Health Rights: Individual. Collective. National?

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

'Socio-economic' rights are a species of so-called 'positive' right that call for performance of certain actions – most often the provision of particular goods and services – on the part of the rights claims' purported corresponding duty-bearers.[1] Advocates of 'socio-economic' rights to health, healthcare, or public health ('health rights') have produced several plausible theories that address some of the most pressing challenges for socio-economic rights claims. Many critics still deny that *moral* health rights exist or that rights-based approaches will best achieve health justice,[2] but health rights theorists at least provide sophisticated answers to basic questions like 'Who possesses the rights and their corresponding duties?' and 'What are the nature, scope, and content of the duties?' Answers to these questions differ and will not convince all critics, but rights-based approaches to the corner of bioethics devoted to health justice now at least constitute part of the scholarly mainstream.[3] Regardless of their theoretical bona fides, in turn, health rights exist in many legal systems. The international right to health is well-

[1] For good summaries, see Rumbold, B.E. (2017). The Moral Right to Health: A Survey of Available Conceptions. *Critical Review of International Social and Political Philosophy* 20(4): 508-528; Hassoun, N. (2015). The Human Right to Health. *Philosophy Compass* 10(4): 275-283; Hassoun, N. (2020). The Human Right to Health: A Defense. *Journal of Social Philosophy* 51(2): 158-179. On the less commonly discussed purported 'right to public health,' see Wilson, J. (2016). The Right to Public Health. *Journal of Medical Ethics* 42(6): 367-375.

[2] Gopal Sreenivasan provides one of the strongest arguments against moral health rights in (2012). A Human Right to Health? Some Inconclusive Scepticism. *Proceedings of the Aristotelian Society* Supplementary Volume 86: 239-265 and (2016). Health Care and Human Rights: Against the Split Duty Gambit. *Theoretical Medicine and Bioethics* 37(4): 343-364, though he recognizes that legal rights exist and may be justified. Cohen, J. (2020). Paradigm Under Threat: Health and Human Rights Today. *Health and Human Rights Journal* 22(2): 309-312 has a nice, succinct overview of criticisms of rights-based approaches to health justice and attempts to respond to such critiques.

[3] The last two comments build on sources cited in note 1. For a succinct discussion focused on theorizing the international rights, see Wolff, J. (2012). *The Human Right to Health*. New York: WW Norton.

established and most domestic constitutions recognize rights to healthcare, if not broader rights to health or public health.[4] Theorists should and do attempt to 'make sense' of this phenomenon.[5]

Theories of health rights nonetheless raise a classic problem: How does one weigh individual health rights against competing collective rights or other non-rights-based values that may motivate health policy? This issue is critical to our understanding of socio-economic rights and questions about how to realize socio-economic rights in existing political structures where the subjects of such rights exist alongside many other important social goods. Most health rights theories assume a unitary state that possesses primary authority to set healthcare policy and to distribute primary duties to fulfill health rights.[6] Yet the questions 'Who should possess authority to establish health policy? and 'Who should hold primary duties to fulfill health rights?' may not have the same answer – and a unitary government may not best answer either question.

Notably, for instance, the internationally recognized right to health is supposed to be consistent with many different forms of governance, including federal governance. Federal states, including the U.S.A. and Canada, provide authority over social policy to sub-state entities such as provinces, länder, cantons, and American 'states' (henceforth 'provinces.') This fact alone neither violates the right to health recognized in many international legal instruments nor absolves federal governments from international legal duties to fulfill it.[7] Yet different outcomes

[4] United Nations, *International Covenant on Economic, Social and Cultural Rights,* 16 December 1966, 993 UNTS 3, art 12; Evan Rosevear et al., "Justiciable and Aspirational Economic and Social Rights in National Constitutions" in Young, K.G. ed. (2019). *The Future of Economic and Social Rights* (pp. 37-65). Cambridge: Cambridge University Press.

[5] The language here is inspired by Nickel, J.W. (1987). *Making Sense of Human Rights: Philosophical Reflections on the Universal Declaration of Human Rights.* Berkeley: University of California Press. Wolff, *supra* note 3 is an example of an attempt to 'make sense' of existing laws from a philosophical perspective.

[6] McKay D. & Danis, M. (2016). Federalism and Responsibility for Health Care. *Public Affairs Quarterly* 30(1): 1-29 is a rare exception.

[7] Da Silva alludes to this fact and examines its implications in (2018). The International Right to Health Care: A Legal and Moral Defense. *Michigan Journal of International Law* 39(3): 343-384 and discusses it in more detail in (2021). *The Pluralist Right to Health Care: A Framework and Case Study*. Toronto: University of Toronto Press.

across provinces in federal countries raise questions about whether and when the moral reasons that could justify providing authority over health policy to provinces can justify differential rights realization.[8] Can, for instance, the moral reasons justifying provincial control also justify not publicly funding access to insulin? Or, to the contrary, should the federal state stand as the guarantor of certain minimal thresholds in the recognition of citizens' health rights, with diversity within federal systems only occurring permissibly above those thresholds?

Sub-state entities, like provinces, that traditionally receive discrete powers in federal constitutions, plausibly bear some responsibility for the delivery of health policy, but intuitions may differ concerning other groups with plausible claims to control health policy. Consider 'nations' with international legal internal self-determination rights (e.g., the Quebecois, Scottish, Roma). Where national status is often developed through the development of social policy, exercising self-determination may require controlling such policy.[9] Or consider Indigenous groups subjected to grievous wrongs. Remedial justice may require Indigenous control over health policy.[10] One can view these groups as having rights to control health policy that overrides individual right claims. Some group members invoke such collective rights. Attending to these groups' claims to govern health policy and resolving attendant disputes requires clarity on the scope of and relationship between relevant rights, duties, and other (e.g., remedial) concerns.

These issues can arise in any pluralist ethical system but are acute in health-related settings. It is simultaneously plausible that each individual right against the state should be realized, that some groups possess special collective rights, and that realizing all these rights at

[8] See e.g., Michener, J. (2018). *Fragmented Democracy: Medicaid, Federalism, and Unequal Politics*. Cambridge: Cambridge University Press (on the U.S.A.).
[9] Béland D. & Lecours, A. (2008). *Nationalism and Social Policy*. Oxford: Oxford University Press is a particularly good, if somewhat dated, discussion of the relationship between nationalism and social policy.
[10] Boyer, Y. (2005) *Moving Aboriginal Health Forward: Discarding Canada's Legal Barriers*. Vancouver: University of British Columbia Press has a good overview of some health-related wrongs in our home country.

the same time is difficult at best and possibly self-defeating. Even simply recognizing all healthcare rights could make it economically impossible to fulfill other 'rights' to more collective goods, including legally-recognized 'rights' to at least some of the social determinants of health (e.g., housing). Some self-determination rights may, in turn, be weighty enough to justify group decisions to prioritize liberty interests over the collective provision of healthcare.

Tensions (if not outright conflicts) are also unavoidable given that individual health rights claims require institutional structures. Any health right plausibly requires a functioning healthcare system.[11] Health rights are unlikely to have any substantive impact absent such institutional settings, making health rights implicitly a concern for larger groups. Yet all healthcare systems need to make choices about how to rank individual and group interests, with different results for relevant individuals and collectives. Tensions between individual health rights and collective goods, like the principles and values of subsidiarity, diversity, national self-determination, and cultural protections, will arise even if one finds collective health *rights* implausible.[12] These goods can plausibly limit individual health rights and, perhaps, ground other collective rights. Attempted resolutions of these apparent tensions will have health consequences. After all, extant divisions of healthcare policy-making powers impact outcomes.[13]

The articles in this issue explore aspects of the relationship between individual and collective health rights and related values. In the process, they further highlight the interrelation of theoretical and practical concerns in practically relevant discussions of health rights – and

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[11] Da Silva, M. (2020). The Complex Structure of Health Rights. *Public Health Ethics* 13(1): 99-110.
[12] For more on these principles and their implications for the division of authority, albeit in 'federalism' settings, see e.g., Føllesdal, A. (2003/2018). "Federalism." *Stanford Encyclopedia of Philosophy*. Retrieved from: https://plato.stanford.edu/entries/federalism; Karmis, D. & Norman, W. eds. (2006). *Theories of Federalism: A Reader*. New York: Palgrave MacMillan; Fleming, J.E. & Levy, J.T. eds. (2014). *Nomos 55: Federalism and Subsidiarity*. New York: New York University Press. Daniel Weinstock's contribution to this issue focuses on subsidiary and contains more citations to work on that principle.
[13] Recall note 8 and surrounding.

point to other issues that future health rights research should address. Addressing the relevant tensions requires attending to several foundational issues about the nature, grounding, scope, and content of relevant rights and duties, the identities of rights-bearers and duty-holders, the different of moral interests that may interact with health rights (including self-determination rights), and the relationship between different rights and between rights and other interests.

Éliot Litalien, Michael Da Silva and Daniel Weinstock primarily address more theoretical considerations. Litalien argues that a concern with agency grounds both individual and collective health rights, and that attending to which decisions best promote human agency dissolves apparent tensions. Da Silva agrees that genuine conflicts of rights will be rare but takes a different path to this conclusion. He then highlights three possible bases for collective 'national' rights to govern healthcare and argues that only one is likely to produce regular conflicts with any individual health rights. Da Silva also addresses a further foundational issue that future work should address in more detail, namely what to do when moral interests conflict or when other concerns override health rights. Weinstock argues that properly attending to the concerns that have underpinned the privileging among many theorists of federalism of some form of "subsidiarity" – the principle favouring 'most local' effective control over a domain – actually tell against federalism as it is most commonly understood, that is, as involving a constitutionally entrenched and therefore relatively inflexible division of responsibilities among federal partners.

Amie Zimmer, Leticia Morales, and Sara Cohen-Fournier et al. then highlight the value of attending to the concrete realities in which health rights claims appear. Their contributions focus on real cases in different parts of healthcare and legal systems. Zimmer explores conceptions of 'health' in contrasting models of health rights and their implications for health insurance markets in the U.S.A. and that country's specific realization of a right to healthcare. In

the process, Zimmer highlights the need to attend to how we conceptualize the subjects of rights (e.g., able-bodied or otherwise) and the larger social systems in which rights claims appear (e.g., societies that assume able-bodied status will not properly vindicate the rights of those with disabilities). Morales highlights issues with recognizing and institutionalizing legal health rights. Drawing on case law from Chile, Morales defends judicial interpretation of health rights claims against a common objection that courts lack 'epistemic competence' to evaluate health policy. Her paper underscores the need for an arbiter for resolving real-world rights conflicts – and makes the case for judicial solution to the problem.[14] The paper also highlights the need to examine what, if anything, the law should do about these apparent tensions. Whether and when law should recognize health rights, the extent to which these rights must reflect corresponding moral rights, and how the law should resolve conflicts remains contestable. [15] Indeed, Cohen-Fournier et al. ultimately argue that intercultural negotiation is preferable to judicial conflict resolution in contexts where different epistemic standards with implications for how rights and duties are understood produce tensions in how to resolve 'bedside' medical decision-making.

Despite their different points of emphasis, each article also highlights the interrelation of theoretical and systemic concerns in the relevant contexts. Litalien, Da Silva, and Weinstock point to the need to assess the practical realities in which their proposals exist by couching their arguments in cases idealized from real conflicts. Zimmer, in turn, presents important insights into the nature of rights and assumptions about relevant 'persons.' Morales addresses the moral and epistemic legitimacy of courts while Cohen-Fournier et al. also stress moral and epistemic concerns as they are manifested not just in theory but in the practice of healthcare systems.

[14] Whether, if, and how judges should address socio-economic rights claims is the subject of a large literature. For a good recent volume, see e.g., Young, *supra* note 4 – or many of the works cited in Morales's contribution.
[15] Etinson, A. ed. (2018). *Human Rights: Moral or Political?* Oxford: Oxford University Press.

The mix of theoretical and practical insights in these works is the unifying thread running through the papers assembled here. We hope that future work on health rights includes a similar blend. The nature of and relationship between individual and collective rights is not merely of academic interest but raises important questions in law and public policy. Our home country of Canada recently produced debates about whether courts can enforce an individual 'right' to access a healthcare good or service when doing so will have a detrimental impact on the healthcare system and whether groups' 'rights' to exercise their customs or beliefs override general norms of healthcare treatment.[16] Debates persist regarding whether and when Indigenous Canadians or the Quebecois should possess unique healthcare powers. Philosophical rigour can help produce better responses to such queries. At the same time, real political claims in each have challenged our traditional stances on who should what possess rights, as Cohen-Fournier et al. makes clear.[17] Given these interconnected theoretical and practical concerns, reflective equilibrium, which emphasizes both philosophical plausibility and "fit" with what we know about real cases, appears to be a fruitful method for the academic discussion of health rights.[18]

The articles in this issue only scratch the surface of the difficult issues concerning individual and collective rights, including but not limited to those related to self-determination. We believe reflecting on the potential conflicts between individual and collective health rights will allow for the re-framing and reconsideration of many questions that have been at the centre

[16] On the former, see *Cambie Surgeries Corporation v British Columbia*, 2020 BCSC 1310 (echoing *Chaoulli v Quebec*, [2005] 1 SCR 791, 2005 SCC 35). On the latter, see *Hamilton Health Sciences Corp v DH*, 2014 ONCJ 603; *Hamilton Health Sciences Corp v DH*, 2015 ONCJ 229.
[17] Their piece is based on *DH, ibid* but motivates authority claims beyond its scope.
[18] For discussions of reflective equilibrium as an appropriate methodology in ethics and political philosophy, see Daniels, N. (1996). *Justice and Justification. Reflective Equilibrium in Theory and Practice*. Cambridge: Cambridge University Press and Norman, W. (1998). Inevitable and Unacceptable? Methodological Rawlsianism in Anglo-American Political Philosophy. *Political Studies* 46(2): 276-294.

of the discussion of health rights in recent years. In closing this introductory editorial, we would accordingly like to identify several such questions which, we hope, will guide future research.

One set of questions concerns how to adjudicate competing demands in the context of scarce resources. The realization of health rights faces the problem of scarce resources at least two levels. First, there is the question of how to balance the claims made as between the health needs of a population and the needs and interests covered by other policy domains, such as education, housing, and the like (a question made even more complex by the fact that, as we know from "social determinants of health" research, such policy domains themselves have measurable health effects).[19] The second has to do with what Cass Sunstein has termed "health-health" trade-offs, that is, the question of how to distribute resources within the space of health policy, given the potentially limitless claims that health can make on the national budgets even of affluent nations.[20] Complicating the resolution of resource allocation problems by placing them in the context of multi-level decision-making structures in which some groups incorporated within such structures claim collective rights raises a number of questions, to do with whether there is a normatively "right" way or range of ways in which such problems should be resolved, or whether collective rights necessarily involve the ability to make choices about resource allocation in the context of scarce resources unconstrained by other normative considerations.

Research on the realization of health rights in an institutional context that gives weight both to individual and collective rights should also include work on the kinds of entities that can plausibly claim collective rights over health, and the normative grounds that permit them to do so. For instance, "nations" have traditionally claimed to be unique among groups in possessing

[19] Weinstock, D. (2015). Health Justice after the Social Determinants of Health Revolution. *Social Theory & Health* 13: 437-453.
[20] Sunstein, C. (1996). Health-Health Tradeoffs. *University of Chicago Law Review* 63(4): 1533-1571.

features that justify the ascription to them of the right to self-determination, and thus to large swaths of policy-making autonomy, within federal or quasi-federal structures, but some have doubted whether there is anything about nations that warrant this claim to uniqueness.[21] Some theorists, including a co-author of this piece, also claim that whatever features warrant granting autonomy over health policy to provinces ought also to grounds claims made by other kinds of entities, such as cities.[22] Should the normative grounds on the basis of which some collective entities have claimed collective rights include rights over health policy? Or is there something about health policy that requires that responsibility over it be held at levels above the local? In general, how does the abstract question of the various grounds on the basis of which different collective entities claim collective rights speak to the specific issue of the way in which the right to health, and the healthcare systems that serve that that right, are realized institutionally?

In keeping with the method of wide reflective equilibrium, questions as to what kinds of groups are qualified to take on responsibilities in the area of health policy should be dealt with through a combination of inductive and deductive studies. The latter should inquire into the way in which the various normative grounds that can be invoked to justify apportioning rights over health policy specify certain kinds of groups (and, presumably, not others), whereas the former would have to do with the groups that actually do claim soon degree of control over the policies required to realize their members' right to health, the specific aspects of health policy that they claim jurisdiction over, and the normative grounds on the basis of which they do so.

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[21] Buchanan, A. (1997). What's so Special about Nations? *Canadian Journal of Philosophy* Supplementary Volume 22: 283-309.

[22] Weinstock, D. (2014). Cities and Federalism. In J.E. Fleming & J.T. Levy, eds., *Nomos 55: Federalism and Subsidiarity* (pp. 259-290). New York: New York University Press; Hirschl, R. (2020). *City, State: Constitutionalism and the Mega-City*. Oxford: Oxford University Press.

Attending to these concerns will require further attention to issues in social ontology and political philosophy that should have implications beyond the health rights context. Indeed, the insights gained from attending to these concerns should inform further discussion of socio-economic rights in general, if not rights simpliciter. Another future line of research should analyze whether and how findings about individual and collective health rights extend to the discussion of other rights – and the division of authority over other policy areas. For instance, in addition to the questions above, questions like 'Do non-governmental entities have rights-related responsibilities and how do such responsibilities relate to governmental duties?' and 'Should authority for a policy area track responsibility for fulfilling a related right?' apply in many sectors. While the challenges above are acute in health-related settings, they are not unique to those settings and this issue could be viewed as a case study in a broader philosophy of human rights. We suspect that the method used here could be fruitful for other rights-related inquiries.

Addressing some of the health rights-related issues we proposed for future research is also likely to tell us something not just about the manner in which health rights should be institutionalized in a complex institutional context, one that incorporates different jurisdictional "levels," but also about the contending values and normative considerations in play. For example, the manner in which potential conflicts among values, say between the values involved in the individual right to healthcare and the collective right that some groups claim over health policy, will tell us something about both sets of values. If, for instance, ethical arguments were to converge on the position that any group that claimed the right to organize its own health system was constrained in its choices by certain normative considerations – such as the right that all citizens have to be able to access potentially life-saving medical treatment regardless of ability to

pay – this would at least complicate claims that might be made by some concerning the paramountcy of considerations of collective self-determination over other candidate values.

Once again, the papers collected in this issue only address a small subset of issues raised by the confrontation of individual and collective health rights claims. We very much hope, however, that they will prompt others to embark upon the lines of research suggested here.