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Exploring fairness in health care reform*

Summary

This article considers the increasing challenge of the fair allocation of scarce public health care resources by focusing on services for women and girls. It considers different ways of thinking about fairness in health care reform, the role of courts in promoting fairness, and the use of affirmative action measures to remedy health disparities. The health of individuals and populations is shown to be affected by clinical services, the organization and functioning of health systems, and underlying socio-economic determinants. Different theories of justice are addressed that affect assessments of fairness, considering availability, accessibility, acceptability of and accountability for services. The transition in judicial dispositions is traced, from deference to governmental resource allocation decisions to evidence-based scrutiny of governmental observance of constitutional and human rights legal obligations. The appropriate use of affirmative action measures to improve equality in health status is explored, given the increasingly unacceptable disparities in health among subgroups of women within countries.

'n Onderzoek na billikheid in die hervorming van gesondheidsorg

Hierdie artikel ondersoek die toenemende uitdaging van die billike allokasie van skaars openbare gesondheidsbronne, deur te fokus op die dienste vir vroue en meisies. Dit oorweeg verskillende maniere van dink oor billikheid in gesondheidsorghervorming, die rol van die hof in die bevordering van billikheid, en die gebruik van regstellende aksie maatreëls om ongelykheid in gesondheidsorg reg te stel. Dit word aangedui dat die gesondheid van individue en bevolkings geraak word deur kliniese dienste, die organisasie en funksionering van gesondheidsisteme, en onderliggende sosio-ekonomiese faktore. Verskillende geregtigheidsteorieë, wat die beoordeling van billikheid beïnvloed, met betrekking tot die beskikbaarheid, toeganklikheid van en toerekenbaarheid van dienste. Die tradisie in judisiële ingesteldheid word nagegaan, vanaf terughoudendheid ten opsigte van besluite oor die allokasie van regeringsbronne tot getuienis-gebaseerde ondersoek na die nakoming van konstitusionele en menseregteverpligtinge. Die toepaslike gebruik van regstellende aksie maatreëls om gelykheid in gesondheidstatus te verbeter word ondersoek, gegewe die toenemende onaanvaarbare ongelykheid in gesondheid onder subgroepe van vroue in lande.

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1. Introduction

Fairness in health care reform, both within a country and among countries, is becoming an increasingly pressing national and international challenge. The reasons are many. They include:

- Rising costs and expectations of health care, and related reforms that may cause public rationing of scarce health resources,
- The growing intolerance of health disparities and unfair health outcomes among groups, whether disparities are due to unequal availability of, or unequal access to, services.

Rising costs will vary according to country, and will include the rising costs of therapeutic drugs and of treating aging and health compromised populations. Moreover, there are increased expectations that compel rapid uptake of expensive technological advances that could prolong life.

Examples of health disparities and unfair health outcomes include preventable premature death due to differential prevalence rates of HIV/AIDS among different income groups, differential rates of unwanted pregnancy among different age groups, and differential rates of maternal mortality and morbidity between northern and southern countries. The underlying conditions necessary for health, such as safe drinking water, sanitation, adequate income, education and housing, and empowerment of communities marginalized by sex, race and age, also vary within and among countries. In addition to these explanations of growing attention to fairness in health care reform, is a more generalized reason of an informed and engaged citizenry that seeks to protect health as a fundamental value, and is increasingly requiring government to ensure reasonable availability of and access to health services.

Where democratic governments are not providing such services, they risk being voted out of office or being held accountable for fair and effective provision through court challenges using constitutional and human rights principles. In some countries, such as Canada, where there is no explicit constitutional protection of health,¹ access to health care is viewed as part and parcel of the right of nondiscrimination² and, for example, the right to security of the person.³ In other countries, such as South Africa, where there is specific constitutional

1 The Canadian Charter of Rights and Freedoms, Part I of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (U.K.), 1982, chapter 11.

2 *Eldridge v British Columbia (Attorney General)* (1977), 151 D.L.R. (4th) 577 (The Supreme Court of Canada decided that failure to provide funding for sign language interpretation that would equip hearing-impaired patients to communicate with health services providers in the same way that unimpaired patients can, constitutes discrimination in violation of Section 15(1) of the Canadian Charter on Rights and Freedoms).

3 *R v Morgentaler* (1988) 44 DLR (4th) 385 (The Supreme Court of Canada held that the restrictions of the criminal abortion law violated a woman's right to security of the person protected by Section 7 of the Canadian Charter of Rights and Freedoms).

protection of the right to health care,⁴ this right is being interpreted to require fair access to health care.⁵

There are many governmental health care reform initiatives,⁶ including moves toward decentralization, emphasis on cost recovery, and an expanded role for the private sector. Each one of these initiatives justifies an article in itself. This article will explore fairness in health services, especially as it impacts on women and girls, by looking at three matters:

- Different ways of thinking about fairness in health care reform,
- The role of the courts in promoting fairness in health resource allocation, and
- The use of affirmative action to promote equality in health. The thesis is that courts have a significant role to play in the dynamics of health care reform, and remedying inequities that result from stagnation or misguided reforms in allocation of scarce health resources.

Health is affected by:

- clinical services,
- health systems, and
- the underlying socio-economic conditions and other determinants of health.⁷

Medicine focuses on improving the health of individuals in the context of clinical services to treat physical and to a lesser extent mental illness. Health systems go beyond clinical services to determine how the health of populations can be maximized. Health systems use epidemiological and health systems research to plan and implement health interventions that emphasize prevention of diseases and promotion of health. Social science research has underscored the importance of underlying conditions and determinants, and the importance of socio-economic, gender and racial factors in affecting health outcomes.

Courts continue to play a significant role in regulating the delivery of clinical services, by ensuring respect for patient autonomy⁸ and, for example, patient confidentiality.⁹ Recent efforts to reform health care are now requiring courts to scrutinize the fairness of decisions at health system levels; that is, of choices of ministries of health, in allocating scarce health resources. Just as courts have developed an important body of jurisprudence and norms regulating the delivery of clinical care, so too is their role significant in developing norms and

4 South African Constitution, sections 27(1)(a), 28(1)(b) and (c).

5 *Minister of Health v Treatment Action Campaign* (No 2) 2002 (5) SA 721. The Constitutional Court of South Africa held that reasonable provision of treatment to pregnant women with HIV/AIDS is required by the right to health care services of the South African Constitution.

6 See Canada, Commission on the Future of Health Care in Canada 2002.

7 Cook *et al* 2003:218-221, 256-259.

8 *Reibl v Hughes* (1980), 114 D.L.R. (3d) 1 (Supreme Court of Canada).

9 *W v Egdell* [1990] 1 All E.R. 835 (English Court of Appeal).

standards at the health systems levels, especially in the fairness of allocating scarce health resources. This article concentrates on fairness in structuring and funding governmental health systems.

2. Ways of thinking about fairness in health care reform

Fairness in health care reform is likely to be contentious because of competing interests. There are many different ways of thinking about fairness.¹⁰ One approach to fairness explains that fairness in a health care system requires, at a minimum, equity in health outcomes, reasonable availability of health care, efficiency in management of services, patient autonomy, and accountability.¹¹

Underlying any approach to fairness in health resource allocation are theories of justice, which include compensatory justice, distributive justice, utilitarian and liberal theories of justice.¹² Compensatory justice justifies the use of measures that compensate particular groups for historical wrongs they have suffered. When this rationale is applied, proof of past discrimination is usually necessary, to ensure that measures achieve correction only to the extent of those past wrongs. Debates often center on the extent of the discriminatory harm, and the nature of the proof that is necessary to show the harm.

Compensatory justice may have little to offer in the health field, since mandating fair treatment for those who have suffered historical wrongs will not be compensation for them, but only the fair enforcement of nondiscriminatory health policies to which they are properly entitled. That is, the required measures do not provide any special advantage, but rather enforcement of measures equal to those that comparable individuals and groups have been accustomed to enjoy.

In contrast to compensatory justice that focuses on making up for unfair past treatment, distributive justice rationale is prospective in focus. It may be employed to justify future equitable availability of health resources to subgroups at abnormally high levels of risk. For instance, affirmative action might be justified to develop early diagnosis of cervical cancer and treatment programs for subgroups of women at high risk, until such time as their survival rate is the same as that of the general population. In other words, courts can require the temporary allocation of scarce resources in order to reduce present or anticipated exceptional need.

A utilitarian rationale may be employed to introduce measures to improve the welfare and capacities of the female half of society in order to increase overall social satisfaction, and productivity. This rationale might justify programs to promote equality in availability of services to ensure that women's distinctive health needs are satisfied, such as maternity care.

A liberal theory of justice justifies empowerment of women as autonomous, rational agents to determine their own clinical care, and remove barriers,

10 Dahlgren & Whitehead 1991.

11 Daniels *et al* 2000a; Daniels *et al* 2002; Daniels *et al* 1996; Daniels *et al* 2000b.

12 Beauchamp & Childress 2001:230-235; Raday 2003:35-44.

such as husbands' authorization requirements, to access to care. Liberal theories can be criticized for overemphasizing abstract notions of autonomy, and not taking sufficient account of women's contexts and the underlying determinants of health such as how societies structure women's reproductive and productive roles in ways that disadvantage their access to services.

These and other theories of social justice are examined from different feminist perspectives to determine the extent to which they accommodate women's needs and interests.¹³ Relevant to theories of justice and considerations of fairness within health care systems is the work of many disciplines, including the contributions of philosophy,¹⁴ political science,¹⁵ public health and epidemiology,¹⁶ law¹⁷ and, for example, sociology and health systems.¹⁸

This article will draw on different disciplines and theories of justice, and use the framework of the Right to the Highest Attainable Standard of Health, protected by the International Covenant on Economic, Social and Cultural Rights (the Economic Covenant).¹⁹ The Covenant's monitoring body, the Committee on Economic, Social and Cultural Rights (the Economic Committee) has developed a General Comment on the Right to the Highest Attainable Standard of Health.²⁰

This Comment on the Right to Health provides guidance to the Covenant's member countries in reporting to the Economic Committee on what they have done to protect this right to satisfy the criteria of what are described as the four A's. These criteria require that health services are: available, accessible, acceptable, and where they are not, to ensure that government is accountable to remedy deficiencies in availability, accessibility or acceptability in health care delivery.

This General Comment explains that 'States parties have a core obligation to ensure the satisfaction of, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care.'²¹ It needs to be read in conjunction with General Comment on the Nature of States Parties Obligations under Article 2(1) of the Covenant, which reads in part:

13 Lacey 2003:13-55.

14 Daniels *et al* 2000a.

15 Tuohy 1999.

16 Braveman & Gruskin 2003a:583; Braveman 2003:181-192; Braveman & Gruskin 2003b:254-258.

17 Flood 2000.

18 Van Rensburg 2004; Doyal 2000:931-939.

19 Article 12, International Covenant on Economic, Social and Cultural Rights, 16 Dec. 1966, 993 UNTS 3, entered into force 3 Jan 1976.

20 Committee on Economic, Social and Cultural Rights, General Comment 14: The right to the highest attainable standard of health, CESCR, General Comment 14, UN ESCOR 2000, UN Doc. E/C.12/2000/4, 11 August 2000.

21 General Comment 14, par 43; Chapman 2002:185-215.

a State party in which any significant number of individuals is deprived of ... essential primary health care ... is, prima facie, failing to discharge its obligations under the Covenant. If the Covenant were to be read in such a way as not to establish such a minimum core obligation, it would be largely deprived of its *raison d'être*. By the same token, it must be noted that any assessment as to whether a State has discharged its minimum core obligations must also take account of resource constraints applying within the country concerned. Article 2(1) obligates each State party to take the necessary steps 'to the maximum of its available resources'. In order for a State party to be able to attribute its failure to meet at least its minimum core obligations to a lack of available resources it must demonstrate that every effort has been made to use all resources that are at its disposition in an effort to satisfy, as a matter of priority, those minimum obligations.²²

The General Comment on the Right to Health, read together with the General Comment on State Obligations, require that states parties ensure that a minimum core of primary health care is available, accessible, and acceptable.

2.1 Availability

The General Comment on the Right to Health explains that the minimum core includes the obligation of states to ensure the right of access to health facilities, goods and services on a nondiscriminatory basis, especially for vulnerable or marginalized groups, and the provision of essential drugs as determined by the World Health Organization have to be available in sufficient quantity. The precise nature of the facilities, goods and services will vary depending on numerous factors. They include the underlying determinants of health, such as safe drinking water and adequate sanitation facilities.²³ Most significantly, these minimum core rights are non-derogable: 'a State party cannot, under any circumstances whatsoever, justify its non-compliance with the core obligations.'²⁴

In terms of women's health, one needs to ask how health care reform ensures availability of services specific to their health needs, and whether services are delivered in ways that are responsive to women's needs. One commentator has explained that:

A women's health needs approach is concerned with the implications for women of differences in the epidemiological profile between the sexes. This approach highlights the specific health needs of women and girls as a consequence particularly (although not exclusively) of the biology of reproduction.²⁵

22 Committee on Economic, Social and Cultural Rights, General Comment 3, The Nature of State Parties Obligations (article 2(1)), UN Doc. E/1991/23 (1990), par 10.

23 General Comment 14, par 43.

24 General Comment 14, par 47.

25 Standing 1997:1-18.

The same commentator explains that two broad strands flow from this approach.

One stresses the need to provide specific, women focused health care interventions as a basic right in order to address the imbalance of need. The rights approach to women's health needs is underscored by the right to sexual non-discrimination. This right requires that like cases be treated alike and different cases be treated according to their differences. In the context of women's health, the right to non-discrimination requires that societies treat different biological interests, such as in pregnancy and childbirth, in ways that reasonably accommodate those interests. The Convention on the Elimination of All Forms of Discrimination against Women (the Women's Convention) requires member states to ensure equality by protecting women's distinct interests in health.²⁶

The other approach emphasizes the cost effectiveness of interventions which focus on women and girls (particularly reproductive health interventions), both in comparison to other types of interventions and as a means to improve the health of those dependent on women's care, namely infants and children.²⁷ The cost effectiveness rationale is further reinforced by a wider theme of investing in women's health, to reduce the overall economic burden in communities of disease and poverty.

Whether a rights justification to promote women's health or a cost effectiveness rationale is employed, accommodating women's health needs requires provisions of services specific to their health needs, such as to prevent unwanted pregnancy, to treat the consequences of unwanted pregnancy, and to secure safe pregnancy, childbirth and neonatal care, and, for example, early diagnosis and treatment of cervical cancer. Moreover, serving women's health needs requires that governments address the underlying conditions that lead to ill-health, such as societal tolerance of violence against women and abusive sexual practices.

2.2 Accessibility

The Economic Committee's General Comment requires that health facilities, goods and services have to be accessible to everyone. Accessibility has interrelated dimensions, such as:

- Nondiscrimination,
- Physical accessibility, and
- Affordability.²⁸

26 Article 12, Convention on the Elimination of All Forms of Discrimination against Women, 18 Dec. 1979, GA Res. 34/180, UNGAOR, 34th Sess, Supp. No. 46 at 193, UN Doc. A/34/46, entered into force 3 Sept 1981; Committee on the Elimination of Discrimination against Women, General Recommendation 24, Women and Health in HRI/Gen/1/Rev.4 (2000).

27 Standing 1997:1-2.

28 General Comment 14, par 12.

If health care facilities, personnel and resources are to be accessible, governments must do more than simply provide them as bulk services. Accessibility requires that the delivery and administration of health care is organized in a fair, nondiscriminatory manner, with special attention to the most vulnerable and marginalized. The enumerated grounds of discrimination are open ended, and include race, sex, sexual orientation, physical and mental disability and health status.²⁹

Administration of health care has to respond to the medical, as well as, psychological, social, and economic needs of the health care system users.³⁰ Research has provided insights into how constructions of gender 'produce vulnerability to ill health or disadvantage within health care systems and particularly the conditions which promote inequality between the sexes in relation to access and utilization of services.'³¹

2.3 Acceptability

The General Comment requires that all health facilities, goods and services must be respectful of medical ethics, and be culturally appropriate.³² That is, they must be respectful of marginalized groups, and sensitive to gender and life-cycle requirements, as well as being designed to respect confidentiality. A subset of acceptability is the requirement that services be 'scientifically and medically appropriate and of good quality'.³³

Services are not acceptable when they lack quality, fail to protect free and informed decision making and, for example, neglect to respect confidentiality. Studies show, for instance, that where confidentiality is not respected, adolescent girls are deterred from seeking reproductive and related health care.³⁴ Where services, such as for treatment for cervical cancer or sexually transmitted diseases, are not delivered in respectful, non-stigmatizing ways, women are deterred from seeking early diagnosis and treatment.³⁵

2.4 Accountability

All sectors of society, including those marginalized by sex, age, disability, race, and or poverty, must be able to hold the health system accountable for lack of availability, accessibility and acceptability of services, and more widely their obligations regarding the right to the highest attainable standard of health.³⁶ The General Comment on health explains that victims of violations

29 General Comment 14, par 18.

30 Health Canada 2001.

31 Standing 1997:2.

32 General Comment 14, par 12.

33 General Comment 14, par 12.

34 Ford *et al* 1997:1029-34.

35 Gomez-Jauregui *et al* 2004.

36 General Comment 14, pars 57-58; N. Daniels *et al* 2000a.

should have ‘access to effective judicial or other appropriate remedies...’³⁷ This is a provision to which the courts in many countries are responding, by becoming willing to provide remedies to ensure fairness in availability of and access to public health services.

Claimants before courts may draw on the results of health systems studies to show disparities, and governments responding to judicial demands for effective remedies of unfair policies may similarly turn to such studies, to show their reformed compliance with required standards.

An emerging issue for governments to show compliance with standards and for those challenging governmental decisions is to identify approaches that can be taken to determine whether governments have complied with their human rights obligations. Two approaches are through human rights needs assessments, and gender-based analysis.

- Human rights needs assessments are designed to determine whether health systems are complying with their obligations to ensure that needed services are available, accessible and acceptable.³⁸
- Gender-based analysis is designed to determine whether and how women’s health needs are accommodated, and to identify opportunities to improve services on which women’s health depends.³⁹

These approaches are not mutually exclusive, and are perhaps best explored in combination.

A key question in both approaches is the choice of indicators to assess availability, accessibility and acceptability of health care services. The UN Special Rapporteur on the Right to Health has suggested that three broad categories of indicators might be useful in assessing state compliance with the right to health, namely:

- structural indicators,
- process indicators and
- outcome indicators.⁴⁰

Structural indicators, which include health policy indicators, ‘address whether or not key structures, systems and mechanisms that are considered necessary for, or conducive to, the realization of the right to health are in place.’⁴¹ Structural indicators address laws and policies, as well as the outcomes of these policies. They may be examined by such questions, for example, as:

37 General Comment 14, par 59.

38 Gostin & Lazzarini 1997: 57-67.

39 Health Canada 2003.

40 Commission on Human Rights, *Note by the Secretary General: Interim Report of the Special Rapporteur of the Commission on Human Rights on the Right of Everyone to the Enjoyment of the Highest Attainable Standard of Physical and Mental Health, Mr. Paul Hunt, A/58/427*, 10 Oct 2003, para. 15.

41 Interim Report of Special Rapporteur, par 19.

- Does the state constitutionalize the right to health?
- Has the government adopted a national strategy and plan of action to reduce maternal mortality?
- Does the government have an Essential Medicines List?
- Which medicines are free of charge at primary public health facilities: [including] HIV/AIDS-related medicines, and free medicines for under-fives/pregnant women/elderly persons/all who cannot afford them?⁴²

Structural indicators might also explore the extent to which health systems produce or exacerbate vulnerabilities of groups marginalized by sex, race or, for example, age that contribute to their health disadvantage or disease burden. For example, the socio-cultural constructions of gender might usefully be examined to determine how they inhibit or accommodate women's health needs and access to services.

Process indicators, which include health service indicators, 'provide information on the processes by which a health policy is implemented. They measure the degree to which activities that are necessary to attain certain health objectives are fulfilled, and the progress of those activities over time. They monitor, as it were, effort, not outcome.'⁴³ Examples of process indicators include:

- '... number of facilities with functioning basic essential obstetric care per 500,000 population.
- percentage of people with advanced HIV infection receiving antiretroviral combination therapy.'⁴⁴

Outcome indicators, which include health status indicators, 'measure the results achieved by health-related policies. They show the 'facts' about people's health, such as maternal mortality, prevalence of HIV, prevalence of rape...'⁴⁵

These indicators assist in thinking about fairness, and have strengths and weaknesses.⁴⁶ A difficulty with indicators is that it might be difficult to determine how services should accommodate different reproductive functions of the sexes and how the different hormonal and genetic constitution of the sexes affects non-reproductive facets of health, such as in the different incidence of disabilities and reactions to medical interventions. In addition to the hormonal and genetic factors, there are underlying socio-economic conditions that affect health outcomes. Consequently, health outcomes indicators are useful but not conclusive when determining allocation of scarce health resources. In order to address differential health outcomes, health ministries will have to address hormonal and genetic factors and other militating factors such as underlying socio-economic conditions. Indicators will develop over time as understandings of the causes and consequences of health disparities evolve through improved dialogue among the different disciplines.

42 *Interim Report of Special Rapporteur* 2003, par 20.

43 *Interim Report of Special Rapporteur* 2003, par 26.

44 *Interim Report of Special Rapporteur* 2003, par 27.

45 *Interim Report of Special Rapporteur* 2003, par 28.

46 Cook *et al* 2003:225-228.

3. The role of courts in promoting fairness in health resource allocation

National courts spanning the globe, from Australia to Venezuela, from South Africa to Canada, are now acting as forums for public deliberation on health care rationing. International human rights tribunals and committees are also considering questions of fair access to health care. Whether before national or international courts, governments are now required to justify the choices they have made in allocating public resources, according to human rights principles. Governments have to explain the criteria that underpin their decisions, and satisfy the courts that they have considered all interests, but only relevant interests. Courts are requiring greater transparency in decision-making, whether it be in scientific review, or in fairness in the process of review. Generally in the area of allocation of health care resources, courts are moving from a mode of deference to the executive branch of government, to a mode of deliberation.⁴⁷

Common complaints against government allocation decisions concern those of discrimination in access to care, or denied or delayed access. The grounds on which discrimination claims are made include sex,⁴⁸ race,⁴⁹ health status or disability,⁵⁰ marital status,⁵¹ and sexual orientation.⁵² Where there is no discrimination in access to care, courts are being asked to decide whether

47 Syrett 2004:190-198.

48 *New Mexico Right to Choose/NARAL v William Johnson*, Secretary of the New Mexico Human Services Department, 126 N.M. 788, 792 (1999) Supreme Court of New Mexico (the state's prohibition of funding for medically necessary abortions denies Medicaid-eligible women equality under the law because it does not apply the same standard of medical necessity to men and women).

49 *Linton v Tenn. Community Health & Environmental*, 779 F. Supp. 925, affirmed 923 F.2d 855 (6th Cir. 1981) (bed certifications policies with adverse disparate impact on racial and ethnic minorities held discriminatory and in violation of title VI of the Civil Rights Act and the Medicaid statute).

50 *Eldridge v British Columbia (Attorney General)* (1977), 151 D.L.R. (4th) 577. (The Supreme Court of Canada decided that failure to provide funding for sign language interpretation that would equip hearing-impaired patients to communicate with health services provides in the same way that unimpaired patients can constitute discrimination in violation of the Canadian Charter on Rights and Freedoms); *Auton (Guardian ad Litem of) v British Columbia (Attorney General)* (2002) 220 D.L.R. (4th) 411 (B.C.C.A.) (The British Columbia Court of Appeal upheld British Columbia Supreme Court's decision in finding that governmental failure to provide services for autistic children constituted discrimination on grounds of disability in violation of the Canadian Charter on Rights and Freedoms, and could not be said to be reasonably justifiable.) An appeal is pending before the Canadian Supreme Court; *Cameron v Nova Scotia Attorney General* (1999) D.L.R. (4th) 611 (The Nova Scotia Court of Appeal decided that Nova Scotia's refusal to fund infertility services, while discriminatory, was justified due to costs and lack of proven effectiveness.)

51 *McBain v Victoria* (2000) 3 Commonwealth Human Rights Law 153 (denying an unmarried woman artificial insemination violates her right to nondiscrimination on the ground of marital status) Federal Court of Appeal of Australia.

52 *Korn v Potter* (1996) 134 DLR (4th) 437 (denying a lesbian woman artificial insemination is a violation of her right to nondiscrimination on the ground of sexual orientation) Supreme Court of British Columbia.

denial of basic health care,⁵³ is a form of inhuman or degrading treatment, or whether it infringes rights to life⁵⁴ or security,⁵⁵ or offends complainants' right to health care.⁵⁶ This has arisen in such areas as fair access to emergency care,⁵⁷ palliative care,⁵⁸ treatment for HIV/AIDS,⁵⁹ kidney failure⁶⁰ and care for prisoners.⁶¹

Where judicial determination on the merits of cases is pending, courts will generally apply the precautionary principle to prevent the risk of harm beyond the courts' means of subsequent remedy. The precautionary principle

53 *Case 7615* (Brazil) (1985), Inter-Am. Comm. H.R. Res. No. 12/85, Annual Report of the Inter-American Commission on Human Rights, 1984-85. (The Commission held Brazil responsible for failure to take effective measures to preserve health of the Yanomami Indians pursuant to Article XI of the American Declaration of the Rights and Duties of Man).

54 *X v United Kingdom* (1978), Eur. Comm. H.R. Application No. 7154, Decision 12 July 1978, European Commission of Human Rights, Decision & Reports 14: 31-35, June 1979. (U.K. had taken appropriate measures to prevent death from vaccination but, had appropriate measures not been taken, the state would have been in breach of its duty to safeguard life under Article 2 of the European Convention on Human Rights).

55 *R. v Morgentaler* (1988) 44 DLR (4th) 385 (the restrictions of the criminal abortion law violated a woman's right to security of the person under the Canadian Charter of Rights and Freedoms).

56 *Treatment Action Campaign; Cruz Bermudez, et al. v Ministerio de Sanidad y Asistencia Social (MSAS)*, Case No. 15789, 1999 (Pursuant to the rights to life and health, the Venezuelan Supreme Court required the Ministry of Health to provide the medicines prescribed to all HIV positive Venezuelans by government doctors, cover the cost of HIV blood tests in order for patients to obtain the necessary anti-retroviral treatments and treatments for opportunistic infections, develop the policies and programs necessary for treatment of affected patients, and make the reallocation of the budget necessary to carry out the decision of the Court (Articles 58, 76, the 1961 Venezuelan Constitution).

57 *Paschim Banga Khet Mazdoor Samity v State of West Bengal* (1996) 4 SCC 37; (1996) 3 SCJ 25, digested in (1998) 2 Commonwealth Human Rights Law Digest 109. (The Supreme Court of India held that the right to life protected by Article 21 of the Indian Constitution was breached when various government hospitals denied a complainant emergency treatment for serious head injuries.)

58 *D v United Kingdom* (1997), Eur. Ct. H.R., 24 E.H.R.R. 423. (The European Court of Human Rights held that the U.K. could not deport a convicted drug trafficker, who was at a very advanced stage of terminal and incurable AIDS, to his native country where he would not receive appropriate care, would constitute inhuman treatment contrary to Article 3 of the European Convention on Human Rights.)

59 *Treatment Action Campaign*.

60 *Soobramoney v the Minister of Health, Kwazulu Natal*, 1998 (1) SA 776. (The Constitutional Court of South Africa held that the state was not constitutionally required to provide long-term renal dialysis treatment because the claimant fell outside the guidelines for medical eligibility and the exercise of the right to health, protected by Section 27 of the South African Constitution. Therefore the protection offered by section 27 can be reasonably limited by lack of resources.)

61 *Williams v Jamaica*, Comm. No. 609/1995, U.N. Doc. CCPR/C/61/D/609/1995 (17 Nov 1997). (The Human Rights Committee held Jamaica responsible for denying a death row inmate adequate medical treatment for his mental condition as inhuman treatment contrary to Article 7, and as contrary to the respect for the inherent dignity of his person, protected by Article 10(1) of the International Covenant on Civil and Political Rights).

provides that, even in the absence of scientific evidence of cause and effect relationships, precaution should be taken to preserve the status quo in case the effects of change would prove disastrous to the important interests at stake. Courts are applying the precautionary principle to require governments to provide interim health care pending their judicial decisions.⁶²

3.1 Deference

Historically, barriers to private individuals and institutions bringing actions in courts have shielded governmental policies from judicial scrutiny. Barriers have included legal doctrines of state immunity from proceedings brought against governments in their national courts. Government bureaucracies have been unaccustomed to having to justify their policies before courts of law, or explain to judges how the outcomes of their policies protect the human rights of individuals.

However, courts in many countries have become more accessible to private initiatives to hold governments to legal account for health care policies and their consequences. Courts have relaxed ancient legal doctrines, such as the offences of champerty and maintenance that prohibited third parties and special interest groups from maintaining or sponsoring private individuals to incur the financial costs of bringing litigation. Moreover, courts have become more accommodating of class action suits, and to allowing interventions in governmental proceedings by third parties appearing as friends of the court, called *amicus curiae*, to represent interests that the original parties to the litigation may fail to address or protect. Some jurisdictions, such as South Africa, have not left the justiciability of class actions to judicial benevolence, and have instead made specific provisions in their constitutions.⁶³ Many of these private initiatives were not only resisted by governmental administrations, but were also unfamiliar to the judges themselves, who were inclined to defer to governments on matters of resource allocation.

For instance, when private individuals or interest groups brought proceedings to require governmental funding of health care services, courts did not require governmental authorities even to explain the reasons on which their decisions were based. In a leading case in the English Court of Appeal, rejecting a parental claim for treatment of a 10-year old child with leukemia, it has been observed that:

62 *Jorge Odir Miranda Cortez et al v. El Salvador*, Case 12.249, Report No. 29/01, Inter-Am. C.H.R. OEA/Ser.L/V/II.111 Doc. 20 rev. at 284 (2000); *Juan Pablo et al. v Chile* (2001) Annual Report of the Inter-American Commission on Human Rights, OEO/Ser./LV/II.114, doc 5 rev. 2001 (precautionary principle applied as an interim measure to require El Salvador and Chile respectively to provide treatment to those with HIV/AIDS pending decision on the merits of their claim to be entitled to treatment) (Inter-American Commission on Human Rights); *Eisler (Litigation Guardian of) v. Ontario* (2004) 234 D.L.R. (4th) 169 (application for an interlocutory injunction granted since the autistic children would suffer irreparable harm if their treatment were discontinued).

63 South African Constitution, section 38(c).

Difficult and agonizing judgments have to be made as to how a limited budget is best allocated to the maximum advantage of the maximum number of patients. That is not a judgment the court can make. In my judgment, it is not something that a health authority ... can be fairly criticized for not advancing before the court⁶⁴

This reasoning has been echoed by courts in other countries.⁶⁵

When courts were inclined to require or receive evidence of reasons, they were similarly disposed to observe that for them to mandate the supply of services from limited health care budgets would deny resources to other equally entitled individuals or interests that were not represented before the court. Judges recognize the polycentric nature of health systems, and understand that changing one part of the system will have ramifications in another part. It has been suggested that it might be 'improper for the court to make an order of mandamus compelling [a government authority] to do that ... which it can do at the expense of others not before the court ...'⁶⁶ The judges ruled that a decision favorable to the initiators of such proceedings would risk causing injustice to the unrepresented interests. Accordingly, the court declined to entertain these claims on their merits.

Courts strictly applied the constitutional doctrine of Separation of Powers. As the English Court of Appeal has observed 'It is not for this court, or indeed any court, to substitute its own judgment for the judgment of those who are responsible for the allocation of resources.'⁶⁷ The courts will intervene only in the event of 'a decision which is so outrageous of its defiance of logic or of accepted moral standards that no sensible person who had applied his mind to the question to be decided could have arrived at it.'⁶⁸ An additional argument is made that 'courts are not institutionally equipped to make the wide-ranging factual and political enquiries necessary....'⁶⁹ As a result, judges have tended to hold that the allocation of scarce public resources among competing interests must remain the responsibility of the executive branch of government, answerable only to the electorate, without general scrutiny by the judicial branch of government.⁷⁰

64 *R v Cambridge Health Authority ex p. B*, [1995] 2 All E.R. 129, at 137 (Sir Thomas Bingham, M.R.).

65 *Shortland v Northland Health* [1998] 1 NZLR 433 (CA) (The Court of Appeals of New Zealand upheld a lower court decision not to review a clinical determination to withhold long-term dialysis to a man with end stage renal failure because he was not a suitable candidate for dialysis.).

66 See *R v Bristol Corporation*, ex p. Hendy [1974] 1 All E.R. 1047 at 1051 (Scarman LJ); for a commentary on this case, see Newdick 1996: 119-135.

67 *R v. Secretary of State for Social Services*, ex p. Walker (1992), 3 BMLR 32, per Sir John Donaldson, MR at 35.

68 *Council of Civil Service Unions v. Minister for the Civil Service*, [1985] AC 3 74, per Lord Diplock at 410.

69 *Treatment Action Campaign*, par 37.

70 Syrett 2004:289-321.

3.2 Scrutiny

Courts, however, are gradually moving from the practice of deference to government in matters of resource allocation, to a mode of scrutiny. Courts are recognizing that governments under the rule of law are bound to respect individual legal rights protected by national constitutions and international human rights treaties. Further, courts are now requiring greater transparency and rationality in governmental health policy making to ensure substantive and procedural fairness. As evidence-based medicine is emerging as the standard in clinical care,⁷¹ so too is evidence-based health policy emerging as the standard for fairness in health systems. This will be increasingly the case as evidence-based decision-making (EBDM) continues to be applied in health care systems to promote best health care practices and effective delivery of health care.⁷² It has been noted that ‘EBDM has the potential — and far more potential than other decision-making methods — of creating a health care system that delivers not only excellent health care, but also great patient equality, autonomy and dignity. Accordingly, judicial review of health care decisions should use standards that promote EBDM.’⁷³

Canadian courts are moving in a direction of scrutiny, particularly as they apply the Canadian Charter of Rights and Freedoms of 1982, which gives domestic effect to the International Covenant on Civil and Political Rights. The Charter binds only government agencies. However, in *Eldridge v. British Columbia (Attorney General)*, the Supreme Court of Canada held that governments can not evade their Charter obligations by delegating responsibilities they have assumed to private agencies or corporations, such as public hospitals, which despite substantial government funding, have legal status as private corporations.⁷⁴ Governments are legally bound to ensure that agencies discharging governmental functions, whether governmental agencies or private corporations, comply with individual rights and freedoms protected by the Charter. Accordingly, in *Eldridge*, the Supreme Court held the provincial government in breach of its Charter duties by permitting a hospital to discriminate against hearing impaired patients on grounds of their disability. The Court required the government to submit a scheme for its approval that satisfies patients’ right to care and treatment without discrimination.

The British Columbia Court of Appeal subsequently went further in *Auton (Guardian ad Litem of) v British Columbia (Attorney General)* holding the province’s withholding of treatment for autistic children unconstitutionally discriminatory on grounds both of disability and age.⁷⁵ The Court found support

71 Oxford Centre for Evidence-Based Medicine 2004.

72 Dobrow *et al* 2004:207-217.

73 Greschner 2005.

74 *Stoffman v Vancouver General Hospital* [1990] 3 SCR 483 (Supreme Court of Canada).

75 *Auton (Guardian ad Litem of) v British Columbia (Attorney General)* (2002) 220 D.L.R. (4th) 411 (B.C.C.A.) An appeal is pending before the Supreme Court of Canada.

in Canadian ratification of the Convention on the Rights of the Child,⁷⁶ which is not incorporated into domestic law but which governments are judicially presumed to intend not to violate, because '[t]he Convention has moral force'.⁷⁷ The Court was not content to require the government to propose a scheme that would respect its legal responsibilities, but mandated the government to fund a particular form of intensive behavioral therapy with a disputed success rate for particular pre-school age autistic children who fell outside the government's scheme of provision of services. This decision has been criticized as not requiring the plaintiff to produce sound scientific evidence of medical effectiveness of the disputed treatment. In so doing, the Court raised questions about what degree of effectiveness is required for a medical treatment to be publicly funded.⁷⁸

The Supreme Court of Canada is considering the government's appeal not only against the finding of Charter violation, but also against the Court of Appeal compelling funding of a particular form of intensive behavioral therapy with a disputed success rate. The government claimed it was answerable only to the electorate. This is a claim that the courts have traditionally accepted. However, it has been observed that:

[w]hile in some circumstances excessive cost may justify a refusal to accommodate those with disabilities, one must be wary of putting too low a value on accommodating the disabled. It is all too easy to cite increased costs as a reason for refusing to accord the disabled equal treatment ... Government agencies perform many expensive services for the public they serve.⁷⁹

The Supreme Court of Canada will accordingly have to decide in the *Auton* case if and how cost considerations justify overriding the executive branch's obligations under the Canadian Charter.

Governmental policies can be upheld by courts, not out of deference, but out of judges' independent assessments that they are justified, as the Constitutional Court of South Africa determined in the *Soobramoney* decision.⁸⁰ Where they are found not justified, however, courts can require that services be made fairly available, as the Constitutional Court ruled in the *Treatment Action Campaign* case.⁸¹ That case concerned the public distribution of nevirapine, a drug approved and registered by the Medicines Control Council of South Africa as safe and effective to reduce mother to child transmission of HIV. The case challenged the government policy that limited the public

76 Convention on the Rights of the Child, 20 Nov 1989, GA Res. 44/25 (XLIV), UNGAOR, 44th Sess, Sipp. No. 49 at 167, UN Doc A/44/49, entered into force 1990; entered into force for Canada 12/01/92.

77 *Auton* at 440.

78 Greschner & Lewis 2003: 501.

79 *British Columbia (Superintendent of Motor Vehicles) v. British Columbia (Council of Human Rights)* [1999] 3 SCR 868, para 41 (Madam Justice (now Chief Justice) McLachlin) (Supreme Court of Canada).

80 *Soobramoney v Minister of Health, KwaZulu-Natal*, 1998 (1) SALR 765 (CC).

81 *Treatment Action Campaign*.

distribution of nevirapine to two public health facilities in each province. The claimants alleged that the government had acted unreasonably in

- a) refusing to make nevirapine generally available to pregnant women with HIV in the public health sector for cases where it was thought to be medically indicated,
- b) failing to establish a time frame for implementing a national program to prevent mother to child transmission of HIV.⁸²

The Constitutional Court of South Africa drew on their reasoning in *Grootboom*, where they explained that national framework legislation on housing was insufficient because a coherent public program is necessary to ensure effective implementation of that legislation.⁸³ The Court reasoned that 'A Programme that excludes a significant segment of society cannot be said to be reasonable...'⁸⁴ In the *Treatment Action Campaign* decision, the Court applied this reasonableness standard to hold a Ministry of Health program that excluded 90% of pregnant women with HIV/AIDS from the public distribution of nevirapine unreasonable, and therefore in violation of the constitutional right to health under Article 27.⁸⁵

In so doing, they rejected the minimum core approach of the Committee on Economic, Social and Cultural Rights, as first elaborated in their General Comment 3.⁸⁶ The Court evidenced some uncertainty over what would constitute the particular elements of a minimum core of services in the circumstances of this case: '[i]t should be borne in mind that in dealing with such matters the Courts are not institutionally equipped to make the wide-ranging factual and political enquiries necessary for determining what the minimum-core standards ... should be, nor for deciding how public revenues should be most effectively spent.'⁸⁷ The Court did not consider the further elaboration of the minimum core concept in General Comment 14 on the right to health in its judgement, even though it was adopted in 2000.

The Court explained that '... the socio-economic rights of the Constitution should not be construed as entitling everyone to demand that the minimum core be provided to them.'⁸⁸ Rather, the Court held that the obligation was to the progressive realization of rights: 'in its language, the Constitution accepts that it cannot solve all of our society's woes overnight ... one of the limiting factors to the attainment of the constitution's guarantees is that of

82 *Treatment Action Campaign*, par 2.

83 *Republic of South Africa v Grootboom*, 2000 (11) BCLR 1169, pars 40-42 (The Constitutional Court of South Africa held that the national housing programme was in violation of the right to have access to adequate housing under Article 26 because it had no provision for those in desperate need.)

84 *Grootboom*, par 43.

85 *Minister of Health v Treatment Action Campaign*, par 80.

86 *Treatment Action Campaign*, pars 26-39.

87 *Treatment Action Campaign*, par 37.

88 *Treatment Action Campaign*, par 34.

limited or scarce resources.⁸⁹ The Court explained that its 'function in respect of socio-economic rights is directed towards ensuring that legislative and other measures taken by the state are reasonable.'⁹⁰ The Court further elaborated:

Courts are ill-suited to adjudicate upon issues where Court orders could have multiple social and economic consequences for the community. The Constitution contemplates rather a restrained and focused role for the Courts, namely, to require the State to take measures to meet its constitutional obligations and to subject the reasonableness of these measures to evaluation. Such determination of reasonableness may in fact have budgetary implications, but are not in themselves directed at rearranging budgets. In this way the judicial, legislative and executive functions achieve appropriate constitutional balance.⁹¹

However, they did not preclude the possibility of considering what others thought to be the minimum core for a particular economic, social and cultural rights in their determination of reasonableness under Article 27 of the South African Constitution.⁹²

The Court in the *Treatment Action Campaign* decision missed the opportunity to consider the particular needs of pregnant women with HIV in its assessment of reasonableness of the program. The judges failed to explore whether neglecting the needs of pregnant women with HIV is discriminatory on grounds of sex, disability or possibly race under Article 9 on equality. Had the Court taken a more contextual approach to constitutional interpretation, it could have built upon its Article 9 jurisprudence on substantive equality, and in so doing apply the norms of the Women's Convention, which South Africa has ratified.⁹³ Their equality jurisprudence has specifically called for measures to address the continuing effects of past discriminatory wrongs:

Particularly in a country such as South Africa, persons belonging to certain categories have suffered considerable unfair discrimination in the past. It is insufficient for the Constitution merely to ensure, through its Bill of Rights, that statutory provisions which have caused such unfair discrimination in the past are eliminated. Past unfair discrimination frequently has ongoing negative consequences, the continuation of which is not halted immediately when the initial causes thereof are eliminated, and unless remedied, may continue for a substantial time and even indefinitely ... One could refer to such equality as remedial or restitutionary equality.⁹⁴

The General Recommendation on Women and Health which elaborates the content and meaning of Article 12 on health of the Women's Convention explains that neglecting to provide health care that only women need is a form

89 *Treatment Action Campaign*, par 43.

90 *Treatment Action Campaign*, par 36.

91 *Treatment Action Campaign*, par 38.

92 *Treatment Action Campaign*, par 34.

93 Ratification date for South Africa to the Women's Convention, 14/01/96.

94 *National Coalition for Gay & Lesbian Equality v Minister of Justice* 1999 (1) SA 6 (CC) AT 38-39 per Ackerman J.

of discrimination.⁹⁵ They might have also considered the intersections of different grounds of discrimination, including sex, health status and possibly race. The opportunity was also missed to build on the General Recommendation on Gender-related dimensions of racial discrimination⁹⁶ made by the Committee on the Elimination of Racial Discrimination, under the International Convention on the Elimination of All Forms of Racial Discrimination, which South Africa has ratified.⁹⁷

In acknowledging the particular form and manifestation of discrimination against women marginalized by sex, race and health status in accessing nevirapine, the Court would have at least placed government health officials on notice that such manifestations warrant careful scrutiny. Had the Court addressed the barriers that women face in accessing health care in the way they addressed the 'most urgent' needs of children in accessing nevirapine,⁹⁸ they could have signalled that governments have obligations to accommodate women's particular needs. It is through the acknowledgment of its different forms and manifestations that discrimination can be recognized, identified and effectively addressed.

The Women's Health Report 1998 concludes that 'Women's health is inextricably linked to their status in society. It benefits from equality and suffers from discrimination.'⁹⁹ Had the Constitutional Court been inspired to acknowledge the discriminatory dimensions of the governments program, it would have moved well beyond the jurisprudence developed by courts in other countries on the constraints faced by women and girls in accessing health care. Courts have helpfully eliminated requirements for partners' authorization for provision of care to women,¹⁰⁰ and parental consent requirements regarding mature adolescent girls.¹⁰¹ Rulings have generally held that such third party authorization requirements violate the right to private life.

95 CEDAW General Recommendation 24.

96 Committee on the Elimination of Racial Discrimination, General Recommendation 25, UNGAOR 2000, UN Doc. A/55/18, Annex V, 152.

97 South African ratification of the Convention on the Elimination of All Forms of Racial Discrimination, 9/01/99.

98 *Treatment Action Campaign*, pars 74-79, Sections 28(1)(b) and (c) on children's rights to access to basic health care.

99 World Health Organization 1998: 8.

100 *A v B*, 35 (iii) P.D. 57 (Supreme Court of Israel, 1981); *Attorney-General (QLD) ex rel. Kerr v T*, 46 ALR 275 (High Court of Australia, 1983); *C. v S.*, 2 W.L.R. 1108 (Court of Appeal, England, 1987); *Judgment of Feb. 15, 1978*, Dec. No. 157/77, 3 Yugoslav Law 65 (Constitutional Court of Yugoslavia, 1979); *Judgment of Oct. 31, 1980*, Conseil d'Etat, D.S. Jur. 19,732 (Council of State of France, 1980); *Judgment of Mar. 31, 1988*, Corte Cost., Gazz. Ufficiale, 1 serie speciale, April 13, 1988, n.15; Giur. Cost. e Civ. 2110 (Constitutional Court of Italy, 1988); *Kelly v Kelly*, 2 FLR 828 (Court of Session, Scotland) (1997); *Planned Parenthood v Danforth*, 428 U.S. 52, 69 (Supreme Court of the United States, 1976); *Tremblay v Daigle*, 62 D.L.R. (4th) 634, 665 (Supreme Court of Canada, 1989).

101 *Gillick v West Norfolk and Wisbech Area Health Authority* [1986] AC 112 (House of Lords).

These decisions prohibiting third party authorization requirements are based on liberal theories of justice that tend to address only what governments must not do. The courts might have considered what positive provisions are needed to ensure that women can actually exercise their autonomy in ways that will protect and promote their health. Courts might come to consider how the patriarchal nature of authorization requirements produced women's vulnerability to ill health and disadvantage within the health care system.¹⁰² It would have been a significant contribution to jurisprudence had courts examined how such requirements reproduce patriarchy, and what governments should do to change patriarchal values that obstruct women's access to health care.

Advocates and legal scholars face the challenge to guide courts to go beyond liberal theories of autonomy, in order to consider positive measures that can be taken to acknowledge the discriminatory harms that persist in the realities of women's lives. Progress might be achieved, for instance, if governments were required to train health officials to examine, through human rights needs assessments and gender analysis, how women's health needs can be accommodated in fact.

Courts in some countries have declined to require public health ministries to make emergency contraception available,¹⁰³ while in others litigation is pending.¹⁰⁴ In still others, however, courts have explained that failure adequately to disclose an emergency contraceptive option within 72 hours of women's unprotected intercourse, when competent practitioners would have provided information about that option, will justify awards of damages for negligence if women show that they would have taken the option, and that they have suffered injury as a consequence of the option being denied.¹⁰⁵

102 Standing 1997:2.

103 *Sara Phillipi et al. v Ministerio de Salud, Instituto de Salud Pública and Laboratorio Silesia* (2001), Supreme Court 2186-2001, August 30th, 2001 (Supreme Court of Chile).

104 *Ages v Instituto de Salud Pública* (2004) 20^o Juzgado Civil, rol 5839-02; *Ages v Instituto de Salud Pública*, (2004) Santiago Court of Appeals, rol 4200-03 (an appeal against a lower court decision to ban an emergency contraceptive product and a stay of that opinion is pending before the Santiago Court of Appeals of Chile); *Carlos Humberto Gómez Arámbula* (File No 88119) (a declaration is sought to invalidate the Resolution 266285 approving the emergency contraception, Postinor 2, by Ministry of Social Security's National Institute of Vigilance for Medicines and Food (INVIMA) (Council of State of Colombia, Administrative Law Section); *Juan Carlos Barrera* (File No. 17.806) (appeal might be sought against the decision of Sept 30, 2004 that an action of Protection (Tutela) in the name of the non-born (nasciturus) against Profamilia for distributing emergency contraception with Levonorgestrel 0.75 mg and the pharmaceutical laboratories that produce medicines using the Levonorgestrel 0.75 mg. as an active principle (Schering, Wyeth, HRA Pharma, Leiras; Gedeon Richter) is the proper mechanism to challenge the approval of INVIMA of emergency contraception with Levonorgestrel 0.75 mg is not the proper means to impugn the proceedings of a general character (Colombian Supreme Court of Justice-Penal Chamber).

105 *Kathleen Brownfield v Daniel Freeman Marina Hospital* (1989) 208 Cal. App 3d 405, 412, 413 (California Court of Appeals, 2nd Appellate District (div 4) explained that failure to adequately disclose an emergency contraceptive option within 72

Legal application of a tort or delictual standard of care to provision of emergency contraception is an important step to ensure that women have the necessary information to make informed choices about their care. As against this application, courts have often failed even to consider the impact on maternal mortality and morbidity of prohibition of emergency contraception, and the manifold harms women face from violation of their rights to liberty and security of the person, and to non-discrimination. Judges have ignored scientific facts that show that emergency contraception can act only to prevent pregnancy, simply stating that emergency contraception is a form of abortion. Scientific evidence shows, however, that it prevents pregnancy, and is of no effect after pregnancy has occurred.¹⁰⁶

Denial takes many forms.¹⁰⁷ Denial of women's human rights to medically indicated health services is marked by misrepresentation of scientific facts, by refusal to recognize the history of women's oppression and denying responsibility for past and present practices that violate women's rights. Courts have a significant role to play in overcoming these many forms of denial by:

- acknowledging health-related violations, whether it be against women or, for example, those marginalized by race and ethnicity,¹⁰⁸
- requiring public accountability for those violations, and
- formulating appropriate measures to remedy such violations.¹⁰⁹

4. The use of temporary special measures to promote equality in health

Given the disparities in health status, whether measured by structural, process or outcome indicators,¹¹⁰ among different subgroups of populations, it might be necessary for ministries of health and courts to consider the use of affirmative action measures to promote fairness and substantive equality in health care reform. Generally speaking, affirmative action is based on temporary positive measures intended to increase opportunities for health advancement for historically and systemically disadvantaged groups. The Women's Convention describes affirmative action as temporary special measures, and explains in Article 4(1) that:

Adoption ... of temporary special measures aimed at accelerating de facto equality between men and women shall not be considered

hours of unprotected intercourse, when a skilled practitioner would have provided information about that option, can justify an award of damages for negligence if the woman shows that she would have taken that option, and suffered injury as a consequence of the option not being offered).

106 Grimes & Raymond 2002:181.

107 International Council on Human Rights Policy 2000.

108 Randall 1995:147-224; Chapman and Rubenstein (eds) 1998.

109 Boven 200:111-133.

110 *Interim Report of Special Rapporteur* 2003.

discrimination ..., but shall in no way entail as a consequence the maintenance of unequal or separate standards; these measures shall be discontinued when the objectives of equality of opportunity and treatment have been achieved.

Article 4(1) is explanatory in nature. It distinguishes permissible temporary special measures, aimed at achieving *de facto* or substantive equality, from otherwise discriminatory measures.¹¹¹ It explains that, if States do take such measures, they will not be considered discriminatory,¹¹² provided that the measures satisfy the following three tests:

First, they must accelerate equality in fact,

Second, they must not entail the maintenance of unequal or separate standards, and

Third, they must be discontinued when the objectives of equality of opportunity and treatment have been achieved.¹¹³

Temporary special measures can range from small initiatives that encounter little resistance, such as provision of health promotion information, to more costly training programs, and, finally, to more controversial measures, such as programs to facilitate access of high risk groups to necessary health services until such time as those groups are at no more than the ordinary risk in the general population. The more targeted and robust the measures are, the more contested they become.

According to Article 12(1) of the Women's Convention, courts may find that temporary special measures are required where such measures are the most 'appropriate ... to eliminate discrimination against women in the field of health care ...' The criteria for determining which measures are 'appropriate' to eliminate discrimination against women are more difficult to determine in the field of health than in such areas as participation in political and public life, and access to education and employment, where affirmative action measures have been frequently used.

The success of affirmative action is often measured by the degree to which men and women are recruited equally into the work force and educational institutions, because eligibility for employment and education does not usually depend on differences in sex. However, in matters of health, the issue is not only one of treating equal eligibility equally, but also of reacting appropriately to biological and physiological differences between the sexes and the underlying social conditions that affect the sexes differently. That is, temporary special measures are generally used to ensure that similar cases are treated in similar ways. Such measures have not commonly been used to ensure that

111 Committee on the Elimination of Discrimination against Women (CEDAW), General Recommendation No. 25, on article 4(1) of the Convention on the Elimination of All Forms of Discrimination against Women, on temporary Special Measures, CEDAW/C/2004/I/WP.1/Rev.1, 30 Jan 2004 CEDAW, par 18.

112 This view is also taken by the Human Rights Committee in its General Comment 18: Non-discrimination at par 10 HRI/Gen/1/Rev.4 (2000).

113 General Recommendation 25, pars 18-24.

different situations or conditions are treated fairly according to those differences. As a result, temporary special measures might be more usefully applied to require equality in access to specific therapeutic drugs and services among subgroups of women, as measured by process indicators.

A focus of the Women's Convention is on the elimination of all forms of discrimination against women, including multiple forms. Where subgroups of women are differentiated by health indicators, especially process and outcome indicators, and those health indicators correlate, for instance, with race, ministries of health might use temporary special measures. Such measures might well be appropriate to address discrimination on the compounded grounds of race and sex, where such measures are proportional to the end of achieving substantive equality in access to specified treatment among subgroups.

It is unlikely that courts will order temporary special measures to address the underlying socio-economic conditions because the evidence of the effectiveness of addressing such conditions is more complex, indeterminate and variable. In this sense, the law in general and temporary special measures in particular are limited in achieving substantive equality in the health context because of their inability to address the underlying socio-economic conditions.¹¹⁴

5. Conclusion

As courts move from a mode of deference to governmental authority to a mode of deliberation on governmental responsibility enforceable by law, they will play an increasingly important role in generating thoughtful and informed debate about fairness in health care reform. Health care decisions can no longer be protected by governmental political choices or concealed behind veils of clinical or scientific judgments or cost-effective assessments. Health care reform has to be planned and undertaken in a transparent manner, and needs to comply with principles of fairness embodied in constitutions and human rights treaties.

Greater dialogue is needed among all sectors of society about fairness in health care reform. Where judicial review is understood as a dialogue among judges, governments and legislatures,¹¹⁵ evidenced-based health assessments are necessary to inform the debate. Health professionals have to engage with wider audiences concerned with equity and human right issues more generally. Moreover, courts have to ensure that their decisions are grounded in sound understandings of clinical care, health systems and underlying determinants of health, and have to provide objective reasons why particular reforms will achieve greater fairness. Courts will always be sensitive to their particular institutional role and capacities relative to other branches of government, and will continue to carve out a 'restrained and focused role'¹¹⁶ in resource allocation decisions.

114 Ngwena 2000:111-131, 126

115 Fitzpatrick Slye 2003:669-680, 680; Roach 2004.

116 *Treatment Action Campaign* at par 38.

Health care reform cannot be debated in a normative vacuum. Reforms need to be evidenced-based, and grounded in principles of fairness and justice. Where reforms are not evidenced-based, publicly understood or justified, they may be challenged through the courts by the application of constitutional and human rights values.

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