# Introduction: Marrying Human Rights and Health Care Systems

## *Contexts for a Power to Improve Access and Equity*

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Marriage is a matter of more worth
Than to be dealt in by attorneyship.
*1 Henry VI* 5.5.50–51

In this volume, we explore the power of health care rights in diverse health care systems. Does a right to health care serve to advance greater equity or does it in fact advance the opposite result? Does the recognition of a right to health care help sustain public values (like equality) in systems that are undergoing privatization? Or, to the contrary, does a focus on rights-based norms foster individualism and exacerbate inequalities brought about by privatization? Does the legal means by which health care rights are established make a difference (whether in a constitutional document, in a statute, etc.)? How do courts balance the rights of an individual against collective needs in the distribution of health care? Has this differed depending on the wording of health rights protections? To what extent are broader legal, economic, and political considerations taken into account in the courts' reasoning about health rights? Does the interpretation of the right to health vary depending on the model of health system involved (e.g., private insurance, social insurance, single payer [public/tax-financed])?

### WHY WE WROTE THIS BOOK

Many of us who teach or practice human rights law believe as an article of faith that pursuing the realization of health rights will result in public welfare improvements and, in particular, will improve the plight of some of the most vulnerable in society. But increasingly we are pressed to question this assumption, as statistics continue to underscore widespread inequities in health and access to health care. In colloquial terms then, we address whether the creation and judicialization of health rights is a force for good or ill. We also deeply appreciate that law is part of a larger

socioeconomic, political, and cultural context, and we are interested in how these contextual factors influence health care rights, for better or for worse.

A variety of social, political, and philosophical factors culminated in the framing of health as a human right. As Eleanor Kinney describes it, notions of a positive right to health originated in the nineteenth century, when public health reformers advocated government involvement in public health.[1] Pointing to the Enlightenment, the Latin American philosophy of human rights, and the rise of the modern welfare state, John Tobin suggests that the health and human rights approach indicates "an embrace of liberal values with an acceptance of the need for states to take measures to mitigate the harm caused by excessive liberalism and capitalism."[2]

But while the right to health as discussed later was included in the Universal Declaration of Human Rights (UDHR) from 1948, the rights in the UDHR were split into two separate covenants in 1966, one including civil and political rights and the other social and economic rights.[3] Jack Donnelly notes that Cold War tensions further bifurcated the development of human rights, with the West focusing on civil and political rights, while leaders in the East (particularly those in the Soviet bloc) focused on economic and social rights.[4] In dominant human rights discourse, the right to health care, as part of the framework of social and economic rights, was relegated to a second-class status.[5]

Seven factors contributed to the reemergence of rights to health and health care since the 1990s at both the national and international levels:

1. To some extent, the end of the Cold War reduced the ideological divide between civil and political rights and economic and social rights, as apparent in the Declaration adopted by the Second World Congress on Human Rights, referring to the two sets of rights as "universal, indivisible, and interdependent and interrelated."[6]
2. The growing critique of the international human rights movement, especially from postcolonial countries, arguing that the West's focus on civil and political

[1] Eleanor D. Kinney, The International Human Right to Health: What Does This Mean for Our Nation and World?, 34 IND. L. REV. 1457, 1459 (2001).
[2] John Tobin, THE RIGHT TO HEALTH IN INTERNATIONAL LAW 42 (2012).
[3] For a discussion, *see* Daphne Barak-Erez & Aeyal M. Gross, *Do We Need Social Rights? Questions in the Era of Globalisation, Privatisation and the Diminished Welfare State*, in EXPLORING SOCIAL RIGHTS: BETWEEN THEORY AND PRACTICE 3 (Daphne Barak-Erez & Aeyal Gross, eds., 2007).
[4] Jack Donnelly, UNIVERSAL HUMAN RIGHTS IN THEORY AND PRACTICE 27 (2002).
[5] *Id.* at 7–8.
[6] Vienna Declaration and Programme of Action, U.N. General Assembly World Conference on Human Rights, A/CONF/157/23 (1993). On the effect of the end of the Cold War, *see also* Mindey Jane Roseman & Siri Gloppen, *Litigating the Right to Health: Are Transnational Actors Backseat Driving?*, in LITIGATING HEALTH RIGHTS: CAN COURT BRING MORE JUSTICE TO HEALTH? 246, 249 (Alicia Ely Yamin & Siri Gloppen, eds., 2011); Tobin, *supra* note 2, at 1; For a discussion of this and some of the other factors, *see also* Helena Nygren-Krug, *The Right to Health from Concept to Practice*, *in* ADVANCING THE HUMAN RIGHT TO HEALTH 39 (Jose M. Zuniga, Stephen Marks & Lawrence Gostin, eds., 2013).

rights ignored the harsh social distress experienced by much of the world's population, whose lack of access to housing, food, health care, and other material living conditions is no less detrimental than violations of rights such as freedom of speech or religion. The human rights movement recognized that it could not remain relevant while ignoring or downplaying social rights.[7]

3. Growing demands for health services spurred by technological developments and (in many developed countries) an aging population in combination with a neoliberal imperative to reduce public spending/privatize. Neoliberal economic measures emanating from the Washington Consensus, the International Monetary Fund, and the World Bank have encouraged policies that inadequately respond to the growing demands for health services. In some countries, especially those in Latin America, the result was the forced adoption of structural adjustments programs, involving reduction of government services and privatization, which had a particularly detrimental impact on health care.[8]
4. Also in the context of globalization, the Trade-Related Aspects of Intellectual Property Rights agreement created global patents in drugs, pitting a conflict between international trade law and access to medicines in poor countries.[9] The global campaign for universal access to antiretroviral therapies was grounded in the idea of health as a human right.
5. The wave of health care reforms enacted since the middle of the 1980s – internal market reforms, managed competition reforms, and the rise of managed care – has sought to control the cost, volume, and quality of health services supplied.[10] Patients facing denial or delays in care often turn to the courts, invoking the right to health.

[7] *See* Barak-Erez & Gross, *supra* note 3, at 5.

[8] *See* Roseman & Gloppen, *supra* note 6, at 249; David Harvey, A Brief History of Neoliberalism (2007). In the context of health, *see* Sue L. T. McGregor, *Neoliberalism and Healthcare*, 25 Int'l J.Consumer Stud. 82 (2001); Dani Filc, *The Health Business under Neo-Liberalism: The Israeli Case*, 25 Critical Soc. Pol'y 180 (2005); Paul O'Connell, *The Human Right to Health in an Age of Market Hegemony*, *in* Global Health and Human Rights: Legal and Philosophical Perspectives 190 (J. Harrington & M. Stuttaford, eds., 2010). *See also* Alicia Ely Yamin, *Power, Suffering and Courts: Reflections on Promoting Health Rights through Judicialization*, *in* Litigating Health Rights, *supra* note 5, at 333, 340; Jonathan Wolff, The Human Right to Health 94 (2012).

[9] See Phillipe Cullet, *Patents and Medicines: The Relationship between TRIPS and the Human Right to Health*, in Perspectives on Health and Human Rights 179 (S. Gruskin et al. eds., 2005); E 't Hoen, *TRIPS, Pharmaceutical Patents, and Access to Essential Medicines: A Long Way from Seattle to Doha*, *in* Perspectives on Health and Human Rights, id at 100; Wolff, supra note 8, at 100–108; Lisa Forman & Jillian Clare Kohler, eds., Access to Medicines as a Human Right: Implications for Pharmaceutical Industry Responsibility (2012). On the relevance of globalization generally, *see also* Audrey R. Chapman & Salil D. Benegal, *Globalization and the Right to Health*, in The State of Economic and Social Rights: A Global Overview 61 (Lance Minkler ed., 2013).

[10] Colleen M. Flood, International Health Care Reform: A Legal, Economic and Political Analysis 1–9 (2003); Tobin, *supra* note 2, at 351–370.

6. The process of democratization has entailed drafting new constitutions, which often include an explicit justiciable right to health as part of the idea of transformative constitutionalism – a factor apparent in South Africa and Latin America.[11]
7. The rise of AIDS, which played a major role as advocates turned to human rights in order to both tackle discrimination and guarantee access to medications. Many of the groundbreaking cases relate to access to antiretroviral drugs.[12]

All of these factors contributed to a renewed interest in the right to health from the 1990s and into the 2000s. This growing recognition of health as a human right led to its articulation in myriad legal instruments, both international and domestic. Health rights, both general and specific, now appear in numerous international agreements,[13] as well as domestic state constitutions and statutes.[14] But for all these formal declarations of human health at the global level, we continue to see extreme inequalities – health care spending per capita for the top 5 percent of the world population is nearly 4,500 times that of the lowest 20 percent; 2.5 million people die annually from vaccine-preventable diseases;[15] and close to 7 million children younger than the age of five died in 2011 from malnutrition and mostly preventable diseases.[16] These sad but familiar statistics force us to take stock: What difference has law, particularly the judicialization of health rights, made?

The Office of the U.N. High Commission for Human Rights reports that at least 115 constitutions around the world speak to the right to health or health care,[17] but they can have varying degrees of legal force. Eleanor Kinney reports that 68 percent

[11] Yamin, *supra* note 8, at 339–340. On this role of social rights in the South African Constitution, *see e.g.*, Aeyal Gross, *The Constitution in Reconciliation and Transitional Justice: Lessons from South-Africa and Israel* 40 STAN. J. INT'L L. 47 (2004).

[12] *See* Yamin, *supra* note 8, at 338–339, 348–350; Wolff, *supra* note 8, at 39–91; Paul Hunt, *The Right to Health: From the Margins to the Mainstream*, 340 THE LANCET 1878 (2002).

[13] *See e.g.*, International Covenant on Economic, Social and Cultural Rights, G.A. Res. 22001 (XXI), U.N. GAOR, 21st Sess., Supp. No. 16, U.N. Doc A/6316, 993 U.N.T.D. 3 (1996); CESCR General Comment No. 14, The Right to the Highest Attainable Standard of Health, U.N. ESCOR, 22nd Sess., U.N. Doc. E/C.12/2000/4 (2000); Constitution of the World Health Organization, pmbl., 62 Stat. 6349, 14 U.N.T.S. 185. On the right to health in international law, *see* Brigit Toebes, THE RIGHT TO HEALTH AS A HUMAN RIGHT IN INTERNATIONAL LAW (1999); Tobin, *supra* note 2.

[14] *See e.g.*, Brazil Const. tit. II, ch. II, art.6 & tit.VIII, ch. II, art.196–197; South Africa Const. ch. II, art. 27–28.On the right to health, *see generally* Andrew Clapham & Mary Robinson, eds., REALIZING THE RIGHT TO HEALTH (2009); Stephen P. Marks, *The Emergence and Scope of the Human Right to Health*, *in* ADVANCING THE HUMAN RIGHT TO HEALTH, *supra* note 6, at 3. See also, Courtney Jung, Ran Hirschl and Evan Rosevear, Economic and Social Rights in National Constitutions (October 16, 2013) at 9, available at http://ssrn.com/abstract=2349680

[15] Lawrence Gostin, *The Unconscionable Health Gap: A Global Plan for Justice*, 375 THE LANCET 1504 (2010).

[16] World Health Organization Fact Sheet No. 178, *Children: Reducing Mortality* (Sept. 2012), *available at* http://www.who.int/mediacentre/factsheets/fs178/en/index.html.

[17] Office of the U.N. Commissioner for Human Rights, Fact Sheet No. 31, *The Right to Health: Fact Sheet* (June 2008), *available at* http://www.ohchr.org/Documents/Publications/Factsheet31.pdf.

of countries have a provision addressing health or health care (including "statements of aspiration" and "programmatic statements") in their constitutions, with 40 percent including a right to health care and 38 percent providing an affirmative duty for the state to provide care. However, her research shows that those with the greatest nominal commitment to health in their constitutions spend less than half as much per capita on health care as do countries with no formal constitutional declarations with respect to health.[18] One could conclude from this that there is a distinct lack of correlation between words on paper and actions on the ground. But that would be too simplistic. As we discuss in the Conclusion, there is indeed some degree of correlation between the constitutional recognition of a right to health and the existence of a weak (or nascent) public health care system. But this is likely attributable to the fact that establishment of a constitutional right to health is part of so-called second-generation rights, which appear mostly in newer constitutions of emerging democracies. By contrast, countries with stronger public health care systems are often established and richer democracies in which the health care system is part of a welfare state, developed historically without explicit reference to health rights.

## OUR CHOSEN COUNTRIES

Our story of the power of health rights involves sixteen countries, each represented by a chapter. In selecting countries for study, we sought to capture a range of approaches to the legal recognition of health rights:

1. Specific health care rights are articulated in the constitution;
2. Constitutional rights (e.g., the right to life) have or could be interpreted to include rights to health care;
3. Health care rights are contained in domestic statutes and regulations; or
4. No legal rights to health care are recognized at all.

We classify our country chapters into three groups that, loosely understood, fall on a spectrum from more to less private. Our typology is as follows:

1. Public/Tax-Financed – these are countries in which public financing, based on taxation revenues, is a defining feature of the health care system. Our representative countries here are the United Kingdom, New Zealand, Canada, and Sweden.
2. Social Health Insurance/Managed Competition – these countries have universal coverage for health care and, like Public/Tax-Financed countries, redistribute (at least to some extent) from the rich to the poor and from the healthy to the sick. But in place of tax revenues, these systems are financed primarily through mandatory contributions from employers and employees to either

[18] Eleanor D. Kinney, *The International Human Right to Health in Domestic Constitutional and Statutory Law*, in Law and Ethics, in Rationing Access to Care in a High-Cost Global Economy 171, 175 (Wendy K. Mariner & Paula Lobato de Faria, eds., 2008).

non-profit social health insurers or competing private not-for-profit or for-profit insurers (managed competition). The representative countries we include in this category are Colombia, Israel, the Netherlands, Hungary and Taiwan.

3. Mixed Private/Public[19] – these are countries in which a private health system fulfills a central role alongside a public system. In these countries health care is not universal (e.g., the United States) or, alternatively, a universal public scheme exists but is so impoverished that private finance/delivery plays a very significant role (e.g., India). The representative countries we include in this section are China, South Africa, Brazil, the United States, Nigeria, Venezuela, and India.

The allocation of countries into these three categories is not cut-and-dried, and we have made judgment calls on categorization in consultation with our contributors. For example, in Hungary (which we classify as a Social Health Insurance country), there is a significant role for extra payments (bribes, etc.) made to doctors and other providers, which undoubtedly distorts the fair allocation of care. Nonetheless, we consider as an overall judgment that Hungary is better situated in the middle of our spectrum of public-private funding.

This framing puts heavy emphasis on the extent to which different mixes of public and private financing interact with health care rights, yielding differing levels of access and equity in health care. In developed countries, the maturation of public health systems and concerns about growing health care costs result in tensions over the inclusion of new technologies, drugs, and services – leading, it seems, to ever-more frequent attempts to privatize existing systems of redistribution. In middle-income and developing countries, issues focus more on developing universal health care systems to ensure access to some minimum of care for all citizens, but also can involve efforts on the part of some to access expensive new drugs and devices at public expense. This text looks at the role that legal rights to health care can and should play in these respective processes, and what is the broader impact on equity in health.

The health care systems considered in the text cover a blend of public, private, and public/private approaches to the funding and delivery of health care, with some systems transitioning toward increased privatization. Beyond formal laws and court actions, the realization of health care rights is impacted by the larger political, economic, and social context of the state; thus two systems with similar rights provisions but different social/political systems may – we hypothesize – show dramatic differences in their realization of health rights.

A further note here on our emphasis on the public/private mix: we also examine whether asserting "rights" can combat further privatization of health care and discuss

[19] "Public" in this context includes systems that are partially funded by tax finance as well as those partially funded by mandatory social health insurance or mandatory private insurance (the managed competition model).

whether health human rights are successful in this regard or not. For example, in 2008, an Egyptian court overturned a significant move on the part of the government to privatize the delivery of health care, finding that the privatization of the health care system would violate the government's obligations to affirm/protect citizens' right to health.[20] This can be contrasted with Canada, where the Supreme Court in *Chaoulli*, held that individuals have a legal right to buy private health insurance but have yet to find any positive obligation on the part of governments to provide public health care.[21]

## SOURCES OF HEALTH CARE RIGHTS

Before going further, we need to provide a little more context on the sources of health and health care rights, which include international law (treaties, conventions, etc.), domestic states' constitutions, and domestic statutes. Rights can also emerge from long-term patterns of public policy, whereby rights, though not formally articulated, are acknowledged to exist (de facto rights). In what follows we discuss the differential impact of litigation of international rights versus the impact of rights contained in domestic legislation (constitutions and statutes) and as a matter of public policy.

### *International Rights*

According to Article 25.1 of the Universal Declaration on Human Rights,[22] "[e]veryone has the right to a standard of living adequate for the health of himself and of his family, including food, clothing, housing and medical care and necessary social services." This concept was affirmed and expanded by Article 12.1 of the International Covenant on Economic, Social and Cultural Rights (ICESCR),[23] which recognizes "the right of everyone to the enjoyment of the highest attainable standard of physical and mental health." Further, Article 12.2 of the ICESCR strengthens the right by outlining the obligations of states to "achieve the full realization of this right."[24] Of the states considered in later chapters, all except South Africa and the United States are parties to this covenant.[25] Following ICESCR, several international instruments included provisions addressing the right to health, for

[20] Nabieh Taha Muhammad al-Bahyetors. vs. The President of the Republic et ors., Case no. 21550/61st judicial year/2008/State Counsel, Court of Administrative Justice (First circuit) (Egypt). (English translation on file with authors).

[21] Chaoulli v. Quebec (Attorney General), 2005 SCC 35 (Can.).

[22] G.A. Res. 217A(III), U.N. GAOR, 3d Sess., U.N. Doc. A/810 (1948).

[23] International Covenant on Economic, Social and Cultural Rights, *supra* note 13.

[24] Id.

[25] United Nations Treaty Collection, UN, http://treaties.un.org/Pages/ViewDetails.aspx?src=TREATY&mtdsg_no=IV-3&chapter=4&lang=en (last visited July 19, 2013). In 2009, Taiwan, while not a signatory to the agreement, passed legislation giving domestic legal effect to the ICESCR.

example, the 1978 Declaration of Alma-Ata.[26] This document is notable in its emphasis on the availability of primary care services and on "unacceptable" health disparities both within countries and between developed and developing countries.

In addition to these general declarations, many international instruments exist that attempt to address a specific global health concern. For example, UN Millennium Development Goal 5 and UN CEDAW Article 12(2) are focused on reducing maternal mortality, whereas the Framework Convention on Tobacco Control focuses on reducing tobacco usage. Another important document is the Doha Declaration, in which the World Trade Organization responded to the high price of AIDS medication by clarifying that patent protections in the Trade-Related Aspects of Intellectual Property Rights Agreement do not preclude member states from taking measures to protect public health.[27]

Although many of these international instruments are several decades old, there is a resurgence of interest in health and human rights. For example, in 2000, the UN Committee on Economic, Social and Cultural Rights issued a comprehensive document ("General Comment 14"), intended to elucidate the right to health, putting an emphasis on issues of equity, equality, and accessibility[28] and developing the "AAAQ" model of availability, accessibility, acceptability, and quality.[29] General Comment 14 reiterates important principles developed in social economic rights interpretation including the tripartite nature of state obligations, which includes the obligations to respect, protect, and fulfill.[30] The Comment also specifies that states have "core obligations" under the ICESCR, notwithstanding the accompanying principle of "progressive realization"[31] – meaning states must ensure, at the very least, minimum essential levels of each of the rights enunciated in the Covenant, including essential primary health care.[32] Finally, the Comment contains a presumption against retrogressive measures.[33] In 2002, the UN Commission on Human Rights appointed a Special Rapporteur on the right to health.[34]

[26] *Declaration of Alma-Ata*, World Health Organization (Sept. 1978), *available at* http://www.who.int/publications/almaata_declaration_en.pdf.

[27] Doha Ministerial Declaration on the TRIPS Agreement and Public Health, WT/MIN(01)/DEC/2, art. 4 (Nov. 14, 2001), *available at* http://www.wto.org/english/thewto_e/minist_e/min01_e/mindecl_trips_e.pdf.

[28] General Comment No. 14, *supra* note 13.

[29] For a discussion, *see* Aeyal Gross, *The Right to Health in an Era of Privatization and Globalization*, *in* Barak-Erez & Gross, *supra* note 3, at 300–305; A. Clapham & S. Marks, International Human Rights Lexicon 207 (2005).

[30] General Comment No. 14, *supra* note 13, at para. 33; Tobin, *supra* note 2, at 185–197.

[31] General Comment No. 14, *supra* note 13, at paras. 30, 43.

[32] Id. at para. 43; Tobin, supra note 2, at 238–252; Wolff, supra note 8, at 9–12; Lisa Forman, *What Future for the Minimum Core? Contextualizing the Implications of South African Socioeconomic Rights Jurisprudence for the International Human Right to Health*, *in* Global Health and Human Rights, supra note 8, at 66–80.

[33] General Comment No. 14, *supra* note 13, at para. 32.

[34] For a description on the role of the Rapporteur, *see* Paul Hunt, *The UN Special Rapporteur on the Right to Health: Key Objectives, Themes and Interventions*, 7 Health & Hum. Rts. 1 (2003);

But as inspiring and influential as these developments may be, the nature of public international law can limit their impact. State sovereignty is invoked by a number of nations as a type of universal trump card to the articulation of health rights in international instruments, and thus an individual's health rights are usually determined by the domestic laws of their state and not by international conventions. In domestic courts, internationally ratified agreements may be used to interpret the meaning of domestic laws – in other words, the court will, if possible, assume that the government intended its domestic laws to be interpreted in a way that would comply with ratified international agreements. Thus, judicial interpretation of international instruments can prove to be an important normative force. In this regard, Andre den Exter notes in Chapter 7 that international human rights law has played an important role in interpreting the Dutch constitution to include a right to health care. Also, as Aeyal Gross notes in Chapter 6, Israeli courts have held that domestic laws should be interpreted to the extent possible so as to be compatible with international obligations. Venezuela offers another example, as its domestic constitution provides that international human rights treaties become part of domestic law immediately following ratification by the government.

### *Domestic Constitutional Rights*

As previously noted, 68 percent of countries make some reference to health in their constitutions. Health care rights may be expressly articulated, as, for example, in Brazil or South Africa, or may be read in or inferred as part of other fundamental rights; thus, for example, in India, the courts have interpreted the right to life as including a right to health.

On the face of it, an obvious benefit of having health rights articulated in a state constitution is that (usually) a constitution is the supreme law of the land with which all other laws must comply. Further, constitutions transcend elected terms of government and tend to be more difficult to change or repeal than ordinary legislation is.

### *Statutory Rights*

A third model arises where health rights do not exist in a domestic constitution but are created by statute. An example here would be Israel, where health rights are articulated in two statutes: the National Health Insurance Law and the Patient Rights Law (although on occasion, similar to India, Israeli courts have grounded a right to health in the constitutional right to life and body). While rights not enshrined

Paul Hunt & Sheldon Leader, *Developing and Applying the Right to the Highest Attainable Standard of Health: The Role of the UN Special Rapporteur (2002–2008)*, *in* GLOBAL HEALTH AND HUMAN RIGHTS, supra note 8, at 28.

in a state constitution would seem to be more fragile than constitutional rights, some note that the right to health now forms part of customary international law, which serves to strengthen the right domestically.[35] Another example is found in the Netherlands where high-level state obligations to "promote public health" are found in Article 22(1) of the constitution, but the formal articulation of specific entitlements to care is found in the country's 2006 Health Insurance Act. A statutory enactment of health rights may allow for a more detailed enumeration of rights (e.g., a patient's bill of rights), as opposed to very abstract and open-ended guarantees common in constitutions. Among other things, open-ended provisions may provide more latitude for judicial interpretation, resulting in very regressive readings of health rights (e.g., *Chaoulli*).

### *De Facto Rights*

Is a formal expression of a positive right to health (domestic or international) a necessary component of such a right existing? It seems this is not necessarily so, particularly in older, established welfare state systems where entitlements to health care have been well entrenched as a result of public policy. Examples here would include Sweden, Canada, New Zealand, and the United Kingdom. While one might expect de facto health rights to be the most fragile of all, these four countries have historically shown some of the strongest, pragmatic affirmation of these rights, based both on the availability of care and the health of their populations.

But despite most of the countries in this category having relatively strong health care systems, there are ongoing structural inequities, and new challenges are on the horizon. In Canada, for example, aboriginal populations have less access to care and a significantly lower standard of health than the non-aboriginal populace does. Further, recent moves by the Canadian government will "delist" many refugee claimants from insured medical care in Canada even in emergency situations.[36] The government's unilateral decision, made without consultation with the public, health professionals, or provincial governments, shows the risk of not having a formal declaration of a right and the resulting need for judicial oversight of government.[37] Moreover, recent fiscal pressures associated with global economic downturns, an aging population, new medical technologies of questionable benefit, and a culture of individualism are pushing a privatization agenda that will test these systems and their lack of articulated health care rights.

[35] Clapham & Marks, *supra* note 29, at 197; E. D. Kinney & B. A. Clark, *Provisions for Health and Health Care in the Constitutions of the World*, 37 Cornell Int'l L. J. 285 (2004).

[36] Order Respecting the Interim Federal Health Program, 2012, SI/2012–26 (Can.).

[37] Canadian Medical Association Bulletin, *Continue Coverage for Refugees: CMA*, 184 Can. Med. Ass'n J. 1212 (2012); *Government Information on Refugee Healthcare Changes is Misleading, May be Fatal*, Canadian Council for Refugees (May 3, 2012), http://ccrweb.ca/en/bulletin/12/05/03 (last visited July 19, 2013); Mark Tyndall, Op-Ed., *An Attack on Vulnerable Refugees*, Ottawa Citizen, May 9, 2012, at A15.