Creating Universal Health Care in Ireland: A Legal Context

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Abstract

In this paper we establish a working definition of, and develop a legal rationale for, the insertion of a constitutional Right to Health (RTH) protection in the Constitution of Ireland. We propose that a legal framework exists for the judicial enforcement of a right to health in Ireland, as based on parallels drawn between Irish case law and that of RSA, a comparable common law constitutional democracy with a developed jurisprudential approach to its constitutional RTH. When modelled after precedential international provisions, this right strengthens and defends health policy goals (such as universal health care) through a common-law system of governmental accountability. Additionally, national rights to health have observable correlations with improved public health, and it stimulates institutional initiatives. The 1937 Constitution of Ireland includes several personal, social, and economic rights, and a RTH would complement the existing right to primary education as a socio-economic right. We note these considerations were discussed during the legislative proposal made in the 32^{nd} Dáil for a constitutional RTH, which emerged in response to Ireland's ongoing efforts toward health policy reform.

Keywords: Universal Health Care; The Right to Health; Ireland; Constitutional Change.

1. Introduction

This paper explores how a constitutional amendment establishing a cognisable Right to Health (RTH), such as that proposed to the 32nd Dáil, would benefit and drive forward Ireland's efforts to provide universal health care and sustain long-term health reform policies. We argue that a constitutional RTH can and does fall within legal jurisdiction to influential effect, and it should not be overlooked by health activists working to improve public health systems in their respective constitutional democracies. In 2019 a bill was introduced on the floor of the 32^{nd} Dáil, the lower house of Ireland's legislature, proposing an amendment to the Irish Constitution that would enshrine a right to 'the highest attainable standard of health protection.' This bill is presented in Figure A1. The proposal sought to establish a judicial mode of accountability over public health reform in Ireland, given recent affairs in health policy: the financial crisis of 2010 had led to austerity-driven cut-backs in the medical sector that sustained for almost a decade thereafter; and from 2015 to 2019, there was a sharp media focus on issues such as shortages of qualified doctors and hospital beds (Meegan et al. [2018]; Corbet [2016]). Burke et al. [2016] had already stated that the Irish healthcare system was at a critical juncture in 2015, outlining the gap between the policy intent and achievement. Burke et al. [2018] presented a thorough outline of the 'Sláintecare' programme introduced by the Irish government in 2017, which proposed to introduce a universal, single-tier health service in Ireland with cross-party government consensus. However, given that the prior government's commitment in 2011 to develop a universal healthcare system had fallen out by 2015 due to political and institutional inertia (Byers [2017], the outcome of the Sláintecare plan remained unclear in the face of a likely post-Brexit election. 'Stakeholders' such as the Catholic church and the private medical profession also continued to exercise a restraining influence (McAuley [2014]). Work by Wang [2012] successfully demonstrates, via power network studies, the necessary political coalition building required to ensure political success and acceptance among patients and clinicians.

An extensive discussion of this topic was made during the 32^{nd} Dáil during the bill's Second Stage debate. Legislators' comments ranged on the question of this constitutional amendment's necessity, specifically how effective would a change to the constitutional law be at securing a change to the Irish health service. Sláintecare was cited as the reason for a constitutional change to be both necessary by supporters and unnecessary by objectors (please see, for example, Parliamentary Debates, Dáil Éireann, Tuesday, 26 Nov 2019, Vol. 990 No. 1, at 94, 98, 102, 106, 107, 112, 117). The 10-year programme aims to deliver population health and universal healthcare but has been

resourced with an additional €23m per annum for the past two years despite the original report calling for €10bn in supporting transitional funding (Burke et al. [2018]). The impetus of the proposal was to encourage a more significant legal requirement to adhere to the commitments of the cross-party Sláintecare proposals (Dáil Éireann, Tuesday, 26 Nov 2019, Vol. 990 No. 1, at 119).

The structure of this papers is as follows: first, an empirical argument can be made on the basis of the correlation between a constitutional RTH and improved health outcomes, as well as on the documented benefits of judicial enforcement on health outcomes. Next, the case example of RSA is submitted as evidence that such effectiveness is achieved in part through the development of rational and democratic legal doctrines.

2. Current Understandings of the Right to Health

Numerous international treaties, international declarations, and domestic constitutions contain some mention of a RTH. Among the international treaties and declarations, the most well-known which contain a RTH include the Charter of Fundamental Rights of the European Union (Art.35, 2016), the International Covenant on Economic, Social, and Cultural Rights (Art.12, ICESCR, 1966), the Convention on the Rights of the Child (Art.24(1),1989), the Convention on the Elimination of All Forms of Discrimination against Women (UN, Art.12, 1979), the International Convention on the Elimination of All Forms of Racial Discrimination (UN, Art.5, 1966)), and the WHO Constitution. Legal provisions containing references to health or health care are present in 67.5% of worldwide constitutional provisions, whether as statements of aspiration, entitlement, state duty, policy approach, or merely referential (Kinney and Clark [2004]). Ireland is not one of these countries, though it is a signatory to the aforementioned international agreements.

The main issue with a lack of a domestic constitutional provision is that international treaties have weak enforcement mechanisms and show no consistent association with improved health or social outcomes (Palmer et al. [2009]); by contrast, empirical data shows that a constitutional RTH is significantly correlated with improved well-being. Kavanagh [2017] discovered that 'an explicitly articulated right to health in a written constitution' reduced under-5 mortality rates, a statistic that 'well-captures' institutional effects (such as those of a constitutional right) on population health. This effect was found to be robust even checking against modernisation trends, national income, female education, ethnic fractionalisation, inequality, urbanisation, political conflict, level of democracy, and time [Kavanagh, 2017, p.334, 337-44]. Across the 144 countries studied, results showed a

RTH has as much of an effect on under-5 mortality as does a major change in polity score. The results provided by Kavanagh are corroborated by Matsuura et al. [2013], who found that a RTH that is 'explicitly stated in the constitution and theoretically enforceable' had a statistically significant impact on infant and under-5 mortality rates, robust against alternative definitions, democratic levels, time, and short-term (five-year) effects of constitutionalising the RTH. Consequently it appears that a constitutional RTH produces clear benefits for national populations.

2.1. Defining the Right to Health

'Right to health' is, unsurprisingly, a nebulous phrase on its own, but the provisions of international declarations and constitutions around the world have given rise to an ample theoretical background from which one can craft an informed constitutional provision with a clear definition to a RTH. We define the RTH as the collection of freedoms and entitlements enabling an individual to achieve the highest attainable standard of health protection in their given jurisdiction. Throughout this article, we use the phrase 'right to health' as a 'shorthand' for its longer definition, following Virginia Leary's usage recommendation for 'right to health' in the same way that phrases like 'right to property' and 'due process' are also shorthand phrases [Leary, 1994, p.30]. Each element of the definition carries specific connotations.

First, every right is composed of 'freedoms and entitlements': freedoms to exercise the right from government interference and entitlements to access that right. An example of a freedom implied in the RTH is bodily autonomy, the freedom from having one's body altered without consent. An example of an entitlement would be the provision of emergency medical care.

Second, a right to health is more precisely a right to 'health protection,' a phrase that receives preference in academic RTH discussions [Smith, 2005, p.1317] because 'protection' indicates both systems of health care and preconditions to good health [Leary, 1994, p.31] without suggesting perfect health, as in the vaguer 'right to health.' Additionally, while a 'right to health protection' is not included verbatim in the aforementioned international agreements, General Comment No. 14 to the ICESCR implies that the term would be more suitable in legal usage for magnifying the entitlement-centric nature of a RTH interpreted as 'extending not only to timely and appropriate health care but also to the underlying determinants of health' (U.N. Doc.E/C.12/2000/4 (2000) at §11).

Two more elements in this definition merit additional explanation. The RTH must retain some

level of individual applicability in order to meet its conception as a 'legal' right, i.e. one for which individual claimants in court can seek remedy [Jamar, 1994, p.12]. In addition, the 'highest attainable standard of health' is closely linked to the concept of 'progressive realisation,' or a 'specific and continuing obligation' toward improvement, without retrogression (U.N.Doc.E/C.12/2000/4 (2000) at §9). This is due to the practical impossibility of instantaneously or even quickly achieving complete health protection [Jamar, 1994, p.35].

3. Legal Challenges in Ireland

Ireland's constitutional background presents several challenges impeding Ireland from emplacing a constitutional RTH. Ireland has displayed judicial reluctance to give constitutional weight to socio-economic rights (SERs), i.e. those which protect or provide for socio-economic benefits, among which is the RTH [McAuley, 2014, §13.2.1]. One reason for this is that the Constitution of Ireland, Bunreacht na hÉireann, mostly mentions socio-economic rights in Art.45, the Directive Principles of Social Policy, which is non-justiciable in Irish courts . Irish judges have also been slow to discover SERs among the Irish Constitution's unenumerated, or implied, fundamental rights, which were first introduced in *Ryan v. Attorney General* ([1965] IR 294). In *O'Reilly v. Limerick Corporation*, for instance, Costello J. rejected plaintiffs' claim to a constitutionally implicit, socio-economic right to housing, on the basis that the implied redistribution of wealth resulting from adjudicating SERs lay beyond the jurisdiction of judicial authority ([1989] I.L.R.M. 181 at 194). Neither have Irish courts followed the example of India, a jurisdiction that used its Constitution's directive principles to discover and strongly defend socio-economic rights [McAuley, 2014, §13.2.1].

3.1. Injunctive Relief in Ireland

If SERs were recognised through other means, i.e. by constitutional amendment, the other question would be its method of enforcement by the judiciary. Bunreacht na hÉireann only includes one explicit, justiciable socio-economic right, the right to free primary education for children. The Supreme Court of Ireland has shown a moderate willingness to issue mandatory injunctions as one form of relief. For example, the landmark education case *Crowley v. Ireland* ([1980] IR 102) appropriately saw the Supreme Court upholding a High Court injunction ordering the Minister for Education to provide transport to alternate schools for local students affected by a teachers' strike.

Mandatory orders or injunctions present a significant type of remedy for rights litigation and have been assumed by both proponents and opponents of socio-economic rights to be a critical aspect of enforcing those rights [Hogan, 2001]. Some argue that the decisions of *Sinnott v. Minister for Education* and *TD v. Minister for Education* have closed off the possibility of injunctive relief in Ireland for socio-economic rights beyond extreme, broadly affecting instances of intentional state recklessness [Hogan and Whyte, 2003]. Under the view that the ability of the judiciary to issue mandatory orders is important and beneficial to the protection of legal rights, this would seem to present an obstacle for Irish courts in the event of a constitutionalised RTH. Yet it could also be the case that the issue will be revisited in the future by Irish courts. The ruling in *Cronin v. Minister for Education and Science* suggests individual plaintiffs might be entitled to injunctive relief for existing state services or facilities ([2004] 3 IR 205). [Whyte, 2006, p.9] argues this standard may not be followed by Irish courts with consistency, since 'extreme circumstances' and 'recklessness' are difficult to gauge against the value of a protected constitutional right (unlike the reasonableness standard of RSA jurisprudence).

3.2. Objections to the Right to Health

There are additionally two theoretical objections to the constitutionalisation of a RTH that explain why the judicial preferences in Ireland and other constitutional democracies are against it.

Opponents of a RTH for reasons of legal theory state that socio-economic rights such as the RTH concern resource allocation, a matter which lies beyond judicial jurisdiction and ought to be settled through the democratic process, i.e. the legislature's power of the purse [Lamm, 1998]. This argument, centred on the proper role of judges as regards distributive justice, is founded on a theoretical framework of human rights based on a positive-negative dichotomy, in which 'negative' rights are civil-political freedoms, requiring minimal to no judicial policy-making, whereas 'positive' rights granting entitlements raise questions as to who could legitimately enforce them [Sandhu, 2007, p.1172]. It is also closely linked to the doctrine of separation of powers, as can be seen in Justice Costello's reasoning in *O'Reilly v. Limerick Corporation* [Whyte, 2006, p.3]. Thus the first theoretical objection: if the RTH were judicialised, either proper separation of powers would sap the right from having any meaningful effect, or separation of powers would have to be effectively ignored by the judiciary.

The other objection is whether the RTH is justiciable in practice, assuming still the need to

balance state resources. Opponents argue that courts are not equipped to handle the complexity of a national health system when adjudicating a legal RTH, and, related to this, that a constitutional right might result in a flood of individual litigation.

Criticism of both kinds were levelled at the judicial decisions of the Colombian Constitutional Court (CCC) and Brazil's Supreme Federal Tribunal (STF). In Colombia, litigants were permitted to bring direct constitutional rights claims through specialised '*tutela*' hearings under Art.86 of the Colombian Constitution (Art.86 (1991)). If a judge found these rights in danger they could with broad discretion order the government to take direct action. The CCC determined early on from the Colombian Constitution's formation in 1991 that a RTH was justiciable through *tutela* hearings [Young and Lemaitre, 2013, p.185-186]. It also established a rule by 1997 requiring the government to reimburse privatised health care providers whenever a litigant successfully claimed they had been improperly denied medicines and services in violation of their constitutional rights to health. These rulings drew criticism for its apparent disregard for separation of powers [Young and Lemaitre, 2013, p.189] and placed the nation's entire universal healthcare system at risk, due to the government's loss of bargaining power over the private providers mediating public health services [Flood and Gross, 2014b, p.68].

In Brazil, litigation was found to be counteractive to the intended purpose of constitutionalising a RTH. The Brazilian STF interpreted RTH as an 'absolute right,' granting specific individual entitlements tailored to the facts of the case while ignoring the limitations of state resources to provide every person with the maximum amount of health attention [Ferraz, 2011, p.1658]. This judicial activism was criticised and questioned for its apparent intrusion on the separation of powers [Rosenn, 2009, p.861-862]. Moreover, because Brazilian courts do not hold to any explicit principle of stare decisis [Ferraz, 2011, p.1656], claims could be brought by any individual seeking relief, independent of prior court decisions, yet only the wealthier had means to afford litigation costs, and the judicialisation of a constitutional RTH hurt rather than helped the poor in Brazil [Ferraz, 2011, p.1662].

The decisions of the CCC and STF exemplify two risks with judicialising a constitutional RTH: first, a 'run on the courts' resulting from individual litigation, and second, the practical inability — not simply the political illegitimacy — of judiciaries to balance litigant claims against finite state resources. The first risk is less likely in jurisdictions (such as Ireland) that operate under a British common-law system, since the doctrine of stare decisis would prevent identical claims

from being brought and decided repeatedly, and there is no means similar to 'tutela' hearings by which constitutional claims can be brought directly by litigants. On the other hand, practical considerations of the CCC's and STF's decisions are more relevant to a common-law jurisdiction. Any decision made by a common-law court that overextends the distribution of limited means may run up against the challenges faced by Colombia and Brazil, both of which relinquished control over equitable resource allocation in favor of strict constitutional interpretations.

4. The Right to Health in South Africa

In the Republic of South Africa (RSA), a 'low-intensity' form of justiciability developed with regard to the RTH in Section 27 of the RSA Constitution [Young and Lemaitre, 2013, p.181]. The jurisprudence of the Constitutional Court of South Africa (CCSA) has been cited by scholars as one of the most studied and influential legal doctrines surrounding a constitutional RTH [Sandhu, 2007, p.1154]; [Singh et al., 2007, p.521-552]; [Flood and Gross, 2014a, p.69]; [Kavanagh, 2016, p.349]. Three of its cases together developed and implemented what is known as the 'reasonableness' standard for the judicialization of Section 27 and of other SERs in the nation's constitution: *Soobramoney v. Minister of Health*, *Government of the Republic of South Africa v. Grootboom*, and *Minister of Health v. TAC*. In this section we outline the benefits and limitations of RSA's 'reasonableness' standard, arguing that the separation of powers and resource allocation objections were prudently addressed by the RSA Constitutional Court. The above three cases and subsequent RSA case law demonstrate how Irish courts might enforce a similar, if not improved, legal standard for adjudicating a constitutional RTH.

Section 27 of the RSA Constitution states that '1) Everyone has the right to have access to: (a) health care services, including reproductive health care [...] 2) The state must take reasonable legislative and other measures, within its available resources, to achieve progressive realisation of these rights; and 3) No one may be refused emergency medical treatment.' (Constitution of the Republic of South Africa, 1996)

Through the aforementioned cases, the CCSA developed three major aspects to health rights jurisprudence, namely: enforcing government transparency, requiring reasonableness, and exercising judicial authority to deliver mandatory injunctions against state violations. Each aspect highlights the Constitutional Court's gradual development of a legally and politically legitimate, ultimately workable legal doctrine for the protection of socio-economic rights.

4.1. Soobramoney *and Transparency*

In *Soobramoney v. Minister of Health*, the CCSA affirmed its ability to answer health right litigation without directly imposing policy. The CCSA simultaneously acknowledged that the State's obligation to protect public health was limited 'within its available resources' and that the State must nonetheless explain how its policies worked to achieve its Article 27 obligations (1997 (12) BCLR 1696 (CC) (S. Afr.)). The plaintiff was denied access to state-funded renal dialysis at a KwaZulu-Natal hospital, as the treatment's limited availability necessitated a balance of resource allocations against health claims—though the plaintiff was terminally ill, the hospital's guidelines meant only patients whose illnesses could be cured through the treatment were eligible (1997 (12) BCLR 1696 (CC) (S. Afr.) at para. 25, 28). It was incumbent upon the legislature, rather than the judiciary, to make these resource-balancing decisions and to justify them through publicised policy evaluations (1997 (12) BCLR 1696 (CC) (S. Afr.) at para. 29). This did not mean that the RSA judiciary would leave complete discretion to the state to realise nationally a RTH. The judiciary's role was to uphold and monitor the legislature's constitutional obligation to actively determine the resource allocations necessary to advance access to health services. So while the CCSA ruled in favor of the state, it in fact laid the groundwork for future judicial review of government health policies, carefully moderated by the conditions of resource availability and reasonableness ((12) BCLR 1696 (CC) (S. Afr.) at para. 31, 36) [Sandhu, 2007, p.1177]. By requiring the state to explain and underscore the reasonableness of its policies controlling access to renal dialysis, the case 'established a standard of transparency in government decision making that might not be achieved absent a justiciable right.' [Sandhu, 2007, p.1178]. The Constitutional Court shed light on government decision making specifically by examining whether the rationing of kidney dialysis treatment to patients was necessary under the limitations of state resources, and whether that policy was applied 'fairly and rationally.' [Moyo, 2016, p.18] It was the reasonableness of the government's policy that was made transparent by the CCSA's scrutiny. This constitutes the primary achievement of the Soobramoney decision: the CCSA assuaged fears that adjudicating a constitutional right to health would result in unlimited, individualised litigation. Instead, the case cemented the RSA judiciary's role in holding legislative and executive actions accountable to constitutional obligations. Jegede et al. [2018] have noted that through this watchdog-type role, RSA courts have had a significant influence over policy without overstepping their political boundaries.

4.2. The Grootboom *Reasonableness Test*

Government of the Republic of South Africa v. Grootboom (*Grootboom*), concerned with a constitutional right to housing, upheld the State's positive obligation to defend alike socio-economic constitutional rights in accordance with a three-pronged 'reasonableness' standard: the state's measures must be 1) reasonable; 2) designed to achieve progressive realisation; and 3) within available state resources (2000(ll) BCLR.1169(CC) (S.Afr.) para.38). This standard has been taken to apply to RSA's constitutional RTH as well, given that Sections 26 (RTH) and 27 (right to housing) in the RSA Constitution are similarly worded, and subsection (1) of each section is qualified by the elements of its respective subsection (2) [Steinberg, 2006].

The respondents were squatters who, after being evicted from their 'informal homes,' had claimed their right to housing under Sections 26 and 28(1)(c) (the right of access to housing and the right of children to have shelter, respectively) required the government to provide them with housing (2000(ll) BCLR.1169(CC) (S.Afr.) para.4,13). Yacoob J. delivered the judgement of the Constitutional Court, issuing a declaratory order that the state housing programme in the Cape Metropolitan area failed to meet Section 26 requirements, i.e., the state had failed to 'devise and implement within its available resources a comprehensive and coordinated programme,' with 'reasonable measures,' to 'progressively...realise the right of access to adequate housing' (2000(ll) BCLR.1169(CC) (S.Afr.) para.99). The programme did not 'make reasonable provision within its available resources' for those in need in the Cape Metropolitan area who lacked access to land, housing, or tolerable living conditions (2000(ll) BCLR.1169(CC) (S.Afr.) para.99). Echoing the accountability-centric judgement in *Soobramoney*, Yacoob J. mentioned the necessity of proper planning, budgeting, and monitoring between 'the different spheres of government' (2000(ll) BCLR.1169(CC) (S.Afr.) para.68). So while it was the role of the government program to 'clearly allocate responsibilities' and take 'appropriate financial' decisions, it was the role of the CCSA in *Grootboom* to determine whether this was done in reality (2000(ll) BCLR.1169(CC) (S.Afr.) para.39,66).

Grootboom 'reasonableness' has been characterised as a politically detached standard, similar to reasonableness review in administrative law (2000(ll) BCLR.1169(CC) (S.Afr.) para.39,66.). Wesson [2004] clarifies this comparison: the reasonableness test of *Grootboom* does not match traditional administrative law 'irrationality' tests, which require the decision to be 'so unreasonable that no reasonable body could have reached it.' The *Grootboom* standard of reasonableness relies instead on whether state programs progressively realising socio-economic rights leave out a 'significant

sector of society,' this being the most vulnerable and underprivileged portions of the population. This enables a form of political 'collaboration' between the branches of government in which the Constitutional Court determines whether state programs are first inclusive and then reasonable [Wesson, 2004, p.295]. That evaluation of reasonableness is in addition 'far more intense' than in administrative law, since the CCSA conducts close scrutiny of the state's policies and budget, judging them for proportionality as well as rationality [Steinberg, 2006, p.281]. The Constitutional Court's approach does not require perfection from state policies [Steinberg, 2006, p.266], though it does require such policies to be comprehensive, workable, attentive to the needs of the most desperate, flexible, progressive, strategic, significantly inclusive, expeditious, and balanced [Forman, 2008, p.669-670]. If any one element is missing without reasonable justification, the Constitutional Court reserves the authority to issue a declaratory or mandatory order to enforce state obligations (2000(ll) BCLR.1169(CC) (S.Afr.) para.94). The standard, in short, exhibits the CCSA's willingness to scrutinise social policy against constitutional criteria and order its rectification where necessary [Forman, 2008, p.672].

4.3. Treatment Action Campaign

The CCSA did not fully exercise its ability to issue mandatory orders until *Minister of Health v. Treatment Action Campaign* (*TAC*), in which the Court determined that the state, in failing to act to extend access to the antiretroviral drug Nevirapine for HIV-positive pregnant women and newborn children, had breached its obligations to reasonably and progressively realise the RTH under Section 27 (2002(10) BCLR.1033(CC) (S.Afr.), para.80,125). The Court stated that '[w]here a breach of any right has taken place, including a socio-economic right, a court is under a duty to ensure that effective relief is granted,' including the issuance of an injunctive relief in special and warranting circumstances (2002(10) BCLR.1033(CC) (S.Afr.), para.106). Having declared this, the Court ruled the RSA government's refusal to extend access was unreasonable, and it directly ordered the government to remove the restrictions that had prevented the antiretroviral Nevirapine from being made available to HIV-positive mothers and newborn children (2002(10) BCLR.1033(CC) (S.Afr.), para.135). Its decision was handed down in the midst of political deadlock—the government had neglected to legislate stronger measures to fight HIV/AIDS, citing baseless resource complaints and even denying the scientifically proven link between HIV and AIDS [Forman, 2008, p.719]. Leaving the RTH to the legislative and political sphere would not have

forwarded any steps to resolve RSA's AIDS crisis. In consequence, with sensitivity to the balance of powers, *Treatment Action Campaign* demonstrated the benefits of adjudicating a constitutional RTH through both declaratory and injunctive relief.

The case is one of the best-known examples of socio-economic rights jurisprudence in the world [Pieterse, 2014, p.65]. It concerned a tremendously vital health issue; at the time the case was decided, the CCSA stated that HIV/AIDS was 'the greatest threat to public health in our country' (2002(10) BCLR.1033(CC) (S.Afr.), para.93). Also, it signalled to the government that the RSA judiciary was willing to go further than general declaratory orders to protect the constitutional RTH [Moyo, 2016, p.20]. Proponents of constitutionalizing a RTH are quick to point out that this case and the social mobilisation of the Treatment Action Campaign, the public-interest organisation that had brought suit, made significant strides in RSA's HIV/AIDS crisis, leading to a nationwide anti-retroviral therapy program being announced almost one year after the case, delivering treatment to 500,000 people by 2008 [Pieterse, 2014, p.70]. Much of the impact this case had on health outcomes was due to TAC's subsequent activity, including contempt of court proceedings against disobedient provincial premiers, which garnered public attention and ensured the mandatory orders were implemented [Young and Lemaitre, 2013, p.204-205]; [Forman, 2008, p.681]. The strategy of litigation worked in tandem with social mobilisation, bringing awareness to the public and applying pressure to the government to follow the mandatory orders issued by the judiciary [Heywood, 2003, p.314].

The *TAC* decision (and the *Grootboom* reasonableness standard it employed) is not without its detractors. One criticism of RSA's health rights jurisprudence is its failure to go further, legally speaking, by establishing a 'minimum core' standard for a RTH [Bilchitz, 2003, p.533]; [Coomans, 2005, p.194]; [Pieterse, 2014, p.68]. A minimum core approach makes specific levels of access to health a fundamental, indisputable obligation of the state. One of the most well-known forms of the doctrine is that created by the UN Committee on Economic, Social, and Cultural Rights (General Comments 3 & 14), both of which lay out several core obligations of member states to progressively realise the RTH [Pieterse, 2014, p.15]. These include right of access to health facilities without discrimination, basic food, shelter, essential drugs, and a national public health strategy (U.N. Doc.E/C.12/2000/4 (2000) at §43).

The CCSA refrained from deciding whether there was a minimum core obligation for the state to provide access to housing in *Grootboom* (2000(ll) BCLR.1169(CC) (S.Afr.) para.33), and it out-

right rejected the minimum core approach to SERs explicitly in *TAC* (2002(10) BCLR.1033(CC) (S.Afr.), para.26-39). In consequence, the Constitutional Court neglected to expand on the content of a constitutional RTH, such as whether it contained 'temporal priorities' and more specific definitions of desperate populations [Forman, 2008, p.682]. Critics thus declare the reasonableness standard vague and unhelpful for delineating either a clearly expanded or clearly restrained role in adjudicating SERs [Coomans, 2005, p.187]. For those seeking a more active judiciary, the reasonableness standard fails to provide guidance to the government for the realisation of SERs like the RTH [Bilchitz, 2003, p.533]. Conversely, the apparently content-less, morphable standard has the danger of eventually breaking down the separation of powers [Coomans, 2005, p.187].

Despite these remarks the minimum core approach has not been shown definitively to improve health outcomes through litigation more than the RSA approach. At the time contemporary to the *TAC* decision, 'virtually no national judiciaries' utilised the minimum core standard with any significant success [Kende, 2003]. There was no empirically-driven reason why the RSA Constitutional Court should have been less cautious and accept theoretical arguments in favour of establishing a minimum core standard. In fact, deviating from the reasonableness standard does not necessarily yield the intended benefits, as seen in Brazil where a content-based approach to the RTH was instituted by the STF, or in Colombia where a minimum core to the RTH was recognised by the CCC [Ferraz, 2011, p.1645-1646]; [Young and Lemaitre, 2013, p.190].

Other scholars have addressed the theoretical objections to the reasonableness standard in favour of minimum core. One is that a minimum core standard would create an over-individualised right, such that anyone (with the presumed means) would be able to bring litigation, turning rights adjudication into a chaotic, 'first-come, first-serve basis' [Kende, 2003, p.623]. Wesson [2004] argues that the CCSA's claim, 'It is impossible to give everyone access even to a 'core' service immediately,' has merit upon closer inspection [Wesson, 2004, p.302-303]. Either the enforcement of a minimum core to a RTH would be too rigid, leading to an overprioritisation on short-term policies; or the minimum core obligations would have no greater priority than existing policies for resource allocation, in which case it would be deprived of its own urgency; or, to avoid either interpretation, a judiciary would have to engage in the direct allocation of resources to find a middle ground, except this would be a clear violation of judicial restraint [Wesson, 2004]. Another counterargument posited, namely that any formulation of a minimum core standard, whether as a specific list of entitlements or a general obligation, involves a 'utilitarian calculus of social good' that inevitably

leans Constitutional or Supreme Courts into policy-making, thereby stifling the evolution of an experienced, more reflective jurisprudence [Steinberg, 2006, p.272]. While it is beyond the scope of this paper to settle the debate between RSA's reasonableness standard and the minimum core standard of other jurisdictions, these points suggest the Constitutional Court's cautious approach to socio-economic rights, and the RTH in particular, should not be quickly dismissed as impractical or uncommitted because it refrained from affirming minimum core obligations.

4.4. Additional Cases in RSA

Other cases in RSA have developed its judiciary's health rights jurisprudence, though to a less significant extent than the above three. We cite here Marius Pieterse, who gives a comprehensive discussion of several such cases decided in the wake of *TAC*, not all of which directly involve Section 27. These include: *Minister of Health and Another v. New Clicks South Africa (Pty) and Others*, which references constitutional state obligations to show how they remain influential in judicial decisions, even when a specific constitutional right is not invoked in argument [2006(1) BCLR.1(CC)]; [Pieterse, 2014, p.70]; *N and Others v. The Government of South Africa and Others*, a case before the Durban High Court that demonstrates the capacity of RSA's right-to-health legal doctrine to bring direct relief to litigants [2006(6) SA.543(D) (No 1)]; [Pieterse, 2014, p.75]; and *Law Society of South Africa v Minister for Transport*, which showed the CCSA's 'strongest affirmation of an individual, health-related entitlement' not by forcing the expansion of a law, but by striking down a regulation that would result in inequitable health services against the constitutional RTH [2011 (2) BCLR 150 (CC)]; [Pieterse, 2014, p.77]. These cases demonstrate the normative, injunctive, and declaratory benefits that a constitutional RTH can deliver through its enforcement by Supreme and lower courts.

That said, health-rights litigation is difficult to access in RSA relative to other jurisdictions, and the legal system encourages cases brought by larger public interest groups, such as the Legal Resources Center or TAC, than individual litigants [Young and Lemaitre, 2013]. This might explain why there has not been another breakthrough case for health-rights, but the cases outlined above show that RSA courts are willing to protect the constitutional RTH. We argue the CCSA deftly handled the practical and theoretical objections to constitutionalizing and adjudicating a RTH, even as it refrained from instituting a minimum core doctrine to socio-economic rights. It maintained a respect for separation of powers by holding the state accountable to constitutional obligations,

rather than by creating new ones. It avoided a precedent that would enable a flood of individual litigation, as occurred in Brazilian and Colombian jurisdictions. The CCSA and lower courts left open the possibility of mandatory orders, supervisory jurisdiction, and individual entitlements in their legacy of cases, all while maintaining a pragmatic, democratically inviting doctrine of justiciability [Steinberg, 2006, p.269].

5. The Potential of Health Rights Justiciability in Ireland

We contend that, with a constitutional provision to a RTH such as that proposed in the 32^{nd} Dáil, the Irish judiciary would likely follow RSA jurisprudence. In the first place, the text of the bill was intentionally modelled off the RSA provision, containing similar key clauses such as 'progressive realisation' and 'within its available resources' (Please see Figure A2). Both judicial branches work off a British common-law legal system. Were a constitutional RTH claim to ever be brought before Irish courts, we argue the Irish public health system would enjoy comparable, if not improved, benefits, due to Ireland's unique legal context setting up theoretical groundwork for the hypothetical RTH to develop into a prudent and feasible legal doctrine. Elements of this legal context include the proportionality doctrine established by the Supreme Court of Ireland for the adjudication of fundamental constitutional rights claims, as well as a more espoused willingness than RSA to exercise or threaten supervisory jurisdiction. Under the view of this article, the Irish judiciary would be expected to respond to constitutional RTH litigation by, like the CCSA, upholding government transparency, providing declaratory relief, issuing mandatory injunctions, and (unlike the CCSA) retaining supervisory jurisdiction as necessary.

5.1. Proportionality and Reasonability

Currently the Supreme Court of Ireland follows a doctrine of proportionality when evaluating fundamental constitutional rights claims. This test was explained by Costello J. *in Heaney v. Ireland*:

'In considering whether a restriction on the exercise of rights is permitted by the Constitution, the courts in this country ... apply the test of proportionality, a test which contains the notions of minimal restraint on the exercise of protected rights, and the exigencies of the common good in a democratic society. The means chosen must pass a proportionality test. They must: 1) be rationally

connected to the objective and not be arbitrary, unfair or based on irrational considerations; 2) impair the rights as little as possible; and 3) be such that their effects on rights are proportional to the objective' ([1994] 3 IR 593, at 607).

The three elements of the Irish Supreme Court's doctrine of proportionality map in principle onto the *Grootboom* reasonableness standard in the following ways. First, both require a minimum level of rationality in government decision-making. Second, the proportionality doctrine requires Ireland to limit the exercise of rights to the minimum extent required to achieve its goal; under the 'progressive realisation' element of RSA's reasonableness doctrine, the state must justify any 'deliberately retrogressive' measures taken, implying that any such retrogression restricting the RTH must be minimised (2000(ll) BCLR.1169(CC) (S.Afr.) para.45). Third, in the same way that Ireland's regulations are viewed in light of the proportionality of the restriction's scope to its intended objective, the concept or principle of proportionality controls the scope of RSA's constitutional mandate to make the most efficient use of its available resources. This latter point is supported by the scholarship on RSA RTH jurisprudence: Forman [2008] argues the CCSA took a 'holistic approach' in Soobramoney to balancing rights and government interests, with proportionality necessarily in mind to evaluate trade-offs; Steinberg [2006] contends the CCSA's socio-economic rights decisions from Grootboom onward exercised proportionality by 'weighing the urgency of the need against the degree of the denial of the rights and against the state's reason for failing to meet it;' and Contiades and Fotiadou [2012] likewise cite Grootboom and TAC as strong case examples for a proportionality-driven approach to social rights justiciability. The principle of proportionality moreover contains a 'creative dimension' through which the content of socio-economic rights can be better understood as it is balanced against various interests [Contiades and Fotiadou, 2012, p.665-666]. Proportionality ensures in a state of crisis that rights do not become permanently weakened or over-politicised by the judiciary [Contiades and Fotiadou, 2012, p.740-746]. At least in legal principle, then, proportionality can suit as a theoretical foundation in Ireland for judicial enforcement of the RTH.

Proportionality as a legal doctrine, as opposed to a mere legal principle, is also not definitively unsuited for application to socio-economic rights. That the doctrine of proportionality has traditionally been applied in the realm of civil-political rights does not automatically render it ineffective for SERs. This distinction relies on a dichotomous positive-negative rights framework, one which is

being increasingly characterised as an oversimplification of the nuanced relationship between modern judicial enforcement, the inevitable need for affirmative state action to protect all rights, and the dual nature of socio-economic rights as freedoms and entitlements [Sandhu, 2007]; [Kinney and Clark, 2004]. Extensive discussion has been raised over the potential advantages and disadvantages of directly combining proportionality (as a distinct legal analysis) and *Grootboom* reasonableness in the context of socio-economic rights [Young and Lemaitre, 2013]. While it is not being submitted in this article that, in the event of a constitutionalised RTH, the Supreme Court of Ireland could or would simply transfer its proportionality doctrine to the realm of SERs, the compatibility of the Irish and RSA doctrines strongly imply the Supreme Court of Ireland already has the doctrinal foundation and theoretical common ground to adopt a similar standing as the CCSA regarding the justiciability of a RTH. Such a standing enjoys the benefits of case-by-case development and adaptability and does not shy away from issuing injunctive relief where necessary.

5.2. Supervisory Jurisdiction

There is one other ongoing development in Irish case law which suggests that a constitutionalised RTH could be effectively enforced by the judiciary, namely, a willingness to undertake creative forms of supervisory jurisdiction. A valid criticism of the CCSA's approach to the RTH, and to constitutional-socio-economic rights in general, is that it failed to exercise supervisory jurisdiction over its rulings. As mentioned above, there are exceptions in rulings by the High Courts not expressly affirmed by the CCSA; yet the silence of the Constitutional Court on this issue allowed the RSA government to delay in following through with judicial mandatory orders when the Constitutional Court had already expressed its willingness to direct reform [Wesson, 2004]; [Bilchitz, 2003]. Unlike with the CCSA, cases in the Supreme Court of Ireland have not refused to address the topic. *NHV v. Minister for Justice and PC v. Minister for Social Protection* (*NHV*) showed movement toward a doctrine of 'deferred orders' ([2017] IESC 35 & [2017] IESC 63 respectively). This principle allows time for the legislature to create new laws and regulations following a challenge in the courts, whereas traditionally the former law would have been immediately struck down as constitutionally repugnant. In the case of *NHV*, the Supreme Court eventually decided that the challenged statute would be invalidated at a predetermined date, forcing the legislature to prepare a constitutionally satisfactory replacement (NHV v. Minister for Justice, Judgement (ex tempore) of the Court delivered on 30 November 2017 by Clarke CJ). In effect the Supreme Court established

a form of supervisory jurisdiction, promising to return to a flawed policy if it could not be reformed by a hard deadline. Deferring a declaratory order would keep the Court from breaking into the policy-making sphere, but it could just as easily set the stage for more creative judicial remedies in the event of legislative inaction. Consequently, even supposing the Supreme Court of Ireland would turn away for good from the issuance of mandatory injunctive relief for the infringement of a socio-economic right, there is the countervailing assurance that health rights litigation will nonetheless lead to meaningful and possibly innovative judicial remedies.

There remains one un-discussed benefit of health litigation, which is that it also changes the political sphere of activity through significant precedents, acting as what Pieterse terms a 'focal point' for rights mobilisation and social movements [Pieterse, 2008, p.386]. As with *Grootboom* and *TAC*, legal precedents can generate wide-reaching health legislation, clarify State goals, and motivate further efforts to initiate policy reform. Likewise, the publicity of such cases shapes the political discourse over poverty, social services, and health care to arouse public sympathy and support [Pieterse, 2008, p.384]. The constitutionalisation of the RTH works beyond the domain of the courthouse by acting as a driver for institutional reform. A constitutional provision can be, as Kavanagh describes, an 'ideational tool for bureaucratic initiative'—or a means of political legitimation that forwards the creation and implementation of new health policy. For example, Kavanagh [2017] found RSA's constitutional provision to be a key element in framing the debate over creation of a National Health Insurance in RSA, which is now in its second developmental phase. In essence, a legal right grants a political foothold from which reform can issue. A constitutional right embeds itself, as if by nature, in a nation's political culture, since it defends overlooked minority rights against the ever-shifting tide of public opinion. By the same token, minority populations in Ireland such as children and criminal defendants have had their own rights insulated from majoritarian domination.

In summary, the measured jurisprudence and balanced coercive remedies that RSA courts brought to a constitutional RTH find a similar basis for future development in Irish case law. It is important to note that the Irish bench's preference for judicial restraint that may find the CCSA too activist as highlighted by Mr Chief Justice Keane in Keane [2003] and more generally in Mac Cormaic [2016] The fact that such litigation has had success in another constitutional democracy quells fears of a legal health right's non-justiciability or inefficacy. Similar cases are unlikely to be heard under the Irish Supreme Court's current refusal to read unenumerated socio-economic

rights into the Constitution of Ireland's personal rights provisions. The example of RSA presents a strong argument in favour of enshrining the human RTH within Bunreacht na hÉireann.

6. Conclusion

As this article has discussed, an appropriate judicial protection of a fundamental RTH stimulates and, when necessary, demands state action, bringing about social and political awareness of health threats encountered especially by minority voices. We propose the RSA approach to the constitutional RTH, with several adjustments, can achieve this result in Ireland. The first adjustment is the affirmation of supervisory jurisdiction. Another, connected to the first, is a change in constitutional language allowing for creative forms of judicial remedy beyond declaratory and mandatory orders. This explains why the amendment proposed in the 32nd Dáil lacks an explicit provision for mandatory relief.

A related potential development for RTH adjudication in Ireland may also emerge from the international setting: RTH scholars such as Lisa Forman and Bruce Porter remark on the potential for the Optional Protocol on the ICESCR to act as an international enforcement mechanism by allowing individuals from ratifying/acceding countries to submit claims to the Committee on Economic, Social and Cultural Rights. It is notable that the Protocol imparts a reasonableness standard largely inspired by the CCSA [Forman, 2015, p.567-568], and it remains to be seen how this may replace, 'sideline,' or create an evaluative framework for the Committee's previous emphasis on a contrasting minimum core approach. [Forman, 2015, p.572-573]; Perehudoff and Forman [2019]. While Ireland is a signatory to this Protocol, it has yet to ratify or accede to it, meaning the Protocol cannot be enforced. Further discussion would be useful to consider whether and to what extent a reasonableness approach to a RTH may enter the Irish jurisdiction through an international agreement rather than a domestic constitutional provision.

The aim of the proposed amendment was not to create a dangerous approach to judicial policy-making; it was intended to bring about consistent accountability to the political system to deliver the cross-party supported Sláintecare programme. The work by Wang [2012] highlights how complex it is to obtain this support, but the lack of policy implementation progress over the past four years limits the longevity of this coalition of support. A constitutional RTH may not be immediately accepted, and further research is required to understand how a combination of political support,

EU Fiscal Rules, Bunreacht na hÉireann and the jurisprudence of the Irish Bench can achieve the effective introduction of universal healthcare.

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Appendix A

Text of the legislation as published by the Oireachtas[1]:

Figure A1: The 39th Amendment of the Irish Constitution

THIRTY-NINTH AMENDMENT OF THE CONSTITUTION (RIGHT TO HEALTH) BILL 2019

Bill

entitled

An Act to amend the Constitution.

WHEREAS by virtue of Article 46 of the Constitution any provision of the Constitution may be amended in the manner provided by that Article:

AND WHEREAS it is proposed to amend Article 40 of the Constitution:

Be it therefore enacted by the Oireachtas as follows:

Amendment of Article 40 of the Constitution

1. The Constitution is hereby amended as follows:

(a) the subsection, the text of which is set out in *Part 1* of the *Schedule*, shall be added to section 3 of the Irish text; and

(b) the subsection, the text of which is set out in *Part 2* of the *Schedule*, shall be added to section 3 of the English text.

Citation

2. (1) The amendment of the Constitution effected by this Act shall be called the Thirty-ninth Amendment of the Constitution

(2) This Act may be cited as the Thirty-ninth Amendment of the Constitution (Right to Health) Act 2019.

AN BILLE UM AN NAOÚ LEASÚ IS TRÍOCHA AR AN mBUNREACHT (CEART CHUN SLÁINTE), 2019

Bille

dá ngairtear

Acht chun an Bunreacht a leasú.

DE BHRÍ gur cead, de bhua Airteagal 46 den Bhunreacht, foráil ar bith den Bhunreacht a leasú ar an modh a shocraítear leis an Airteagal sin:

AGUS DE BHRÍ go bhfuil beartaithe Airteagal 40 den Bhunreacht a leasú:

Achtaítear ag an Oireachtas ar an ábhar sin mar a leanas:

Airteagal 40 den Bhunreacht a leasú

1. Leasaítear leis seo mar a leanas an Bunreacht:

(a) cuirfear an fo-alt a bhfuil an téacs de leagtha amach i *gCuid 1* den *Sceideal* le halt 3 den téacs Gaeilge; agus

(b) cuirfear an fo-alt a bhfuil an téacs de leagtha amach i *gCuid 2* den *Sceideal* le halt 3 den téacs Sacs-Bhéarla.

Lua

2. (1) An Naoú Leasú is Tríocha ar an mBunreacht a thabharfar ar an leasú a dhéantar ar an mBunreacht leis an Acht seo.

(2) Féadfar an tAcht um an Naoú Leasú is Tríocha ar an mBunreacht (Ceart chun Sláinte), 2019 a ghairm den Acht seo.

[1] https://data.oireachtas.ie/ie/oireachtas/bill/2019/92/mul/initiated/b9219d.pdf

Figure A2: The Schedule of the 39th Amendment of the Irish Constitution

SCHEDULE

PART 1

4° i Admhaíonn an Stát go bhfuil comhcheart ag gach saoránach chun an chaighdeáin is airde is féidir a bhaint amach ó thaobh cosaint sláinte de; agus déanfaidh an Stát iarracht tabhairt i gcrích an chirt sin a bhaint amach go forchéimnitheach.

ii Déanfaidh an Stát iarracht, de réir na n-acmhainní a bheidh ar fáil dó, rochtain inacmhainne a ráthú ar tháirgí, seirbhísí agus saoráidí liachta is cuí chun sláinte an duine aonair a chosaint.

iii Ó tharla go mbaineann sláinte an phobail leis an duine aonair agus le gach duine le chéile, áfach, féachfaidh an Stát go cuí d'aon leasanna sláinte a rachaidh chun fónaimh do riachtanais leas an phobail.

PART 2

4° i The State recognises the equal right of every citizen to the highest attainable standard of health protection; and the State shall endeavour to achieve the progressive realisation of this right.

ii The State shall endeavour, within its available resources, to guarantee affordable access to medical products, services, and facilities appropriate to defend the health of the individual.

iii The health of the public being, however, both individual and collective, the State shall give due regard to any health interests which serve the needs of the common good.