Rethinking rights and rationing in healthcare resource allocation

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Introduction

Modern-day health systems have suffered from a mismatch between the seemingly limitless demand for health services and the finite physical and financial resources available to supply such services almost since their inception.\(^1\) However, the affordability of such systems has undoubtedly risen up the policy agenda recently to become a significant contemporary problem worldwide, as the impact of demographic change, costly new health technologies, shifts in the pattern and burden of disease and impacts of the global economic crisis have called into question the sustainability of health systems over the medium to long term.\(^2\)

The greater attention being paid to affordability has had various interlocking consequences. It has impacted upon the manner in which allocation of resources takes place in health systems in so far as there has been an increased recent tendency for allocative decisions to make explicit reference to cost considerations as a rationale for limitation of access to services and treatments, as distinct from decision-making which may have been implicitly guided by such considerations but in which they remained largely concealed beneath a ‘veil’ of clinical judgment.\(^3\) Relatedly, it has had consequences for the identity of the decision-maker. Physicians still play a vitally important ‘gatekeeping’ role, but their clinical discretion is now supplemented – and, in some instances, subverted – by decisions made, or policies instituted, by other parties, including health service or health fund managers, agencies undertaking health technology assessment (HTA) and appraisal,\(^4\) and government officials. Thirdly, the decision-making criteria which govern access to healthcare resources have evolved. Of course, the clinical needs and the capacity to benefit of the patient remain fundamental to determining access to services and treatments, but other factors impinge upon the decision whether to grant or deny such access. Most notably, the rise to prominence of the discipline

\(^1\) The architect of the UK National Health Service, Aneurin Bevan, resigned in March 1951, fewer than three years after its establishment, as a consequence of the decision to introduce prescription charges for dentures and spectacles, the £2 million set aside for free spectacles over the first nine months of the Service having been exhausted within six weeks.


\(^3\) For discussion, see K. Syrett, Law, Legitimacy and the Rationing of Health Care (Cambridge: CUP, 2007), Chapter 3.

\(^4\) ‘Appraisal’ may be distinguished from ‘assessment’: the latter denotes the scientific/technical process of gathering and analysing information on a health technology, while the former refers to decision-making or policy advice on that technology, on the basis of a synthesis of the scientific evidence combined with other factors such as social values. However, ‘health technology assessment’ is frequently used to cover both forms of activity.
of health economics as a tool of health technology assessment and appraisal has led to increased emphasis upon the extent to which health gains eventuate for the population as a whole, rather than just for the individual patient. For example, the widely used ‘Quality Adjusted Life Year’ (QALY) metric, which functions as ‘proxy for the utility of a medicine’,\(^5\) allows limited resources to be used in the most cost-effective manner possible by enabling comparisons to be made between different treatments and services (even, potentially, across different conditions) so as to determine which produces the greatest aggregate health gain. Priorities can be drawn up on this basis and certain interventions excluded altogether from coverage by the health system.

Underpinning each of these developments is the desire of government to exercise greater oversight of, and control over, expenditure on healthcare by utilising scarce resources in a more rational, efficient manner and by limiting the discretion of clinicians to allocate resources in whatever manner they please. Priority-setting in healthcare has thus unequivocally taken on the character of an activity by which ‘the state seeks to encourage or direct behaviour which (it is assumed) would not occur without such intervention’, that is, a form of regulation.\(^6\) This is most obviously true in publicly-funded health systems, but even in market-based systems such as that operating in the United States, policies have been implemented whose consequence is to increase the role of the state.

One significant outcome of these trends has been to emphasise the contestation inherent in the allocation of healthcare resources. Physicians and patients may now find themselves ranged in opposition to health service or plan managers, HTA agencies or politicians when seeking to access a particular service or treatment; the potential for conflict is exacerbated by the presence of other stakeholders in the arena, such as pharmaceutical companies and patient pressure groups. In various states worldwide, resort has increasingly been made to courts in an effort to resolve such disputes.\(^7\) This is frequently considered to be problematic. For example, it has been claimed that ‘the courts are ill-equipped to deliberate about issues of limit-setting... Court procedures... leave the final decision to those... (with) little understanding of the organisational context within which the issue has arisen’,\(^8\) and that ‘courts appear ill-equipped to stake a middle ground between doing nothing to check insurers and doing too much to protect individual patients’.\(^9\) The engagement of the judiciary with priority-setting in healthcare (even at the level of review of the primary decision-making process) is therefore regarded with disquiet and suspicion, while at the same time the high stakes of the ‘tragic choices’ entailed,\(^10\) coupled with the ‘special moral importance’ attached


to healthcare, make it inevitable that the legal process will sometimes be activated by disappointed individuals.

Elsewhere, the author has argued that, while we may accept that courts are not the ideal forums for resolution of such issues, the predominantly negative attitude towards judicial engagement in priority-setting questions in healthcare understates the potentially useful contribution which the process of adjudication can make to the enhancement of legitimacy in this area of public policy, especially by enforcing obligations of transparency, participation and reason-giving. This can assist in addressing the ‘legitimacy problem’ which Daniels and Sabin have identified as central to limit-setting choices in healthcare.

Nonetheless, it should not be supposed that involvement of the courts is unproblematic: there remain sizable objections to any form of involvement of the courts, which might be classified as those relating to institutional and constitutional (in)competence. I have explored various elements of these in my work elsewhere. The focus of this paper is upon one aspect of the judicial incompetence argument. Particularly thorny issues appear to arise in the context of adjudication by courts upon claims of alleged violations of individual or group rights to health or access to healthcare, claims which may be expected to be reasonably frequent given the significant numbers of jurisdictions worldwide which afford some form of constitutional recognition to health-related rights. It is the goal of this paper both to outline the nature of these difficulties and, more specifically, to explore the potential for a reconceptualisation of the nature of the rights claim in this context, such that judicial involvement in allocative decision-making might plausibly possess at least the potential to facilitate such choices, rather than acting as an impediment to them.

The trouble with rights

Writing in 2007, the former UN Special Rapporteur on the Right to Health, Paul Hunt, expressed surprise that the ‘human rights community’ had not given ‘sustained attention’ to priority-setting in healthcare, given that ‘priority-setting raises profound human rights issues’. This observation perhaps overstates the case since, as Tobin notes, the unavoidability of the need to prioritise allocation of scarce resources in the context of measures to secure the right to health has led a number of theorists and human rights practitioners to reflect upon the congruence between prioritisation and rights.

11 See eg N. Daniels, Just Health Care (Cambridge: CUP, 1985).
13 Daniels and Sabin, above n.8.
16 Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health A/62/214 (2007), [14]-15.
However, the overwhelming consensus is that the right to health and priority-setting are, at best, uneasy bedfellows. An extreme version of this position is reported in Rennie’s account of empirical research into community attitudes towards rationing of access to AIDS anti-retroviral treatment in Kinshasa, Democratic Republic of Congo: Médicins sans Frontières (MSF)-Belgium refused to participate in the study on the basis that ‘the research question ‘How should anti-retroviral treatment be rationed among those in need?’ conflict[ed] with MSF’s ideal of universal access to treatment, which in turn [wa]s based on the more fundamental human right to health’.18 This response suggests that the human right to health and priority-setting are, quite simply, antithetical and may be seen as a subset of a broader debate within public health upon the congruence between approaches grounded in health equity and those which focus on human rights.19

A more moderate stance is evident in some of the theoretical literature. For example, Arras and Fenton comment that:

any concept of a right to health or health care, developed within either a national or a global setting, is incapable of solving complex allocation problems within a context of scarcity—that is, within the context of the real world. As bioethicists have gradually learned over the past three decades, the notion of a right to healthcare may be crucially important, but it is also quite limited in what it can tell us.20

Daniels reaches a similar conclusion. Echoing the words of the former UN Special Rapporteur, he describes priority-setting as ‘one of [the] important blind spots’ of the human rights movement.21 However, he notes that a human rights approach is necessarily limited in the work which it can undertake – it ‘identifies the different claimants competing for resources that would lead to better satisfaction of different rights’ and ‘the magnitude of the benefits they may get. But it does not establish priorities among them’, ‘since there is no basis for saying that claimants to one right have priority over claimants to another’.22 His ‘solution’ is to apply his familiar accountability for reasonableness model to the human rights approach, so that stakeholders regard priority-setting as legitimate. This view, therefore, regards the human right to health as a plausible starting-point for allocative decision-making in the situations of resource scarcity which appear inevitable, even in developed countries,23 but regards it as insufficient in itself, given the need to set priorities. It is lent support by the former UN Special Rapporteur, who concludes that ‘while human rights have a constructive contribution to make to prioritization, they are unlikely to provide neat answers to highly complex issues, any more than do ethics, economics or general theories of justice. They are

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21 N. Daniels, Just Health (Cambridge: CUP, 2008) 314
22 ibid, 324. Emphasis in original.
23 ibid, 332.
likely to rule out some processes and some choices, leaving a number of options, all of which are legitimate.\footnote{24}

The apparent lack of congruence between the human right to health and priority-setting can, in very large part, be explained by the conceptualisation of human rights as individualist in orientation, grounded in a ‘liberal consensus on universal human rights’.\footnote{25} For those, such as MSF-Belgium, whose goal is to secure universal access to treatment (or, as near to such a state as is possible), this is welcome. A rights claim is normatively and discursively potent as a consequence of the presumptive weight which it carries. This has the consequence that countervailing considerations – such as the need to set priorities between competing uses of scarce resources – will normally be overridden, at least in the absence of substantial objective justification put forward by the allocating agent. This conceptualisation, which reflects Dworkin’s metaphor of rights as ‘trumps over some background justification that states a goal for the community as a whole’\footnote{26} is problematic for those who acknowledge the need to set priorities for precisely the opposite reason: it threatens to displace collective choices on meeting population health needs fairly in circumstances where resources are scarce in favour of individual claims to access treatments, often from those with the loudest voices or deepest pockets. As Evans observes, this is a primary reason why the human right to health has been regarded with considerable scepticism:

the liberal consensus argues that the problem of the ‘deluge’ remains. This concerns the question of how much of a particular resource can be claimed legitimately in satisfaction of a positive claim, given the conditions of scarcity. In the case of health, do all individuals have a right to a heart transplant, access to a kidney dialysis machine or the medical technology that allows parents the right to choose the sex of their unborn child? Liberals argue that if positive claims like the right to health are not related to any kind of charge or control on the supply, the demand would be unlimited, effectively creating a right that could never be fulfilled. From the liberal perspective, acknowledging a right to health brings the spectre of demand fast outstripping supply and the impoverishment of all sectors of society.\footnote{27}

This discomfiture with the human right to health fuses into the broader concern as to judicial engagement with priority-setting questions in healthcare which was identified above. A primary reason for distrust of the involvement of courts is a perception that they are prone to privilege the claims to resources of those individual litigants appearing in front of the court over and above those of multiple, unidentified members of the wider population to whom the resources might alternatively be allocated. I have argued elsewhere that this view, while holding some validity, represents a somewhat superficial understanding both from a conceptual perspective because it is rooted in a partial and overly individualistic view of the functions of law (especially, public law);\footnote{28} and from a doctrinal perspective because it...

\footnote{24} Above n.16, [31].
\footnote{27} Above n.25, 202-03.
\footnote{28} K. Syrett, ‘Opening eyes to the reality of scarce resources?’ [2006] Public Law 664, 669.
understates the capacity of certain legal principles to give effect to the interests of the community vis-a-vis the individual. However, as Robson acknowledges, constitutional adjudication – of which rights adjudication forms a significant part – is especially problematic in that, by contrast to ‘administrative law [which] lays equal stress on public needs: on the duties owed by the citizen to the public, on the subordination of private interest to the common weal’, ‘constitutional law emphasises individual rights’. The question which this paper seeks to confront is: can these supposed ‘individual rights’ be recast in such a manner that realisation of the right is intrinsically bound to the process of setting of priorities in healthcare, rather than the two standing in opposition to each other or (at best) with the former having little of concrete value to contribute to undertaking of the latter activity? In order to address this difficult question, it is necessary first to briefly outline the legal framework as it bears upon the human right to health/healthcare and rationing of scarce resources.

Rights and rationing in international and national law

As Daniels points out, the existence of the concept of progressive realisation in the context of the right to health, whether in international law – such as Article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR), or national law – such as Article 27 of the Constitution of South Africa, envisages the setting of priorities for the allocation of resources in healthcare: ‘decisions will have to be made about what entitlements a right to health actually assures under existing limits.... How we specify those entitlements is the problem of priority-setting, and it lies at the core of the idea of progressive realisation of the human right to health’. Thus, it has been stated that progressive realisation is ‘an implicit recognition that States have resource constraints’, and that ‘prioritisation must be conducted in this context of progressive realisation’. One aspect of this is that the core minimum obligation of the right to health – which, in Article 12 ICESCR includes, inter alia, provision of essential drugs and equitable distribution of all health facilities, goods and services – should be accorded priority over other measures, albeit that the level of provision is, ‘to some extent, resource-dependent’. It might be concluded from this that the setting of priorities is not proscribed by the legal framework; rather, it is in fact prescribed, at least to the limited extent that achievement of the core minimum should be accorded precedence over other possible uses of scarce resources allocated to healthcare.

31 Above n.21, 318.
33 Report of the Special Rapporteur, above n.16, [23].
However, it is possible to go further than this. Both international and regional human rights treaties and national Bills of Rights or constitutions envisage limitations to rights, either in the form of a general limitations clause such as Article 4 of the ICESCR or Article 36 of the Constitution of South Africa or specific restrictions on certain rights, such as those contained in the European Convention on Human Rights. Such provisions offer the possibility of limiting the right to health or healthcare by reference to the scarcity of available resources. This will not necessarily be a straightforward matter: the justificatory burden in respect of the limitation falls upon the state, which must demonstrate that it is in accordance with law, consonant with ‘the promotion of general welfare’, or ‘justifiable in an open and democratic society based upon human dignity, equality and freedom’, and proportionate in so far as it is a minimally intrusive limitation upon the right relative to other limitations which were available. Nonetheless, as Tobin notes, this permits – indeed, requires – some degree of cost-benefit analysis of the use of healthcare resources for alternative purposes in situations where limits to the right are necessitated by scarcity of resources.

The consequence is that the right to health which is recognised in international and national law is not absolute. Rather, it has a ‘heavily contingent nature’: ‘contrary to the individualised stereotype that is often used to characterise human rights... the human rights of an individual are very much located in a communitarian paradigm’. The ‘trumps’ metaphor fails to capture the fact that ‘rights represent a balance between potentially conflicting interests, some individual, some social’, it being the job of the courts utilising the doctrine of proportionality (broadly understood) to assess whether this balance has been properly struck.

An individualist conception of the human right to health as a trump card which carries the potential to displace collective decision-making on allocation of scarce resources is, therefore, somewhat out of step with the manner in which the right appears to be operationalised in international and national legal instruments. The latter appears to chime more closely with Daniels’ somewhat more nuanced understanding of human rights in the health context, in which the right

has a specific content only relative to the conditions in a specific society. The specific content of a right consists of the entitlements it includes. Those entitlements are determined by the reasonable choices made by appropriate agents in that society when they decide how to promote normal functioning under resource constraints... [the right-holder’s] medical entitlements – given his right – depend both on his condition

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36 ICESCR Article 4
37 Article 36(1), Constitution of South Africa.
38 Above n.17, 72
39 Ibid, 70.
41 See further Syrett, above n.3, Chapter 9; above n.29.
and on the array of interventions it is reasonable to provide the population of which he is a member. That reasonable array in turn depends on what we know is effective, what resources we have, and what priority should be given to meeting his need compared to those of others.\textsuperscript{42}

Yet, as noted previously, Daniels remains suspicious of any involvement of the courts in review of the process of priority-setting in healthcare. One might speculate as to two possible reasons for this. First, it should be borne in mind that Daniels is an ethicist and philosopher, not a legal or jurisprudential scholar. It may simply be that his understanding of the nature of judicial adjudication in this context is incomplete or inaccurate. Alternatively (or additionally), it is plausible that the courts are not in practice interpreting the right to health under circumstances of scarce resources in a manner which is contingent, rather than absolute. Some evidence in support of the latter possibility is afforded by empirical studies of health rights litigation: for example, Ferraz comments of the Brazilian model of right to health litigation that it ‘diverts essential resources of the health budget to the funding of mostly high-cost drugs claimed by individuals who are already privileged in terms of health conditions and services’,\textsuperscript{43} while Yamin, Parra-Vera and Gianella observe that ‘generous concessions [by courts] of individual healthcare benefits without regard to whether they could be universalised appear to have exacerbated rather than ameliorated inequities within the Colombian healthcare system’.\textsuperscript{44}

It would appear that the precise nature of the judicial role in interpretation of the right to health against a background of scarce resources is not fully understood. Such uncertainty appears even to extend to judges themselves. This is can be illustrated by reference to statements made by the judge who has arguably been most explicit in recognition of the need to reconceptualise rights to health/healthcare in light of scarcity of resources. In the first case concerning Article 27 of the South African Constitution to reach the Constitutional Court of South Africa, \textit{Soobramoney v Minister of Health (KwaZulu Natal)}, Justice Albie Sachs took a relatively radical approach in which scarcity of resources was seen not as a limitation on realisation of the right under the Article, operating in opposition to it, but rather as part and parcel thereof:

\begin{quote}
In all the open and democratic societies based upon dignity, freedom and equality with which I am familiar, the rationing of access to life-prolonging resources is regarded as integral to, rather than incompatible with, a human rights approach to healthcar... Traditional rights analyses accordingly have to be adapted so as to take account of the special problems created by the need to provide a broad framework of constitutional principles governing the right of access to scarce resources and to adjudicate between competing rights bearers. When rights by their very nature are shared and interdependent, striking appropriate balances between the equally valid entitlements or expectations of a multitude of claimants should not be seen as
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\textsuperscript{42} Above n.21, 317.
\textsuperscript{44} A. Yamin, O. Parra-Vera and C. Gianella, ‘Colombia: Judicial Protection of the Right to Health’, \textit{ibid}, 126.
imposing limits on those rights, but as defining the circumstances in which the rights may most fairly and effectively be enjoyed.⁴⁵

Yet, notwithstanding this enlightened and unusual acknowledgment of the contingency of the right and its integrality with rationing choices, which – in his view – demanded evolution of ‘a new analytical framework based on the notion of human interdependence’,⁴⁶ Sachs expressed uncertainty as to its precise character and consequences. Writing extra-judicially, he observes that:

Socio-economic rights in this respect are different in their mode of enjoyment, if not in their essence, from civil and political rights... The progressive realization of socioeconomic rights within available resources, on the other hand, indicates that a system of apportionment is fundamental to their very being. I am not sure as to the full implications of this distinction, both in terms of conceptualizing the nature of the right and in respect of determining appropriate remedies for a breach. Yet I am convinced that the exercise of a right that by its nature is shared, often competitively, with other holders of the right, must have different legal characteristics from the exercise of a classical individual civil right that is autonomous and complete in itself.⁴⁷

As Sachs hints in this passage, one reason for the lack of clarity as to the nature of the judicial task in cases where a right to health or to access healthcare seems to be the fact that the normative basis of the right has been inadequately explored. As Yamin argues: ‘given the inherently contested nature of justice in health and the explosion of health rights litigation over the past fifteen to twenty years, there is remarkably little literature interpreting the normative foundations of the right to health’.⁴⁸ She considers identification of such a foundation to be of ‘central importance’, and argues that failure to do so has had the consequence that ‘the definition of the right appears to set out an absolute demand, not subject to the ambiguities of resource allocation or progressive realisation’.⁴⁹ Her conclusion is that ‘clarifying the normative foundations and conceptions of health will be critical in order for courts to provide a framework for facilitating appropriate decision-making processes relating to constantly evolving claims of what we owe each other in regard to health and healthcare’.⁵⁰

The final section of this paper attempts to make a small contribution to this undertaking through discussion of an alternative approach to the concept of ‘autonomy’ in the healthcare context. It should be noted that this is not intended to constitute a complete normative theory of health/healthcare – for example, it is not my goal to explore the broader question of why

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⁴⁵ [1997] ZACC 17, [52], [54].
⁴⁶ ibid, [54].
⁴⁹ ibid, 359.
⁵⁰ ibid, 361.
rights warrant protection in this context – rather, I seek to delineate a path to rethinking a specific element of the bundle of normative concepts which are comprised within the right to health/healthcare which may assist in clarifying the relationship between the right and the rationing of scarce healthcare resources.

Reconciling health rights and rationing: towards a relational account of autonomy and rights

Dignity of the person is the cornerstone of human rights. The Universal Declaration of Human Rights proclaims that ‘recognition of the inherent dignity and of the equal and inalienable rights of all members of the human family is the foundation of freedom, justice and peace in the world’,\(^{51}\) and both the International Covenants on Civil and Political Rights and on Economic, Social and Cultural Rights recognise that the rights enumerated in the respective instruments ‘derive from the inherent dignity of the human person’.\(^{52}\) Particularly within liberal political philosophy, a close connection exists between dignity, human rights and autonomy. The former expresses an ‘understanding of the inner (moral) nature and worth of the human person and his or her proper (political) relations with society’;\(^{53}\) human rights constitute a ‘particular social practice that aims to realise a distinctive substantive conception of human dignity’,\(^{54}\) and in turn the moral primacy which human rights accord to individual interests vis-à-vis the state and society enhance autonomy, understood as the ‘right to have and pursue interests and goals different from those of the state or its rulers’.\(^{55}\) Hence:

For the liberal, the individual is not merely separable from the community and social roles, but specially valued precisely as a distinctive, discrete individual-which is why each person must be treated with equal concern and respect. The state and society are conceived, in more or less contractarian terms, as forms of association for the fuller unfolding of human potential, through the exercise and enjoyment of human rights. Human dignity, for the liberal, is largely encompassed in the vision of life as an equal and autonomous member of society, enjoying a full range of human rights.\(^{56}\)

This approach to autonomy is, in essence, Kantian, it being ‘commonly argued that his concept of autonomy specifies the very essence of human rights’.\(^{57}\) Simply stated, a Kantian vision of autonomy sees the individual as self-legislating, ‘subject to the will of no other’.\(^{58}\) It amounts to ‘the capacity to be one’s own person, to live one’s life according to reasons and

\(^{51}\) Preamble.
\(^{52}\) Preamble.
\(^{54}\) id.
\(^{55}\) ibid. 804.
\(^{56}\) ibid. 803.
Dignity and autonomy are also central organising concepts in bioethics and biolaw – it has been argued that ‘autonomy as a governing philosophical principle has been prioritised in medical ethics at the expense of other ethical principles’.\(^59\) However, Beyleveld and Brownsword seek to distinguish two understandings of dignity in this context, ‘human dignity as empowerment’ and ‘human dignity as constraint’.\(^61\) The first of these is the meaning outlined above and that captured in the International Bill of Rights, in which ‘the capacity to make unforced choices, personal autonomy, equates to human dignity and from here constructs a regime of human rights centred on the promotion of such autonomy’.\(^62\) By contrast, the authors maintain that ‘human dignity as constraint’ is ‘more closely concerned with human duties than with human rights’,\(^63\) acting as a constraint upon free choice either ‘as a collective good that represents each society’s vision of the kind of society it wants to be’ and/or springing from ‘the view that it is as wrong to compromise one’s own dignity as it is to compromise the dignity of others’.\(^64\) This dichotomous reading of dignity carries obvious resonance for the issues explored in this paper. In particular, the first of the two rationales for the ‘constraint’ approach chimes with the collective process of priority-setting necessary in situations of scarce healthcare resources, a process which may be said to be undertaken with a view to fulfilling ‘society’s vision of the kind of society it wants to be’: for example, by pursuing health system goals such as the maximisation of aggregate population health or the minimisation of health inequities. Yet it is unclear how far this conception of dignity (as distinct from the ‘empowerment’ variant) is consistent with the notion of autonomy and, by extension, rights.

Indeed, some have argued that a shift from ‘empowerment’ to ‘constraint’ may necessitate development of an ‘alternative vocabulary’ to the ‘language of rights and autonomy’.\(^65\) However, other work has emphasised the continued centrality of the concept of autonomy, but sought to offer an alternative reading of it which is better suited to the context examined in this paper. Of especial importance here are the discourses and perspectives of care ethics, which offers a moral orientation or perspective through which various relationships of dependency (including those between the seekers and providers of medical treatment) can be understood and evaluated. Within this framework, autonomy is not understood in terms of independence and self-governance since ‘patients necessarily relinquish their full autonomy to experts’,\(^66\) nor does it carry the atomistic connotations alluded to previously in this paper.


\(^{63}\) Above n.61, 1.

\(^{64}\) ibid, 11.

\(^{65}\) C. Elliott, A Philosophical Disease: Bioethics, Culture and Identity (New York: Routledge, 1999) xxviii.

\(^{66}\) Tauber, above n.60, 486.
But this ‘does not imply a rejection of the notion of autonomy altogether’. Rather, autonomy takes a relational form:

“Relational autonomy” is the label that has been given to an alternative conception of what it means to be a free, self-governing agent who is also socially constituted and who possibly defines her basic value commitments in terms of interpersonal relations and mutual dependencies. Relational views of the autonomous person, then, valuably underscore the social embeddedness of selves while not forsaking the basic value commitments of (for the most part, liberal) justice. These conceptions underscore the social components of our self-concepts as well as emphasise the role that background social dynamics and power structures play in the enjoyment and development of autonomy.

From this standpoint, ‘it is... necessary that we rethink the human condition as interdependent’, autonomy is constituted by such interdependence in so far as ‘one of the fundamental ways a person conceives of himself and thinks about the world around him is in terms of the relationships in which he is involved’, and social environments and the relationships within them are decisive in enhancing or impeding it.

This conception of autonomy therefore appears to satisfy Sachs’ demand for ‘an analytical framework based on the notion of human interdependence’. But how far is it consonant with a human rights approach to healthcare which, it will be recalled, Sachs regards rationing as ‘integral’? It is notable that authors operating within this framework often emphasise – as do Beyleveld and Brownsword – the significance of obligations, duties and responsibilities as distinct from rights. For example, Tauber argues that a relational approach to autonomy ‘radically recasts widespread beliefs about individuality and rights. It shifts the burden of moral action on meeting obligations to others, as opposed to asserting self-defined liberties’. Others working within the care ethics approach have been openly critical of rights for their (perceived) tendency to ‘insulate’ existing structures of power domination, as well as for their oppositional character: rights being seen in conflictual terms requiring determination of the weightier, ‘winning’ claim and thus emphasising the separation, rather that interconnectedness, of individuals from each other and from the collective.

An alternative strand of theory, however, acknowledges that rights remain of value. While space precludes a detailed examination of these arguments, three elements may briefly be

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69 Verkerk, above n.67, 291.
70 ibid. 292.
71 See eg Tauber, above n.60, 489; Verkerk, above n.67, 291.
outlined. First – and most minimally – rights are required to provide a minimum ‘floor’: for example, those who are treated inequitably by reference to criteria which should not be relevant to decision-making on the allocation of scarce resources within a community (eg for reasons of gender, race etc), may utilise rights in order to protect fair equality of opportunity. Secondly, rights carry transformative potential: rights discourse (and litigation) amount to powerful mechanisms for recasting existing structures of domination within society in such a manner that interdependence, rather than independence, is encouraged: as Spring notes, ‘inadequate, abusive, or imperialistic state practice should compel us to employ our entire arsenal of intellectual self-defence, including rights advocacy, to combat such moral failings’. Finally, rights themselves – like the concept of autonomy which is central to them – can be understood as relational in character. Thus, Nedelsky argues that ‘what rights do and have always done is construct relationships – of power, of responsibility, of trust and obligation... in defining and enforcing rights, the law routinely structures and sometimes self-consciously takes account of relationship’. As she notes, this is self-evidently the case in fields like family law, but is also true in areas in which rights appear more individualistic in orientation, such as contract or property law. Nedelsky proceeds to argue that such a reconceptualisation of rights also entails a shift in their status within the constitutional order: understood as expressions of relationships, rights no longer function as conclusory ‘trumps’ but rather, as dialogic mechanisms enabling governmental institutions (not just courts) to evaluate whether the choice which has been made serves to ‘foster the structures of social relations that make the development of autonomy possible’.

Conclusion

The primary goal of this paper has been to argue that there is, at least, potential to reconceptualise rights in the health/healthcare context in such a way that rationing of scarce resources is integrally understood as an aspect of rights rather than antithetical to, or a limitation upon, their realisation. However, while theoretical groundwork has been undertaken which can assist in this undertaking, the scale of the task should not be underestimated. The atomistic, conclusory reading of rights has considerable hegemony both as a legal claim and as an element of political discourse, and it will be a sizeable challenge for anyone who wishes to argue for a relational and dialogic approach grounded in autonomy understood in terms of interdependence, rather than independence, to displace this. Nevertheless, the effort is surely worthwhile in view of the increasing frequency with which claims of right are articulated in the context of scarce healthcare resources, not least because a failure to engage with the normative foundations of rights in this field is likely - as Yamin

75 See Tauber, above n.72, 456.
76 Above n.70, 74.
notes\textsuperscript{79} – to lead to allocative consequences which are not in the best interests of the broader community.

\textsuperscript{79} Above n.49 and accompanying text.