DOES THE CONSTITUTIONAL RIGHT TO HEALTH MATTER? A REVIEW OF CURRENT EVIDENCE

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Introduction

In recent decades there has been a tension between the exercise of the right to health by individuals and health-care priority-setting at the level of the general population. Health is widely recognized as a basic human *right*. However, it has been claimed that the introduction of a legally enforceable right to health and associated court rulings has led to distortions that undermine the optimal resource allocation of health care and potentially harm population health (Yamin, Gloppen and Bergallo 2011; Hogerzeil et al. 2006). This claim represents a population health issue that goes beyond the question of human rights laws within court systems.

Considering the right to health as a statement of a desirable goal creates ethical issues. Thinking about the right to health as a legal instrument for achieving desirable health outcomes, however, we have formulated an empirical question that can be addressed with data: namely, does the introduction of a right to health or associated legal rule X improve or deteriorate population health outcomes measured by Y, implied by a right to health?

The empirical examination of health laws has recently grown in the area of empirical legal studies. Researchers have conducted hundreds of studies using data to estimate the effects of health laws on accident rates, health outcomes, health care utilization and costs and other outcome variables (Mello and Zeiler 2008). The empirical examination of a legal right to health or an associated legal rule can be seen as part of this empirical legal tradition.

There are at least three objectives in the empirical investigation of a legal right to health or to health care. The first is to examine whether or not a right to health in constitutions or associated health laws is consistent with achieving the health objectives of the targeted population implied by the right. Secondly, it is equally important to check whether or not such legal strategies are, in fact, the most effective way to translate this right into actual health policies and health outcomes. Thirdly, attention should also be paid to the side effects of such legal strategies. The right to health is not the only goal of a society. The implementation of such rights must be financed through national budgets, which may mean that the implementation of one right harms other, competing social objectives.

To maximize the benefit and minimize the cost of a legal right to health, the right to health as a legal instrument requires strong empirical evidence. This article summarizes recent progress and challenges associated with empirical investigations of the imposition of a right to health or associated health legislation. We confirm the health- or health-care-access improving effects of these laws and no health-deterioration effects based on the available studies. The rest of the paper is organized as follows. The next section summarizes the historical development of a right to health or to health care as legal instruments for improving individual and population health. The following section discusses the concept and definition of a right to health or to health care. Section *Constitutional right to health and its direct effects* examines the literature on the constitutional right to health and its direct effect on health outcomes. Section *Health legislation, regulations, and access to health care: lessons from the United States and other developed countries* examines the literature on health legislations enacted in order to achieve this right and assesses their effect on population health outcomes. The last section concludes the paper.

From social objectives to legal instruments

Before the 20th century, the right to health or to health care was merely an ethical norm, or, at most, it was considered to be one of the objectives of social progress.

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The idea that it is the government's duty to secure patients' access to health care or maintain an adequate level of health existed previously, but it was not until the last half of the 20th century that a right to health came to be incorporated into national and international laws and began to be considered as a legal instrument for achieving the health objectives implied by this right.

The idea of a right to health first appeared in the political arena in the late 18th century. During the French Revolution, revolutionaries incorporated the idea of a social contract into their theory of public health and sought to implement a right to health (La Berge 1992). Reformers, however, soon faced political, religious, and professional opposition once the revolutionaries seized power (Weiner 1993). In the end, the term "health" was eventually excluded from the Declaration of the Rights of Man and of the Citizen in 1789, as well as from the French Constitutions of 1791, 1793, and 1795. On the other side of the Atlantic, the term "right to health" first appeared prior to 1796 during congressional debates over quarantine laws in US politics (Visscher 1972).

One hundred years later, Article 7 Section 20 of the Wyoming Constitution of 1889 in the United States recognized a right to health in the state's constitution.[2] Since then, the right to health has increasingly been given a more concrete form through certain definitions and measurements with a view to applying this right to actual health policies. In 1936, the USSR became the first nation to provide a guarantee of access to health care at the national level, although Article 120 of the USSR Constitution focused exclusively on access to health care rather than on a right to health in general.[3] The provision is also clear about the strategies to achieve this right to health care access.[4]

The concept of a right to health has spread widely from the constitutions of socialist countries to the constitutions of democratic countries, but is called "a right to health" rather than "a right to health care" in the post-World War period. The Constitution of the Italian Republic enacted in December 1947 became the first democratic nation's constitution to recognize the right to health at the national level.[5] In December 1948, the Universal Declaration of Human Rights (UDHR) was adopted by the 56 members of the United Nations.[6] Article 25 of the UDHR provides for an "adequate" level of medical care and other necessary social services for health and well-being. Furthermore, the International Covenant on Economic, Social and Cultural Rights (ICESCR) was adopted as a legally binding treaty in December 1966.[7] Ambitiously, the ICESCR moves the goal from an "adequate" level of medical care to the "highest attainable standard". Finally, the Declaration of Alma Ata (1978) and General comment 14 of the UN Committee on Economic, Social, and Cultural Rights (2000) further addresses this issue and provides a more detailed list of what the right to health should include. With greater recognition of this right by the international community, a constitutional right to health has spread to a number of Latin American and African countries since 1980.

In Latin America, South Africa and other parts of the world, courts have started assuming more active roles in redressing the failures of government health policy by using this right in the last 20 years (Hogerzeil et al. 2006). Successful cases have been primarily connected to constitutional provisions of this right, which are supported by international treaties (Hogerzeil et al. 2006; Biehl et al. 2012).

The emergence of judicial activism regarding health rights attracts both praise and criticism. While some see this right as a powerful tool in the struggle against poverty and health inequality, others criticize that this rights-based litigation has distorted the allocation of health resources and should be used as a last resort (Pieterse 2008; Yamin, Gloppen and Bergallo 2011; Hogerzeil et al. 2006). The empirical investigations of the imposition of a right to health or associated health legislation contributes to the literature and provides a method for directly examining both sides of these claims, by using existing datasets at population level.

Right to health versus right to health care

According to today's understanding, the right to health is a broad and inclusive concept, extending not only to timely and appropriate access to health care, but also to the underlying social determinants of health such as

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[2] "As the health and morality of the people are essential to their well-being it shall be the duty of the legislature to protect and promote these vital interests" (Article 7 Section 20, Wyoming Constitution of 1889).

[3] More precisely, "the right to maintenance in old age and also in case of sickness or loss of capacity to work" (Article 120 of the USSR Constitution).

[4] This right was "ensured by the extensive development of social insurance of workers and employees at state expense, free medical service for the working people, and the provision of a wide network of health resorts for the use of the working people" (Article 120 of the USSR Constitution).

[5] Effective on January 1948.

[6] UN. Universal Declaration of Human Rights. G. A. Res. 217A (III), UN GAOR, Res. 71, UN Doc. A/810. New York: United Nations, 1948.

[7] UN. International Covenant on Economic, Social and Cultural Rights (ICESCR). New York: United Nations, 1966.

income, education or social cohesion (Anand, Peter and Sen 2004). The reference to "health" rather than "health care" can be regarded as a practical way of characterizing the relevant socially controllable factors outside the traditional health care system (Sreenivasan 2008). This method, however, has its limitations. If a person's health status is not the result of the actions of other people or society at large, but is deemed a personal responsibility instead, then it is difficult for individuals to claim protection under this right (Daniels 2013). Recent literature has attempted to identify the conditions under which avoidable health inequalities are not unfair or a violation of a right to health (Sreenivasan 2009).

Regardless of the scope and extent of the term "health", many agree that a right to health at least includes a right to access health care. The right of access to health care is perhaps the least difficult area for a court in terms of justifiability. However, in terms of enforceability, this right is one of the most difficult human rights. Courts are generally reluctant to direct government on issues of resource allocation. Even in countries where health care is recognized as a basic legal right, there is also an ongoing debate over the scope and extent of a right to health or to the health care enforceable by individuals.

Constitutional right to health and its direct effects

In the last 70 years, the UN and other international organizations have adopted international treaties and other instruments that include a right to health. They have gradually developed the concept of a right to health or to health care, with a view to applying this right to actual health policies. Despite its significant contribution to the wider recognition and understanding of this right in the international community, recent research has found that the effects of these international treaties are limited, even in the countries that ratified them. Palmer and his colleagues have investigated the relationship between the cumulative numbers of treaty ratification and health indicators like maternal, infant, and child mortalities, and found no systematic association between them (Palmer et al. 2009).

Given that some of the successful court cases dealing with the right to health litigation are connected to constitutional provisions of this right, Matsuura reviewed the constitutional right to health or to health care of 157 countries and found that, with the exception of South Africa, only countries with French commercial law or Soviet socialist law origins gave their citizens a constitutional right to health or to health care (Matsuura 2013). Unlike international treaties, the study found that infant and under-five mortality rates decreased significantly after these countries introduced a right to health provision into their national constitutions. This effect seemed to be much larger in countries with good governance and a high democracy score, which reflects both political competition and the rule of law.

This study is further supplemented by the study of the US state constitutions (Matsuura 2012). The US is a nation with typical British common-law origins, which means that it does not guarantee health care as a fundamental right in its constitution. However, the federal constitutional design allows fifteen state constitutions to contain provisions relating to health and health care (Leonard 2010). The study found that the introduction of a stronger constitutional commitment, which imposed a duty on state legislatures to provide health care specifically to the poor, was associated with a reduction in infant mortality rates. Such health-improving effects are found mainly in non-white populations, which have been historically disadvantaged.

Current empirical evidence dealing with a right to health focuses on the availability of a right to health described in national or state constitutions, but human rights lawyers have traditionally focused their attention on case law and how to apply general principles described in national and international law to specific circumstances. From the viewpoint of empirical legal studies, there is still an empirical question as to whether the provision of a right to health in constitutions or the practical application of such provisions actually improves population health outcomes. Unfortunately, while legal instruments and litigation are increasingly common as ways to enforce the constitutional right to health, they are still limited to countries such as South Africa and some Latin American countries. However, this is a testable hypothesis. The next challenge in this area will be to investigate these issues using the sample of Latin American countries from the Demographic and Health Surveys (DHS).

Health legislation, regulations, and access to health care: lessons from the United States and other developed countries

Like many other human rights provisions in constitutions or treaties, a right to health or to health care is extremely ambiguous and would have only limited practical application without associated health legislation. To achieve a right to health or to health care, health laws and regulations must tackle a wide variety of barriers that combine to prevent patients from seeking necessary health care. The inability to pay for health care services strongly affects access to health care. However, even for paying patients, there remain barriers to treatment based on race, disability, and other factors such as nationality, fear, cultural beliefs, language, residence, and distance. In the last quarter of the twentieth century, legislation designed to assure patients' legal right to access health care has been enacted in different ways across different countries. This section focuses on the empirical studies of four different legislative approaches that are designed to protect patients' right to access health care: (1) regulating the formation of patient-physician relationships, (2) guaranteeing the right to access to emergency medicine rather than health care, (3) anti-discrimination laws, and (4) requiring hospitals to provide charitable care.

Many countries have adopted one or more of these health laws, even without a constitutional right to health. However, these health laws are more important in some countries than in others. Without any doubt, these laws are most important in countries where universal health care has not yet been achieved like the United States. However, even among the countries with universal health care systems, these laws are perhaps more important in some countries than in others. The existence of these laws are more important in countries where health care is financed via social insurance, but health care is delivered by the private sector,[8] than in countries where hospitals and medical staff are directly financed by the state and patients have direct access to these facilities.[9]

Regulating the formation of patient-physician relationships

The formation of the patient-physician relationship is one of the most highly-regulated fields in contract law. The laws in this area attempt to balance the rights and responsibilities of both health care provider and patient. The freedom of physicians and hospitals to refuse or accept patients is to some degree – and sometimes severely – regulated in order to provide health care to the whole population.

In common-law countries like the United States and the United Kingdom there is no general duty for either physicians or hospitals to provide health care to others, even in emergency situations (Mulheron 2010). At least one American court has concluded that: "Even the Hippocratic Oath, by which every doctor is morally bound, assumes a pre-existing relationship of patient and physician, which relationship in its inception is basically contractual and wholly voluntary."[10] This position is distinct from Japan, where Article 19 of the nation's 1948 Medical Practitioner Law and other health laws stipulate that physicians and other health professionals cannot refuse to care for patients if they are asked to do so (Matsuura and Sase 2013). Unfortunately, no empirical study to date has investigated the effect of such regulations.

Guaranteeing the right to access emergency medicine rather than health care

The no obligation rule in common law contributed to instances of 'patient dumping' in the United States, especially prior to 1986 when the federal anti-patient dumping law was enacted. Since its enactment in 1986, the Emergency Medical Treatment and Active Labor Act (EMTALA) has become the single most important legal tool governing Americans' access to emergency medical care. Under EMTALA, hospitals are required to examine all people who need care in the emergency room and to provide treatment to stabilize their condition if necessary (Treiger 1987; Moy 1999). EMTALA has been a controversial mandate ever since its creation. While it guarantees life-saving treatment to patients under emergency conditions, the unfunded nature of EMTALA's mandate has been criticized as a major source of emergency room overcrowding and a cause of financial pressure for hospitals (O'Shea, 2007). Despite these criticisms, empirical results indicate that, while EMTALA had health-improving effects among children, the law did not contribute to either emergency department overcrowding or cost pressure to hospitals in aggregate (Matsuura 2012). Instead, studies showed that the laws only shifted emergency department patients and hospital costs from public and non-profit hospitals to for-profit hospitals. Although the study confirms the obvious benefit of EMTALA, EMTALA only guarantees the right to access to emergency medicine, not the right to health care. In this sense, the health-improving effect of EMTALA is expected to be smaller than the regulation of the formation of patient-physician relationships.

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[8] such as Japan, Germany, and France.

[9] such as the United Kingdom and the United Arab Emirates.

[10] Agnew v Parks, 172 Cal App 2d 756, 764 (1959).

Anti-discrimination laws

Many countries have adopted a wide variety of anti-discrimination laws and treaties. In the United States, anti-discrimination laws such as Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act of 1990, and Section 504 of the Rehabilitation Act of 1973, prohibit health care providers from refusing treatment on certain bases. Title VI of the Civil Rights Act of 1964 prohibits any program or activity that receives federal financial assistance from discriminating against individuals on the grounds of race, color, or national origin. Some studies have found that the civil rights movement and a range of anti-discrimination legislation had health-improving effects in areas such as infant mortality rates and traffic accident mortality rates. (Zhou 2011; Almond, Chay and Greenstone 2006). Zhou also reported that the distance that African Americans had to travel to the nearest hospital fell by 50 miles after the desegregation of hospitals in the Deep South (Zhou 2011).

Section 504 of the Rehabilitation Act of 1973 and the Americans with Disability Act (ADA) of 1990 affect patients' ability to access health care. Bragdon v. Abbott[11] first drew attention to the application of these disability laws and how they protect the rights of disabled patients to access health care. The court affirmed that physicians cannot use a patient's disability, including HIV/AIDS, as a reason not to provide health care. There is extensive literature examining the employment effects of the ADA, but no study has yet examined the effect of the ADA on access to health care or health outcomes (Stapleton and Burkhauser 2003). Recently, Honeycutt (2011) examined the effect of ADA on a participation restriction in health coverage and found a shift in health coverage away from private health insurance toward public coverage in his PhD dissertation. However, there is no study to date that examines the relationship between the ADA and disabled patients' access to health care.

Finally, undocumented immigrants face significant challenges in accessing health care. In many EU countries, undocumented immigrants have the right to access emergency care, but access to more advanced health care is restricted and may be subject to additional payment (Terminski 2013). In the United States, while EMTALA protections may apply to undocumented immigrants who seek emergency care, Congress has also sought to reduce immigrant use of public assistance programs by passing legislation such as the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA). PRWORA restricts many public benefits, including retirement, welfare, health, and disability benefit, to certain immigrants. Derose and her colleagues reviewed the empirical literature of the effect of PRWORA and found a decline in immigrants' health insurance coverage, use of health care, and the satisfaction of health care quality following the passage of PRWORA (Derose et al. 2009).

Requiring hospitals to provide charitable care

Another approach is to require hospitals to provide some kind of charitable care to the community. In the case of the United States, some hospitals are required to provide charitable care under laws such as the Hill-Burton Act and § 501(c)(3) of the Internal Revenue Code.[12] The proportion of US physicians in a hospital setting providing charity care, however, dropped from 66 percent in 1996/1997 to 54 percent in 2004/2005 (Cunningham and May 2006).

The Hill-Burton Act of 1946 provided grants and low-interest loans for hospital construction, and specified that recipients would be obliged to provide charity care for 20 years after the initial fund had been disbursed. Almond and his colleagues investigated the infant health benefits of the Hill-Burton Act and found that charity care requirements were, in fact, binding on hospitals, but that private hospitals under the obligation "cream skimmed" the least risky maternity patients (Almond, Currie and Simeonova 2011; Almond et al. 2007). In this way, they provided less intensive maternity services than public hospitals without compromising patient health.

Non-profit hospitals under Section 501(c)(3) were primarily used as an instrument to tackle market failures that existed when only for-profit hospitals were in control of the market. Over the last forty years, however, both government and non-profit hospitals have been steadily declining, while for-profit hospitals have been growing substantially (Cutler 2000). The changes in ownership type have come under increasing criticism from advocates of non-profit hospitals. Recently, Malani and his colleagues began to argue in favor of what might be called "for-profit" charity (Henderson and Malani 2009; Malani and Posner 2007). Malani and Posner (2007) argue that philanthropic services could be carried on equally well by for-profit firms. The ma-

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[11] Bragdon v Abbott, 524 US 624, 631 (1998).

[12] Sabeta v. Baptist Hospital of Miami, Inc. 410 F. Supp. 2d 1224 (S.D. Fla. 2005).

jority of empirical studies support their view, and find that non-profit hospitals do not reduce their provision of uncompensated care following a change to for-profit status (Needleman, Lamphere and Chollet 1999; Desai, Young and VanDeusen; Lukas 1998; Young and Desai 1999). Studies have also found that with the change to a for-profit structure, hospitals introduce few changes of hospital provision of other essential community services like emergency departments (Chollet and Kirk 1999; Hadley, Gray and Collins 2001).

Conclusion

This article summarizes recent progress made in empirical research into a right to health or to health care in national and state constitutions, as well as in health legislation and regulation. Although not all laws have been empirically examined, the literature generally found that these health provisions have had significant health- or health-care-access improving effects. A few exceptions to this rule are the effect of a right to health in international treaties and the tax-free status of non-profit hospitals under Section 501(c)(3). According to literature on the subject, the effects of these international treaties are limited even in the countries that ratified them. However, these international treaties have provided for a better recognition and understanding of this right by the international community and promoted its introduction at the constitutional and legislative level in each country. The same is true for not-for-profit hospitals. A large market share of not-for-profit hospitals in the region may contribute to the creation of the norm that charitable care must be provided even in for-profit hospitals.

Although we were able to generally confirm the health- or health-care-access improving effects of these laws from the available studies, there are at least three potential challenges in applying the empirical evidence in this field to current health policies. Firstly, current empirical evidence has concentrated too much on the United States, where empirical legal research is particularly active. More evidence is needed from outside of the United States. Secondly, implementation of these laws may be an unreliable way of allocating research resources. Judicial court cases may reflect the power of interest groups or the preference of judges, rather than the effect of the right to health. We need to seek institutional, demographic, and social conditions that maximize the benefit of the constitutional right to health and appropriate health legislation. Thirdly, these empirical papers are designed to obtain the effect of specific health laws on health and other health-related outcomes and assume that the effects of other laws do not modify that analysis. In reality, however, the effects of these laws combine to guarantee access to health care. To promote the better legal design of a right to health, we need to examine the interaction of these laws and address which legal strategies can best improve the health of the targeted population.

Finally, we arrive at the consequentialist nature of empirical legal studies. The main claim of this paper is that a right to health as a legal instrument requires a strong empirical base to justify the existence of legal intervention. In other words, the value of a right to health as a legal instrument is determined by how much associated laws improve the population health outcomes implied by the right. This position asserts that moral rightness depends only on population health consequences. This idea is not always accepted in actual health policies.

Despite the challenges outlined above, I am fairly optimistic about the future of empirical research on health and human rights and its potential to change the field of health and human rights. Human rights lawyers tend to focus on individual legal cases, but the effects of a right to health are bigger than just these cases. Thus, we need to pay attention to the population health effect of relevant legislation. The right to health, of course, includes certain components that are legally enforceable through the court system, but this right also imposes an ethical obligation on individuals and society to protect it. This ethical demand is likely to involve legal instruments for enforcement, but is even more likely require individuals, governments, and non-state players to internalize public ethical norms in order to enhance implementation and compliance with the right to health (Ruger 2006). The estimated effects of a right to health and associated health legislation include not only the effects through the judiciary system, but also the political and social effects of these laws. By taking this approach, empirical research will extend the scope of traditional human rights law. It will inform health policies and apply the best methods to achieve the health objectives implied by this right beyond the judicial system.

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