build a national language and nation in tandem if one possesses the powers necessary to develop and foster a uniform language; EJ Hobsbawm, *Nations and Nationalism Since 1780*, 2d ed (Cambridge UP, 1990/1992). Social policy powers can also promote nation-building; e.g., Béland & Lecours, *supra* note 6; Nicola McEwan, "State Welfare Nationalism" (2002) 12(1) Regional and Federal Studies 66.
[61] Seymour, Henderson & McEwan, and Béland & Lecours (cited above) make or identify this claim.
[62] See social policy-related sources in note 60.
[63] [Redacted] again has more detail.

powers to be unique sites for self-determination and yet not require *healthcare* policymaking powers. Nations can exist even if they cannot make any choices in scenarios above.

The self-determination-based case for national control over healthcare policy, then, only applies in limited cases. It will rarely create conflicts that plausibly favour self-determination over substantive RTHC realization. Self-determination-based cases only appear plausible where healthcare policy is necessary to protect solidaristic values or healthcare policy is necessary to build a nation. The former justification applies narrowly. The latter may not generalize at all and sacrificing individual RTHCs to create a future entity capable of more effectively marshalling others' self-determination rights is worrisome anyway. Conflicts with procedural and systemic RTHCs should be rarer still. The idea that self-determination requires freedom to make decisions according to one's own processes is plausible, but 'values'-based and 'nation-building' self-determination arguments are unlikely to guarantee such broad contexts of choice.

Moreover, RTHCs will usually condition exercises of any self-determination rights in healthcare settings, rather than conflicting with such rights. Conflicts of rights will thus remain rare even if self-determination rights in healthcare settings are more common than I claim. Genuine rights typically constrain action by imposing duties. *Human* rights, like the RTHC, are partially constituted by their ability to constrain state action. Nations who possess authority over healthcare policy fill the state's role in that domain. How a 'rights constraining authority' story becomes a 'conflicts of rights' case when the authority changes is, at best, difficult to parse.

The nature of authority also makes subjecting exercises of sub-state national authority to at least some RTHC-based constraints appropriate. States that fail to provide de minimus well-being to their citizens fail to meet basic standards needed for legitimate authority. One has little reason to accord healthcare-related decisions by governments that do not secure basic conditions for health. The same could be true of nations. Free Market Nation and National Morality present as governance failures. Neither states nor nations should be able to make the decisions therein.

Whether the RTHC should constrain otherwise valid exercises of authority is a fair question, but it concerns whether the RTHC exists, not what to do when it interacts with other concerns. Conflicts will not be *possible* if RTHCs are non-existent. More interesting questions concern the relationship between individual RTHCs that exist and any authority to create healthcare policy. RTHC's plausibility as constraints depends on one's theory of 'rights,' but even political norms that justify self-determination rights justify *some* RTHC-related constraints.

At minimum, plausible self-determination rights presuppose basic commitments to liberal freedom and equality that require fair procedures and democratic institutions capable of safeguarding procedural fairness and any substantive entitlements selected from a fair system.[64] Political considerations may identify substantive constraints on exercising self-determination rights in healthcare settings. For example, many principles for identifying substantive RTHC content also protect the goods necessary to even be involved in politics.[65] Self-determination-based political concerns thus do not undermine a case for the pre-requisites for entering political arenas. At least circumscribed RTHCs focused on basic healthcare necessary for political participation could thus plausibly constrain the exercise of self-determination rights.

If a conception of the RTHC cannot plausibly constrain action, that is evidence against the conception, not evidence that plausible RTHCs regularly conflicts with national control 'rights.' A conception's failure to plausibly constrain action simply does not support strong national rights to control healthcare policy that override individual RTHCs. Any 'special' moral considerations that could change this calculus are unlikely to do so absent widespread health-related injustice that applies to at most a few national groups. We are then discussing remedial rights below. The defeasibility of typical RTHCs blunts further worries that recognizing RTHCs unduly constrains self-determination in *all* cases, but such 'defeat' will again be rare.

Conflicts will arise if the RTHC has systemic content requiring institutional configurations that are non-amenable to national control. If, for instance, the RTHC requires a national healthcare system (rather than national *policies* required by international law), it may not permit sub-national differences.[66] Yet predominantly or even exclusively systemic RTHCs are unlikely to be rights to state-wide healthcare systems without variation that may unduly limit valid self-determination rights. Existing systemic accounts allow institutional variations consistent with multiple forms of governance, including national control.[67] Requiring basic political freedom guarantees, quality healthcare facilities, data collection, or means of challenging healthcare policy decisions in those accounts should be consistent with national

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[64] This potentially controversial claim appears in influential arguments; e.g., Seymour, *supra* note 5; Will Kymlicka (*Liberalism, Community, and Culture* (Clarendon, 1989); Yael Tamir (*Liberal Nationalism* (Princeton UP, 1993)).
[65] See minimalist views discussed in Rumbold, *supra* note 2 or, perhaps, the political approach of Hessler & Buchanan, *supra* note 33. Moral versions of "Int'l," *supra* note 21's dignitarian legal view may also qualify.
[66] See "Int'l," *ibid* for the international requirement.
[67] Hessler & Buchanan, *ibid* is representative. The international right also claims to be agnostic about forms of government. See the legal sources above (and discussion thereof in e.g., Toebes, *supra* note 30).

control over healthcare policy. Adequate national control should guarantee them. Insofar as self-determination rights justify national control, exercising them could help realize individual RTHCs. National control could provide the system necessary to realize individual RTHCs and collect data necessary to measure individual rights realization. Whether exercising 'rights' to control healthcare policy will better achieve aspects of any RTHC is an empirical matter. Yet the possibility of pairing national control, fair processes, and systemic guarantee suggests that national control could help rights realization (and/or be valuable for getting information necessary for identifying how best to realize same). This possible coherence undermines claims that individual RTHCs and national control are likely to regularly conflict.

Finally, the remedial case for national control over healthcare policy provides the strongest case for deviations from 'universal' human rights norms and requires explanations of how to weigh values but may not generate any conflicts of *rights*, let alone common ones. Ongoing injustices stemming partly from applications of purportedly universal norms create justifiable skepticism about any necessary constraints on national authority.[68] Suitably grave injustices may require providing wronged groups with stronger authority over policy areas that permits deviations even from procedural fairness guarantees. Injustice, not groups' status as 'nations,' would ground any consequent conflicts.[69] They may not be traditional conflicts of rights; the individual rights are traditional human rights and governance 'rights' are remedial entitlements, not rights simpliciter. How to classify the conflict is at least contestable.

These cases raise conflicting morally weighty concerns regardless of how we classify them, but conflicts are rare on any reading. Some sub-state groups with national features faced healthcare-based injustices. These could ground stronger cases for sub-state national control. Any attendant conflicts will require response. Yet this outcome too is remarkably rare regardless of whether it presents conflicts of rights. Uncontroversially gross health-/healthcare-related injustices against non-Indigenous 'nations' are hard to identify.[70] Those who accept Different Values, Different Care are likely moved by problematic state failures to provide necessary

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[68] Borrows, *supra* note 50 and Lu, *supra* note 50 again appear relevant.
[69] "What's," *supra* note 45.
[70] TRCC, *supra* note 46 provides details on one Indigenous case. While epistemic humility requires that one take care when discussing the presence of injustice, the sociological and historical record on nationalism (in works above and elsewhere) present few examples of non-Indigenous cases presenting wrongs analogous to those in Indigenous cases. For more ways in which the Indigenous case may differ from other sub-state nationalisms and require a different analysis, see Dale Turner, *This is Not a Peace Pipe* (U Toronto P, 2006).

healthcare or suspicions, sourced in the case's real-world analogue, that relevant national beliefs about what constitutes 'care' have been unduly suppressed. But the relevant wrong must be very great to justify even considering accepting the broad national control that would permit that case outcome – and, I will argue, we can still fault those who use a 'right' to affect that outcome.

Resolving Conflicts of Rights/Weighing Other Moral Concerns

If the forgoing is correct, conflicts between the RTHC and decisions by sub-state nations who control healthcare policy are rarely genuine conflicts of rights. This is partly because no authority, 'national' or otherwise, has a clear right to not fulfill a RTHC. Moral considerations justifying authority may provide collective rights to rule that allows nations to decide 'not-X' where 'X' fulfills part of the RTHC. Yet such cases will be rare and will usually only create prima facie conflicts with substantive RTHCs. Relevant rights are unlikely to include entitlements that would warrant not realizing an individual RTHC. Moreover, general rights to rule are usually understood as constrained by human rights, including the RTHC. Enforcement of constitutional RTHCs arguably already take this view: Governmental decisions not to allow a basic healthcare good into a state, as in a state-level version of National Morality, constitute enforceable violations of constitutional RTHCs.[71] The same should be true of sub-state nations.

Detailing how to respond to genuine conflicts requires another work, but I would be remiss if I did not say something about how to address them. Individual health rights, self-determination rights, or remedial rights likely cannot be clearly prioritized as classes, making it difficult to provide general advice on what to do in all conflict cases. But brief words on how to continue to recognize the moral value of the considerations underlying what one chooses not to do should be valuable for understanding what to do when rights conflict. I propose that RTHC realization should be as an evaluative criterion for the *good* exercise of collective governance rights if and where a national right to control healthcare policy outweighs conflicting individual RTHCs. Policies that infringes (or even fails to help realize) RTHCs are worse for so doing. RTHCs are thus morally relevant even where collective rights conceivably override them.

Rights being potentially overridden is necessary where competing moral considerations can apply in the same choice context.[72] If there are genuine conflicts of rights, multiple very weighty moral considerations can exist in a context. Considerations should not simply disappear

[71] E.g., *TAC*, *supra* note 16.
[72] W.D. Ross, *The Right and the Good* (Oxford UP, 1930/2002) provides a classic 'pluralist' account.

when overridden. They remain by definition. Why they should lose their normative status is opaque. A token of their remaining value is appropriate. Rights are supposed to have a special moral status, making recognition of their continued normative weight particularly compelling.

Using RTHC realization to evaluate sub-state national healthcare policy recognizes the ongoing normative value and status of a RTHC even when the case for *requiring* its fulfillment in a circumstance is overridden – and can help ensure individual actors do so too. The standard story of how to address cases where multiple irreducible weighty moral considerations applies calls for the person who performs an action that is all-things-considered justified but in some way wrongful to feel compunction for and/or compensate the person wronged by the action.[73] That may apply here regarding those who draft a constitutional document allocating responsibility for healthcare in a way that allows rights violations and/or those who use their authority over healthcare policy in non-RTHC-promoting ways. But conflicts like those at issue here implicate institutional considerations that go beyond any decision and may require a broader institutional mechanism for recognizing the variety of moral considerations at play in decisions about allocating healthcare policymaking powers. Using a RTHC to evaluate healthcare policies reflects the right's continued moral relevance in a way analogous to that demanded by the case of individual action. Tracking the extent to which policies infringe upon the rights may ensure that healthcare decision-makers have the appropriate institutional equivalents of compunction and/or compensation when they use their powers in non-rights-maximizing ways. Using RTHCs as evaluative tools would then be valuable even if recognizing wrongfulness was only necessary for individual actors, though I think the case for some institutional response has merit.

This approach is also appropriate where rights weigh against other morally weighty concerns. One may argue that it is confused with respect to genuine conflicts of rights cases: they permit rights violations and the moral status is accounted for in initial determinations of how to allocate responsibility for healthcare policy. But rights to control healthcare policy need not *require* rights violations. Permitting rights violations does not entail accepting that exercising that permission is fully morally acceptable, particularly where one can also permissibly act in rights-respecting ways. Moreover, if a right is only exercisable in a way that violates a RTHC, that violation could still make the world worse in some way. One difference between such a case and standard rights violation cases concerns appropriate responses thereto. Our feelings of

[73] E.g., *ibid*; Robert Nozick, "Moral Complications and Moral Structures" (1968) 13 Natural Law Forum 1.

compunction could, for instance, be weaker where the RTHC violation was not only all-things-considered justified but also necessary to realize another right.

This view does not unduly constrain exercise of any right to control healthcare policy. A right to control healthcare policy unfettered by external actors need not be a right to do so absent critique. Indeed, healthcare policymaking powers likely *should* not be free from critique. International law thus arguably already subjects those who possess the right to control healthcare policy to a RTHC-based evaluation. It does not condition state authority over healthcare on realizing the RTHC, but it highlights failures to do so as problematic exercises of authority.[74] The non-enforcement of these rights conditional on authority to govern plausibly uses health rights realization as an evaluative criterion for the exercise of authority. It is not the strongest measure available in international law; failure to realize the RTHC never fully undermines international rights to control healthcare policy.[75] It is an important way of evaluating authority exercises.[76] Acknowledging state sovereignty over healthcare policy while chastising them for failure to realize health rights through their healthcare policies seems entirely appropriate. The same should be true of any sub-state national control over healthcare policy.

Plausible intuitions about the cases above likely suggest this much, supporting a final, reflective equilibrium-based case for my proposal. Even a strong remedial right to control healthcare policy that would warrant powers that would permit the action in Free Market Nation or Different Values, Different Care would not render use of those rights morally unproblematic. We should still say that the outcomes in those cases are worse exercises than one would hope. An individual RTHC accordingly maintains a role in moral analysis, providing a measure for exercising self-determination rights: exercises are worse insofar as they fail to fulfill that RTHC.

Conclusion/Suggestions for Further Work

The preceding at least establishes that tensions between individual RTHCs and national self-determination rights are rarely conflicts of rights, so one does not need the philosophical machinery meant to resolve conflicts of rights to such tensions; duties to realize individual

[74] States are subject to reports on socio-economic rights realization but enforcement mechanisms for socio-economic rights like the right to health remain nascent at best. Even proponents of the responsibility to protect as a ground for intervention in sovereign states do not generally view non-realization of these rights as triggering intervention.
[75] Recall discussions of the scope of internal self-determination rights and secession claims above.
[76] Evaluations could even pressure governments to realize rights. I am unaware of strong evidence that they do now.

RTHCs limit most health-related self-determination rights; and where self-governance rights *do* outweigh individual RTHCs, an individual RTHC can still play a role in moral analysis.

Arguments above suggest further findings about the nature of rights generally, self-determination rights particularly, and the relationship(s) between healthcare authority, health rights, and health justice. I can merely sketch possible implications here, but suggestive comments highlight the preceding's generative potential and directions for further research.

First, the forgoing suggests 'rights' are a special moral entity characterized by correlativity relationships and the production of special moral relationships. The above coherently discussed 'rights' to healthcare that fit a basic schema whereby all rights require correlative duties held by identifiable duty-bearers *even if* those duties are not strictly circumscribed.[77] It did not justify the concept of a RTHC or this looser sense of correlativity, let alone identify the RTHC conception that best fits the schema. Yet the ability to coherently discuss RTHCs in an action-guiding manner plausibly supports the idea of 'socio-economic' rights with this kind of normativity. This further suggests that there can be 'directed duties' correlative to rights even if the duties do not specify a unique action duty-bearers must take.

Second, the forgoing demonstrated that 'rights' do not exhaust morally weighty concerns. One can do what is within one's right and yet be open to moral sanction. This supports a common distinction between "the right" and the "good" found in other literatures.[78] To do what is your right is not to escape any moral censure. Even if one's action does not violate a directed duty that would ground one kind of complaint, one can still remain open to charges that they did not do what is morally optimal. One may still face the charge that one's act is 'not good.'

Third, the above suggested that any claim to authority over healthcare requires justification and the moral considerations providing it may not override individual rights. Self-determination rights need not entail secondary 'rights' to control healthcare policy. This supports the view that 'the right to self-determination' is better understood as a cluster of related rights, each of which requires independent justification.[79] It also highlights that questions about who should control healthcare policy cannot be easily resolved by pointing to a single principle.[80] Future work must examine which principles justify providing authority over healthcare to which

[77] This suggests that the schema in note 22 sources make *some* sense, blunting concerns in note 23 sources.
[78] Ross, *supra* note 72.
[79] "Rule," *supra* note 57.
[80] *Cf.* note 41 sources on "subsidiarity."

levels of government when.[81] One can use some moral considerations above to examine cases for federal, provincial, or municipal control. The forgoing provides a general approach for analyzing authority claims: one must search for principles explaining why an entity should possess a decision-making power and, if principles select multiple candidate authorities in a sphere, weigh all moral considerations. Given the moral concerns above, it is unlikely that other entities will possess strong claims that would justify not realizing RTHCs. This further suggests (without proving) that RTHCs almost always constrain healthcare policy decision-making.

Finally, the forgoing highlights difficulties with using rights-based considerations to achieve health justice. Familiarity with the mixed history of legal health rights, including middle-class capture of the rhetoric to increase health inequities within states,[82] makes the claim that 'health rights' may not achieve 'health justice' unsurprising. It now seems that even moral health rights claims may not attend to the range of moral concerns that a complete account of health justice must address. Trying to fit sub-state authority claims into a rights framework limited their application above. Moreover, a justice-based case for sub-state authority is possible absent rights-based concerns: one can plausibly hold that sub-state nations should have authority where and because they will improve healthcare provision for the unit collectively without discussing 'rights.'[83] Such justice-based accounts may better reflect moral complexities by letting group interests do more work. Once we recognize the distinction between the right and the good and rights-based accounts' difficulties addressing plausible moral interests, the value of rights-based approaches becomes a live issue. The forgoing demonstrated that the tensions at issue are not best described as conflicts of rights. Future work should examine whether alternative approaches to health justice better address relevant moral considerations and promote preferable outcomes.

[81] The note 8 source makes a similar claim for different reasons.
[82] E.g., Alicia Ely Yamin & Siri Gloppen, eds, *Litigating Health Rights: Can Courts Bring More Justice to Health?* (Harvard Law School, 2011); Alicia Ely Yamin, "The Right to Health in Latin America: The Challenges of Constructing Fair Limits" (2019) 40(3) U Penn J Int'l l 695.
[83] I thank a reviewer for this point.