Is There a Human Right to Private Health Care?

Aeyal Gross

1. Introduction

Recent years have seen an increase in the turn to rights discourse within the context of access to health and specifically health care. Developments took place at both the national and global levels, with a significant increase in right to health litigation around the world[1] and developments at the international level,[2] such as the appointment of a Special Rapporteur on the Right to Health[3] and the adoption of a "General Comment" on the topic by the UN Committee on Economic, Social and Cultural Rights.[4]

The social economic rights regime, recognized at the international level within the International Covenant on Economic, Social and Cultural Rights,[5] is expected by many to address questions of social-economic justice.[6] In the context of the right to health, it has the potential to assist in expanding equal access to health (and health care) and redressing disadvantage. However, a few contradictions abound: as this article shows, rights discourse has been used to attempt to advance arguments that will actually allow access to private or semi-private health insurance in ways that may exacerbate disadvantage (Canada and Israel); it is used to expand access to medications to the middle-class, sometimes (arguably at least) at the expense of the poor (Brazil);[7] and it competes with other rights (especially intellectual property within the trade regime).[8] Also, there have been attempts (even if those ultimately failed) to use rights arguments in order to undermine the expansion of access to health care under President Obama's health care reform in the U.S.[9] This is in addition to the "medicalization" of the right to health, i.e., the frequent focus on health care rather than on social determinants of health such as education, nutrition, and housing.[10]

While there has been growing attention in recent years to some of these contradictions,[11] this article focuses on the first of them: the contradiction between on the one hand the ability of the right to health to reinforce privatization and commodification of health care, by rearticulating claims to private health care in terms of human rights, and on the other hand, its ability to reinforce and reinstate public values, especially that of equality,[12] against the background of privatization and commodification.[13]

As will be discussed throughout the article, claims of access to private or semi-private health programs have been made using human rights arguments with success (Canada) and with failure (Israel). These claims may be seen as undermining the egalitarian concept of the right, but one may also wonder whether

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to quickly dismiss the argument for rights to access to private or semi-private health insurance. While that argument supports the notion of access to health care based on the ability to pay, rather than only on need, some may claim nonetheless that when the state does not provide adequate health care coverage, it is better to allow access to private/semi-private insurance in a way that will at least expand and ensure access for the middle class to important drugs and services. The upper class, it may be argued, will be able to buy the services privately without such insurance. I argue we should reject the equation of "privatization or death"[14] entailed in such an argument, and in what follows I explore what it means to think of the right to health as a tool for equality when it is clear that it is being used, or perhaps co-opted, to create a limited rather than a universal expansion of access.[15]

The article focuses on the role of rights discourse and litigation at this intersection of the public and the private, and considers the role rights play in affecting health policy and health systems at this intersection. While it does not aim to analyze the architecture of the health systems itself but rather the role that rights analysis plays within it, my baseline position is one that adopts what Colleen Flood calls "an egalitarian theory of distributive justice in allocating health care resources": that is, one that considers that access to health care should occur on the basis of need as opposed to ability to pay.[16] As Flood notes, this requirement turns the usual market assumptions on their head.[17] Health cannot and should not be treated as a commodity given a few factors: its "overriding importance" and its nature as a pre-condition to our participation in democratic, economic, and civil life, as well as it being "fundamental to our feelings of wellbeing, security, comfort and ultimately happiness";[18] the fact that inequalities in health constitute inequalities in people's capability to function,[19] in a way that makes health care different than other goods;[20] the uncertainty about our needs,[21] combined with the inelastic nature of the demand,[22] and with the information asymmetry between health providers and patients;[23] and finally the fact that given the link between social inequalities and health,[24] then generally the poorer we are the sicker we are, and thus our health care needs are bigger. All of those factors point to the special characteristics of health and to the fact that if we do not guarantee that members of society who are in greater need will get the care they need, with funding for the poor by those in society who are able to pay,[25] then we will end up increasing health disparities between the rich and the poor.

So if our starting points are these assumptions, is rights discourse at all helpful to maintain equity in the sphere of public health care, and if so, how? I will examine this issue by contrasting the position of the Canadian Supreme Court and its acceptance of the framing of a right to private health care as a constitutional right, with that of the Israeli Supreme Court and its rejection of this approach. While the Canadian and Israeli health systems against which respective backgrounds the litigation took place are very different, with the first a tax-funded system and the latter a social insurance one, both are at least nominally universal health care systems that are committed to "quality health care without financial or other barriers" (Canada)[26] and to "justice equality and mutual assistance" (Israel).[27]

2. Canada: Public Health Care/Private Rights

In *Chaoulli*,[28] the Canadian Supreme Court accepted a challenge to laws in Quebec, similar to laws existing in most other provinces,[29] prohibiting private health insurance for "medically necessary" hospital and physician services. The applicant, Dr. Chaoulli, argued that the prohibition deprives patients of timely access to health care services[30] in a way that violates a patient's rights to life and security, under both section 7 of the *Canadian Charter of Rights and Freedoms* and section 1 of the Quebec *Charter of Human Rights and Freedoms*.[31] A majority of the Court justified its decision to strike down the law under the Quebec *Charter* (no majority was reached on the Canadian *Charter*)[32] on the basis of what was portrayed as long and unacceptable waiting times in the public health care system.

The full implications of *Chaoulli* are still unclear.[33] The decision was initially thought to portend the fall of Medicare, Canada's most cherished social program, because of abandonment of the principle that access to care is allocated based on need and not ability to pay. It has been said that its outcome will be the possible creation of a two-tier *Charte*r rights structure;[34] that the implication of this decision is that section 7 of the Canadian *Charter*, rather than guaranteeing a right to publicly funded health care, guarantees a right to buy, if one is able, private insurance covering "medically necessary" services;[35] and that allowing the development of a parallel private insurance system will have serious adverse consequences for the health care rights of low-income Canadians, both by advantaging those who can purchase private health insurance and care and by drawing resources and support away from the publicly funded system upon which people living in poverty rely:[36] if the middle and upper classes do not have a vested interest in a publicly funded system that will offer good and timely services, then the support and resources for this system may erode, and it may

deteriorate into a poor service for poor people.[37] This will jeopardize access for the poor to needed health services.[38]

Indeed, the dissenting judges in *Chaoulli* emphasized that the *Canada Health Act*'s (CHA) policy is that health care will be provided based on need rather than on wealth or status and that the prohibition against private health insurance is a rational consequence of Quebec's commitment to the CHA's goals.[39] They argued further that access to private health care based on wealth rather than need contradicts the CHA's key policy objectives and the principle of promoting equal treatment of citizens in terms of health care.[40] They saw the Quebec law as essential for preventing the disintegration of the health system into a two-tier health system.[41]

At the same time others have pointed to the fact that *Chaoulli* itself, notwithstanding its eventual "political life," has not in fact radically changed the face of Medicare nor ushered in a two-tier system of health care, and should be read on its limited terms. This is especially so given that the Court was equally split on the question of whether the Quebec prohibition violated the Canadian *Charter*, thus limiting the decision as precedent to the province of Quebec alone.[42] In reality, as a result of *Chaoulli*, Quebec has liberalized the law regarding private health insurance for hip, knee, and cataract surgery, while at the same time putting in place a wait time guarantee. Flood and Haugan point to the fact that this policy may negate incentives, if successful, to buy private health insurance in a way that will make the liberalization largely moot.[43] At the same time, new constitutional challenges to regulations restricting the flourishing of a private pay system are now pending in three Canadian provinces, and if successful, may result in the dismantlement of the Canadian model with its emphasis on universality and fairness.[44]

In Canada, Medicare is considered a symbol of Canadian values, and equal and timely access to medically necessary services based on need is considered a right of citizenship: equality of access is considered a core and defining feature of the system.[45] Canada, through its ten provinces, has a series of well-established health care systems, all somewhat different but each committed to principles of universality and accessibility. However, at the same time, as health care spending has increased, particularly as a proportion of total provincial government spending, social assistance programs and benefits have been reduced across the country.[46] In *Chaoulli*, the Court cited the principles of the CHA, including universality and accessibility of healthcare to everyone, and agreed that they have become "the hallmarks of Canadian identity."[47]

As we can see, *Chaoulli* actually justified a policy that would allow for wealth rather than need to determine such access: the idea of access was interpreted in a way that actually reinforces the relationship between wealth and health care, opening the door to a system where the determining factor will not be need but rather the ability to pay for private health insurance.

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Recognition of a positive right to health (i.e., the right to publicly funded timely care) within the framework of s. 7 of the Canadian *Charter* that incorporates the idea of "accessibility" could lead to different results. Such a recognition would interpret "accessibility" as including economic accessibility and as focused, as suggested in General Comment 14, on socially underprivileged groups, and "equity" as mandating that the health expenditure burden borne by poor households not be disproportionate to that borne by wealthier households;[48] thus, a commitment to an egalitarian concept of rights may have led to the requirement that the state must take steps to reduce waiting times in a way that will improve access to *all* within the public system, and not just to the privileged few.[49] As noted by Bruce Porter, "If waiting times in the public system violate the right to life and security, what about the plight of the many who cannot afford private insurance or who will not qualify for it because of illness?"[50] In reality, as Sujit Choudhry suggests, the outcome reached in *Chaoulli* (especially when read with other Canadian Supreme Court cases rejecting arguments for services which were not provided) may be that "those who can afford private health care have won

the right to exit the system, while those trapped in the system without the means to exit get no help at all."[51]

The Canadian case is a paradoxical one: the principles of the CHA which are cited repeatedly emphasize universality and accessibility of health based on need and not on wealth, and health is considered a hallmark of Canadian identity. But at the same time as the system faces the crisis of growing needs and limited resources, coupled with the lack of recognition of a right to health (although arguably the Supreme Court may have reached the same conclusions even based on the recognition of such a right), the Court's approach in *Chaoulli* and other cases stops short of deciding the issues based on the ideals of universality and equal accessibility. Specifically *Chaoulli* is a judgment where in the face of limited resources, rights analysis reinforces privatization in a way that may exacerbate inequality, rather than the opposite.

3. Israel: Private Health/Public Rights

The term "Private Health Services" (PHS)[52] has been used in Israel to refer to a program that allowed patients to choose their doctor — specifically surgeons — within public hospitals, for an additional out-of-pocket payment by the patient. These programs were initiated in governmental hospitals since 1996, through private companies that entered into agreements with the hospitals' research funds.[53] In 2002, the Attorney General pronounced this practice illegal. Both a group of doctors and a group of citizens challenged this determination, but in 2009, the High Court of Justice (HCJ) gave a judgment, *Kiryati*,[54] rejecting their petition and upholding the Attorney General's decision concerning the illegality of the PHS. Writing for the HCJ, Justice Berliner noted that while the PHS was limited in reality to the election through payment of surgeons in governmental hospitals, the issue before the court actually had much broader implications. For example, allowing the PHS would open the door to the possibility of providing of a wide array of health services for pay, through a payment additional to the health tax which all residents pay based on their income, as part of Israel's national health insurance scheme. This, said Justice Berliner, could have significant implications on the character of the health system in Israel, which she described as national and public, and one which is subsidized by the state, with each citizen paying a fixed monthly sum from his or her salary regardless of his or her medical condition, and receiving treatment in accordance with his or her needs.[55] This was in contrast to the PHS, under which the patient could choose the surgeon based on a private out-of-pocket payment, generally in order to ensure treatment by more senior specialists.[56] However, the delivery of health services in hospitals should be according to medical considerations only, held Justice Berliner, and in no way based on an increased capability to pay: the physician with the most expertise will treat the person whose condition requires his or her expertise, and not the person who can buy these services.[57] The services provided to citizens within state hospitals is a public service given for free, and any ability to buy an improved service within the public service which is normally given for free, must be provided for in legislation.[58] Giving those with means a real advantage through choosing a doctor by payment, and thus separating them from the others insured under the National Health Insurance Law (NHIL), violates the fundamental principles of the public health care system in Israel, as articulated in Article 1 of the NHIL: justice, equality, and mutual assistance.[59] While there is a question here of the choice between socialism and a market economy, this decision, she noted, must be made by the legislature: it is up to it to determine whether PHS should be integrated into the health system in Israel.[60]

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The petitioners in this case tried to use a rights approach. They made the following arguments:

- the health system in Israel is not equal as it is;
- there is an equality of opportunity since everyone can purchase PHS services; and
- the prohibition of PHS violates the rights enumerated in the Patients' Rights Law, and also the Basic Law: Human Dignity and Liberty, which protects the autonomy of the individual, including the individual's right to elect the doctor and the hospital in which he or she would be treated.[61]

Justice Berliner rejected these arguments, relying on the previous determinations by the HCJ that only the right to human existence in minimal dignity was recognized in the case law, and not a broader right to health. A right to choose a physician, she said, is not within the core services required for a person for the maintenance of human existence in dignity.[62] Moreover, if the right to choose a physician would have been part of the personal autonomy recognized by the Basic Law, this would have required allowing each patient to elect a physician without payment as part of the Health Services Basket (HSB). The protection of autonomy does not mean that the citizen has a right to each choice in this sphere just because he or she can pay for it.[63]

Justice Berliner's opinion in the PHS case shows a commitment to the principles of the NHIL and to a public health care system where medical services are provided in accordance with need and not the ability to pay — that is, a commitment to an egalitarian concept of health care. Her judgment is also useful in its rejection of the rights argument, with the HCJ justifiably holding that if autonomy means the right to choose one's doctor, then all patients should have this right, and not just to those who can pay for it. This stands in contrast to the Canadian Supreme Court decision in *Chaoulli*,[64] which protected access to private health insurance in the name of the protection of the right to security of the person — but only for those who can pay for it.

Interestingly, to reach her conclusion Judge Berliner relied on the narrow, minimal recognition of the right to health as part of the right to human dignity that was recognized in Israeli law.[65] This minimal understanding served here to justify equal access to health care rather than the opposite. However, given Justice Berliner's rejection of the argument from autonomy, she could have presumably rejected an argument made from the right to health even if that right had been accorded broader recognition by Israeli law, through adopting the same logic she adopted regarding the right to autonomy, i.e., one that requires equal access to rights regardless of the ability to pay. We can consider then reading *Kiryati* that rights discourse can be used, as was done by the petitioners here, to try and advance privatization within the health care system in a way that will expand inequalities. However, a concept of rights grounded in a substantial concept of equality[66] — which was adopted in this case by the HCJ — will reject such claims and point to the fact that for a rights argument to be justified, it must be shown that access is equal and not dependent on the ability to pay. While the judgment left many questions open, including the implications of potential legislation that will allow the PHS program, and was based more on the negation of a positive rights argument than on the recognition of a positive right to health care, it did reject the attempt to use rights analysis in order to reinforce privatization.

At the same time, and as the petitioners justly argued, other factors within the Israeli health care system already undermine the principle of equality and include elements of privatization. Justice Berliner's description of the Israeli health care system seems highly idealized. While the *Kiryati* judgment should be applauded for rejecting the attempt to use rights discourse to increase unequal access, reading it should not make one forget the many forms of inequality and the many places in which access to services, including public services within the HSB, is actually subject to the ability to pay. The one aspect of existing inequality (beyond the PHS) mentioned in *dicta* by the HCJ in *Kiryati* was that of supplementary insurance, offered in Israel by the Sick Funds (who are the providers of health care in the Israeli system) for an extra fee. While Justice Berliner accepted that these violated equality, she determined this violation (unlike the PHS) is anchored in an explicit statutory provision that allowed the Sick Funds to offer the supplementary insurance. She also noted the relevant low price of the premium and the fact that the supplementary insurance covers treatments not covered by the HSB, and thus unlike the PHS does not discriminate between patients regarding access to the most essential services, those covered by the HSB.[67]

However, Justice Berliner's discussion neglects the co-payments that do discriminate between patients regarding access to the HSB itself. This neglect is especially telling as the discussions of the supplementary insurance follows a quote by Justice Berliner from Article 8 of the NHIL, including the paragraphs concerning the co-payments, but does not discuss them. Notwithstanding this silence, her logic must lead to the conclusion that co-payments are illegal. Arguably, the logic of *Kiryati* may serve in future challenges to co-payments, which have become a major bar to equal access within the public health insurance system in Israel.[68] In a previous case the HCJ upheld significant co-payments demanded for cochlear implant operations provided within the HSB, rejecting arguments from rights in the name of deferral to government policy:[69] consider then that while *Kiryati* prohibited discrimination between patients within the public hospital in regard to choice of surgeon, based on the ability to pay, the previous judgment actually upheld discrimination within the public hospital, based on the ability to pay, regarding the very possibility of even having an essential operation. This gap points to the

limit of the HCJ's discourse, and perhaps to the fact that it was easier for it to protect equality in *Kiryati*, where for doing so, it did not need to intervene in, but rather upheld, government policy. In order to hold co-payments illegal in the name of equal access, the HCJ would have to go one step further than it did in *Kiryati,* where it upheld government policy in the name of equal access while rejecting rights based argument that tried to undermine the policy, and actually use rights discourse to create a *positive right* to equal access while striking down government policy.

The question of the supplementary insurance itself[70] was also the subject of litigation when some of the Sick Funds in 2007 introduced new upgraded "platinum" or "gold" supplementary insurance, which would cover medications not included in the HSB, including life-saving and life-prolonging medications. Whereas the supplementary insurance previously covered services considered "nice to have" (e.g., second opinion, alternative medicine, and more), it had not covered potentially life-saving or life-extending medications. By that time, about 80% of the population was insured through supplementary insurance[71] and presumably, given the relatively small premium increase involved, most people would have chosen to upgrade to the new programs. The new programs created controversy, with critics arguing that the inclusion of potentially life-saving or life-extending medicines in supplementary insurance would eventually lead to the erosion of the universal HSB: it would create two baskets, one for the ones who can afford the "gold" or "platinum" programs (which would have been more expensive than the existing supplementary insurance, but not significantly so) and a second for those who cannot. The result would be a decrease in the pressure to update the HSB, as those with the power to create such political pressure would have access to the richer basket.[72]

Although the new programs were initially approved by the Ministry of Health, as a result of widespread opposition the NHIL was amended in 2008 to include a provision that programs for "additional health services," the formal name for the supplementary insurance, cannot include life-saving or life-prolonging medicines.[73] During the discussion of this amendment in the Knesset, the legal advisor to the Labor, Welfare and Health Committee issued an opinion arguing the proposed bill violates the constitutional rights to life and dignity of members of the Additional Health Services plan. The opinion argued that these members would be left with the alternative of buying expensive drugs for their full price, or buying private commercial health insurance — an option not viable to many of them due to age, medical condition and financial condition. Since the amendment would reduce the number of patients with access to life-saving and life-prolonging medications (that are not covered within the HSB), it would also increase inequality.[74] Similar arguments were made in the *Levy* petition, which asked the HCJ to declare the amendment as unconstitutional under the Basic Law.[75] During oral argument, the HCJ suggested to the petitioner that they withdraw the petition, with President Beinish citing the values of "justice, equality and mutual assistance."[76] The petitioner eventually agreed, and the result is that the HCJ's position remains unanchored in a judgment. Nonetheless, in this case, just as in the *Kiryati* case, the HCJ *de facto* rejected arguments that attempted to argue for a constitutional right to further privatize the health system. At the same time, the legal opinion issued in the Knesset on this matter and cited above, as well as the petition itself, shows that this type of argument is being made within the Israeli legal system and may in the future gain more resonance.

4. Conclusion

As Colleen Flood notes, in every country there is in reality a two-tier system, but the specter of what she calls "an unacceptable two-tier system" may be significantly lessened if a comprehensive range of health care services is included in the publicly funded basket and if it is ensured that the quality of services is at a level acceptable to the majority of society.[77]

The cases discussed in this article illustrate how introducing human rights to the area of public health care may be used not to expand equality, but rather to re-articulate claims to private health care as human rights claims. These kinds of arguments, if successful, implicate rights in the shifting of part of the financing of the health system from public funding (through general taxation or social insurance) to private funding. As Robert Evans argued, whereas public funding places a larger burden on people with higher incomes, and does not give them access to better or more prompt care, a shift to more private funding places a larger burden on those who become ill, or are at most risk of becoming ill, and also permits people with higher incomes to buy their way to the front of the queue and ensure that "rationing" is imposed on others.[78]

In both Canada and Israel, the challenged legislation aimed to curtail or at least restrict the creation of a two-tier system, but with notable differences. The Canadian case's legislation barred private health insurance, but in the Israeli cases, the legislation aimed to restrain the existing incursion of private elements into the public system. However, in both countries what the legislation under attack attempted to prevent was a shift from accessibility based on medical need, to

accessibility based on the ability to pay. In *Chaoulli* and in *Levy,* as well as in *Kiryati*, rights arguments were made in a way that aimed to undermine regulation that may be seen as lessening the "specter of an unacceptable two-tier system" through the protection of the publicly funded system and the restriction put upon exiting from it into privately funded systems that will provide essential services. Although the Canadian courts have accepted this line of argument, and Israeli courts rejected it, one should also consider the limit of these decisions. While the Canadian case of *Chaoulli* may not have had the broad implications its critics feared, the Israeli cases represented deferral to the existing state policy rather than judicial intervention in the name of equality, and as noted above, previous case law concerning co-payments points to the limits of the HCJ's intervention, to date, in the name of equality in health care. Moreover, the HCJ refused to intervene when the state allowed a program similar to the one addressed in *Kiryati* in a non-governmental but publicly funded hospital.[79] At the same time, the Israeli Court's position is significant in its rejection of the right to private health care for those who can pay for it, while the Canadian Court seemed to have opened the door for the recognition of such a right.

Paul O'Connell pointed to the ways in which the market paradigm, which is dominant in neo-liberalism, conflicts with the human right to health, in a manner that raises questions about the extent to which the right to health can genuinely be realized in a context of market hegemony. He further points to the ways in which commitment to neo-liberalism means adopting a logic of privatization and commodification which in turn produces exclusions that are at odds with the principles of equality and non-discrimination which are at the heart of the right to health.[80] While I share O'Connell's concern, as we have seen throughout this article, rights discourse may sometime actually be *part of* the processes of privatization and commodification, rather than "at odds" with them. Indeed a notion of rights that incorporates the principles of substantive equality will not be part of these processes,[81] rather the opposite. However, one of the unintended consequences of inserting rights analysis into public health care may be that it will reinforce rather than challenge privatization. As we have seen throughout the article both can happen, and unless we insist on a concept of rights grounded in substantial concept of equality, then the idea of an abstract right may actually undermine the promise of equality that draws advocates of health equity to the human rights arena.

Note

The author is a member of the Association for Civil Rights in Israel which was involved in some of the Israeli litigation discussed in the article. The opinions expressed in the article, however, are his own.

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2. On the right to health at the international law level, see J. Tobin, *The Right to Health in International Law* (Oxford: Oxford University Press, 2012).
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4. General Comment 14: The Right to the Highest Attainable Standard of Health (Article 12), E/C12/2000/4, CESCR (August 11, 2000). These developments were accompanied by the proliferation of research on the topic as apparent in journals, research institutes and different publications addressing the link between health and human rights. See A. Gross, "The Right to Health in an Era of Privatization and Globalization: National and International Perspectives," in D. Barak-Erez and A. Gross, eds., *Exploring Social Rights: Between Theory and Practice* (Oxford: Hart Publishing, 2007): at 289-339, 291.
5. International Covenant on Economic, Social and Cultural Rights, G.A. Res. 2200A (XXI), 21st Sess., Supp. No. 16, U.N. Doc. A/6316 (December 16, 1966).
6. See generally Barak-Erez and Gross, *supra* note 4.
7. See O. L. Motta Ferraz, "The Right to Health in the Courts of Brazil: Worsening Health Inequities?" *Health and Human Rights* 11, no. 2 (2009): 33-45; M. Prado, "Provision of Health Care Services and the Right to Health in Brazil: The Long, Winding and Uncertain Road to Equality," in Flood and Gross, eds., *supra* note 1. On the right to health as potentially "skewing" public resources, see W. Easterly, Financial Times, *Human Rights Are the Wrong Basis for Healthcare* (October 12, 2009).
8. For the latter topic, see Gross, *supra* note 4, at 289-339, 331-336; P. O'Connell, "The Human Right to Health in an Age of Market Hegemony," in Harrington and Stuttaford, eds., *supra* note 3, at 190-209, 203-205. See also E. R. Gold, "Patents and

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9. A. Hoffman, "An Emerging and Endangered New Right to Health: Expanding Access through U.S. Health Reform," in Flood and Gross, *supra* note 1.
10. See on "medicalization" in this context B. M. Meier, "The World Health Organization, the Evolution of Human Rights, and the Failure to Achieve Health for All," in Harrington and Stuttaford, eds., *supra* note 3, at 163-189. On social determinants, see A. Chapman, "The Social Determinants of Health, Health Equity and Human Rights," *Health and Human Rights* 12, no. 2 (2010): 17-35.
11. In the context of right to health litigation, see especially the literature cited in *supra* notes 1 and 7; see also A. Clapham and S. Marks, "Health," in *Human Rights Lexicon* (Oxford: Oxford University Press, 2005): at 197-208.
12. The relationship between the concepts of "equality" and "equity" in this context is a complex one that goes beyond the scope of this article. Dahlgren and Whithead argue that "health inequalities count as inequities when they are avoidable unnecessary and unfair." See G. Dahlgren and M. Whitehead, *Policies and Strategies to Promote Social Equity in Health. Background Document to WHO – Strategy Paper for Europe* (Stockholm: Institute of Future Studies, 1991), *available at* <http://www.framtidsstudier.se/wp-content/uploads/2011/01/20080109110739filmZ8UVQv2wQFShMRF6cuT.pdf> (last visited February 11, 2013). However, as Yamin notes, "There is no consensus as to what is avoidable, unnecessary, and unfair": see A. E. Yamin, "Shades of Dignity: Exploring the Demands of Equality in Applying the Human Rights Frameworks to Health," *Health and Human Rights* 11, no. 2 (2009): 1-18, at 9. For the purpose of the discussions here, I work under an understanding that both "equality" (understood as substantive equality) and equity share in the basic idea of health justice addressed in the text, which requires that access to health should be based on need and not on one's ability to pay for it. For a discussion of the complexities of the concept of equality in the context of health rights, see Yamin, *id*.
13. On this background, see S. McGregor, "Neoliberalism and Healthcare," *International Journal of Consumer Studies* 25, no. 2 (2001): 82-89; D. Filc, "The Health Business under Neo-Liberalism: The Israeli Case," *Critical Social Policy* 25, no. 2 (2005): 180-197.
14. This terms follows on a letter from Avner Pinchuk, The Association for Civil Rights in Israel, on behalf of Adva Center, Physicians for Human Rights-Israel and the Association for Civil Rights in Israel, "The Exclusion of Life Saving Medicines from the Sick Funds Additional Health Services," to the Speaker of the Knesset and others (December 23, 2007).
15. For a discussion of how in the U.S. resort-to-rights discourse with its individualist bent may, in the context of public health, entail risks of co-opting the right to health to the detriment of sound public health policies, see P. Jacobson and S. Soliman, "Co-opting the Health and Human Rights Movement," *Journal of Law, Medicine & Ethics* 30, no. 4 (2002): 705-715.
16. C. Flood, *International Health Care Reform: A Legal, Economic and Political Analysis* (London: Routledge, 2003): at 27.
17. *Id*., at 28.
18. *Id*.. See also S. Anand, "The Concern for Equity in Health," in S. Ahmed, F. Peter, and A. Sen, eds., *Public Health, Ethics and Equity* (Oxford: Oxford University Press, 2004): at 15-32, 16, discussing the intrinsic and instrumental value of health and its critical nature because it directly affects a person's well-being and is a prerequisite to her functioning as an agent.
19. *Id.* (Anand), at 17-18. See also A. Sen, "Why Health Equity," in S. Ahmed, F. Peter, and A. Sen, eds., *Public Health, Ethics and Equity* (Oxford: Oxford University Press, 2004): at 21-33.
20. As Anand notes, inequalities in health, nutrition and health care offend us much more than inequalities in clothes, furniture, motor cars or boats. Anand, *supra* note 18: 17.
21. See Flood, *supra* note 16, at 28.
22. The inelastic nature of the demand means that people will continue to buy health insurance and services even when very expensive, and the demand for services is relatively unresponsive to changes in price. See Flood, *supra* note 16, at 19.
23. See Flood, *supra* note 16, at 23-25.
24. See N. Daniels, B. Kennedy, and I. Kawachi, "Health and Inequality, or, Why Justice Is Good for Our Health," in Ahmed, Peter, and Sen, eds., *supra* note 18, at 63-91.
25. See Flood, *supra* note 16, at 28.
26. Canada Health Act, R.S.C., c. C-6, s. 3 (1985). For background to the Canadian health system, see C. Flood, "Litigating Health Rights in Canada: A White Knight for Equity?" in Flood and Gross, *supra* note 1.
27. The National Health Insurance Law, 5754 – 1996, 1469 LSI 156 §1 (1994) (Isr.) (Hebrew). For background to the Israeli health system, see A. Gross, "The Right to Health in Israel Between Solidarity and Neo-Liberalism," in Flood and Gross, *supra* note 1.
28. *Chaoulli v. Quebec (Attorney General)*, [2005] 1 S.C.R. 791, 2005 SCC 35.
29. M. Jackman, "Misdiagnosis or Cure: *Charter* Review of the Health Care System," in C. Flood, ed., *Just Medicare: What's In, What's Out, How We Decide* (Toronto: University of Toronto Press, 2006): at 58-79, 59.
30. See *Chaoulli*, *supra* note 28, at para 2.
31. See *Chaoulli*, *supra* note 28, at para 14; *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act,* 1982, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11; *Charter of Human Rights and Freedoms*, R.S.Q., c. C-12.
32. The case was decided by a 4-3 majority. All four majority judges held that the statute violated the Quebec *Charter*. Three of them determined that it also violated the Canadian *Charter*.
33. For a comprehensive look see C. Flood, K. Roach, and L. Sossin, eds., *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (Toronto: University of Toronto Press, 2005).
34. C. Flood, "Introduction," in Flood, ed., *supra* note 29, at 5. See also Andrew Petter's description of *Chaoulli* as possibly implying that Canadians who can afford private health insurance will have access to better medical care than those who cannot. A. Petter, "Wealthcare: The Politics of the Charter Revisited," in Flood, Roach and Sossin, eds., *supra* note 33, at 116-138, 116. The decision was also criticized for lacking a serious factual basis which would justify the reasoning that allowing private health insurance will improve accessibility. See also page 118 of the same book; C. Flood, M. Stabile, and S. Kontic, "Finding Health Policy 'Arbitrary': The Evidence on Waiting, Dying and Two-Tier Systems," in Flood, Roach, and Sossin, eds., *supra* note 33, at 296-320.
35. C. Flood, M. Stabile, and C. Tuohy, "What's In and Out of Medicare? Who Decides?" in Flood, ed., *supra* note 29, at 15-41, 28. Similarly the dissenting judges in *Chaoulli* warned of use of the *Charter* by the wealthy to "roll back" benefits of a legislated scheme that helps the poor. See *Chaoulli*, *supra* note 28, at para. 274.
36. See Jackman, *supra* note 29, at 66. The Court in *Chaoulli* did express the view that the prohibition on private insurance will create an obstacle especially for people with average incomes, as the very wealthy can afford to pay for entirely private services. See *Chaoulli*, *supra* note 28, at para. 55. See also the concurring opinion at para. 106.
37. On such risks see Flood, *International Health Care Reform*, *supra* note 16, at 34.
38. *Id.* (Flood).
39. See *Chaoulli*, *supra* note 28, at para. 164.
40. *Id*., at para. 181.
41. *Id*., at para. 166.
42. See P. Russel, "*Chaoulli*: The Political versus the Legal Life of a Judicial Decision," in Flood, Roach and Sossin, eds., *supra* note 33, at 5-18, 6-9; B. Dickens, "The *Chaoulli* Judgment: Less Than Meets the Eye – or More," in Flood, Roach, and Sossin, eds., *supra* note 33, at 19-31, 25.

43. C. Flood and A. Haugan, "Is Canada Odd? A Comparison of European and Canadian Approaches to Choice and Regulation of the Public/Private Divide in Health Care," *Health Economics, Policy and Law* 5, no. Special Issue 3 (2010): 319-341, 335-336.
44. See Flood and Hugan, *supra* note 43, at 321. See also A. Picard, "Who's Fighting for Private Health Insurance in Canada?" *The Globe and Mail*, September 25, 2012, *available at* <http://www.theglobeandmail.com/life/health-and-fitness/whos-fighting-for-private-health-insurance-in-canada/article4568340/> (last visited February 11, 2013).
45. See Jackman, *supra* note 29, at 58-59 and sources cited therein; Petter, *supra* note 34, at 117.
46. See Jackman, *supra* note 29, at 65.
47. See *Chaoulli*, *supra* note 28, at para. 6.
48. See General Comment 14, *supra* note 4, at 12(b).
49. See Petter, *supra* note 34, at 117-119.
50. B. Porter, "A Right to Health Care in Canada – Only If You Can Pay for It," *ESR Review* 6, no. 4 (2005): 8-12, *available at* <http://www.communitylawcentre.org.za/ser/esr2005/2005nov_canada.php#canada> (last visited February 11, 2013).
51. S. Choudhry, "Worse Than Lochner?" in Flood, Roach and Sossin, eds., *supra* note 33, at 75-100, 93-94.
52. In the Hebrew acronymic "Sharap".
53. For a discussion, see G. Ben-Nun, Y. Berlovitz, and M. Shani, *The Health System in Israel*, 2d ed. (Tel Aviv: Am Oved Publishing, 2010) (Hebrew): at 131-137; Y. Shuval and O. Hanson, *Ha'Ikar HaBriut [Most Importantly, Health]* (Jerusalem: Magnes, 2000) (Hebrew): at 307-314.
54. HCJ 4253/02 *Kiryati et v the Attorney General* [2009] Nevo Legal Database (by subscription) (Isr.).
55. See *Kiryati*, *supra* note 54, at para. 2.
56. *Id.*, at para. 3.
57. *Id.*, at para 34.
58. See *Kiryati*, *supra* note 54, at para. 36. Concurring Justice Naor expressed the opinion that primary legislation is not required in order to allow for PHS while concurring Justice Jubran chose to leave the answer open. Thus there is no majority opinion on this point.
59. See *Kiryati*, *supra* note 54, at para. 41.
60. See *Kiryati*, *supra* note 54, para. 48. Justice Berliner based her decision also on a few statutory provisions, including the prohibition on the use of state property for private use without the government's approval, the prohibition on the provision by a private health cooperation of medical services in a public health care organization; and the prohibition on the provision on health services by a physician in a public health care organization except for services given within his employment. See *Kiryati*, *supra* note 54, at paras. 26-27. A later petition questioned the legality of PHS in publicly funded hospitals which provide public services, but are operated by private companies and are not government hospitals in the same way the hospitals addressed in *Kiryati* were. The HCJ rejected the petition, basing its reasoning mostly on the laches doctrine, holding that the petition was submitted with significant delay, but also distinguishing the case from *Kiryati* based on the difference between the types of hospitals involved. Addressing the question of whether because of the nature of the rights involved the HCJ should consider the merits of the case notwithstanding the delay, the Court noted that even if the right to equal access to health care is to be recognized as derivative of the constitutional right to human dignity, then the right is at the periphery and not at the core of the constitutional right. HCJ 2114/12 *The Association for Civil Rights in Israel vs. Government of Israel*, The Judicial Authority Website [2012] (Isr.) (Hebrew).
61. See *Kiryati*, *supra* note 54, at para. 24.
62. *Id.*, at para. 52.
63. *Id.*, para. 57.
64. See *supra* notes 28-32 and accompanying text.
65. See A. Gross, "In Search of the Right to Health in Israeli Constitutional Law," in *Israeli Constitutional Law at a Crossroads*, edited by A. Barak, D. Barak-Erez, and G. Sapir (Oxford: Hart 2013, forthcoming).
66. See M. Horwitz, "Rights," *Harvard Civil Rights-Civil Liberties Law Review* 23, no. 2 (1988): 393-406.
67. See *Kiryati*, *supra* note 54, at para. 42.
68. On the issue of co-payments, see Gross, *supra* note 27.
69. HCJ 2974/06 *Israeli v Committee for the Expansion of the Health Basket* [2006] The Judicial Authority Website (Isr.)
70. On supplementary insurance, see C. Shalev, *Health, Law and Human Rights* (Tel-Aviv: Ramot, 2003) (Hebrew): at 255-258, 262-263.
71. Ben-Nun, Berlovitz, and Shani, *supra* note 53, at 256-261.
72. See letter from Pinchuk, *supra* note 14.
73. The National Health Insurance Law, 5754-1996, 1469 LSI 156 §10(b)(4) (1994) (Isr.) (Hebrew).
74. See letter from Judy Wasserman, Legal Advisor to the Knesset's Labor, Welfare and Health Committee, "The Prohibition on the Including of Life Saving and Life Prolonging Medicines in the Additional Health Services Plans," to the Speaker of the Knesset and others (December 13, 2007) (Hebrew).
75. HCJ 73/08 *Levy v. The Knesset*, The Judicial Authority Website (Isr.) (Hebrew).
76. E-mail from Avner Pinchuk who represented the Association for Civil Rights in Israel in the proceedings, dated July 17, 2008 (Hebrew).
77. See Flood, *supra* note 16, at 274.
78. R. Evans, "Health Care Reform: Who's Selling the Market, and Why," *Journal of Public Health Medicine* 19, no. 1 (1997): 45-49, at 47. See also R. Evans, "Going for the Gold: The Redistributive Agenda behind Market-Based Health Care Reform," *Journal of Health Politics, Policy and the Law* 22, no. 2 (1997): 427-465.
79. See *The Association for Civil Rights in Israel*, *supra* note 60. For a discussion of the HCJ's reasoning in the case, see *supra* note 60.
80. See O'Connell, *supra* note 8, at 190-209.
81. See Horwitz, *supra* note 66. See also in this context Norman Daniels's argument that we may claim a right to health care only if it can be harvested from an acceptable general theory of distributive justice or from a more particular theory of justice for health and health care, that will tell us which kinds of right claims are legitimate. N. Daniels, *Just Health: Meeting Health Needs Fairly* (Cambridge: Cambridge University Press, 2008): at 15.