California Law Review
August, 2007

Comment

*1151 A LEGAL RIGHT TO HEALTH CARE: WHAT CAN THE UNITED STATES LEARN FROM FOREIGN MODELS OF HEALTH RIGHTS JURISPRUDENCE?

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Part of the American dream is the idea that health care is a right, not a privilege. [FN1]

Introduction

With the employer-provided health care system eroding and prospects for a national solution dim, [FN2] advocates of expanded access to health care are once *1152 again invoking the idea of a right to health care. [FN3] For example, on November 8, 2005, 69% of Seattle voters approved a symbolic ballot measure that stated simply, “Every person in the United States should have the right to health care of equal high quality” and that Congress should “immediately implement” legislation to vindicate this right. [FN4] In March 2006, members of Tennessee's faith community engaged in three days of fasting and prayer to advocate for the poor's right to health care. [FN5] In New York, one commentator has called for a state constitutional amendment to “guarantee basic health care as a fundamental right to every resident.” [FN6] In the summer of 2006, advocates for the poor in Utah began circulating a petition to amend the state constitution to ensure medically necessary care for all citizens. [FN7] Most prominently, Massachusetts held a constitutional convention in July 2006 to consider an initiative amendment that would create a right to health care for all residents. [FN8]

*1153 The popular conviction that health care is or ought to be a right stands in stark contrast with the reality of health care provision in the United States. Nearly forty-six million non-elderly Americans, including nine million children, lacked health care coverage in 2004. [FN9] The rate of uninsurance is disproportionately high among minorities: 17% of Asian Americans, 21% of African Americans, and 32% of Hispanics are uninsured, compared to 11.3% of Whites. [FN10] The resulting costs to society are high. Uninsured individuals lose between 65 and 130 billion dollars annually in the form of increased morbidity and premature mortality. [FN11] The Institute of Medicine estimates that communities nationwide spend 35 billion dollars annually on uncompensated care for the uninsured. [FN12] Public disaffection with the current system and its dependence on shrinking employer-provided health benefits [FN13] is considerable. In a recent poll conducted by the Kaiser Family Foundation, Americans ranked health care as the third most important issue that the government needs to address, ahead of terrorism. [FN14]

It is generally accepted that no right to health or health care exists in the U.S. Constitution. [FN15] Some argue that even if a right to health or health care *1154 existed, it would not be justiciable because enforcement via the courts would be impossible without exceeding judicial competence, stretching separation of powers, and

undermining democratic accountability. [FN16] International experience, however, rebuts the argument that courts cannot, or should not, adjudicate social rights like the right to health care. Both South Africa and Canada have grappled with giving content to a legal right to health care, either constitutional (as in South Africa) or statutory (as in Canada). In three seminal cases, the South African Constitutional Court has both asserted and bounded its role in enforcing and giving content to this constitutional guarantee, ensuring fairness in access to health care and striking down a government policy decision in one exceptional instance. Canada has struggled to balance a statutory collective right to health care with constitutionally protected individual freedoms. The Canadian experience raises the specter of conflict between the legal decisions of the courts and the policy goals of the political branches of government. However, it also suggests that even where plaintiffs are unsuccessful, judicial elaboration of rights can propel government action to improve access to health care where it might otherwise be content to allow the status quo of unequal access to remain.

Americans believe that access to health care should not be limited to those who can afford it, [FN17] yet the federal government has not managed to ensure universal access to health care. Creating a judicially cognizable right to health care may effectively break the political stalemate and achieve universal access by requiring the government to take action. An affirmative legal obligation, either statutory or constitutional, to ensure access to health care (combined with judicial enforcement) would create the positive pressure needed to force the political branches to make the difficult decisions and compromises necessary to create a comprehensive health care system that they heretofore have proven reluctant to make.

This Comment forwards two propositions: First, that there are strong moral, political, and social arguments supporting the creation of a legal right to health care in the United States. Second, that the South African and Canadian experiences demonstrate a right to health care need not raise troubling problems of justiciability. Part I identifies the arguments for recognizing a legal right to health care. While the right to health care finds support in the concepts of effective citizenship and fair equality of opportunity, the Supreme Court has not recognized nor have the political branches ever implemented such a right, ***1155** notwithstanding strong and sustained public support. Nevertheless, the creation of an explicit right to health care, either by constitutional amendment or by statute, could provide the impetus needed to break the political logjam that has prevented the adoption of comprehensive national health care reform.

Part II challenges the main practical objection to enshrining a right to health care: the notion that such a right--like other social rights--is not justiciable. [FN18] A close examination of the South African and Canadian experiences in enforcing the right to health care demonstrates that this right is suited for judicial determination. Courts can effectively adjudicate the right to health care in three ways: by making transparent the decision making of the political branches; by directing them to acceptable means of implementation; and, in rare instances, by providing direct declaratory relief. [FN19] I conclude that the fear that a right to health care would strain judicial competence is not a sufficient reason to reject the creation of such a right.

I

Visions of the Right to Health Care

"Rights are not moral fruits that spring up from bare earth, fully ripened, without cultivation." [FN20]

To advocate the establishment of a new right, it is necessary to define the purposes of the right, outline its scope and meaning, and demonstrate the feasibility of its creation. Part I.A begins by describing the moral, polit-

ical, and social arguments for creating a right to health care. Next, Part I.B tackles the problem of suitably defining a right to health care such that it can be effectively implemented by the political branches and interpreted and elaborated by the judiciary. From there, Part I.C explores the Supreme Court's fleeting flirtation with locating social rights, like health care, in the Fourteenth Amendment. This Part concludes with an examination of how a right to health care could be created by constitutional amendment or by statute.

***1156** A. Justifications for the Right to Health Care

> "Right at this moment there's something going on in my body, but I can't afford to find out or at least have an idea of what's going on. So, I continue on, praying.
> Right now God is my only doctor." [FN21]

There are strong moral, political, and social arguments for a right to health care. Respect for human dignity and sensitivity to suffering demand a guarantee of health care. Health is of "foundational importance . . . for human happiness, the exercise of rights and privileges, and the formation of family and social relationships." [FN22] From a moral perspective, health is thus an essential prerequisite to autonomy and personhood.

The political ground for a right to health care is that it is instrumental for effective citizenship [FN23] and the exercise of other fundamental rights. [FN24] Effective citizenship requires not only civil rights like voting and freedom of speech, but also the satisfaction of basic needs. [FN25] Ill health may compromise or eradicate a person's liberty, autonomy, and exercise of the franchise. [FN26] Healthy citizens are more likely to engage in, and thus contribute to, a robust democratic process. [FN27] Put more broadly, civil and political rights and social rights are not distinct, but interdependent; the exercise of civil and political rights depends on the ***1157** fulfillment of social rights. [FN28] Essentially, by producing health, a right to health care promotes active participation in society by the greatest number of citizens.

There is a social argument to be made for the right to health care. Equal opportunity, a concept that justifies unequal outcomes in our society, requires equitable access to health care. [FN29] Under this line of reasoning, if every member of society has equal opportunity to achieve their life goals, inequalities in outcomes are the acceptable result of differences in skill, talent, effort and social capital, rather than merely moral luck. [FN30] For example, Norman Daniels explains that health care is requisite for maintaining normal functioning in society so that individuals may act within their normal opportunity range, [FN31] the "array of life plans reasonable persons in [a given society] are likely to construct for themselves." [FN32] While an individual's success, or share of the normal opportunity range, will depend on her skills or talents, fair equality of opportunity requires that individuals with the same skills or talents have the same opportunity. [FN33] Thus, although not every fleet-footed runner will become an Olympian, each is entitled to an equal opportunity to try, unhindered by external, morally irrelevant restraints. [FN34] When a person might have achieved Olympic status but for a preventable or curable disease or disability (that is, morbidity that could have been ameliorated by health care), equal opportunity is undermined. [FN35] If an individual is physically ill or mentally preoccupied due to a lack of access to health care, it will be more difficult for him to exercise effectively the privileges, and bear the responsibilities, of citizenship. If society demands equal opportunity to justify unequal outcomes, it can hardly do so when poor health care determines outcomes for many. [FN36] When society ***1158** mitigates moral luck by providing a right to health care, the social fabric is strengthened as citizens may accept unequal outcomes as fair rather than arbitrary.

B. Defining the Right to Health Care

Rights discussions can take place on at least three planes: the moral/philosophical, the aspirational, and the legal. On the moral plane, we might discuss Rawlsian justice: society should provide, according to need, the amount of health care that everyone would choose for himself if he could not know what his health needs, or ability to pay for health care, would be in the future. On the aspirational plane, a "right to health" can be thought of as a declarative goal: a government's commitment to achieve a progressively healthier society. On the legal plane, we might invoke international human rights treaties as grounds for a right to health care. [FN37] Discussions of such a right often focus on the moral/philosophical and the aspirational planes - and avoid the legal realm - because of the difficulty of precise definition. [FN38] For example, the problem of defining and implementing a right to health is three-fold: indeterminacy (how to characterize it), [FN39] justiciability (how to enforce it), [FN40] and progressive realization (how to raise the standard over time). [FN41]

A brief look at international declarations of the right to health illustrates these difficulties. International documents dating back to 1946 acknowledge health (and consequently health care) as a human right. [FN42] None of these, however, moves past the aspirational plane to impose concrete obligations. The World Health Organization (WHO) Constitution names "[t]he enjoyment of the highest attainable standard of health" as a "fundamental right [] of every human being." [FN43] The WHO has clarified this definition over time to create a "right to ***1159** primary health in accordance with the ability of the state and the international community to provide it." [FN44]

Article 25 of the Universal Declaration of Human Rights proclaims, "[e]veryone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care." [FN45] The International Covenant on Economic, Social, and Cultural Rights (CESCR) outlines affirmative health goals for ratifying states. Specifically, Article 12 calls for parties to "recognize the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." [FN46] The Article specifies that ratifying states should take steps to achieve this standard through "the creation of conditions which would assure to all medical service and medical attention in the event of sickness." [FN47]

Unfortunately, these international declarations of rights to health and health care either include mere suggestions for enforcement or have no schemes for domestic enforcement at all, and thus have no "bite." [FN48] While these documents may offer moral direction for policymaking to international organizations like the WHO, they provide no protection for individuals seeking access to health care. [FN49] An American, certainly, would find it absurd to demand the government provide access to health care based on rights enumerated in the Universal Declaration of Human Rights in any forum other than that of public opinion. In other words, an American could in fairness declare, "I have a human right to health care but the law gives me no means of enforcement."

Distinguishing between the right to health and a right to health care helps to solve the indeterminacy problem. By guaranteeing health care rather than health, the government binds itself to providing services rather than guaranteeing good health. Defined narrowly, health is the absence of disease. [FN50] ***1160** More broadly, the WHO defines health as "the state of complete physical, mental and social well-being." [FN51] Health depends on a number of determinants: nutrition, education, social and economic development, the absence of environmental contaminants, public health services, access to medical care, genetic predisposition, and individual choices. [FN52] Health care, on the other hand, is an instrument for the generation of health: "any type of services provided by professionals or paraprofessionals with an impact on health status" or, in an economic framework, the "goods and services used as inputs to produce health." [FN53] In the United States, we tend to think of

health care as equivalent to medical care, [FN54] whether preventive, primary, or specialized. Thus, in the U.S. we could understand the right to health care as a right to particular medical services.

Because a right to health care can be defined more narrowly than an aspirational right to health, it is suitable for adjudication. A right to health implies that every person is entitled to perfect health. [FN55] Although perfect health may be achievable at some point in the future, it is not a realistic benchmark against which to adjudicate a right. [FN56] A right to health care, by contrast, entitles right-holders to the "goods and services" that aid in the achievement of health and, consequently, obligates the government to ensure access to these goods and services. A right to health care may be defined as equality of access: whatever health care resources society provides must be provided to everyone on an equal basis. Alternatively, the right could be defined as the right to a basic minimum of health care necessary to function in society, making the right to health care a welfare right. [FN57]

Defining the right to health care is complicated because health care is unlike other goods. Although everyone values health, people do not know how much health care they need to ensure health. [FN58] In addition, the demarcation of a ***1161** legally enforceable right to health care inevitably raises the politics of distribution as more health care for one means less health care (or more taxes) for another. [FN59] Even so, there is no reason why elaborating the right to health care should be different from developing jurisprudence of any other right. As Stephen Jamar asserts, the process of infusing a right to health or health care with meaning is no different from the process of infusing freedom of speech with meaning. [FN60] He explains:

> [J]ust as the right to free speech is not the same as speech itself, so the right to health is not the same as health itself. Just as 'speech' has been expanded to include non-verbal expression and restricted to exclude from protection some kinds of speech, and just as 'equality' may mean equal opportunity under law, so 'health' may well take on a specialized meaning different from either its common or its public policy usages. [FN61]

Though the right to health care might seem vague, it is possible to delineate the characteristics of a health care system that would constitute fulfillment of this right. [FN62] Daniels, Light, and Caplan use the fair equality of opportunity principle [FN63] to establish benchmarks for evaluating the fairness of the health care system, including universality of access, comprehensiveness of coverage, equitable financing, value for money in quality and efficacy, financial efficiency, public accountability, comparability, and degree of choice. From these benchmarks, they demonstrate that the task of establishing a values-driven health care system based on a right to health care is not insurmountable. [FN64] For this Comment, it is sufficient to assume that health care is a definable basket of goods and services around which it is possible to construct a right-based jurisprudence. The practical task of designing a health care system based on these principles remains with the legislature. The role of the courts is to enforce the right to health care as they enforce other rights.

***1162** C. Why Does the Constitution Lack a Right to Health Care?

1. Lost Opportunity: Looking for a Right to Health Care in the Fourteenth Amendment

Despite the moral, citizenship, and equal opportunity rationales for a right to health care, the Supreme Court has not recognized health care as a constitutional right. [FN65] For a time in the 1960s and 1970s, it seemed highly possible that the Court would do so. [FN66] Frank Michelman, writing in 1969, noted a "reawakened sensitivity" on the part of the judiciary "not to equality, but to a quite different sort of value or claim that might better be called 'minimum welfare.'" [FN67] Professor Michelman asserted that the Supreme Court had determ-

ined that various kinds of economic inequality were anathema to constitutional guarantees. The Court consequently had begun to, and would continue to, "move us towards a condition of economic equality." [FN68] In Professor Michelman's view, the Court was clothing its interest in "minimum welfare" (akin, somewhat, to fair equality of opportunity) in the language of equality in order to justify its holdings under the Fourteenth Amendment. [FN69]

Thus, for example, the Supreme Court invoked citizenship and equal opportunity rationales in discussing due process in the welfare context. In Goldberg v. Kelly, which held that due process rights attach to welfare benefits, the Court stated:

> [f]rom its founding the Nation's basic commitment has been to foster the dignity and well-being of all persons within its borders. . .Welfare, by meeting the basic demands of subsistence, can help bring within the reach of the poor the same opportunities that are available to others to participate meaningfully in the life of the community. . .Public assistance, then, is not mere charity, but a means to "promote the general Welfare, and secure the Blessings of Liberty to ourselves and ***1163** our Posterity." [FN70]

Although the Court recognized the obligation of "meeting the basic demands of subsistence," it declined to use it to impose any affirmative duty, instead holding only that the state must distribute any assistance it chooses to provide in a non-arbitrary manner. In doing so, the Goldberg Court praised public assistance generally without finding that the government had a positive obligation to provide resources or that citizens had a fundamental right to receive them. While the rhetoric seemed to herald a constitutional right to "minimum welfare," the Goldberg Court did not find one.

The Supreme Court's limited decisions in Shapiro v. Thompson and Memorial Hospital v. Maricopa County further demonstrate the feebleness of the Fourteenth Amendment as a foundation for the right to health care. In Shapiro, the Court struck down one-year residency requirements for state welfare benefits, declaring them impermissible restraints on the right of interstate travel and an "invidious classification," apparently between two classes of indigents: those resident for more than twelve months and those resident for fewer than twelve months. [FN71] Building on the foundation laid in Shapiro, the Court in Maricopa County struck down an Arizona law imposing a similar residency requirement for non-emergency medical treatment for indigents. Analogizing to Shapiro, the Court in Maricopa County reasoned that it:

> would be odd, indeed, to find that the State of Arizona was required to afford [an indigent person] welfare assistance to keep him from discomfort of inadequate housing or the pangs of hunger but could deny him the medical care necessary to relieve him from the wheezing and gasping for breath . . . . [FN72]

What is truly odd about the Shapiro and Maricopa County decisions is that, in spite of recognizing the fundamental importance of food, shelter, and medical care to participation in society, their holdings rest on "invidious classifications" and impermissible burdening of the right to travel. [FN73] The underlying concerns about sustenance and deprivation raised by the Justices are not central to their holdings. For example, in Maricopa County, Justice Thurgood Marshall contends that providing non-emergency medical assistance to indigents is wise because it relieves the burden of uncompensated care on private hospitals and individuals with health insurance, saves money in the long run as healthy indigents are more likely to work and not need welfare assistance, and prevents unnecessary suffering. [FN74] While these are powerful policy justifications for ensuring access to health care, they do not support the ***1164** constitutional finding of a violation of equal protection under the Fourteenth Amendment, given that the Court relies on the distinction between resident and non-resident indigents as "the evil to be curbed" "rather than nonsatisfaction of a particular want." [FN75]

These cases demonstrate that under existing jurisprudence the Fourteenth Amendment provides only anemic support for the right to health care. First, even if interpretations of the Fourteenth Amendment that demand remedies for economic inequalities have merit, they do not fit the right to health care. For example, Kenneth Karst has argued that equal citizenship, a "guiding principle" of equal protection clause interpretation, "call[s] for judicial intervention when economic inequalities make it impossible for a person to have a 'fully human existence' and the political branches of government turn a blind eye." [FN76] This highlights a key difficulty in using the Fourteenth Amendment to formulate a right to health care. Only where the political branches have turned "a blind eye" to inequality may the Supreme Court step into the breach. Fitting health care into this kind of analysis would prove difficult. Medicare and Medicaid already provide health care for the oldest, the sickest, and the poorest, while lack of health insurance remains a significant problem for working families, the middle-class, and the near-poor who do not qualify for government benefits. [FN77] ***1165** It would be difficult to demonstrate that the federal government has completely ignored stark inequalities in health disproportionately affecting the poor. Unlike other welfare rights, which remedy stark inequalities felt disproportionately by the poor, a right to health care would remedy a problem faced by Americans from many socioeconomic classes. Thus, even if the Court were willing, the Fourteenth Amendment might be a poor home for a right of all Americans to health care.

Second, in practical terms, the Supreme Court retreated from visions of the Fourteenth Amendment that imposed an obligation on government to provide for minimum welfare soon after opening the door to them. In Dandridge v. Williams, [FN78] the Court held that decisions regarding the content of welfare benefits should be subject to rational basis review, not strict scrutiny. [FN79] In that case, the Court refused to intervene when the State of Maryland imposed a cap on welfare benefits that meant that some large families received the same benefit as smaller families, without regard to their greater needs. [FN80] The Court concluded that while the Constitution may demand procedural safeguards for the provision of state benefits, as it held in Goldberg, that "does not empower this Court to second-guess state officials charged with the difficult responsibility of allocating limited public welfare funds among the myriad of potential recipients." [FN81] While this "judicial hesitancy to establish an equal protection doctrine that impels massive governmental expenditures is . . . understandable," [FN82] it means that "the theory that economic status precluding access to health care imposes affirmative governmental obligations" [FN83] is dead. Unless the Supreme Court radically changes course, it is unlikely that a constitutional right to health care can be found in the Fourteenth Amendment. In sum, the Fourteenth Amendment does not now provide for a right to health care, and its focus on formal equality rather than on deprivation makes it a poor vessel for such an entitlement.

2. Arguments for a Legal Right to Health Care

Some have argued, "[I]t is fruitless and even dangerous to look to the courts for the first and last word on any matter concerning the vindication of fundamental societal values." [FN84] Yet, absent a judicially enforceable right to health care, can we expect the political branches of government to implement comprehensive access to health care? Anyone familiar with the sorry history of health care proposals throughout the twentieth century cannot be blamed for ***1166** displaying a great deal of cynicism about the prospects of comprehensive access to health care in the near future. After describing the history of failed proposed reforms, the remainder of the Section suggests how a legal right to health care, whether constitutional or statutory, could propel Congress finally to make the necessary compromises essential to creating a system of comprehensive health care coverage.

Health care is a perpetual loser in the political system. The failed attempts at comprehensive health care reform throughout the twentieth century [FN85] suggest that legislative action is unlikely to establish universal access to comprehensive health care in the foreseeable future. As early as 1912, President Theodore Roosevelt

made health care a plank in his presidential platform. [FN86] Health care was considered in early versions of the Social Security Act, but was eliminated in part to ensure that the retirement benefits portion would pass. [FN87] In 1944, President Franklin D. Roosevelt called for a "Second Bill of Rights," including "the right to adequate medical care and the opportunity to achieve and enjoy good health." [FN88] President Harry Truman made a stirring health care address calling for universal coverage in November 1945. Notably, his plan called not for a health care benefit for the needy but a plan to include all classes of Americans. [FN89] The program faced immediate resistance from doctors' groups and fell prey to Cold War hysteria, including a fear of "socialized medicine," once the Republicans took control of Congress in 1946. [FN90]

Abortive attempts at statutory reform continued in the post war period. In ***1167** 1956, President Eisenhower praised market-based health care reform as a way to achieve universal access. [FN91] President Kennedy pushed for health care coverage and his efforts partially paid off, posthumously, with the passage of Medicare and Medicaid in 1965. [FN92] In 1970, there was a strong push in Congress for the Kennedy-Griffiths Bill, a single payer plan. [FN93] In 1974, President Nixon proposed a plan for universal coverage via group purchasing that was soundly rejected by those on the left, with some accusing him of attempting to use the plan to divert attention from the Watergate scandal. [FN94] By 1979, President Carter made only feeble efforts to pass his campaign proposal of a national health plan. [FN95] The 1990 Pepper Commission suggested a "play-or-pay" solution not dissimilar to the program put forward by President Nixon some sixteen years earlier. [FN96] President George H.W. Bush pushed for health care reform in his final state of the union address. [FN97] President Clinton's Health Security Act, considered in 1993 and 1994, proved to be a colossal policy and political failure. [FN98]

3. A Constitutional Right to Health Care.

As the Supreme Court is unlikely to find a right to health care hidden in constitutional penumbrae, the creation of a constitutional right to health care would require an amendment. Even Cass Sunstein, who does not support grounding social rights in the Constitution, [FN99] acknowledges that to those ***1168** looking to establish social rights, "it might well be hazardous to rely on ordinary political processes. Consider the mixed and in some ways disgraceful record of the United States, permitting violations to persist amid great plenty. For example . . . tens of millions of citizens lack decent health care." [FN100] Indeed, instead of ensuring access to health care by undertaking comprehensive reform, successive Congresses have enacted a hodgepodge of laws that provide piecemeal access to health care for the elderly, [FN101] the very poor, [FN102] some children, [FN103] and people in need of emergency care or women about to give birth, [FN104] leaving millions without coverage.

Yet would an explicit constitutional right to health care make a difference in access to health care or health outcomes? Empirical data and comparative law suggest that it might not. At least one investigator finds no correlation between a constitutional right to health or health care and government commitment to universal coverage or to health outcome indicators like infant mortality and life expectancy. [FN105] Even though more than two-thirds of the constitutions of countries around the world include some statement regarding health and health care, [FN106] many of these constitutional statements are aspirational. Unlike constitutional designations of civil and political rights, they are not self-executing. [FN107] Generally, these constitutional commitments do not endow individuals with corresponding legal rights. [FN108] They merely recommend that the government strive towards achieving a healthy society. [FN109] A notable exception is South Africa's Constitution, described in detail below, which includes a specific right to health care. [FN110]

***1169** These problems would not plague the proposed right to health care. In the United States, constitutional language imposes restraints and obligations on the government, rather than functioning as a mere recommendation. In proposing a health care amendment to the Constitution in 2005, one Congressman summed up the argument this way: “health care is a human right, but it only becomes an American right--except for Supreme Court interpretation and precedent--if it's in the Constitution.” [FN111] Similarly, advocates of a state constitutional health care amendment in Massachusetts believe that the amendment will produce universal health care. Supporters see the amendment as “creating the legal and political framework for reaching a realistic, sustainable solution to the health care affordability crisis.” [FN112] Entrenching a constitutional right to health care in the U.S. Constitution would therefore be more effective in producing access to health care than the aspirational declarations found in foreign constitutions. [FN113]

Of course, passing a constitutional amendment is a Herculean and rarely achieved feat, subject to the same political vicissitudes that heretofore have prevented the establishment of comprehensive health care. Yet the Massachusetts example raises another possibility of how a constitutional amendment or the threat thereof can be effective in producing political action on health care. Although political maneuvering prevented the proposed amendment from being put to the state's voters for ratification, [FN114] the legislature and governor did agree to create a statewide system for comprehensive access to health care. [FN115] The effect of the push for a state constitutional amendment on the passage of the legislation is not certain. Nevertheless, it is not improbable to speculate that the political branches of the ***1170** state government preferred to hammer out a compromise on their own terms rather than face a constitutional mandate. [FN116] A constitutional right to health care in the United States, or perhaps even the threat of a constitutional amendment, would force political action to break the special interest logjam that has bedeviled efforts at health care reform by obligating Congress to address health care comprehensively. [FN117]

An added benefit is that the prospect of judicial elaboration of a health care right would elevate the importance of health care policymaking and the underlying values of effective citizenship and equality of opportunity. [FN118]

4. A Statutory Right to Health Care.

A legal right to health care need not be constitutional in nature. It could be created by statute. A statute could declare the broad outlines of a right to health care, setting the stage for the creation of a comprehensive system of universal access to health care. For example, Congress could pass legislation akin to the Canada Health Act, which requires the provinces to provide health care that is universal, accessible, portable, comprehensive and publicly administered, in return for federal funding. [FN119] Although the Act subsequently has been elaborated by legislation and judicial interpretation, it set the foundation for comprehensive access to health care. In the United States, this approach would have the advantage of capitalizing on the popular consensus that Congress should act on the problem of access to health care [FN120] without presenting the obstacles of constitutional amendment.

***1171** In essence, it may be easier to adopt a general statement of a right to health care, either constitutional or statutory, than it has proved to pass legislation to create universal access to health care. [FN121] At the federal level, such a declaration of a right to health care could be effective in creating universal access to health care by imposing a concrete, judicially enforceable obligation on the political branches. An explicit, textual right to health care would drive comprehensive and specific governmental action.

Part I has reviewed the desire for health care in the U.S. and the moral, practical, and political reasons to guarantee it. It has surveyed nearly a century of abortive attempts to establish comprehensive health care. Finally, it has traced the jurisprudence that seemed to point toward a Fourteenth Amendment protection of minimum needs, as well as the Supreme Court's retreat from that horizon. The next Part addresses fears about a legal right to health care. By examining the experiences of South Africa and Canada this Comment shows that a right to health care can be successfully adjudicated.

II

A Justiciable Right to Health Care: Examples From Canada and South Africa

In addition to the question of how a right to health care ought to be created, the question remains as to how a court might enforce such a right. A frequent refrain in discussions of social rights is that such rights are not justiciable; critics assert that legal adjudication of a seemingly indeterminate right undermines democratic accountability, violates separation of powers, and exceeds the institutional competence of courts. [FN122] Some commentators express the concern that expanding legal rights to include a right to health care, a relative rather than an absolute right, [FN123] would water down the narrow meaning of legal concepts, increasing confusion by eliminating precision in legal discourse. [FN124] In this view, social “rights” may not deserve the designation because they are more properly seen as privileges or entitlements. [FN125] Further, it ***1172** may be unclear who possesses the right and how and when rights-holders may enforce it. Unlike a private health insurance contract between provider and patient, which yields legally enforceable contractual obligations, health care as a right is bound to raise difficult questions of who has standing to enforce the right, the extent of the right, and the proper remedies. [FN126]

These concerns about the justiciability of a right to health care emerge in part from the fact that the American Constitution is a constitution of negative rights, limited to political and civil rights to be free of government restraint. The Constitution is an early constitution, which defines inherent rights (i.e. rights that antecede government, upon which government may not infringe) [FN127] unlike later constitutions (e.g. nineteenth century European constitutions), which “granted” citizens positive rights defined and provided by the state. [FN128] The latest generation of constitutions, emerging from the post-socialist period, includes collective human rights, rights that depend on a shared vision of societal good. [FN129] Unlike the American Constitution, which aimed to achieve freedom and autonomy through specifically enumerated rights endowed in individuals, more modern constitutions include “positive” social rights aimed at achieving equality without the expectation of individual enforcement via the courts. [FN130]

There are two reasons that the skepticism of an enforceable right to health care is unfounded. First, sharp distinctions between civil and political rights and social rights seem increasingly inapt in the face of modern examples. [FN131] Health care “is a good example of a human right that falls within the categories of both civil and political rights, on the one hand, and economic, social, and cultural rights, on the other hand.” [FN132] The same action may violate both civil rights and the right to health care. [FN133] For example, denial of health care to the ***1173** incarcerated could simultaneously violate the Eighth Amendment's prohibition of cruel and unusual punishment [FN134] (a civil right) and the prisoners' right to maintain health by obtaining necessary medical care (a social right). A comprehensive vision of the right to health care is simultaneously positive and negative because society must act to promote the health of its members while also avoiding actions that interfere with their ability to maintain good health. The sharp distinction between civil and political rights as judicially en-

forceable and social rights as unenforceable is thus not accurate, particularly in the context of health care.

Second, hostility to a right to health care is unwarranted because U.S. courts already have a substantial policymaking role. Even the American constitutional regime envisions "courts as governors [via] judicial review of legislative action." [FN135] We are accustomed to the elaboration of legislative policy via judicial holdings interpreting and enforcing legislative enactments. From labor rights to the right to clean water, Americans are untroubled by seeking legal enforcement of legislatively created social rights. [FN136] As government increasingly makes social and economic objectives its business, the judiciary necessarily has become involved in outlining and interpreting the meaning of these objectives. [FN137]

The U.S. can learn from two nations with a great deal of experience with adjudicating the right to health care: South Africa and Canada. In the sections that follow, I explore the South African and Canadian approaches in giving meaning to the right to health care. Together, the experiences of these two countries demonstrate the feasibility of a legal right to health care-- notwithstanding the considerable challenges. The burgeoning jurisprudence of social rights in South Africa demonstrates that the traditional distinction between civil and political rights as justiciable and social rights as nonjusticiable does not hold. The South African experience over the last decade illustrates the feasibility of legal adjudication where a society, its judiciary, and its Constitution explicitly accept that the state has affirmative obligations to its citizens. Further, the South African case illustrates that the court must balance some of these rights against the reality of resource limitations, and that the judiciary is competent to ensure both substantive and procedural fairness. The justiciability of social rights depends on the societal acceptance of these rights followed by the judiciary's willingness to find a way to adjudicate them, rather ***1174** than simply deferring to other branches of government. [FN138]

The Canadian experience also demonstrates how social rights can be successfully adjudicated. However, it shows the significant challenges in effecting a legal right to health care. On one hand, advocates have used the Charter of Rights and Freedoms' equality guarantee with some success to expand access to health care to specific minorities and in prodding the provincial governments to deal with pressing health issues. On the other hand, the right is subordinate to others. Several cases have demonstrated that constitutional civil and political rights can undermine the right to health care where, as in Canada, that right does not possess equal constitutional stature. These cases demonstrate that civil and political rights may trump the right to health care. On balance, the subordination of the right to health care is a greater challenge than the fear that a legally enforceable right to health care will result in the judiciary improperly usurping the role of the legislature.

A. South Africa: The South African Bill of Rights and the Constitutional Right to Health Care

The South African Bill of Rights includes not only "freedoms from" government restraint, but also "rights to" the foundations of human dignity and equality, including housing, health care, and social security. [FN139] It explicitly recognizes socioeconomic rights and renders them enforceable in South Africa's courts. [FN140] The judiciary has taken up the challenge of infusing socioeconomic rights with legal meaning, providing an important enforcement mechanism to the sometimes-reluctant political branches of government. [FN141] The Constitutional Court has addressed accountability, institutional competence, and separation of powers in the context of adjudicating social rights. [FN142] In doing so, the Court squarely rejected the argument that adjudication of social rights violates separation of powers by empowering courts to dictate policymaking decisions and budget allocations. All judicial decisions, according to the Constitutional Court, "carry budgetary implications [and] much judicial review makes social policy." [FN143] Adjudication of social ***1175** rights presents no novel threat

to separation of powers.

Section 27 of the South African Constitution is an explicit right to access to health care. [FN144] Section 27(1)(a) requires that health care be delivered equitably while section 27(2) imposes an affirmative obligation on the government to provide access. Section 27 as a whole marks an intersection between the civil and political (the individual) and the social and economic (the collective). [FN145] This right to access to health care is both negative and positive. It is at the same time a "right to" access to basic health care services and "freedom from" government denial of emergency medical treatment. In creating a constitutional right that both frees citizens from the burdens of discrimination and entitles them to social and economic protections, Section 27 of the South African Constitution of 1996 "is an affirmation of the confluence between civil/political rights and socioeconomic rights and, thus, challenges the classical liberal assumption that the latter are too polycentric and too politically charged to be amenable to adversarial adjudication." [FN146]

The Constitutional Court itself considers settled the question of whether social rights are justiciable. It views its task as determining how best to enforce these rights on a case-by-case basis. [FN147] In elaborating social rights, the Constitutional Court has made clear that the judiciary can adjudicate social rights by: (1) making transparent the government's decision-making process in the allocation of scarce resources; [FN148] (2) calling the state's attention to acceptable means of fulfilling its constitutional obligations; [FN149] and (3) providing direct declaratory relief where the government clearly infringes on these rights. [FN150] Through these means, social rights are more than guideposts or aspirations but the court does not become a super-legislature.

***1176** 1. Creating Transparency in the Government's Decision-making Process

The South African Constitutional Court first considered the content of the constitutional right to health care in Soobramoney v. Minister of Health (KwaZulu-Natal). [FN151] In this case, a forty-one year old man suffering from renal failure ran out of funds to pay for private renal dialysis. [FN152] He applied to the renal unit of the state hospital but was denied access. [FN153] Because it had a limited number of dialysis machines, [FN154] the hospital provided dialysis only to those whose renal failure could be cured by dialysis or those for whom dialysis served as a stopgap to kidney transplantation. [FN155] Mr. Soobramoney's precarious health made him unsuitable for transplantation and thus ineligible for dialysis in the state hospital. He brought suit, claiming the hospital's refusal to provide him dialysis, without which he would die, amounted to a denial of emergency care in violation of Section 27(3). [FN156]

In rejecting Mr. Soobramoney's appeal, the Court deferred to the political branch, declaring:

> . . .[t]he state has to manage its limited resources in order to address all these claims [to health, housing, shelter, and employment]. There will be times when this requires it to adopt a holistic approach to the larger needs of society rather than to focus on the specific needs of particular individuals within society. [FN157]

Holding that Section 27(3) could not reasonably apply to terminally ill patients, [FN158] the Court lamented, "At present the Department of Health in KwaZulu-Natal does not have sufficient funds to cover the cost of services which are being provided to the public . . . there are many more patients suffering from chronic renal failure than there are dialysis machines to treat such patients." [FN159] It deferred the resource allocation decisions to the legislature, who must be responsible for the "difficult decisions" regarding how to fund health services and which services to provide. [FN160]

The Constitutional Court established that the right to access to health services is necessarily constrained by

resource limitations, but its analysis did ***1177** not end there. [FN161] The majority opinion and two concurring opinions hone in on a notion of collective and holistic decision making about the right to health care. While the Court acknowledged that the right to access to health care is not absolute, it did not close the door on future judicial elaboration of the right. The majority opinion, for example, reaffirmed the state's duty to achieve progressive realization of Section 27, while allowing that in this case, the political branches' reasoned decision not to provide an expensive treatment did not violate this duty. [FN162] Instead, as Justice Sachs contended in a concurring opinion, "health care rights by their very nature have to be considered not only in a traditional legal context structured around ideas of human autonomy but in a new analytical framework based on the notion of human interdependence." [FN163] With this framework, the Court handed Mr. Soobramoney a defeat [FN164] but also required the government to answer about how it had observed his Section 27 rights. It opened the door, in future cases, to require further action from the state if it violated the right to health care.

In Justice Sach's view, the judiciary can only give meaningful content to the right to health care by acknowledging that a traditional, individual-focused rights analysis will often lead to the wrong conclusions. [FN165] Vindicating Mr. Soobramoney's putative right to prolongation of his life via state-provided renal dialysis would necessarily mean cutting back on health care services for other citizens. Some of these treatments might be health-restoring rather than simply death-delaying. If the court were to rule for the individual, noting only the impact on him, it would diminish the right to access of other South Africans not bringing claims. Justice Sachs underscored this point, asserting:

> Traditional rights analyses accordingly have to be adapted so as to take account of the special problems created by the need to provide a broad framework of constitutional principles governing the right to access to scarce resources and to adjudicate between competing rights bearers. When rights by their very nature are shared and interdependent, striking appropriate balances between the equally valid entitlements or expectations of a multitude of claimants should not be seen as imposing limits on those rights. . .but as defining the circumstances in ***1178** which the rights may most fairly and effectively be enjoyed. [FN166]

Soobramoney, therefore, undercuts many of the concerns raised by those who object to the creation of constitutional rights to health and health care. The savvy court will acknowledge its institutional limitations in determining the correct array of policy priorities and implementation schemes, as the Constitutional Court did in Soobramoney when it explicitly acknowledged its inability to choose, in any fairer way than that chosen by the political branches, which patients should receive renal dialysis. [FN167] Although the Court did not order the government to take a specific action, the challenge itself forced the government to describe the policy, explain its decision making and trade offs, and reevaluate whether the policy accorded with its constitutional obligations. In answering the challenge before the Court, the government answered for its policy to the public as well. This case, therefore, established a standard of transparency in government decision making that might not be achieved absent a justiciable right.

2. Signaling to the Legislature that Social Rights Are Binding

In cases subsequent to Soobramoney, the South African Constitutional Court has infused the right to access to health care with meaning and carved out a stronger role for judicial review of governmental action. In Government of the Republic of South Africa v. Grootboom, [FN168] addressing a claim by squatters that their eviction from empty land constituted a violation of their right to housing (Section 26) [FN169] and of the right of the child to shelter (Section 28), [FN170] the Constitutional Court held that the state's efforts to implement social rights must be (1) reasonable, (2) aimed at achieving progressive realization, and (3) within the state's available resources. [FN171] The plaintiff, Irene Grootboom, and her family occupied privately held land intended for a

low-income housing ***1179** development. They were evicted and consequently made homeless. [FN172] They could not return to their previous shelter, in a shanty settlement, because others now occupied their space. [FN173] Mrs. Grootboom's family erected plastic sheeting on a sports field, which proved to be inadequate shelter from the rain. [FN174]

More forcefully than in Soobramoney, the Constitutional Court in Grootboom declared that the constitutional language allowing for the progressive (as opposed to immediate) realization of social rights was not simply a way for the legislature to claim poverty as a reason for not effectuating the right to housing, health care, and other social rights. Progressive realization provides the legislature with some flexibility but it obligates the state to act affirmatively to achieve greater social rights. [FN175] The duty of progressive realization renders "retrogression . . . constitutionally unacceptable." [FN176] In this particular case, however, the Court found that the State's ongoing program of organized low-income housing development met its obligation under Section 26(2). [FN177] Again, the Court did not sit as a super-legislature nor did it attempt to determine legislative facts but it did signal to the political branches that their obligations under Section 26 were not merely aspirational. The Court clarified the government's obligations to work toward the progressive realization of social rights while leaving it to the government to determine how to meet this obligation. Thus the South African court showed that the judiciary has the institutional competence to implement social rights.

3. Providing Declaratory Relief Only Where Absolutely Necessary

In Minister of Health v. Treatment Action Campaign, [FN178] the Court used a more robust form of judicial review to require the state to act. This case demonstrates that the Constitutional Court will intervene to overturn a policy decision in egregious circumstances. In Treatment Action Campaign, the Court found the state violated its constitutional obligations under Section 27 by refusing to extend access to antiretroviral drugs to HIV-positive pregnant women when the drug manufacturer offered to provide them for free. [FN179] In doing so, the Court found patently unreasonable the government's choice to limit antiretroviral treatment to a few test clinics, despite the drug's demonstrated efficacy in preventing mother-to-child HIV transmission. This refusal unfairly excluded "those who could reasonably be included" within ***1180** available resources. [FN180] The Court held that Sections 27(1) and (2) required the government to implement a program of prevention of mother-to-child HIV transmission within its available resources. [FN181] Nevertheless, the Court's direct intervention in this case represents the exception rather than the rule.

Notably, the South African Constitutional Court has persistently refused to define a minimum core obligation to provide health care. The Court's refusal demonstrates that judicial restraint can effectively maintain separation of powers. The Court may have limited itself because the legislature was better equipped to digest the great quantity of information specific to the context of the right to health care that determines the "minimum threshold for the progressive realization" of any social right. [FN182] The Court first rejected the minimum core notion in Grootboom and elaborated its rationale in Treatment Action Campaign: a judicial establishment of a minimum core of state obligations would require it to directly impinge on the executive and legislative functions and stretch beyond its competence by weighing social rights against each other. [FN183] Nevertheless, as one commentator has noted, the government's "failure to act rationally and urgently when millions of lives hang in the balance seems to demand the invocation of protections at the heart of South Africa's constitution[]." [FN184]

Soobramoney, Grootboom, and Treatment Action Campaign had significantly different outcomes for the individuals challenging government action, but the cases were all successful in one important respect: the plaintiffs forced the government to justify its policy decisions. Soobramoney, for example, was of intense public

interest in South Africa as the country was just beginning to live under a new regime of constitutional rights. Although the Constitutional Court did not order the government to take additional action, the bright light of the Court's attention forced the government to describe the policy, explain its decision-making process, and reevaluate whether the policy accorded with its constitutional obligations. Similarly, in Grootbroom, while the Court did not remedy the Grootbrooms' immediate problem of homelessness, it signaled to the government that constitutional social rights are not merely aspirational. Its careful scrutiny of the government's housing policy signaled to the political branches that they must actively pursue the progressive realization of social rights--that they are "binding obligation[s]." [FN185] These cases establish a standard of transparency in government decision making that ***1181** might not have been achieved absent judicial review. Finally, in Treatment Action Campaign, the Constitutional Court's ruling gave teeth to the Section 27 health care right by holding that while the government has a wide range of discretion, it does not have the discretion not to act in certain cases.

In summary, the South African approach has been to take the middle way-- constitutional socioeconomic rights are neither merely declaratory, nor as individually enforceable as civil and political rights. [FN186] The South African Constitutional Court rejected attempts to convert constitutional socioeconomic rights into individual rights requiring the immediate provision of certain government services. At the same time, the Court also refused to leave the protection of socioeconomic rights entirely to the political branches. It has instead intervened in a manner necessary to propel the political branches to meet their obligation to work toward the realization of constitutional social rights.

B. Canada: The Canadian Charter of Rights and Freedoms and the Canada Health Act

South Africa's Constitutional Court has worked to give meaning to a constitutional right to health care in the context of resource constraints. In Canada, the judicial calculus is different because there is no constitutional right to health care. [FN187] Nevertheless, most Canadians "believe access to medically necessary health care services is a 'right of citizenship.'" [FN188] The Canadian commitment to providing its citizens with health care emerged in the early twentieth century and was firmly ingrained in culture and law by the 1960s. [FN189] That commitment to health care culminated in the Canada Health Act of 1985, which is, in essence, a contract between the federal government and the provinces. In exchange for federal financing, the provinces agree to provide health care that is comprehensive, universal, portable, accessible, and publicly ***1182** administered. [FN190] Despite its non-constitutional status, the Canada Health Act "has achieved an iconic status that makes it untouchable by politicians." [FN191]

Despite its popularity as an entitlement, the government's statutory obligation to provide health care remains subject to the vicissitudes of ordinary legislation. [FN192] Civil and political rights, on the other hand, have constitutional status in the Charter of Rights and Freedoms. [FN193] The resulting interplay between the collective commitment to health care in the Canada Health Act and the individual rights and freedoms constitutionally protected by the Charter has produced somewhat surprising results. Specifically, where constitutional civil and political rights conflict with a provincial government policy that effectuates the collective statutory right to health care, the constitutional right trumps. Thus, the preferential protection of constitutional civil and political rights poses challenges for achieving the collective commitment to universal health care.

Some Canadian commentators have bemoaned the dangers of Charter challenges for the same reasons those in the United States might be concerned: the judiciary that would be interpreting these rights is a countermajoritarian, non-democratic institution. However, in Canada's experience, the judiciary's interference with the policy

prerogatives of the political branches has been limited. [FN194] In two-thirds of cases where the Canadian Supreme Court invalidated legislation for breach of the Charter, the Canadian Parliament subsequently amended the law to eliminate the Charter problem and achieved the original intent of the legislation. [FN195] Thus, in its first two decades, the Charter of Rights and Freedoms has "act[ed] as a catalyst for a two-way exchange between the judiciary and legislature on the topic of human rights and freedoms, but it rarely acted an absolute barrier to the wishes of democratic institutions." [FN196] Because the Court's decisions generally have left room for the ***1183** legislature to amend the law to protect Charter freedoms and yet still achieve the original objectives, the Court's involvement in this area withstands charges that it undermines democratic legitimacy. [FN197]

The Sections that follow describe how Charter challenges can both strain and strengthen the collective commitment to health care. The first Section describes how Charter rights pressed by individual rights-holders can present challenges for provincial policy-makers. Specifically, when a government policy aimed at pursuing the collective right to health care clashes with an individual Charter right, the Charter right will prevail. This forces the political branches back to the drawing board to meet the challenge of devising policy that provides fair access to health care without impinging on individual rights. Next, this Comment explores how Charter challenges have the potential, particularly those based on the Charter equality guarantee, to help ensure that citizens have fair and equal access to health care. In these cases, although most plaintiffs do not prevail, the government nevertheless seems to be motivated by the threat of judicial review to justify and adapt its policies to the demands of citizens. The Canadian example demonstrates that a right to health care is determinable and justiciable. At the same time, the Canadian experience highlights the challenges the United States would face if it enacted a statutory, rather than a constitutional, right to health care.

1. Straining the Collective Commitment to Health Care

Despite the centrality of health care policy--health is the single largest area of public spending in Canada--only thirty-three Charter challenges to health care policies have reached the Canadian Supreme Court between 1985 and 2002, and of these, only a third have been successful. [FN198] Notwithstanding their relative infrequency and the lack of success for plaintiffs, these cases can have significant impact on provincial governments' abilities to fulfill their obligations under the Canada Health Act. Two cases demonstrate the tension created when constitutional civil and political rights conflict with the statutory right to health care. [FN199] In each case, the right with constitutional status trumped the right to health care.

In Waldman v. British Columbia, the Court considered doctors' right to ***1184** travel and the interest of rural residents in access to health care. Physicians planning to practice in British Columbia challenged a provincial "physician supply management" policy aimed at controlling medical care costs and improving the availability of health care in rural parts of the province by placing significant economic disincentives to new physicians settling in urban areas. [FN200] The policy "grandfathered" in practicing physicians and those training to be physicians already in British Columbia, while physicians entering British Columbia from other provinces would be at an economic disadvantage if they chose to settle in an urban area. [FN201]

In holding that the policy violated physicians' Section 6 mobility rights, the British Columbian court noted that these rights exist to guarantee that a citizen would be treated "equally in his capacity as a citizen throughout Canada." [FN202] While the application of mobility rights in this case served the stated purpose of allowing Canadians to travel freely throughout the country to pursue their livelihoods, [FN203] the vindication of this right came at a significant cost. The physicians did not challenge the aims of the policy as being illegitimate. [FN204] Instead, they asserted that their Charter-protected right to travel trumped the province's interest in pursuing its

legitimate aims. [FN205] The Court cut off a reasonable means of controlling health care costs and providing equitable access to medical care for rural residents, forcing the province to find another means to achieve its aims--one that did not burden physicians' right to travel.

Opponents of creating enforceable social rights have argued that such rights cannot be defined or adjudicated. In this case, however, the Court determined with specificity the effect of the government's program on the Charter rights of the individuals before the court. [FN206] The other right at stake, that of rural communities' access to medical care, however, was not only diffuse and somewhat abstract, but also belonged to a group of people not before the Court. [FN207] Effective adjudication may require that social interests yield to the concrete Charter interests of the individuals bringing suit. [FN208] In fact, this case was the third time courts had rejected, on Charter grounds, the province's attempts to design a policy to encourage physician availability for rural residents. [FN209] Had the right to health care been established as the ***1185** constitutional right of rural residents perhaps the access interests of rural people would have weighed more heavily against the Charter right of doctors to practice where they please. At the very least, a competing constitutional right would have been far more difficult for the court to dismiss. [FN210]

More recently, the Court again placed individual Charter rights before the collective right to health care. In Chaoulli v. Quebec, the Canadian Supreme Court struck down Quebec's restrictions on private health insurance, holding that waiting times for certain surgeries had become so long as to violate citizens' Charter rights to life and liberty. [FN211] This was a 4-3 decision, with no one rationale commanding a majority. The plurality, however, clearly prioritized the individual interests of the appellants, a patient on a waiting list for hip replacement and a physician eager to provide medical services via private insurance, over the public interest in maintaining a single-tier health care system in Quebec, consistent with the principles of equality on which the system was founded. [FN212]

Although there was no majority, a common thread across the different opinions of the Court was that the problem giving rise to the litigation--waiting lists for surgical services in Quebec --" falls within the authority of the state and not of the courts." [FN213] Nevertheless, the plurality determined that the government's failure to deal with the problem of waiting lists had passed some ill-defined threshold of constitutionality, such that Quebeckers should not be forced to deal with the public health system if they wished to turn to a private one. [FN214] In doing so, the plurality acknowledged the tremendous political debate surrounding the health care system and waiting lists in particular, but nevertheless felt obligated to intervene given the government's apparent failure to handle the problem. [FN215] Chaoulli thus reveals both a danger and opportunity in judicial review of access to health care: while the court might intervene in decisions that are best left to the political branches of government, it can also use the moral force of its opinions to embarrass and goad the government into taking action to ensure access to health care. If the provincial government did not address the pressing problem of waiting lists, the Court would authorize patients to seek alternatives, even if these alternatives could undermine aspects of the provincial health care system.

***1186** In the leading opinion in Chaoulli, Justice Deschamps was careful to acknowledge deference to the political branches, noting that the Court's challenge was to base its decision on legal principles and not on social policy considerations. [FN216] Before concluding that the waiting lists, when combined with the effective prohibition of private insurance under Quebec law, violated the right to life, Justice Deschamps explained that "courts . . . leave it to the legislatures to develop social policy. But when such social policies infringe rights that are protected by the charters, the courts cannot shy away from considering them." [FN217] In other words, where "the government has assigned proper weight to each of the competing interests," a court must show defer-

ence. [FN218]

Chaoulli, according to Justice Deschamps, was a case in which the Court had the necessary evidence to support dispassionate judicial decision making, rather than simply substituting the Court's policy preferences for the provincial government's. [FN219] Despite the passage of time and recommendations of commissions, the government provided no answer to the problem of waiting lists. Now, according to Justice Deschamps, the plaintiffs were justified in seeking recourse in the courts because the provincial government had consistently and over a long period refused to act. [FN220] By this reasoning, the Court had to conclude that the waiting list problem infringed the Charter right to life and the province's continued denial of access to a parallel, private medical system was unjustified. [FN221]

In an opinion joined by two Justices, Chief Justice McLachlin pointed out that:

> [t]he appellants do not seek an order that the government spend more money on health care, nor do they seek an order that waiting times for treatment under the public health scheme be reduced. They only seek a ruling that because delays in the public system place their health and security at risk, they should be allowed to take out insurance to permit them to access private services. [FN222]

The implication is that while the Court would not have authority to order the government to provide services or reduce waiting times, the Justices could nevertheless determine that waiting times had passed some constitutional ***1187** threshold such that they violated the appellants' Charter right and rendered the legislation barring private insurance unconstitutional. [FN223] That the Justices' decision on whether long waiting times violated the Charter right to life created a policy challenge for the political branches did not "permit [them] to avoid" tackling the legal question. [FN224] The Court issued its judgment based on Charter concerns; the provincial government would now have to determine how to adjust its health system, without damaging it, to avoid a continuing violation of its citizens' rights. Chaoulli thus demonstrated how the judiciary, in vindicating a Charter right, might provide remedies that undermine the collective commitment to health care.

The Chaoulli decision, whatever its ultimate effect on the structure of provincial health care systems, is an indictment of the legislature's political dithering in ensuring timely access to health care. Both the majority and the dissent agreed that the government had done little to address the public's pressing concern about waiting lists for surgery. While the majority may have exceeded the Court's institutional competence in allowing the remedy of private insurance, the intervention might be excused as a response to an extreme case of political inaction. Thus, Chaoulli provided the "kick in the pants" needed to force the legislature to address a problem that, at least in the Court's view, had become intolerable. [FN225]

Chaoulli also has implications for the United States. If the U.S. adopted a legal right to health care, patients and physicians alike would find ways to craft constitutional challenges to changes in benefits, restrictions in remuneration, and policies resulting in unequal access. While such challenges might not always be successful, the possibility of recourse to the courts would provide an incentive to the political branches to deal more swiftly with systemic problems of access to health care, if only to avoid the embarrassment of a judicial scolding.

***1188** 2. Extending the Right to Health Care through Charter Litigation

Charter-based challenges can extend the right to health care when the government fails to provide equal access to those services it has determined to provide. The Canadian Supreme Court has interpreted Section 15(1) of the Charter to compel the government to take positive action by providing health care services, albeit in limited circumstances. Section 15 of the Charter [FN226] is an equality guarantee akin to the Equal Protection

Clause of the Fourteenth Amendment. [FN227] The most notable case in this area is Eldridge v. British Columbia, where the Court held that the province's refusal to provide sign language interpreters to deaf patients violated the right to equal protection in accessing health care because it excluded a traditionally marginalized group. [FN228]

At issue in Eldridge was not the scope of health services the province provided to citizens but whether the province's refusal to pay for sign language interpreters meant that the law conferred a benefit to which the hearing impaired did not enjoy equal access. [FN229] The Court determined that the disadvantage to deaf persons arising from the failure to provide interpreters was more insidious than it seemed at first glance. Because effective communication is essential to obtaining medical services, the refusal to pay for interpreters for the hearing impaired was discriminatory. [FN230]

The Court pointed to the "principle that discrimination can accrue from a failure to take positive steps to ensure that disadvantaged groups benefit equally from services offered to the general public . . ." [FN231] Having thus determined that the failure to provide interpreter services violated Section 15(1) of the Charter, the Court turned to Section 1, which allows for the government's compelling interest to temper enumerated rights. Since the cost of the program was only $150,000 (Canadian) annually, the Court could not find that the provincial government's budgetary concerns justified an override of the Section 15(1) rights of deaf persons. [FN232] It ordered the government to ***1189** provide the services. [FN233]

The Eldridge decision did not mean, however, that every denial of medical benefits violates the Section 15 guarantee of equal application of statutory benefits and burdens. The Canadian Supreme Court made this clear in a recent case, Auton v. British Columbia, in which the parents of autistic children sued the provincial government for its refusal to fund a specific treatment program designed for children aged three to six years. [FN234] The Auton Court reaffirmed that where there is unequal access to benefits the government has chosen to provide, the Court will remedy that discrimination. However, where the government chooses not to provide a particular benefit at all, the Court will not require the government to provide it. [FN235]

Because in Canada there is no independent constitutional right to health care, the Eldridge and Auton decisions examined Section 15 of the Charter, the equality guarantee. The question before the Court was whether the government provided available benefits unequally, not whether the government should provide particular benefits to a minority group. Thus, in Eldridge, the government was obliged to provide sign language interpreters so that disabled citizens could share in the general benefit of access to medical care. In Auton, however, the Court could not order the provision of a specific behavioral therapy because the decision whether to provide a benefit at all belongs to the province, not the Court, so long as the province makes the decision in a nondiscriminatory manner. [FN236]

The Auton Court consciously deferred to provincial judgment on which health services to provide. In refusing to order the government to pay for the services, the Canadian Supreme Court noted that the provincial government was aware of the parents' requests (the petitioners had spent years lobbying for funding) and had repeatedly refused to grant them. [FN237] The Court explained it would not step in to override the legislative judgment not to provide a specific ***1190** benefit: "One sympathizes with the petitioners, and with the decisions below ordering the public health system to pay for their therapy. However, the issue before us is not what the public health system should provide, which is a matter for Parliament and the legislature." [FN238] The Court limited its role to determining whether the failure to fund the specific treatment under the provincial health plan "amounted to an unequal and discriminatory denial of benefits under that plan, contrary to s. 15 of the Charter."

[FN239] While declining to order the government to provide the therapy, the Court nevertheless took the opportunity to chide the government's slow reaction to advances in autism therapy. [FN240]

Together, the Eldridge and Auton cases demonstrate how individuals may use the Charter to instigate a public discussion of health care rights in Canada:

> Even if people do not intend to launch legal actions to vindicate rights, they may resist controversial changes to health care services as encroachments upon their rights. Or, they may use rights language not as a shield to protect the existing system but as a sword to pressure governments into facilitating changes that they prefer . . . [FN241]

Although the Auton petitioners failed in both their political lobbying and legal challenges, they garnered the moral victory represented by the Court's reproof of the government's slow response to advances in autism therapy. After the instigation of the suit, the government of British Columbia came up with an "Autism Action Plan" and an "Autism Action Implementation Plan." [FN242] The province's creation, during the course of the litigation, of "action plans" to address autism illustrates that although the Court restrained itself from interfering with the determination of precisely what health care services the province ought to provide, it nevertheless used its power of the pen to force the government to finally act. [FN243] Thus, even without an explicit right to health care ***1191** in the Charter, Canadians can use their civil and political Charter rights to promote change in the health care system, which has the cultural status, if not the constitutional status, of a fundamental right.

C. Lessons from the South African and Canadian Experiences

Long experience suggests that establishing a right to health care in the United States, either constitutional or statutory, would be no easy political feat. Nevertheless, the South African and Canadian experiences undercut the argument that such a right would be nonjusticiable. These international examples refute claims that a right to health care in the United States would stretch the competence of the courts or interfere with separation of powers. Both countries have grappled with cases raising highly emotional questions--when should the government deny medical care to individuals who require life-changing (or life-sustaining) therapy or medical care?--and yet reached considered, thoughtful, and ultimately dispassionate decisions based on law.

In addition, the South African and Canadian experiences demonstrate that establishing a right to health care (whether constitutional or statutory) could help ensure access to health care. First, the prospect of justiciability would force Congress to justify its resource decisions before the Court and lay bare its decision-making process before the people. Second, the courts could order the government to provide services in the relatively rare instances when the failure to provide services is the result of unequal application of the law or is patently unreasonable. Finally, where a court declined to disturb the decisions of the political branches, the moral force of its opinion could impel government to take action where political inertia might leave it content to do little or nothing at all.

Conclusion

> "Ultimately, of course, it is the people who must make the Constitution meaningful. All the structures and all the guidelines and safeguards become ineffective if there is no motivation in the people for a true transformation of society." [FN244]

South Africa and Canada have, in different ways, managed to make their visions of the right to health care

concrete without trampling democratic accountability, stretching beyond judicial competence, or breaching separation ***1192** of powers. In the United States, where every political question eventually becomes a judicial question, [FN245] a judicially enforceable right to health care is the best chance for overcoming the combination of market failure and democratic failure that has left nearly a fifth of the population without reliable access to health care. This is not to argue that the judiciary is the branch most suited to determine what kinds of health services to which Americans should have access. It is not for the judiciary to make this type of policy decision. Rather, agreeing to and establishing the broad idea of a legal right to health care would push the political branches finally to adopt a program to achieve the goal of comprehensive access to health care for all. Further, the fear that enshrining a right to health care will necessarily result in judicial usurpation, as demonstrated by both the South African and Canadian examples, is unfounded.

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[FN1]. Los Angeles Mayor Antonio Villaraigosa, quoted in Lisa M. Sodders, Health Care a 'Right,' Mayor Says; Citizens Group Seeks Solutions, The Daily News of Los Angeles, Mar. 5, 2006, at N4.

[FN2]. The last real effort for comprehensive national access to health care failed spectacularly. Despite initially high levels of public support, President Clinton's Health Security Plan was abandoned, the victim of (depending on whom you ask) the President's feckless policy process, the Republican anti-government revolution, massive public confusion, or a general American unwillingness to sacrifice or pay higher taxes. See generally Theda Skocpol, Boomerang: Health Care Reform and the Turn Against Government 5-6 (1997); Peter Swenson & Scott Greer, Foul Weather Friends: Big Business and Health Care Reform in the 1990s in Historical Perspective, 27 J. Health Pol. Pol'y & L. 605 (2002). Several states, including Vermont, Massachusetts and California, have passed or are discussing legislation to expand health care access but the success of these programs and their ability to withstand federal preemption remains to be seen. See, e.g., Posting of Paul M. Secunda to Workplace Prof Blog, Massachusetts Universal Health Care and ERISA Preemption, (Apr. 5, 2006), http://lawprofessors.typepad.com/laborprof_blog/2006/04/the_ beginning_o.html; Retail Indus. Leaders Assn. v. Fielder, 475 F.3d 180 (4th Cir. 2007), (finding Maryland's Fair Share Health Care Fund Act (the so-called Wal-Mart Law) requiring large employers to contribute to employee health insurance directly or by paying the state preempted by ERISA). While the Employee Retirement Income Security Act of 1974, Pub. L. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 29 U.S.C.) is not discussed in this Comment, the federal preemption of state plans under ERISA doctrine is a major stumbling block for state health care reform. See, e.g., Mary Anne Bobinski, Unhealthy Federalism: Barriers to Increasing Health Care Access for the Uninsured, 24 U.C. Davis L. Rev. 255 (1990) (discussing the paralyzing impact of ERISA preemption on various state efforts to achieve universal health care coverage).

[FN3]. See, e.g., A Right to Health, St. Louis Post-Dispatch, Aug. 5, 2005, at B8; Susanne L. King, Health Care for All, The Berkshire Eagle, Oct. 3, 2005. The last push for a right to health care came in the late 1960s and early 1970s, when advocates pushed for recognition of health care rights in the Fourteenth Amendment. Norman

L. Cantor, The Law and Poor People's Access to Health Care, 35 Law & Contemp. Probs. 901 (1970) (discussing the feasibility of economic discrimination theory under the Fourteenth Amendment or a generalized constitutional "right to life" as possible sources of health care rights); Paul Starr, The Social Transformation of American Medicine 388-393 (1982) (describing the "uncontroversial" nature of the idea of health care as a right during the Civil Rights era).

[FN4]. Jim Brunner, Ballot in Seattle to Contain Statement on Health, The Seattle Times, Sept. 7, 2005, at B2; Press Release, CQ Transcriptions, Seattle Votes for a Right to Health Care (Dec. 7, 2005), available at 2005 WLNR 19730701.

[FN5]. Becca Stevens & Charles Strobel, Join our Fast for the Sake of Poor and Ill Tennesseans, The Tennessean, Mar. 1, 2006, at 13A.

[FN6]. Jon Cohen, 3 Million Uninsured: A Crisis; It is Time for New York to Step up to the Growing Challenge of Health Care Reform, Newsday, May 12, 2005, at A47.

[FN7]. Kirsten Stewart, Activists Say Give Health Care to All, The Salt Lake Tribune, July 10, 2006.

[FN8]. In July 2006, a constitutional convention considered the amendment (proposed by advocates who obtained sufficient signatures under the state's procedures) and referred it to a committee for further study, ensuring that it would not be submitted to voters in November 2006. If supported by at least fifty state legislators, voters would have had the chance to ratify or reject the amendment in November 2008. See Health Care for Massachusetts Campaign, http://www.healthcareformass.org (last visited Sept. 25, 2006). However, in January 2007, the Massachusetts Legislature failed to vote the amendment out of committee, thus preventing a vote on whether to put the amendment to the voters. See Jim O'sullivan & Priscillia Yeon, Lawmakers Nix Petition Guaranteeing Health Care Access, State House News Service (Jan. 2, 2007), available at http://www.healthcareformass.org/press/documents/LAWMAKERSNIXPETITIONGUARANTEEINGHEALTHCA. This means that the legislature never considered the merits of the health care amendment. By refusing an up or down vote on the health care amendment, the Massachusetts Legislature violated a decision of the Massachusetts Supreme Court issued just a week earlier, relating to an initiative gay marriage amendment. Doyle v. Sec'y of the Commonwealth, 448 Mass. 114 (2006) (holding the Legislature had a constitutional duty to give all pending constitutional amendments an up or down vote on the merits but that the court did not have the authority to issue a declaratory judgment).

[FN9]. Carmen DeNavas-Walt et al., U.S. Census Bureau Current Population Reports, Income, Poverty, and Health Insurance Coverage in the United States: 2004, 16 (2005), available at http://www.census.gov/prod/2005pubs/p60-229.pdf; Kaiser Commission on Medicaid and the Uninsured: Key Facts, November 2005, http://www.kff.org/uninsured/upload/The-Uninsured-and-Their-Access-to-Health-Care-Fact-Sheet-6.pdf.

[FN10]. DeNavas-Walt et al., supra note 9, at 16-17.

[FN11]. Committee on the Consequences of Uninsurance, Institute of Medicine. Hidden Costs, Value Lost: Uninsurance in America 110-11 (2003), available at http://books.nap.edu/catalog/10719.html.

[FN12]. Id. at 110.

[FN13]. Lisa Clemans-Cope & Bowen Garret, Changes in Employer-Sponsored Health Insurance Sponsorship, Eligibility, and Participation: 2001-2005, 15, 33 (2006), http://www.kff.org/uninsured/upload/7599.pdf (reporting that there were 3.4 million more uninsured employees in 2005 than in 2001 and describing how increasing insurance premiums and the continuing shift away from long-term stable employment relationships may be the reason for declining employment-based insurance coverage). The dramatic shrinking of the manufacturing sector of the U.S. economy in the 1980s and accompanying business strategies that cut back on generous benefits has also left many Americans with no health insurance or less comprehensive health insurance. See also Stephen H. Long & M. Susan Marquis, Stability and Variation in Employment-Based Health Insurance Coverage, 1993-1997, 18 (6) Health Affairs 133 (1999). See also, e.g., Lawrence R. Jacobs & Robert Y. Shapiro, Public Opinion's Tilt Against Private Enterprise, 13 (1) Health Affairs 285, 286 ("By 1990 the reduction of benefits had prompted 55 percent of strikers to hit the picket lines just to hold onto their health care benefits."). This trend reversed slightly during the economic boom of the late 1990s. Long & Marquis, supra, at 137 (reporting that health insurance premiums for many firms stabilized or declined slightly, encouraging employees to participate in employment-based health insurance).

[FN14]. Kaiser Family Foundation, November/December 2005 Health Poll Report Survey, http://www.kff.org/kaiserpolls/upload/November-December-2005-Health-Poll-Report-Survey-Toplines.pdf.

[FN15]. Although Shapiro v. Thompson, 394 U.S. 618 (1969), suggests that advocates could use a theory of economic discrimination under the Fourteenth Amendment to require the government to provide welfare benefits, this approach has been undermined by subsequent cases. See infra Part I.C. See also Starr, supra note 3, at 389.

[FN16]. See Cass R. Sunstein, The Second Bill of Rights: FDR's Unfinished Revolution and Why We Need it More than Ever 175-176 (2004) [hereinafter The Second Bill].

[FN17]. See infra notes 87 to 99 and accompanying text.

[FN18]. See discussion, infra, Parts I.B. & II.A. Social rights include rights to the necessities of life, including health care, housing, education, employment, and a baseline income. Kim Lane Scheppele, A Realpolitik Defense of Social Rights, 82 Tex. L. Rev. 1921, 1921 (2003). They may include, for example, President Franklin Roosevelt's "Second Bill of Rights." The Second Bill, supra note 16, at 13 (listing housing; education; medical care; employment; protection in old age, disability, and unemployment; etc.).

[FN19]. In undertaking this task, I take to heart Mary Ann Glendon's "proposition that American thinking about rights and welfare would benefit from examining the experiences of other liberal democracies and to speculate about the insights that might emerge from such a comparative analysis." Mary Ann Glendon, Rights in Twentieth-Century Constitutions, 59 U. Chi. L. Rev. 519, 519-20 (1992).

[FN20]. Norman Daniels, Just Health Care 5 (1985).

[FN21]. Philip Odum, describing losing his health insurance after a lay off. Americans for Health Insurance, Health Care Story of the Week, Apr. 12, 2006, http://www.americansforhealthcare.org/story_odom.cfm.

[FN22]. Lawrence A. Gostin, Securing Health or Just Health Care? The Effect of the Health Care System on the Health of America, 39 St. Louis U. L.J. 7, 11 (1994).

[FN23]. See The Second Bill, supra note 16, at 184-86.

[FN24]. See, e.g., Comm. on Econ., Soc. & Cultural Rights, General Comment No. 14: The Right to the Highest Attainable Standard of Health (Article 12 of the International Covenant on Economic, Social and Cultural Rights), U.N. Doc. E/C.12/2000/4 (2000) (declaring "Health is a fundamental human right indispensable for the exercise of other human rights."), available at http://www.unhchr.ch/tbs/doc.nsf/(symbol)/E.C.12.2000.4.En?OpenDocument.

[FN25]. See, e.g., The Second Bill, supra note 16, at 185.

[FN26]. Gostin, supra note 22, at 13 ("[A] certain level of health is a necessary condition for the exercise of fundamental rights and privileges. Persons with severe physical or mental disabilities, as well as acute and chronic diseases, may not be able to exercise their rights to liberty (e.g. travel), autonomy (e.g. decision making in personal and financial affairs), or the franchise."). See generally Alastair V. Cambell, Health As Liberation: Medicine, Theology, and the Quest for Justice 10 (1995) (developing the thesis that ill health, combined with the fear engendered by precarious access to health care and other socioeconomic inequalities, oppresses entire swaths of the population). The Supreme Court acknowledged this indirectly when it noted the states' legitimate interest in preserving life and preventing assisted suicide rests, in part, on the need to protect individuals whose poor health compromises their autonomy. Washington v. Glucksberg, 521 U.S. 702, 732 (1997).

[FN27]. M. David Low, et. al., Can Education Policy be Health Policy? Implications of Research on the Social Determinants of Health, 30 J. Health Pol. Pol'y & L. 1131, 1147 (2005).

[FN28]. Craig Scott & Patrick Macklem, Constitutional Ropes of Sand or Justiciable Guarantees? Social Rights in a New South African Constitution, 141 U. Pa. L. Rev. 1, 15-16 (1992).

[FN29]. Daniels, supra note 20, at 39.

[FN30]. See Tamara Friesen, The Right to Health Care, 9 Health L.J. 205, 210 (2001). In this context, moral luck refers to the fact that "none of us deserves the advantages conferred by accidents of birth--either genetic or social advantages. These advantages from the 'natural lottery' are morally arbitrary, and to let them determine individual opportunity and reward and success in life is to confer arbitrariness on the outcomes." Norman Daniels, Health-Care Needs and Distributive Justice, 10 Phil. & Pub. Affairs 146, 166 (1981). For a primer on "moral luck," see Moral Luck, Stanford Encyclopedia of Philosophy, http://plato.stanford.edu/entries/moral-luck/ (last visited Jan. 26, 2004).

[FN31]. Daniels, supra note 20, at 32-49; Daniels, supra note 30, at 158.

[FN32]. Daniels, supra note 20, at 33.

[FN33]. Id.

[FN34]. Id. at 39.

[FN35]. This assumes a notion of fair equality of opportunity, in which the government is obligated not only to remove or refrain from imposing morally irrelevant barriers to equal opportunity, but also to actively counteract the distorting effects of social advantages and disadvantages. Id. at 41; Daniels, supra note 30, at 166.

[FN36]. See infra notes 62-64 and accompanying text. Generally, a right to health care based on effective citizenship and fair equality of opportunity does not require that every member of society receive the most techno-

logically-advanced medical care. It compels society to create a system of health care to aid its members in achieving the normal functioning they need to enjoy equal opportunity. Thus, the right to health care imposes an obligation on society to provide health care to all, but does not create an unlimited right for individuals to access medical interventions without regard for effectiveness and resource limitations.

[FN37]. Stephen P. Marks, Jonathan Mann's Legacy to the 21st Century: The Human Rights Imperative for Public Health, 29 J.L. Med. & Ethics 131, 133-134 (2001).

[FN38]. Eleanor D. Kinney & Brian Alexander Clark, Provisions for Health and Health Care in the Constitutions of the Countries of the World, 37 Cornell Int'l L.J. 285, 288-293 (2004).

[FN39]. Carlo V. DiFlorio, Assessing Universal Access to Health Care: An Analysis of Legal Principle and Economic Feasibility, 11 Dick. J. Int'l L. 139, 142 (1992); David P. Fidler, International Law and Global Public Health, 48 U. Kan. L. Rev. 1, 40 (1999).

[FN40]. George P. Smith II, Human Rights and Bioethics: Formulating a Universal Right to Health, Health Care, or Health Protections?, 38 Vand. J. Transnat'l L. 1295, 1301 (2005).

[FN41]. Id. at 1300.

[FN42]. Steven D. Jamar, The International Human Right to Health, 22 S.U. L. Rev. 1, 19 (1994); see also Gwendolyn L. Pulido, Immunity of Volunteer Health Care Providers in Texas: Bartering Legal Rights for Free Medical Care, 2 Scholar 323, 326 (2000).

[FN43]. Constitution of the World Health Organization (1946), available at http://policy.who.int/cgi-bin/om_isapi.dll?hitsperheading=on&infobase=basicdoc&record=[C88]&softpage=Document42.

[FN44]. Jamar, supra note 42, at 46-47.

[FN45]. Universal Declaration of Human Rights, G.A. Res. 217A, at 76, U.N. GAOR, 3d Sess., 1st plen. mtg., U.N. Doc A/810 (Dec. 12, 1948) in Health and Human Rights: Basic International Documents (Stephen P. Marks, ed., 2004), available at http://www.unhchr.ch/udhr.

[FN46]. International Covenant on Economic, Cultural and Social Rights, G.A. Res. 2200A, U.N. GAOR, 21st Sess., Supp. No. 16, at 36, U.N. Doc. A/6316 (1966), available at http://www.unhchr.ch/html/menu3/b/a_cescr.htm.

[FN47]. Id.

[FN48]. Amanda Littell, Can a Constitutional Right to Health Guarantee Universal Health Care Coverage or Improved Health Outcomes?: A Survey of Selected States, 35 Conn. L. Rev 289, 313; but see Fidler, supra note 39, at 27-39 (arguing that rights to health are embedded in international law regimes, including trade law (reservations to protect human health in multilateral trade agreements), humanitarian law (treaties requiring medical treatment for prisoners of war), arms control agreements (provisions prohibiting the use of “any weapon that causes superfluous injury or unnecessary suffering”), human rights law, labor, and environmental law).

[FN49]. Friesen, supra note 30, at 205 (“[A] human right, even one supported by international law, is not a legal

right--it is not justiciable, and thus cannot be used as a tool by ... citizens who wanted to be proactive in improving and maintaining the quality of their public health care.”).

[FN50]. Daniels, supra note 30, at 155.

[FN51]. WHO Regional Office for Europe, Terminology - A Glossary of Technical Terms on the Economics and Finance of Health Services (1998), available at http://www.euro.who.int/observatory/Glossary [hereinafter WHO Glossary].

[FN52]. See, e.g., Daniels, supra note 20, at 32.

[FN53]. WHO Glossary, supra note 51.

[FN54]. See Alastair V. Cambell, Health As Liberation: Medicine, Theology, and the Quest for Justice 10 (1995).

[FN55]. Smith, supra note 40, at 1315.

[FN56]. Smith notes that “a fundamental right to health suggests something that usually cannot be guaranteed at all--namely, perfect health.” Id. at 1315. The term “a right to health,” is a “shorthand term for ‘the right to the highest attainable standard of health,’ with the right to health care viewed as an inherent part of the right to health.” Id. at 1315-16. Smith would prefer to talk about “a right to health protection which would include a right to health care and right to live under healthy conditions.” Id. at 1317. Even this kind of right of the individual “must be balanced within a utilitarian construct against societal or communal needs.” Id. at 1319.

[FN57]. Frank I. Michelman, The Supreme Court 1968 Term Foreword: On Protecting the Poor through the Fourteenth Amendment, 83 Harv. L. Rev. 7 (1969-1970). See generally Daniels, supra note 20. See also discussion, infra, Part I.C.

[FN58]. Tom Stacy, The Courts, the Constitution, and a Just Distribution of Health Care, 3 Kan. J.L. & Pub. Pol'y 77, para. 23 (1993/1994); DiFlorio, supra note 39, at 153; Rory Weiner, Universal Health Insurance Under State Equal Protection Law, 23 W. New. Eng. L. Rev. 327, 342 (2002).

[FN59]. Colleen M. Flood, Lance Gable & Lawrence O. Gostin, Introduction: Legislating and Litigating Health Care Rights Around the World, 33 J.L. Med. & Ethics 636, 637 (2005); Daniels, supra note 20, at 17; Friesen, supra note 30, at 207-08.

[FN60]. Jamar, supra note 42, at 8.

[FN61]. Id. at 8-9.

[FN62]. See generally, Norman Daniels, et al., Benchmarks of Fairness for Health Care Reform 35-69 (1996) [hereinafter Benchmarks of Fairness].

[FN63]. See supra note 35 and accompanying text.

[FN64]. See Benchmarks of Fairness, supra note 62, at 25-29.

[FN65]. Stacy, supra note 58, at para. 3 (“[A]nother unquestioned premise holds that legislatures are the sole

forum for any reform of the distribution of health care, and that the Constitution, as interpreted and enforced by the judiciary, has virtually nothing to say...Yet scholars should explore the best understanding of the Constitution, whether or not the Supreme Court is likely to embrace it."); see, e.g., Weiner, supra note 58, at 329; Thomas L. Greaney, How Many Libertarians Does it Take to Fix the Health Care System?, 96 Mich. L. Rev. 1825, 1825 (1998) (describing Richard Epstein's fear that once "inalienable" in the Declaration of Independence is thought of as a positive entitlement, and thus health as a fundamental right is a prerequisite to the pursuit of happiness, universal health care cannot be far off.); Littell, supra note 48, at 290 (lamenting the prevalence of this notion).

[FN66]. Cass Sunstein opines that but for the election of Richard Nixon, and his subsequent appointment of four members of the Supreme Court, we would have an understanding of the Fourteenth Amendment today that included a number of economic guarantees, including the right to medical care. See The Second Bill, supra note 16, at 151-54.

[FN67]. Michelman, supra note 57, at 9.

[FN68]. Id.

[FN69]. Id. at 16-19. Fair equality of opportunity is discussed supra, Part I.B.

[FN70]. 397 U.S. 254, 264-65 (1970).

[FN71]. 394 U.S. 618 (1969).

[FN72]. 415 U.S. 250, 259-60 (1974).

[FN73]. See Michelman, supra note 57, at 38.

[FN74]. 415 U.S. at 265.

[FN75]. Michelman, supra note 57, at 31. Complicating this further are other threads of Supreme Court interpretation that limit the affirmative imperative of the equal protection clause as it applies to health care. Federal pre-emption of state regulation under ERISA effectively means that citizens whose employers pay for, but do not administer, their health insurance enjoy antidiscrimination protections that their counterparts with employer-administered health insurance do not enjoy. See McGann v. H&H Music Co., 946 F.2d 401, 405 (5th Cir. 1991) (finding that employer did not violate ERISA by reducing one million dollar health coverage cap to five thousand dollars for HIV-related illnesses upon learning that plaintiff employee had HIV) and Westhoven v. Lincoln Foodservice Prods., Inc., 616 N.E.2d 778, 784 (Ind. App. 1993) (holding state law barring discrimination in health care coverage for AIDS-related illnesses preempted by ERISA). ERISA pre-emption bars states from enacting the most direct means of providing health coverage for the working uninsured. E.g., Scott D. Litman, Note, Health Care Reform for the Twenty-First Century: The Need for a Federal and State Partnership, 7 Cornell J.L. & Pub. Pol'y 871, 882-84 (1998) (noting that while ERISA's original purpose was to protect employee pensions, courts have interpreted its preemptive effect broadly to strike down state health care reforms). See also Bobinski, supra note 2, at 258 (discussing the difficulty of fashioning effective state health care reforms that can avoid ERISA preemption). The Supreme Court's division of its equal protection jurisprudence into three levels of review effectively quashes equal protection claims on the basis of age discrimination in the government's allocation of health care dollars. Suits brought by the non-elderly seeking equal access to Medicare have failed be-

cause the application of rational review to Congress's policy choice makes proving age discrimination extremely difficult. Howard Eglit, Health Care Allocation for the Elderly: Age Discrimination by Another Name?, 26 Hous. L. Rev. 813, 835 (1989). While at least one commentator has argued for a strategy of implementing universal health insurance under state equal protection doctrines, this legal strategy has not caught on. See generally Weiner, supra note 58.

[FN76]. Kenneth L. Karst, The Supreme Court 1976 Term Foreword: Equal Citizenship Under the Fourteenth Amendment, 91 Harv. L. Rev. 1, 62 (1977).

[FN77]. See, e.g., Lisa Girion, Healthy? Insurers Don't Buy it: Minor Ailments can Thwart Applicants for Individual Policies, L.A. Times, Dec. 31, 2006, at A1.

[FN78]. 397 U.S. 471 (1970).

[FN79]. Id. at 486-87.

[FN80]. Id. at 473-75.

[FN81]. Id. at 487.

[FN82]. Cantor, supra note 3, at 906.

[FN83]. Id. at 907.

[FN84]. Scott & Macklem, supra note 28, at 6-7.

[FN85]. See, e.g., Carolyn V. Juarez, Liberty, Justice, and Insurance for All: Re-Imagining the Employment-Based Health Insurance System, 37 U. Mich. J.L. Reform 881, 885-90 (2004) (noting the effect of Second World War price controls on the advent of employment-based health insurance and the resulting view of health care as a privilege of employment and thereby discouraging comprehensive legislative reform efforts); Barry R. Furrow, From the Doctor to the System: The New Demands of Health Law, 14 Health Matrix 67, 69-80 (2004) (describing the establishment of the health care system in the twentieth century and the “perverse economic market” for health care that has confounded reformers); Jill Quadagno, Physician Sovereignty and the Purchaser's Revolt, 29 J. Health Pol. Pol'y & L. 815 (2004) (describing the power of key stakeholders, including the insurance industry, corporate purchasers, and labor on successive twentieth century attempts at health care reform).

[FN86]. Karen Davis, Universal Coverage in the United States: Lessons from Experience of the 20th Century, 78 J. Urban Health 46, 47 (2001).

[FN87]. See Starr, supra note 3, at 266-270.

[FN88]. The Second Bill, supra note 16, at 243.

[FN89]. Starr, supra note 3, at 281.

[FN90]. Id. at 283-84. See also, e.g., R.L. Hendricks, A Necessary Revolution: The Origins of the Kaiser Permanente Medical System (1987) (dissertation); Daniel J.B. Mitchell, Impeding Earl Warren: California's Health Insurance Plan that Wasn't and What Might Have Been, 27 J. Health Pol. Pol'y & L. 947, 954-55 (noting opponents of an early California health insurance plan painted social insurance as a “Prussian plot”). Today, conversa-

tions regarding expanded access to health care inevitably turn to the dangers of socialized medicine. Paul Starr's account of the development of medicine in America, along with Theda Skocpol's analysis of the failure of the Clinton Health Security Bill, suggests the problem of health care is particularly unamenable to a political solution. See Starr, supra note 3; Skocpol, supra note 2.

[FN91]. Davis, supra note 87.

[FN92]. Starr, supra note 3, at 363-78.

[FN93]. Davis, supra note 87, at 47; Starr, supra note 3, at 394-96.

[FN94]. Davis, supra note 87, at 48; Starr, supra note 3, at 404-05.

[FN95]. Starr, supra note 3, at 411-14.

[FN96]. Davis, supra note 87, at 47; Starr, supra note 3, at 394. “Play-or-pay” describes a health care program in which employers either must provide health care coverage to their employees or pay into a state-administered fund, which would then purchase health care coverage for workers. Zedlewski et al., Play-or-Pay Employer Mandates: Likely Effects, 11(1) Health Affairs 62, 63 (1992). See also Anna D. Sinaiko, Employers' Responses to a Play-Or-Pay Mandate: An Analysis of California's Health Insurance Act of 2003, Health Affairs (Web Exclusive) W4-469, W4-469, (2004), http:// content.healthaffairs.org/cgi/reprint/hlthaff.w4.469v1 (measuring likely effects of a California play-or-pay plan on the labor market and business interests).

[FN97]. President George H.W. Bush, Address Before a Joint Session of the Congress on the State of the Union (Jan. 28, 1992), available at http://www.c-span.org/executive/transcript.asp?cat=current_event&code=bush_admin&year=1992.

[FN98]. See supra note 2; Paul Starr, What Happened to Health Care Reform, The American Prospect no. 20 (1995): 20-31. President George W. Bush has not made health care a priority. Although he presided over the creation of a Medicare prescription drug benefit, President Bush's proposed 2007 budget included $100 billion in reduced spending for government health care programs. Andrew Miga, Bush's new budget could boost health care costs, critics say, Associated Press, Feb. 5, 2007, available at 2/5/07 AP Alert - Political 19:51:55. The President paired these cuts with a plan to expand health insurance by altering the tax code; this plan, however, is unlikely to win congressional support. Sheryl Gay Stolberg, Bush, In Talk-Show Manner, Promotes His Health Plan, N.Y. Times, Feb. 22, 2007, at A18.

[FN99]. Sunstein argues that in addition to explicit constitutional rights, there are some rights (“constitutive commitments”), like the right to social security, that lack constitutional status but which are “widely accepted and cannot be eliminated without a fundamental change in social understanding.” The Second Bill, supra note 16, at 61-64.

[FN100]. Id. at 181.

[FN101]. The Medicare Program provides health coverage for Americans who are over the age of sixty-five, have certain disabilities, or have end-stage renal disease. Medicare Program General Information, available at http:// www.cms.hhs.gov/MedicareGenInfo/ (last visited Feb. 11, 2007).

[FN102]. Medicaid is a state-administered program that provides health coverage for some of the very poor.

Medicaid Program General Information, http://www.cms.hhs.gov/MedicaidGenInfo/ (last visited Feb. 11, 2007).

[FN103]. State Children's Health Insurance Program, Pub. L. No. 105-100 (1997) (codified at 42 U.S.C. §§1397aa-1397jj).

[FN104]. Emergency Medical Treatment and Active Labor Act, Pub. L. No. 99-272, Title X, § 9121(b) (1986) (codified at 42 U.S.C. § 1395dd). See also Sharona Hoffman, Unmanaged Care: Towards Moral Fairness in Health Care Coverage, 78 Ind. L.J. 659, 672-73 (2003).

[FN105]. Littell, supra note 48, at 308-09 (finding no correlation between infant mortality or the presence of universal health coverage and a constitutional right to health in a survey of eleven countries).

[FN106]. Kinney & Clark, supra note 38, at 291.

[FN107]. Cass R. Sunstein, Why Does the American Constitution Lack Social and Economic Guarantees?, 56 Syracuse L. Rev. 1, 4 (2005).

[FN108]. See id.

[FN109]. Littell, supra note 48, at 293.

[FN110]. Flood et al., supra note 59, at 636.

[FN111]. Jesse L. Jackson, Jr., Do We Have a Right to Health Care?, ABCNews.com, Oct. 13, 2006, http:// abcnews.go.com/WNT/PrescriptionForChange/story?id=2563706&page=1. The proposed amendment reads: "Section 1. All persons shall enjoy the right to health care of equal high quality. Section 2. The Congress shall have the power to enforce and implement this article by appropriate legislation." H.R.J. Res. 30, 109th Cong. (introduced Mar. 2, 2005) (Jesse L Jackson, Jr.).

[FN112]. Rand Wilson, Health Care Amendment Campaign Gaining Momentum; Supporters Plan Action for May 10th Constitutional, Blue Mass. Group, Feb. 10, 2006, http://www.bluemassgroup.com (quoting Barbara Roop, Chairperson of the Health Care for Massachusetts Campaign). The proposed amendment reads:

> [I]t shall be the obligation and duty of the Legislature and executive officials, on behalf of the Commonwealth, to enact and implement such laws, subject to approval by the voters at a statewide election, as will ensure that no Massachusetts resident lacks comprehensive, affordable and equitably financed health insurance coverage for all medically necessary preventive, acute and chronic health care and mental health care services, prescription drugs and devices.

[FN113]. Mark Tushnet points out that constitutional social rights may be of three varieties: nonjusticiable or declaratory, judicially enforceable only when the government "dramatically depart[s]" from its constitutional obligations, or judicially enforceable "to the same degree [as] traditional civil liberties and civil rights." Mark Tushnet, Social Welfare Rights and the Forms of Judicial Review, 82 Texas L. Rev. 1895, 1897 (2004).

[FN114]. See supra note 8 and accompanying text.

[FN115]. 2006 Mass. Acts. Ch. 58.

[FN116]. Scott Greenberger, Mass. Group Set to Push for Universal Health Care, Boston Globe, May 26, 2005,

at A1 (describing competing proposals for health reform, including the push for a health care amendment, and the governor's response committing himself to addressing the issue); Editorial, “No-Nos” on Health Care Fix, Boston Herald, June 8, 2005, at 28 (suggesting that politicians will prefer to agree on legislation addressing the rising cost of health care than allow the proposed health care amendment to move forward).

[FN117]. See Herman Schwartz, Do Economic & Social Rights Belong in a Constitution?, 10 Am. U. J. Int'l L. & Pol'y 1233, 1239-40 (1995).

[FN118]. Littell, supra note 48, at 308-09.

[FN119]. R.S.C. 1985, c. C-6, s. 7 (1985).

[FN120]. In a recent CBS News Poll, 90% of Americans stated that the health care system needs fundamental changes or must be completely rebuilt. Poll: Bush's Approval Remains Low, (Jan. 26, 2007), available at http://www.cbsnews.com/stories/2006/01/26/opinion/polls/main1243679_page2.shtml.AKaiserFamilyFoundation/Harvard School of Public Health Poll recently found that 67% of Americans think the federal government spends too little on health care and 64% think health care is something the President and Congress can “do a lot” about. The Public's Health Care Agenda for the New Congress and the Presidential Campaign (Dec. 2006), http://www.kff.org/kaiserpolls/upload/7598.pdf. The consensus for change falters when Americans are presented with specific plans: “Overall, 56 percent [of Americans] say they would prefer a universal care system.... If supporters are challenged with possible downsides of such a plan--less choice of doctors, waiting lists, increased costs to individuals, or more limited coverage of medical treatments--significant numbers change their minds....” ABC News/Kaiser Family Foundation/USA Today, Health Care in America 2006 Survey (Oct. 2006), http://www.kff.org/kaiserpolls/upload/7572.pdf.

[FN121]. See supra notes 87-99 and accompanying text.

[FN122]. Justiciability refers to “the extent to which a matter is suitable for judicial determination.” Scott & Macklem, supra note 28, at 17. E.g. Tushnet, supra note 113, at 1895-97; Schwartz, supra note 117, at 1234-35. See also, e.g., Albie Sachs, Social and Economic Rights: Can They be Made Justiciable?, 53 SMU L. Rev. 1381, 1388-89 (2000); K. Syrett, Deference or Deliberation: Rethinking the Judicial Role in the Allocation of Healthcare Resources, 24 Med. & L. 309, 317 (2005); DiFlorio, supra note 39, at 153 (“The premise that a minimum level of health care is a fundamental right, inevitably raises the issue of justiciability and enforcement. By relying on judicial remedy, we are assuming that judges alone are competent to determine from the bench the minimum level of health care required ... to satisfy this minimum standard.”).

[FN123]. Christopher Newdick, Who Should We Treat? Rights, Rationing, and Resources in the NHS 10 (2005).

[FN124]. See Jamar, supra note 42, at 13; Sunstein, supra note 107, at 6.

[FN125]. See Friesen, supra note 30, at 207 (describing the libertarian view of a right to health care).

[FN126]. See Newdick, supra note 127, at 11. See also Glendon, supra note 19, at 521 (noting how the Bill of Rights, with judicial review as an enforcement mechanism, preceded the advent of the welfare state, unlike France, Germany and Canada where “the foundations of the welfare state were in place well before regimes of constitutional rights appeared.”).

[FN127]. Glendon, supra note 19, at 520 (“[W]hen our Constitution and Bill of Rights were adopted, the welfare

state as we know it was not even a twinkle in the eyes of the Founding Fathers."); see also DiFlorio, supra note 39, at 151.

[FN128]. Smith, supra note 40, at 1298. See also Littell, supra note 48, at 291-92.

[FN129]. Most prominent among these is the South African Constitution. Justice Sachs describes the South African Constitution as containing first- (civil and political), second- (welfare), and third-generation (collective) human rights; despite the generational designations, "social and economic rights are indivisible from and inter-dependent with civil and political rights." Sachs, supra note 122, at 1384; see also Kinney & Clark, supra note 38, at 292-93.

[FN130]. See The Second Bill, supra note 16, at 99-108 (giving an overview of possible explanations for the absence of social rights in the U.S. Constitution).

[FN131]. Fidler, supra note 39, at 41. But see generally Frank B. Cross, The Error of Positive Rights, 48 UCLA L. Rev. 857 (2001) (arguing that positive rights are distinct from negative rights and noting political and economic objections to positive rights enforcement).

[FN132]. Fidler, supra note 39, at 41.

[FN133]. Id. at 42.

[FN134]. See, e.g., Estelle v. Gamble, 429 U.S. 97, 105 (1976) (concluding that "deliberate indifference to serious medical needs of prisoners constitutes the unnecessary and wanton infliction of pain proscribed by the Eighth Amendment.") (internal citation omitted).

[FN135]. Abram Chayes, How Does the Constitution Establish Justice?, 101 Harv. L. Rev. 1026, 1027 (1988).

[FN136]. See Jamar, supra note 42, at 58.

[FN137]. See Chayes, supra note 136, at 1031-32.

[FN138]. Smith, supra note 40, at 1301-02.

[FN139]. South African Constitutional Law: The Bill of Rights (M.H. Cheadle, D.M. Davis & N.R.L. Haysom, eds., 2002).

[FN140]. See, e.g., Government of the Republic of South Africa v. Grootboom, 2000 (11) BCLR 1169 (CC) at para. 20 (S. Afr.).

[FN141]. Lisa Forman, Ensuring Reasonable Health: Health Rights, the Judiciary, and South African HIV/AIDS Policy, 33 J.L. Med. & Ethics 711, 712 (2005).

[FN142]. Syrett, supra note 122, at 319.

[FN143]. See Forman, supra note 141, at 713. This issue was settled at the time of the adoption of the constitution. See Ex Parte Certification of the Constitutional Assembly: in re Certification of the Constitution of the Republic of South Africa 1996 (4) SA 744 (CC) at paras. 77-78 (S. Afr.). See also K.N. Llewellyn, The Normative, the Legal, and the Law-Jobs: The Problem of Juristic Method, 49 Yale L.J. 1355, 1397 (1939-1940) ("Whereas

that line of legal which moves by way of accepted procedures not only may emerge independently of political authority, but...tends to become a major device for holding political authority within bounds--'under law."').

[FN144]. The Section reads:

(1) Everyone has the right to have access to--

(a) health care services, including reproductive health care[...]

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve progressive realization of these rights.

(3) No one may be refused emergency medical treatment.

This language is identical to that of Section 26(2) of the South African Constitution. Geraldine Van Bueren, Health, in South African Constitutional Law: The Bill of Rights, supra note 143, at 481.

[FN145]. Charles Ngwena, The Recognition of Access to Health Care as a Human Right in South Africa: Is it Enough?, 5 Health & Hum. Rts. 27 (2000).

[FN146]. Id. at 28; see also Sachs, supra note 122, at 1384.

[FN147]. Grootbroom 2000 (11) BCLR 1169 (CC) at para. 20 (S. Afr.).

[FN148]. Forman, supra note 141, at 718; Syrett, supra note 126, at 318.

[FN149]. Van Bueren, supra note 148, at 503.

[FN150]. Minister of Health v. Treatment Action Campaign 2002 (10) BCLR 1033 (CC) at para. 107 (S. Afr.).

[FN151]. 1997 (12) BCLR 1696 (CC) (S. Afr.).

[FN152]. Id. at para. 1.

[FN153]. Id. at para. 3.

[FN154]. Id. at para. 2.

[FN155]. Id. at para. 4.

[FN156]. Id. at para. 7. Mr. Soobramoney also claimed the denial of dialysis violated his constitutional right to life.

[FN157]. Id. at para. 31.

[FN158]. The court dismissed the right to life argument by noting that the right to medical care is explicit in the South African Constitution, making recourse to the right to life section unnecessary. See Van Bueren, supra note 148, at 492.

[FN159]. Soobramoney, 1997 (12) BCLR 1696 (CC) at para. 24 (S. Afr.).

[FN160]. Id. at para. 29.

[FN161]. Ngwena, supra note 145, at 32; Van Bueren, supra note 148, at 502 ("Available resources should not

be perceived as a trumping card.").

[FN162]. Soobramoney, 1997 (12) BCLR 1696 (CC) at para. 36.

[FN163]. Id. at para. 54 (Sachs, J., concurring).

[FN164]. Mr. Soobramoney died two days after the Constitutional Court issued its decision. Sachs, supra note 122, at 1386.

[FN165]. Sachs, supra note 122, at 1385. Justice Sachs sees this as the original understanding of the South African Bill of Rights:

"[T]hese rights would not be enforceable in the same, self-executing way as other rights. The provisions say that the state is under a duty to make these rights realizable through reasonable legislative and other measures, which must serve progressively to enhance access to these rights, bearing in mind the financial capacities of the state."

[FN166]. Soobramoney, 1997 (12) BCLR 1696 (CC) at para. 54 (S. Afr.).

[FN167]. The Court, further, did not order the state to purchase more dialysis machines. This restraint by the Court demonstrates that the constitutional right to have access to health care does not mean that the state is not free to concentrate its resources on health measures it determines are more cost-effective. Id. at para. 58.

[FN168]. 2000 (11) BCLR 1169 (CC) (S. Afr.).

[FN169]. The language of Section 26 parallels that of Section 27, the right to access to health care. Both sections describe rights that are subject to progressive realization. See Ngwena, supra note 145, at 25. Section 26 reads:

(1) Everyone has the right to have adequate housing.

(2) The state must take reasonable legislative and other measures, within its available resources, to achieve the progressive realisation of this right.

(3) No one may be evicted from their home, or have their home demolished, without an order of court made after considering all the relevant circumstances. No legislation may permit arbitrary evictions.

S. Afr. Const. 1996 § 26.

[FN170]. Section 28(1)(c) provides "(1) Every child has the right ... (c) to basic nutrition, shelter, basic health care services and social services." Id.

[FN171]. Grootboom, 2000 (11) BCLR 1169 (CC) at para. 38 (S. Afr.).

[FN172]. Id. at para. 3.

[FN173]. Id. at para. 7.

[FN174]. Id. at para. 11.

[FN175]. Id. at para. 45.

[FN176]. Sachs, supra note 122, at 1389.

[FN177]. Ngwena, supra note 145, at 36.

[FN178]. 2002 (10) BCLR 1033 (CC) (S. Afr.).

[FN179]. Id. at para. 125.

[FN180]. Id.

[FN181]. Id. at para. 135; see also Littell, supra note 48, at 301.

[FN182]. Grootboom, 2000 (11) BCLR 1169 (CC), at paras. 32-33, 37 (S. Afr.).

[FN183]. Forman, supra note 141, at 715.

[FN184]. Lisa Forman, Claiming Equity and Justice in Health: The Role of the South African Right to Health in Ensuring Access to HIV/AIDS Treatment, in Just Medicare: What's In, What's Out, How We Decide 86 (Colleen M. Flood, ed., 2006).

[FN185]. Id. at 97.

[FN186]. Tushnet, supra note 113, at 1910-12; Paul Nolette, Lessons Learned From the South African Constitutional Court: Toward a Third Way of Judicial Enforcement of Socio-Economic Rights, 12 Mich. St. J. Int'l L. 91, 115-16 (2003). See also Mark S. Kende, The South African Constitutional Court's Construction of Socio-Economic Rights: A Response to Critics, 19 Conn. J. Int'l L. 617, 618 (2004).

[FN187]. Kinney & Clark, supra note 38, at 294 fig. 2; Littell, supra note 48, at 304. Proposals to add social rights to the Charter have been rejected. Joel Bakan, Just Words: Constitutional Rights and Social Wrongs 134-136 (1997).

[FN188]. Nola M. Ries, The Uncertain State of the Law Regarding Health Care and Section 15 of the Charter, 11 Health L.J. 217 (2003); see also Colleen M. Flood, Just Medicare: The Role of Canadian Courts in Determining Health Care Rights and Access, 33 J.L. Med. & Ethics 669, 669 (2005). Many Canadians take it for granted that the Canada Health Act bestows a specific right to access to health care; in fact, it lays out the federal funding scheme for provincial health programs.

[FN189]. Antonia Maioni, The Commission on the Future of Health Care in Canada, Discussion Paper No. 34, Roles and Responsibilities in Health Care Policy (2002) at 3-4, 24-28, available at http://www.hc-sc.gc.ca.

[FN190]. Canada Health Act, R.S.C. 1985, c. C-6, s. 7 (1985). The Act is more accurately understood to impose a “governmental obligation” or “common good.” See also Friesen, supra note 30, at 212.

[FN191]. Chaoulli v. Quebec, [2005] 1 S.C.R. 791 (Deschamps, J. at para. 16) (citing the report of the Romanow Commission, Building on Values: The Future of Health Care in Canada: Final Report (2002)).

[FN192]. Friesen, supra note 30, at 212.

[FN193]. Adopted in 1982, the Charter of Rights and Freedoms protects civil and political rights, including: freedom of expression (section 2), the right to vote (section 3), the right to travel (section 4), the right to “life, liberty, and the security of the person” (section 7), legal rights in the criminal context (sections 7-13), and (of most interest here) equality rights (section 15). The Canadian Charter of Rights and Freedoms, Canada Act Schedule B 1982 (U.K.) 1982 c. 11.

[FN194]. Colleen M. Flood, Mark Stabile & Carolyn Tuohy, What Is In and Out in Medicare? Who Decides?, in Just Medicare: What's In, What's Out, How We Decide, supra note 184, at 27 (noting that plaintiffs are generally unsuccessful in administrative law challenges and Charter challenges to government health care policy).

[FN195]. Peter W. Hogg & Allison A. Bushell, The Charter Dialogue Between Courts and Legislatures (Or Perhaps the Charter of Rights Isn't Such a Bad Thing After All), 35 Osgoode Hall L.J. 75, 80-81 (1997).

[FN196]. Id. at 81.

[FN197]. See id. at 105.

[FN198]. See Donna Greschner, The Commission on the Future of Health Care in Canada, Discussion Paper No. 20, How Will the Charter of Rights and Freedoms and Evolving Jurisprudence Affect Health Care Costs? (2002) at 1-2, 5, available at http://www.hc-sc.gc.ca/english/pdf/romanow/pdfs/20_Greschner_ E.pdf.

[FN199]. As explained earlier, see supra note 195 and accompanying text, the Canada Health Act establishes the terms of an agreement between the federal government and the provincial governments. Over time, this agreement has attained the cultural status of a right. Id. The right to health care in Canada, therefore, is akin to what Cass Sunstein calls a "constitutive commitment." See supra note 101; The Second Bill, supra note 16, at 175-192.

[FN200]. Waldman, [1999] D.L.R. (4th) 321.

[FN201]. Id. at 328-29.

[FN202]. Id. at 342.

[FN203]. Id. at 342-43.

[FN204]. Id. at 330.

[FN205]. Id. at 329.

[FN206]. Id. at 343.

[FN207]. The Court described the province's challenge over two decades of controlling the oversupply or physicians in urban areas and undersupply in rural areas. Id. at 330.

[FN208]. See Aharon Barak, Foreword: A Judge on Judging: The Role of a Supreme Court in a Democracy, 116 Harv. L. Rev. 16, 25-26, 32 (2002).

[FN209]. Id. at 326. Mia v. Med. Servs. Comm'n of B.C., [1985] 17 D.L.R. (4th) 385; Wilson v. Med. Servs. Comm'n of B.C., [1989] 53 D.L.R. (4th) 171.

[FN210]. Scott & Macklem, supra note 28, at 32.

[FN211]. [791] 1 S.C.R. 791.

[FN212]. See id. at paras. 171-73, 181 ("[I]t cannot be contested that as a matter of principle, access to private

health care based on wealth rather than need contradicts one of the key social policy objectives expressed in the Canada Health Act.").

[FN213]. Id. at para. 2 (Deschamps, J.).

[FN214]. Id. at para. 4 (Deschamps, J.); id. at para. 124 (McLachlin, C.J.).

[FN215]. The dissent likewise found that the case presented a justiciable question but disagreed that the Quebec legislation making private health insurance extremely difficult to implement impacted the appellants' Charter rights. Id. at paras. 183-85.

[FN216]. [791] 1 S.C.R. 791 at para. 85.

[FN217]. Id. at para. 89.

[FN218]. Id. at para. 95.

[FN219]. Id. at para. 96. Chaoulli is "a good example in which the courts have all the necessary tools to evaluate the government's measure. Ample evidence was presented. The government had plenty of time to act. Numerous commissions have been established ...." Id.

[FN220]. Id. Justice Deschamps stated, "[I]t seems that governments have lost sight of the urgency of taking concrete action [on waiting lists]. The courts are therefore the last line of defence for citizens." Id.

[FN221]. Id. at para. 100.

[FN222]. [791] 1 S.C.R. 791 at para. 103 (McLachlin, C.J. and Major, J., concurring).

[FN223]. See id. at para. 107. The Chaoulli dissent focused instead on the impropriety of the Supreme Court hearing the case. It forcefully highlighted the impassioned voices on both sides of the waiting list debate: detractors of the public health system spoke eloquently for the need for private insurance while supporters of the system underscored the detrimental effects of a two-tiered system of health care on a health system long committed to access based on need, not wealth. See id. at para. 161. That the case raised so much impassioned public debate indicated, according to the dissent, that "the debate is about social values. It is not about constitutional law." See id. at para. 166. At the center of the case was the issue of waiting lists, not the appellants' liberty to spend money on private medicine or to practice medicine outside the public system, respectively. "In our view," the dissent stated, "the appellants' case does not rest on constitutional law but on their disagreement with the Quebec government on aspects of its social policy. The proper forum to determine the social policy of Quebec in this matter is the National Assembly." Id. at para. 167.

[FN224]. Id. at para. 108.

[FN225]. See Antonia Maioni & Christopher Manfredi, When the Charter Trumps Health Care--A Collision of Canadian Icons, Pol'y Options, Sept. 2005, at 56.

[FN226]. Section 15(1) reads:

Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or

ethnic origin, colour, religion, sex, age or mental or physical disability.

The Canadian Charter of Rights and Freedoms, Canada Act Schedule B 1982 (U.K.) 1982 c. 11, available at http://laws.justice.gc.ca/en/charter/index.html.

[FN227]. See Ries, supra note 188, at 224-25.

[FN228]. [1997] 3 S.C.R. 624, 635-36. Among the plaintiffs was Linda Warren, a deaf woman who endured the premature and complicated birth of twins without an interpreter. The only communication she had during the birth was via gestures from the nurse. Mrs. Warren's physician did not know sign language and testified that communication during childbirth is "particularly critical." Id. at 638.

[FN229]. Id. at 650.

[FN230]. Id. at 677.

[FN231]. Id. at 681.

[FN232]. Id. at 686.

[FN233]. Id. at 692. Incidentally, the Court's analysis leaves unclear the boundaries of its ruling compelling the government to provide a specific service. Canada has a large and diverse population of immigrants, particularly in its most populous provinces like British Columbia and Ontario. If communication is integral to medical services, as the Court claims, must interpreters be provided for non-English-speaking patients? The Eldridge Court did not consider this implication and one is left to wonder whether the relatively minimal price tag of the interpreter services, particularly when compared to the overall health care budget of the province, influenced the Court's determination.

[FN234]. [2004] 3 S.C.R. 657, 663.

[FN235]. Id. at 675, 678 (noting that the parents had not established that their children were being denied a benefit provided by law or that they were treated differently compared to an "appropriate comparator group").

[FN236]. See Margot Finley, Limiting Section 15(1) in the Health Care Context: The Impact of Auton v. British Columbia, 63 U. Toronto. Fac. L. Rev. 213, 237 (2005) ("Traditionally ... Canadian courts have been reluctant to interfere with government decisions, particularly regarding the allocation of scarce resources among and within social programs.").

[FN237]. Auton, 3 S.C.R. at 664.

[FN238]. Id. at 663.

[FN239]. Id.

[FN240]. "With hindsight, it is possible to say that the government should have moved more quickly. But on the evidence before us, it is difficult to say that the government in purpose or effect put autistic children and their families 'on the back burner' when compared to non-disabled or otherwise disabled groups seeking emergent therapies ... the government's failing was that its actions ... did not meet the 'gold standard of scientific methodology."' Id. at 682. In other words, while the province may have exercised poor judgment or planning in determ-

ining how to reimburse treatments for autism, there was no evidence that this inaction was discriminatory under Section 15. See id.

[FN241]. Greschner, supra note 198, at 3. See also N.M. Ries, Legal Rights, Constitutional Controversies, and Access to Health Care: Lessons from Canada, 25 Med. & L. 45, 51 (2006).

[FN242]. Auton, 3 S.C.R. at 665. It remains to be seen whether these plans translate into better access to a greater array of treatments for autistic children.

[FN243]. Note the similarity between the Eldridge decision and the U.S. Supreme Court's decision in Maricopa County. Like Maricopa County, the Eldridge decision discusses in detail the near-fundamental importance of access to health care (and effective communication while receiving such care), particularly for a traditionally disadvantaged group like the hearing impaired. In Maricopa County, the U.S. Supreme Court similarly acknowledged the necessity of access. Nevertheless, the holdings in both cases rested not on the governments' obligations to provide health care, but on their obligation to provide services on a non-discriminatory basis. The duty to treat everyone equally under the law, under Section 15(1) of the Charter and under the Fourteenth Amendment, respectively, turns into a positive obligation to provide services when applied to the government's provision of health care services.

[FN244]. Pius N. Langa, Discussion: Social Justice and rights: The South African Model, 16 Windsor Y.B. Access Just. 149, 154 (1998) (Justice Langa sits on South Africa's Constitutional Court); see also Ngwena, supra note 145, at 40 (concluding “courts alone cannot ensure the full realization of socioeconomic rights. The onus is ultimately upon the state.”).

[FN245]. Alexis de Tocqueville, Democracy in America, Chapter 16 (1838).
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