

# PRESERVING SOCIAL CITIZENSHIP IN HEALTH CARE MARKETS: THERE MAY BE TROUBLE AHEAD

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*What is social citizenship? How is it relevant to the provision of health care? Discussion of rights tends to focus on individuals, but we need greater emphasis on the position of individuals within a community. This is especially important in connection with access to care in publicly funded health care systems.*

*T.H. Marshall provides a model within which claims may be weighed and assessed without losing sight of their effect on other people. Thus, civil citizenship generates rights that may be more readily enforced as absolutes. By contrast, social citizenship fosters community and equality between people; the rights it creates cannot be considered without regard to their impact on others.*

*Social citizenship deserves to be identified more carefully, particularly in respect of health care. Social citizenship is crucial to our conception of fairness and is central to the aims of public health care systems. Unless we do so, individualistic conceptions of rights may assist the strong and articulate at the expense of those less able to look after themselves.*

*However, three recent decisions of the European Court of Justice, the Supreme Court of Canada, and the House of Lords in England may undermine this objective. I recommend that social citizenship should be given more attention so that rights can be assessed within a community perspective.*

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## INTRODUCTION

In a short but “magisterial” book,<sup>1</sup> which, it is said, cannot be praised too often or too highly,<sup>2</sup> T.H. Marshall describes a conception of the evolution of “citizenship.”<sup>3</sup> Marshall traces the process over three phases. During the eighteenth century, citizenship developed to protect *civil* rights (for example, rights to freedom of speech, religion, and association—the “negative” freedoms) from unwarranted interference by the state. In the nineteenth, it generated *political* rights to vote and to participate in the process of government. Finally, in the twentieth century, it gave rise to *social* rights to minimum levels of subsistence, health, social welfare, and pensions (that is, the “positive” rights of access to the largesse of the state and the redistributive policies that this entails).<sup>4</sup> As Marshall said, social citizenship creates a sense of solidarity and mutual dependency in society and

a general enrichment of the concrete substance of civilised life, a general reduction of risk and insecurity, an equalisation between the more and less fortunate at all levels—between the healthy and the sick, the employed and the unemployed, the old and the active, the bachelor and the father of a large family. Equalisation is not so much between classes as between individuals within a population which is now treated for this purpose as though it were one class.<sup>5</sup>

Isaiah Berlin echoes these sentiments when he compares the potential for conflict between liberty and equality. As he puts it, the Western conscience is troubled if the freedom of a majority can be acquired by the exploitation of the minority. “To avoid glaring inequality or widespread misery I am ready to sacrifice some or all of my freedom ... it is a freedom that I am giving up for the sake of justice or equality or the love of my fellow men.”<sup>6</sup> Perhaps these views inspired the “communitarian” ethic that balances claims to individual rights with the interconnectedness of people and a concern for the principles of altruism and reciprocity.<sup>7</sup>

At one level these are uplifting and energizing sentiments that many share. At another they present a practical challenge that Marshall largely avoided. Exactly how, and how much, should social citizens be expected to invest in the welfare of others? What is social citizenship and what *duties* does it impose? These are not merely abstract questions amenable to no firm response. They go to the root of social welfare policy-making. The following assesses their impact on the way we regulate access to health care. Clearly a “communitarian” conception of rights presupposes a large measure of central supervision in pursuit of public interests. Yet modern health care policy often places confidence in market forces to drive efficiency and value for money, in which individual rights are given special emphasis.<sup>8</sup> How should this “New Governance” approach to social welfare be influenced by the more traditional, public-centered view of rights?<sup>9</sup> The following considers this question in the context of health care rights. I examine the nature of social citizenship and the positive rights to which it gives rise. I also

<sup>1</sup> Amanda Root, *Market Citizenship: Experiments in Democracy and Globalization* (London: Sage, 2007) at 23.

<sup>2</sup> See the comment by Ralf Dahrendorf, *Law and Order* (London: Stevens, 1985) at 85, cited in K.D. Ewing, “Social Rights in Constitutional Law” [1999] P.L. 104 at 113.

<sup>3</sup> T.H. Marshall & Tom Bottomore, *Citizenship and Social Class* (London: Pluto Classic, 1992) at 33. Marshall’s work was first published in 1950.

<sup>4</sup> See Charles Reich, “The New Property” (1964) 73 Yale L.J. 733; Andre Van der Walt, “Protecting Social Participation Rights within the Property Paradigm” in Elizabeth Cooke, ed., *Modern Studies in Property Law*, vol. 2 (Oxford: Hart, 2003) 27.

<sup>5</sup> Marshall & Bottomore, *supra* note 3 at 33.

<sup>6</sup> Isaiah Berlin, *Four Essays on Liberty* (London: Oxford University Press, 1975) at 125.

<sup>7</sup> See e.g. Michael J. Sandel, *Liberalism and the Limits of Justice* (Cambridge, U.K.: Cambridge University Press, 1998).

<sup>8</sup> See generally Daniel Callahan & Angela Wasunna, *Medicine and the Market: Equity v. Choice* (Baltimore: Johns Hopkins University Press, 2006).

<sup>9</sup> “New Governance” describes a policy in which government relaxes its centralizing control over public policy, and encourages consumer-led, market forces to influence decision-making at local level: see text accompanying notes 34-36 below.

consider whether, in the twenty-first century, market-based approaches to public welfare management will destabilize our commitment to social citizenship by their emphasis on individualism and economic forces. The discussion will tend to focus on the National Health Service (NHS), but I hope it will also be relevant elsewhere. I consider: (I) what social rights are; (II) how to enforce social rights; (III) “New Governance” and health care “commodification” in the NHS; and (IV) health care rights and the “market citizen.”

## I

### WHAT ARE SOCIAL RIGHTS?

Western liberal political thought emphasizes the civil and political rights of individualism and a zone of personal autonomy upon which not even the best interests of others may intrude. “If someone has a right to something, then it is wrong for the government to deny it to him even though it would be in the general interest to do so.... [This is] the distinctive concept of an individual right against the State which is the heart ... of constitutional theory in the United States.”<sup>10</sup> This quotation emphasizes the freedom from interference inherent in Marshall’s concept of *civil* citizenship, but to what extent should the relationships between individuals also involve elements of reciprocity, interdependence, and social solidarity? Especially with respect to health care resource allocation, how does it help us understand how priorities should be set between competing demands for finite resources? Put another way, how should individualistic, *negative*, civil rights to liberty co-exist with *positive*, social rights that emphasize equality between citizens? Constitutional theory offers no immediate answer to this question. Indeed, one side of the rights equation, it seems, has matured and developed without proper attention being given to the other. As Frank Michelman has said, commenting on Rawls’ *A Theory of Justice*,

the mainstream of our legal tradition has largely bypassed the outcome-appraising sort of distributional concern. Lawyers and jurists, like economists and political scientists, seem to have instinctively placed distributive-share questions beyond the province of their specialized analysis.... They work under the paradigm of legal order which is noticeably lacking in norms, principles and categories of analysis directly applicable to the evaluation of outcomes.<sup>11</sup>

To some extent, this lacuna was addressed by the “communitarians” in the 1980s who observed that “[t]he classical vision of the self-regulating market as a universe of self-sufficient monads was a formalist fantasy divorced from social reality as most people experienced it. For those who lacked wealth and power, the private rights regime implements a frightening dependence on the arbitrary wills of those who had them.”<sup>12</sup> As Sir John Laws (a member of the English Court of Appeal) has said, to define autonomy in terms of rights alone is a serious mistake. Such a definition denies to society its shared morality:

If it becomes the systematic feature of a prevailing social philosophy, it would tend to give rise to a community of selfish individuals, and therefore to no community. A society whose values are defined by

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<sup>10</sup> Ronald Dworkin, *Taking Rights Seriously* (London: Duckworth, 1977) at 269.

<sup>11</sup> “In Pursuit of Constitutional Welfare Rights: One View of Rawls’ Theory of Justice” (1973) 121 U. Pa. L. Rev. 962 at 963.

<sup>12</sup> William H. Simons, “Rights and Redistribution in the Welfare System” (1986) 38 Stan. L. Rev. 1433 at 1435. See also the “consumer-welfare” approach to contract law in the 1970s:

[A] system in which everybody is invited to do his own thing, at whatever cost to his neighbour, must work ultimately to the benefit of the rich and powerful.... As we look back on the nineteenth century theories, we are struck most of all, I think, by the narrow scope of the social duty which they implicitly assumed. No man is his brother’s keeper; the race is to the swift; let the devil take the hindmost. For good or ill, we have changed all that.... [This reflects] the transition from nineteenth century individualism to the welfare state and beyond (Grant Gilmore, *The Death of Contract* (Columbus: Ohio University Press, 1974) at 95-96).

reference to individual rights is by that very fact already impoverished. Its culture says nothing of individual duty ... and therefore nothing of community.<sup>13</sup>

A wholly “rights-based” approach makes it difficult to visualize a sense of community or collective commitment to health care. We should recognize then that while civil and political rights emphasize rights against others, they do not explain why or how we may also be dependent on others, or that our rights may sometimes be subordinate to theirs. Our sense of identity with others may arise from a common culture, religion, language, history, war, patriotism, education, and so on, all of which can exercise a cohesive influence in ways that generate a social dimension to our lives. Whatever its origin, to emphasize autonomy without also considering the reciprocity created by social rights misses a crucial part of our existence.

In his influential study, Gøsta Esping-Andersen describes the logic of social rights by arguing that wage earners are “commodified” in competitive markets by being valued largely by reference to their economic contribution to a market, compelled to compete against one another, and prey to decisions and forces beyond their control.<sup>14</sup> By contrast, “[i]f social rights are given the legal and practical status of property rights, if they are inviolable, and if they are granted on the basis of citizenship rather than performance, they will entail a de-commodification of the status of individuals *vis-à-vis* the market.”<sup>15</sup> This is the purpose of social welfare: to insulate citizens from the adversities of the market.<sup>16</sup> Of course, the nature and extent of national commitment to such an enterprise varies according to political and social preference. Unlike the position with respect to *civil* rights, which Western democracies broadly agree extend “negative” freedoms against the state, the nature of positive *social* rights is inherently political and cultural. Significant differences exist within Europe, and between Europe and North America, as to the nature and extent of their recognition of social rights. Esping-Andersen uses a “de-commodification” scale to distinguish three broad categories of systems: (a) Australia, Canada, the U.S., and the U.K.; (b) France, Germany, and Switzerland; and (c) Austria, Denmark, Holland, Norway, and Sweden. The more limited welfare coverage in Australia, North America, and the U.K. promises modest assistance as a back-stop against destitution. At the other end of the scale, Austria, Denmark, Holland, and the Nordic countries seek to equalize the market forces that expose individuals to insecurity with social rights that guarantee equal levels of welfare.<sup>17</sup> The point is that, unlike arguments about freedom of speech and democracy, which may be described as fundamental freedoms, responses to access to positive rights of social welfare vary because they are inherently national, cultural, and historical.<sup>18</sup>

Conceding, therefore, that the debate about *social* rights is necessarily more complicated than that concerning civil rights, but assuming that we agree in principle that some such rights should exist, our purpose here is better served by considering how law should recognize and

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<sup>13</sup> Sir John Laws, “The Constitution: Morals and Rights” [1996] P.L. 622 at 624.

<sup>14</sup> *The Three Worlds of Welfare Capitalism* (Cambridge, U.K.: Polity Press, 1990). For the logical end-point of acquisitive individualism, see Thomas Hobbes, *Leviathan* (Harmondsworth: Penguin Books, 1974), including C.B. MacPherson’s introduction in which he says that Hobbes “built his whole system of deductions from a model of man and a model of society which were ... models of bourgeois man and capitalist society” (at 52).

<sup>15</sup> Esping-Andersen, *ibid.* at 21.

<sup>16</sup> As Marshall explains,

civil rights were indispensable to a competitive market economy. They ... made it possible to deny [the citizen] social protection on the ground that he was equipped with the means to protect himself.... But, if you use these arguments to explain to a pauper that his property rights are the same as those of a millionaire, he will probably accuse you of quibbling.... But these blatant inequalities are not due to defects in civil rights, but to lack of social rights (Marshall & Bottomore, *supra* note 3 at 20-21).

<sup>17</sup> See Esping-Andersen, *supra* note 14 at 52.

<sup>18</sup> See generally Steinar Stjerno, *Solidarity in Europe: The History of an Idea* (New York: Cambridge University Press, 2004); Callahan & Wasunna, *supra* note 8. See also Alexander Somek, “Solidarity Decomposed: Being and Time in European Citizenship” [2007] Eur. L. Rev. 787.

respond to “de-commodification” rights, rather than describing in detail what they should contain. The example of health care provides a useful vehicle in which to explore the interconnected and reciprocal nature of social rights.

## II ENFORCING SOCIAL RIGHTS

Although, as Marshall observes, social citizenship constitutes the core idea of the welfare state, the concept needs to be expanded and explained. For example, he states that citizenship carries with it “corresponding duties,” but as to specifics, only that “[t]hese do not require a man to sacrifice his individual liberty or to submit without question to every demand made by government. But they do require that his acts should be inspired by a lively sense of responsibility towards the welfare of the community.”<sup>19</sup> What does this proposition entail? To make sense of the social citizenship that contributes to a sense of community and mutuality, rights theory has to distinguish between the different ways in which social rights may be created and enforced.

We should start by differentiating a number of dimensions of rights, in particular the distinction between public or private, and positive or negative rights. First, the “public-private” dimension identifies the source of the right. *Private* rights, for example in the law of contract and tort, arise between individuals and are generally enforceable between the parties themselves. By contrast, *public* rights are created within a legislative framework and are enforceable against public authorities. Within Esping-Andersen’s model, the nature and extent of public rights created by social welfare policies varies with the will of the legislature. Unlike private bodies, the freedom of welfare agencies to modify the quality of service, or benefit, they provide, or the price at which it is made available, is restricted by statute. This is what is meant by “public” rights: rights and duties conferred on a public authority and enforceable by judicial review within a framework constrained by the legislature.<sup>20</sup>

Second, the “positive/negative” dimension of rights refers to the purpose of the right conferred. Marshall’s *civil* rights may be characterized as *negative* rights that intend to insulate individuals from unwarranted state interference. Thus, the *European Convention on Human Rights*<sup>21</sup> and the *Canadian Charter of Rights and Freedoms*<sup>22</sup> are largely (but not exclusively) concerned with restricting the state’s authority to limit the negative rights of autonomy and freedoms of speech, religion, and assembly. To this extent, they give rise to “*negative/public*” rights (including the need for proper investment in the apparatus of the state, for example an impartial legislature, judiciary, and police force). By contrast, to the extent that social rights are created by the state, the entitlements to which they give rise should be considered as “*positive/public*” rights that imply the existence of state largesse and a system of rules for its distribution to those who qualify for support.<sup>23</sup> These distinctions are imprecise and disputed,<sup>24</sup> but they are crucial if we are to understand the nature of social citizenship.

We require a further “substantive-procedural” dimension. Civil rights may be enforced *substantively* by the courts. Courts are competent to enforce these negative/public rights

<sup>19</sup> Marshall & Bottomore, *supra* note 3 at 41.

<sup>20</sup> Of course, public authorities can also enter *private* agreements, for example when they enter contracts of employment or contracts for the sale of goods.

<sup>21</sup> *Convention for the Protection of Human Rights and Fundamental Freedoms*, 4 November 1950, 213 U.N.T.S. 221 at 223, Eur. T.S. 5.

<sup>22</sup> Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (U.K.), 1982, c. 11 [*Canadian Charter*].

<sup>23</sup> Private contracts routinely contain private/positive rights to damages in case of non-performance of the contractual terms. Our concern with social welfare emphasises the *public* side of positive rights.

<sup>24</sup> See *e.g.* Berlin, *supra* note 6; Raymond Plant, *Modern Political Thought*, (Oxford: Basil Blackwells, 1991) c. 7.

because they represent fundamental values that liberal societies endorse. Of course, these rights may also give rise to very difficult issues for the courts, concerning, for example, the individual's right to determine the time and manner of his or her death, abortion and the rights of unborn children, and the reproductive rights of handicapped people. Importantly, however, the substantive enforcement of these rights does not usually involve awkward questions of resource allocation, because they are not dependent on equal uptake throughout the community.<sup>25</sup> They protect equality of *access*,<sup>26</sup> but not necessarily equality of outcome. For example, it is perfectly plausible for the right to freedom of association to enable successful entrepreneurs to generate more wealth for themselves than poorer members of the community, and for the press to make greater use of the right to freedom of speech than the man on the Clapham omnibus. By contrast, *procedural* rights do not guarantee access to the benefit claimed. Instead, they offer the right to a procedural framework within which the decision to grant or to restrict it may be scrutinized and reviewed. Claims to positive/public rights are often amenable to a procedural response,<sup>27</sup> because the nature of the protection they offer is more heavily dependent on the principle of equality of *outcome* (that is, like cases should receive like benefit). Courts are not well equipped to develop consistent responses across the spectrum of applicants for social welfare. Litigation, after all, is often *ad hoc* and subject to the accident of personal and financial circumstance, and may not represent public interests. Specialist agencies, appointed by virtue of their expertise, are better placed to weigh and balance the sometimes competing demands that may arise. To this extent, therefore, the right should be procedural, because the court may be inclined to defer to the judgment of the expert body appointed to the task.

This is the *procedural* framework in which positive/public health care rights have been enforced in the U.K. The position is illuminated by *R. v. North West Lancashire Health Authority ex parte A., D., and G.*,<sup>28</sup> in which applicants for sex reassignment surgery had their request for treatment refused by their health authority without the merits of their application being properly considered. Their application for judicial review succeeded, and the Court of Appeal remitted the case back to the Health Authority for reconsideration. As the Court of Appeal said, health authorities are required to make difficult decisions about NHS resource allocation. Some treatments, such as life-saving treatment for cancer or for kidney failure, may command a higher priority than sex reassignment surgery. However, although the Health Authority was not duty-bound to provide the surgery, it was obliged to have a fair and consistent system for considering applications of this nature and for considering whether they demonstrated exceptional individual need. The Health Authority had failed to respond to these cases within such a framework and was required to reconsider them in the light of this guidance (after which, as often occurs, the Health Authority resolved not to resist the case further and provided the necessary funding).

Of course, the intensity of this procedural review is crucial. Too little scrutiny and the process becomes a sham with the result that *individual* interests are given insufficient recognition. For example, in *R. v. Central Birmingham Health Authority ex parte Collier* (decided in 1988), a health authority was unable to provide life-saving treatment for a young

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<sup>25</sup> Although exceptionally they may do so if negative rights impose positive duties on others. For example, in *Winnipeg Child and Family Services (Northwest Area) v. G. (D.F.)*, 1997 SCC 193, [1997] 3 S.C.R. 925, 152 D.L.R. (4<sup>th</sup>) 193, a majority of the Court refused to order the detention of a pregnant woman who was addicted to glue-sniffing in order to protect her unborn child, notwithstanding that two of her previous children had suffered permanent brain-damage as a result and were in the care of public authorities. English law takes a similar view that unborn children have no rights against the mother: see *Re MB* (1997), 38 B.M.L.R. 175 (C.A.).

<sup>26</sup> *Eldridge v. British Columbia (A.G.)*, [1997] 3 S.C.R. 624, 151 D.L.R. (4<sup>th</sup>) 577 considers the equal *access* to hospital care of those needing sign language services; this, too, has resource implications.

<sup>27</sup> Although *substantive* public rights also may be created by Parliament (for example, to a pension or an unemployment benefit), access to health care can seldom be quantified in such an exact form.

<sup>28</sup> (2000), 1 W.L.R. 977 (C.A.).

boy with a hole in the heart. It explained that the failure to treat was due to a shortage of pediatric nurses and beds. The court refused the application for judicial review on the ground that there was no evidence of irrationality and that it was in no position to organize hospital waiting lists.<sup>29</sup> Given the gravity of the case, this excess of judicial deference is unsatisfactory. The court did not ask why the boy had not been transferred to an alternative hospital and, in the absence of an explanation, offered inadequate reassurance that the merits of the case were properly weighed and balanced against the needs of others.

On the other hand, too much intensity and public authorities may be so intimidated by judicial review that they concede every challenge and, therefore, tend to overlook *community* interests. In *Otley v. Barking and Dagenham Primary Care Trust*, an applicant with terminal cancer was refused access to a drug for which evidence of general efficacy was equivocal and the cost of the treatment would have been very expensive. Granting judicial review, the court said that closer attention should have been given to the possibility that the applicant had “exceptional” clinical merits, which might have led to an exceptionally positive response to the treatment.<sup>30</sup> Clearly, if this decision suggests a trend toward over-intensive judicial review, it could put a premium on litigation and prejudice those whose interests are not brought to the court’s attention.

Bear in mind that the procedural response is not a search for the “right” answer.<sup>31</sup> Rather, it is to confirm that the public authority has considered a sensible range of factors and given the various components of the decision proper consideration. It may do so, for example, by considering the effectiveness of the proposed treatment (separately and by comparison to others), its absolute cost (and its cost relative to other effective treatments), whether the treatment has priority in the health community as a whole, and whether the patient has exceptional individual need for the treatment.<sup>32</sup> In this way, the process should balance the needs of the individual with those of the community. These distinctions are important as a way of both explaining what positive/social/procedural rights are and illuminating the differences between negative/civil/substantive rights about which understanding is so much more developed.<sup>33</sup>

### III

#### “NEW GOVERNANCE” AND HEALTH CARE “COMMODIFICATION” IN THE NHS

Both Marshall and Esping-Andersen wrote at a time when, at least in the U.K., public authorities were largely responsible for the provision of NHS (and other public) services. The social consensus that grew from the experience of the Second World War dramatically influenced social policy. The U.K. committed itself to combating the “five giants on the road to

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<sup>29</sup> (C.A. (Civ. Div.)) (Lexis), discussed in Christopher Newdick, *Who Should We Treat?: Rights, Rationing and Resources*, 2d ed. (Oxford: Oxford University Press, 2005) at 97-100 [Newdick, *Who Should We Treat?*].

<sup>30</sup> [2007] EWHC Admin 1927, L.S. Law Med. 593.

<sup>31</sup> Note, however, that interest is being expressed in enforcing *substantive*/social rights. See Geraldine Van Bueren, “Including the Excluded: The Case for an Economic, Social and Cultural Human Rights Act” [2002] P.L. 456; Navish Jheelan, “The Enforceability of Socio-Economic Rights” [2007] Eur. H.R.L. Rev. 146; L. Forman, “Justice and Justiciability: Advancing Solidarity and Justice through South Africans’ Right to Health Jurisprudence” J. Med. & L. [forthcoming in 2008]. The danger, however, is that the opportunity cost to those not before the courts may be overlooked.

<sup>32</sup> For the evolution of law in the U.K. in this area, see Newdick, *Who Should We Treat?*, *supra* note 29 c. 5. For current practice, see Christopher Newdick, “Accountability for Rationing: Theory into Practice” (2005) 33 J. L. Med. & Ethics 660.

<sup>33</sup> For more on these distinctions, see Christopher Newdick, “The Positive Side of Health Care Rights” in Sheila A.M. McLean, ed., *First Do No Harm: Law, Ethics and Healthcare* (Aldershot: Ashgate, 2006) at 573; and C. Newdick, “Solidarity, Rights and Social Welfare in the NHS: Resisting the Tide of Bioethics?” J. Med. & L. [forthcoming in 2008].

reconstruction” of want, ignorance, disease, squalor, and idleness,<sup>34</sup> with the state driving the process. Within this top-down model, the state was dominant in setting policy and, through its own domestic taxation policy, provided social welfare at its own discretion. In addition, until the end of the 1970s, state-funded support was also made available to failing industries, at least partly to maintain workers in full employment. This too may be understood as indirect, state-supported, social welfare. Thus, directly or otherwise, the state was central to maintaining levels of employment, education, and standards of health and housing. Both in politics and law, this centrality encouraged collective solutions to social policy, which could be developed and controlled by national governments within their own political and economic priorities.

Today, however, the position is different. Global pressures have forced national governments to reappraise their capacity to control their economies. Now these governments compete for inward investment from international investors who favour regimes with low levels of taxation. As a result, domestic trade barriers have been dismantled and local industries exposed to free international competition.<sup>35</sup> Consequently, despite the misgivings of national authorities, domestic control over social welfare has diminished:

national governments have lost most of their former capacity to influence growth and employment in their economies—most, that is, except for the supply-side options of further deregulation, privatization, and tax cuts, which are perfectly compatible with EU law.... [This is] in conflict with the political aspirations and commitments of countries which, in the post-war decades, had adopted a wide-range of market-correcting and redistributive policies, creating “social market economies” in which the effects of the capitalist mode of production were moderated...<sup>36</sup>

Within this New Governance, trans-national, commercial forces have wrested power from nation states. Now, instead of control exercised by single public authorities subject to judicial review, diffuse, experimental, and largely pragmatic influences have been introduced by government with the intention of reducing public expenditure and enhancing efficiency. Dominant amongst them is the use of the pressures of the market-place as a lever to encourage less complacent, more active competition between service providers.<sup>37</sup> Clearly, in moral and political terms, the impact of these New Governance forces is not neutral.<sup>38</sup> How have they affected Marshall’s notion of social citizenship?

In the NHS in particular, market competition has been introduced to force quality up and to put downward pressure on prices.<sup>39</sup> Private providers now compete with public authorities to provide public services. For example, independent sector treatment centres have been introduced to the NHS in direct competition with NHS hospitals. At present, their work is largely in respect of acute, out-patient care such as the removal of cataracts, but over time they may be expected to offer a full-range of hospital services. Also, “foundation hospitals” have been established out of ordinary NHS hospitals to inject a greater sense of competition in

<sup>34</sup> Sir William Beveridge, *Social Insurance and Allied Services* (New York: Macmillan, 1942) at 6.

<sup>35</sup> See generally OECD, *Governance in Transition: Public Management Reforms in OECD Countries* (Paris: OECD, 1995); David M. Andrews, “Capital Mobility and State Autonomy” (1994) 38 *Int’l Stud. Q.* 193.

<sup>36</sup> Fritz W. Scharpf, “Legitimate Diversity: The New Challenge of European Integration” in Tanja Börzel & Rachel A. Cichowski, eds., *The State of the European Union*, vol. 6 (Oxford: Oxford University Press, 2003) at 92.

<sup>37</sup> Politicians refer to the process as “modernization.” See generally Gráinne de Búrca & Joanna Scott, eds., *Law and New Governance in the EU and US* (Oxford: Hart Publishing, 2006); Neil Walker & Gráinne de Búrca, “Reconceiving Law & New Governance” (2007) 13 *Colum. J. Eur. L.* 519. See also Charles F. Sabel & William H. Simon, “Destabilization Rights: How Public Law Litigation Succeeds” (2004) 117 *Harv. L. Rev.* 1016 (contending that these forces intend to increase uncertainty and enhance opportunities for parties at local level to agree on solutions to problems).

<sup>38</sup> See E. van Leeuwen, “Changing Moral Experiences in European Healthcare” *J. Med. & L.* [forthcoming in 2008].

<sup>39</sup> For an argument, however, that health care markets drive health care costs up, see Steffie Woolhandler & David U. Himmelstein, “Competition in a Publicly Funded Healthcare System” (2007) 335 *B.M.J.* 1126. See also Nigel Edwards, “Using Markets to Reform Health Care” (2005) 331 *B.M.J.* 1464; and, more cautiously, Nicholas Timmins, “Backpedalling from Blair’s Privatisation Agenda” (2007) 335 *B.M.J.* 794.



secondary care. On the basis of their previous good performance, foundation hospitals are awarded greater independence (including the right to borrow money) and may compete (for example, by expanding or absorbing other hospitals) more aggressively than other hospitals for patient throughput.<sup>40</sup>

These market-based changes are not limited to hospital “providers.” Under the “Choice Agenda,” patients are encouraged to regard themselves as “consumers” of health care services. Patients should be offered at least four providers (including a private hospital) in which to receive treatment.<sup>41</sup> Hospital managers will be concerned about the way in which their hospitals present themselves to the public. The advantage is that competition will encourage hospitals to aspire, for example, to better clinical outcomes, standards of cleanliness, shorter waiting times, more attractive facilities, and car-parking. On the other hand, there is a risk that hospitals that wish to foster the *appearance* of having the most modern facilities may be encouraged to purchase equipment as a shop window rather than out of necessity. The point has been made by a U.S. commentator who said that “because we have too many mammography machines, each is underutilized. This doubles the cost of each test. As a result, many women cannot afford screening. Thus, because we have too many mammography machines, we have too little breast cancer screening.”<sup>42</sup> The consequences of this pressure to appeal to consumer preferences may lead to a distortion of public health priorities. As has been said in the U.S., the risk is that we will find hospitals “doing more and more for fewer and fewer people, at higher and higher cost, for less and less benefit.”<sup>43</sup> We should be aware of similar competitive pressures arising in the NHS. These pressures argue for a more unified system of responding to health needs in the community, rather than the diversification that competition brings.<sup>44</sup>

Whatever the balance of the argument, government in the U.K. is committed to the market as a principal mechanism for improving NHS care. Yet social citizenship presupposes a significant public commitment to social welfare and a public consciousness of the need to unite to reduce the risks of individual adversity. Will the New Governance undermine that sense of community and the concept of public rights? Concern is expressed at the commodification of health care in which commitments to human values will be diluted by the market in which every transaction, and every patient, has a cost. Will social citizenship survive the health care market? Or will it create a “market citizen” more interested in individual, rather than community, interests? And will it also reduce the range of cases amenable to judicial review and thereby undermine the role of the courts in bringing a public perspective to dispute resolution? Whereas public rights ought to foster notions of equality and trust in public institutions, the process of commodification tends to enhance the rights of the individual *against* public institutions. The emphasis is toward liberty rather than equality, and toward substantive rather than procedural rights. The point is made by Pellegrino:

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<sup>40</sup> See generally Newdick, *Who Should We Treat?*, *supra* note 29 at 81-86.

<sup>41</sup> See Julian Le Grand, *The Other Invisible Hand: Delivering Public Services Through Choice and Competition* (Princeton: Princeton University Press, 2007). However, choice often offers little variety and may confuse consumers: see Barry Schwartz, *The Paradox of Choice: Why More is Less* (New York: Harper Perennial, 2004). Our concern is health care, but the tension between consumer and “solidarity”-based approaches is likely to be the same whenever market forces are used in welfare services, for example in education.

<sup>42</sup> Gordon D. Schiff *et al.*, “A Better Quality Alternative: Single-Payer National Health System Reform” (1994) 27 J.A.M.A. 803 at 806.

<sup>43</sup> G.J. Annas *et al.*, eds., *American Health Law* (Boston: Little Brown, 1990) at 293.

<sup>44</sup> See Christopher Ham, “Clinically Integrated Systems: The Next Step in English Health Reform?” (Nuffield Trust Briefing Paper, 2007), online: The Nuffield Trust <[http://www.nuffieldtrust.org.uk/members/download.asp?f=/ecomm/files/Clinically\\_Integrated\\_Systems.pdf&a=skip](http://www.nuffieldtrust.org.uk/members/download.asp?f=/ecomm/files/Clinically_Integrated_Systems.pdf&a=skip)>. The English NHS has recently introduced a system of fixed payments for hospital procedures based on *Health Related Groups* (comparable to Diagnostic Related Groups) that may deal with this risk, although the new system may also encourage hospitals to generate income from treatments that could otherwise have been dealt with less expensively in the community.

[T]he commodification of health and medical care means that the transaction between physicians and patients has become a commercial relationship. That relationship, therefore, will be primarily or solely regulated by the rules of commerce and the laws of torts and contracts rather than the precepts of professional ethics. Profit-making and pursuit of self-interest will be legitimated. Inequalities in distribution of services and treatments are not the concerns of free markets.<sup>45</sup>

“Commodification” emphasizes the negative rights of freedom from coercion, but it says nothing about communitarian ethics and the common good.<sup>46</sup> It is not just that professional ethics are diminished in importance. Notions of trust and the public interest are also likely to suffer, together with our sense of unity against adversity. Clearly, any such trend is largely alien to the notion of social citizenship discussed by Marshall.

#### IV

##### HEALTH CARE RIGHTS AND THE MARKET CITIZEN

Can the model of the *social* citizen withstand the prominence given to individualism, especially within the New Governance framework of public sector management? Or is it more accurate to regard the model as a temporary and insubstantial creature, likely to become extinct outside the favourable, post-war habitat of its own time? The social welfare system envisaged by Marshall imposes implicit duties on citizens to contribute to a pool of welfare “insurance.” If we assume, consistent with experience in the NHS, that demand for welfare is likely to exceed the supply of resources available to fund it, sensitive and controversial choices will be required as to priorities. This is why judicial review has developed a system which recognizes public/positive/procedural rights within which claims for priority may be assessed against a range of other factors.

But the concept of the *market* citizen is impatient with such an approach, which seems to distance consumers from a more active role in their own care.<sup>47</sup> Instead, this concept encourages patients to assert themselves against the NHS by means of “choice” and the bodies within the NHS itself to compete with each other to promote their own interests. Economic theory suggests that such market-based relationships will tend to improve quality and reduce cost. But will they also dilute the sense of *duty* to others, which is implicit in social citizenship, by emphasizing the rights of the *individual*? This tendency away from community interests and toward the sanctity of market transactions is illuminated in a series of cases from the European Court Justice (ECJ), the Supreme Court of Canada (SCC), and the U.K. House of Lords, which illustrates the tensions involved between pursuing “public” and “private” objectives in health care policy. Let us consider each in turn.

We commence with the case of *R. (Watts) v. Bedfordshire Primary Care Trust and Secretary of State*,<sup>48</sup> in which a patient aged seventy-two required bilateral hip replacements. Consistent with contemporary NHS policy on maximum waiting times, her Primary Care Trust (PCT) reassured her that her operation would be performed within twelve months.<sup>49</sup> Mrs.

<sup>45</sup> Edmund D. Pellegrino, “The Commodification of Medical and Health Care: The Moral Consequences of a Paradigm Shift from a Professional to a Market Ethic” (1999) 24 *J. Med. & Phil.* 243 at 252.

<sup>46</sup> See *ibid.* at 258.

<sup>47</sup> In the E.U., until the late 1990s, the concept of the “market citizen” referred more formally to those whose *economic* contribution to a “host” Member State entitled them to receive social welfare there. Since *Martinez Sala v. Freistaat Bayern*, C-85/96, [1998] E.C.R. I-2691 and *Grzelczyk v. Centre public d’aide sociale d’Ottignies-Louvain-la-Neuve*, C-184/99, [2001] E.C.R. I-6193, however, these restrictions have been relaxed so that some non-economically active citizens may also obtain social welfare in host Member States: see generally Catherine Barnard, *The Substantive Law of the EU: The Four Freedoms* (Oxford: Oxford University Press, 2004) at 405-20. The following discussion, therefore, takes a broader, less legalistic, view of the concept.

<sup>48</sup> C-372/04, [2006] E.C.R. I-4325, 3 W.L.R. 213 [*Watts*].

<sup>49</sup> The waiting time target is now eighteen weeks. Primary Care Trusts (PCTs) are statutory NHS bodies responsible for purchasing primary and secondary care for the benefit of the population they serve: see the *National Health Service Act 2006* (U.K.), 2006, c. 41 [*NHS Act*]. Their statutory duties include the duty not to exceed their

Watts declined to wait for such a period and arranged to have treatment in France. Shortly before leaving, she was offered treatment at home within four months. She declined the offer, had her hip replacements in France, returned to the U.K., and presented the PCT with a bill for £4,700. The PCT declined to pay, and the case was referred to the ECJ by the English Court of Appeal. The arguments in the case turned on one of the fundamental principles of E.U. law, namely that of freedom of movement of services (that is, that the market for services should be freely available without trade restrictions throughout the Member States).<sup>50</sup>

The U.K. and Bedfordshire PCT argued that this principle should not apply in the case of publicly funded health care. Legal authority for the argument was based on European case law establishing that the right of free movement of services applied to *private enterprises* that wished to obtain access to markets elsewhere in the E.U. Thus, accountants, banks, and insurance companies are entitled to promote themselves throughout the E.U. on the same basis as domestic companies. *Public* services, on the other hand, were said to be different. For example, the ECJ had previously said cross-border education is not available because it is not a “service,” since no commercial remuneration is provided; instead, it promotes activities in the social and cultural field.<sup>51</sup> This argument had also been approved by Advocate-General Ruiz-Jarabo Colomer in *Geraets-Smits v. Stichting Ziekenfonds Vgz; Peerbooms v. Stichting Cz Groep Zorgverzekeringen*, who advised that national health insurance systems should be regarded in the same way, because “sickness funds must be able to expect that, barring rare exceptions subject to their consent, any health care which insured persons require will actually be provided by the practitioners and institutions contracted.” Otherwise, it would be difficult to manage the flows of patients in and out of local health authorities (especially those close to national borders).<sup>52</sup> If the activity anticipated by a public provider was upset by unpredictable patient flows, so that some hospitals had unexpected waiting lists, and others had empty beds and closed wards, the optimum efficiency of the service would be undermined to the detriment of the public generally.

Similar concerns were expressed by the English Court of Appeal when it referred the case to the ECJ for resolution. Given that demand for health care exceeds supply, a reasonable process of priority setting is required that seeks to respond to patient need in a fair and logical manner. This objective aims to promote a sense of equality between community interests. The Court asked the ECJ to consider whether, particularly in the state-funded NHS, the principle of freedom of movement in the E.U. should in any way be tempered by the fact that it “would permit patients with less urgent medical needs to gain priority over patients with more urgent medical needs.”<sup>53</sup> The ECJ ruled in Mrs. Watts’ favour.<sup>54</sup> The response of Advocate-General Geelhoed to the question put by the Court of Appeal precisely summarizes the individualist, “market citizenship” view of patients’ rights in the ECJ. He said simply that

[w]here conditions granting authorisation to receive hospital care in another member state are designed to guarantee the financial stability of the national health system, considerations of a purely budgetary or economic character cannot justify a refusal to grant such authorisation.<sup>55</sup>

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income (s. 229). When treatment is delayed or denied, action in judicial review is normally taken against the responsible PCT. See generally Newdick, *Who Should We Treat?*, *supra* note 29 c. 4.

<sup>50</sup> EC, *Treaty Establishing the European Community*, [2002] O.J. C 325/33, art. 49.

<sup>51</sup> *Belgium v. Humbel and Edel*, C-263/86, [1988] E.C.R. 5365.

<sup>52</sup> C-157/99, [2001] E.C.R. I-5473 at para. 72 [*Geraets-Smits/Peerbooms*]. This argument was rejected, however, by the ECJ: see note 55 below.

<sup>53</sup> *Watts*, *supra* note 48 at para. 42, Judgment.

<sup>54</sup> Following earlier cases on public health insurance systems in which the ECJ had approved cross-border access to health care. See *Decker v. Caisse de Maladie des Employés Privés*, C-120/95, [1998] E.C.R. I-1831; *Kohll v. Union des Caisses de Maladie*, C-158/96 [1998] E.C.R. I-1931 [*Kohll*]. See also Vassilis G. Hatzopoulos, “Killing National Health Insurance Systems but Healing Patients?: The European Market for Health Care Services after the Judgments in the ECJ in *Vanbraekel* and *Peerbooms*” (2002) 39 C.M.L. Rev. 683.

<sup>55</sup> *Watts*, *supra* note 48 at para. 92, Geelhoed Adv. G., Opinion.

The public interest in social cohesion, institutional stability and procedural fairness could not obstruct the private, economic right to obtain health care in another Member State. The ECJ endorsed this view and held that if “normal” treatment cannot be obtained within the “home” state without “undue delay,” as assessed according to the patient’s *individual* need, the patient is entitled under E.U. law to secure the treatment elsewhere. As a result, those who require “normal” treatment, but who do not command priority at home, may oblige the local purchaser to pay for their care on their return and, for accounting purposes, become its *priority*. Fair and reasonable *procedures* to promote equality of community interests are unlikely to withstand the substantive, *individual*, market right of access to goods and services in the E.U.<sup>56</sup> This right puts health authorities in an invidious position. They are duty-bound to promote a “comprehensive” health service in the interest of the community as a whole<sup>57</sup> and, within finite budgets, may have to prioritize some treatments over others. On the other hand, the ECJ in *Watts* tends to encourage patients who have not been given priority to seek treatment elsewhere in the E.U. This result has an inescapable logic. The system will continue to work within the constraints of finite resources. Neither the E.U. nor the ECJ carries a budget to support cross-border treatment. But, if Peter secures access to resources otherwise intended for Paula, then Paula’s treatment may have to be cancelled, delayed, or diluted as a result. What is striking, especially in the debate about access to health care, is for private, economic solutions to be implemented to the *exclusion* of considerations based on a commitment to social welfare. Despite its rhetoric of protecting public health care systems,<sup>58</sup> the ECJ refused to discuss the implications for others of introducing market-based rights to health care. Such is the strength of “market citizenship” in the E.U.

The SCC considered an analogous tension in *Chaoulli v. Quebec (A.G.)*.<sup>59</sup> The case concerned the balance of private and public interests in the availability of private health insurance. The province of Quebec, concerned to promote the equal access of its citizens to health care, made private health insurance unlawful. The broad policy for the restriction was that:

The time a doctor spends working in the private sector is time that cannot be spent in the public system. In the absence of a significant increase in the number of medical professionals in Canada (which would require significant investment of public spending) or a significant increase in the overall hours worked, the emergence of a flourishing duplicate or parallel private tier must mean less time overall will be spent by medical professionals in the public system treating public patients.<sup>60</sup>

Assuming public health care providers were working at capacity, private health insurance would divert clinicians from their public obligations and encourage two-tier access to health care to the detriment of those without private insurance. Accordingly, the province legislated for a single tier of health care provision throughout Quebec with the intention of promoting equality of access.<sup>61</sup> The applicant argued that fundamental rights were infringed by obliging patients to join long waiting lists, increasing health risks which, with private health insurance, many could choose to avoid.

<sup>56</sup> See Christopher Newdick, “Citizenship, Free Movement and Health Care: Cementing Individual Rights by Corroding Social Solidarity” (2006) 43 C.M.L. Rev. 1645.

<sup>57</sup> See *NHS Act*, *supra* note 49, s. 1.

<sup>58</sup> See *e.g. Watts*, *supra* note 48 at paras. 103-06, Judgment; *Garaets-Smits/Peerbooms*, *supra* note 52 at para. 53; *Kohll*, *supra* note 54 at para. 41.

<sup>59</sup> 2005 SCC 35, [2005] 1 S.C.R. 791, 254 D.L.R. (4th) 577 [*Chaoulli*]. See the excellent consideration of the implications of the case in Colleen M. Flood, Kent Roach & Lorne Sossin, eds., *Access to Care, Access to Justice: The Legal Debate Over Private Health Insurance in Canada* (Toronto: University of Toronto Press, 2005).

<sup>60</sup> C. Flood & S. Zavier, “Health Care Rights in Canada: The *Chaoulli* Legacy” J. Med. & L. [forthcoming in 2008].

<sup>61</sup> Precisely this question troubled the U.K.’s Department of Health during the 1970s, but never resulted in litigation. See Michael Ryan, “Hospital Pay Beds: A Study in Ideology and Constraint” (1975) 9 Soc. Pol’y & Admin. 164. See generally Charles Webster, *The National Health Service: A Political History*, 2d ed. (Oxford: Oxford University Press, 2002). The matter has recently been tackled in the NHS by requiring hospital doctors to fulfil their NHS duties before accepting additional private work.

Reversing the decisions of the trial judge and appeal court, the SCC held by a majority that the restriction infringed the right to life, and to personal security, inviolability, and freedom under Quebec's *Charter of Human Rights and Freedoms*,<sup>62</sup> and was not justified by reasons of social policy. The policy was held to be a disproportionate infringement of the rights of the individual. No clear evidence was available to demonstrate the justification for an outright ban; other provinces of the country had less draconian responses to private insurance and prohibition was not thought necessary elsewhere amongst O.E.C.D. nations. In the absence of persuasive evidence of the need to protect the public interest in this way, individual choice and market forces should not be restricted, even if the consequence tends to increase inequality between those who can afford private insurance and those who cannot.

The opposite perspective was expressed by the minority, who understood the case to raise issues concerning social values, rather than constitutional rights.<sup>63</sup> For them, the matter remained within the reasonable discretion of the legislature, which was entitled to believe that the major beneficiaries of a relaxation of the policy would be restricted to a segment of the community with access to private insurance. The rights in contention were better viewed as social and economic rights within the legitimate jurisdiction of the legislature. In the absence of evidence that existing waiting time limits were unacceptable (given that they could never be eliminated completely), the minority considered that the restriction was neither arbitrary nor disproportionate, and cautioned that the "*Charter* should not become an instrument to be used by the wealthy to 'roll back' the benefits of a legislative scheme that helps poorer members of society."<sup>64</sup> Here too, therefore, despite the paucity of hard evidence to support the conclusion, or substantive comparative data from health care systems elsewhere, individual economic interests were given precedence over the more recondite demands of social solidarity.<sup>65</sup>

Before considering the third case, let us pause to consider an argument that may be implicit both in the ECJ in *Watts* and in the majority of the SCC in *Chaouli*, namely that citizens should be free to "exit" from a failing system, both as an expression of their own right and as a lever to encourage improved performance. In truth, however, although this may be persuasive in respect of private providers of goods and services, the dynamics of "exit" from public providers may be very different. As Albert O. Hirschman says, we cannot exit from *public* services in the same way.<sup>66</sup> First, exit tends to diminish the pool of welfare resources available for the remainder, to impoverish the system and, as the process accelerates, increasingly to encourage those with sufficient means to abandon the system, thereby eroding the interests of those that remain. Exit, in the sense of absolving some from the duty to contribute to social welfare, could undermine support for the redistributive ethic on which social rights are dependent. Second, to the extent that we all have an interest in and a right to benefit from public welfare, exit from the system is neither wished for nor possible. Although exit may appear popular when we are young, strong, healthy, and fit (with only short-term, acute illness), our need for public assistance may be very different when we are old, frail, poorly, and disabled—especially if the possibility of "exit" is effectively foreclosed because private health insurance is unavailable to cover long-term, chronic illness. From both a personal and societal point of view, therefore, we should understand the context in which discussion of exit takes place.

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<sup>62</sup> R.S.Q. c. C-12, s. 1 [*Quebec Charter*]. A majority (of 4-3) found a breach of the *Quebec Charter*. However, there was an equal division of opinion (of 3-3) as to the position under the *Canadian Charter*, *supra* note 22, because Deschamps J. expressed no view on this question.

<sup>63</sup> *Chaoulli*, *supra* note 59 at paras. 166, 276, *per* Binnie and LeBel JJ.

<sup>64</sup> *Ibid.* at para. 274. Though the minority was speaking here of the *Canadian Charter*, its reasoning applies to the *Quebec Charter* as well.

<sup>65</sup> For criticism of the case, see Flood & Zavier, *supra* note 60.

<sup>66</sup> See *Exit, Voice and Loyalty: Responses to Decline in Firms, Organizations, and States* (Cambridge, MA: Harvard University Press, 1970) at 98-105 (distinguishing between "exit" from organizations supplying "private" and "public" goods).

Our third case was decided in the U.K. House of Lords. It was not concerned with access to care. Instead, it considered the policy implications of New Governance for the remedies available to individuals under the *Human Rights Act 1998*.<sup>67</sup> Whereas, in the past, judicial review was the appropriate mechanism for testing whether public authorities had fulfilled their statutory obligations to the community, the issue is blurred when *private* bodies are engaged to do so on their behalf. This question is pressing in respect of health and social care in the U.K. How should the law respond as private bodies and charities become enmeshed in the structure of *public* service provision? Should service users (that is, patients and residents) have the same rights of redress as would otherwise be available against those providing public services? Or should private providers be entitled to insist that they are immune from public law review on the ground that they are commercial bodies and should be governed by private law and market forces? To what extent should a public policy to de-regulate service provision also hollow out the legal remedies available to patients and residents of nursing homes? This was the issue in *YL v. Birmingham City Council*.<sup>68</sup>

The applicant was eighty-four years old and suffered from Alzheimer's disease. She was resident in a care home run by Southern Cross Healthcare Ltd. The company had a contract with Birmingham City Council, a public authority, to provide accommodation for residents placed with them by the Council. About 80 percent of the company's business was with public authorities. Dispute arose between the care home and the applicant's relatives, and culminated with the home terminating the applicant's contractual right to remain a resident in the home (within the terms of a contract between the Southern Cross and the Council). The question arose whether the decision of the private nursing home to terminate her right to remain fell within the *Human Rights Act*. The *Act* applies only to a "public authority", which is loosely defined as "any person certain of whose functions are functions of a public nature."<sup>69</sup> However, the *Act* continues that "[i]n relation to a particular act, a person is not a public authority by virtue only of subsection (3)(b) if the nature of the act is private."<sup>70</sup>

A majority of their Lordships found that these facts provoked no *Human Rights Act* issue against the nursing home. Adopting a commercial analysis of the case, they said that Southern Cross was a private business providing services to a public authority purchaser at commercial rates. It received no public funding, was not a charity, had no special powers, and was free to accept or reject residents in its own lawful discretion. It had to compete in a commercial market with others. Although it was performing a function equally undertaken by public bodies, it was necessary to look at the reason why the body was doing so. Southern Cross was doing so for profit. This was fundamentally different from a public authority fulfilling statutory duties. From a *corporate* perspective, the majority speak with an inevitable logic.

By contrast, the minority sought to balance against the corporate, market-based concerns the broader public interests at work. They said that a number of factors should be weighed to determine whether the private body was subject to public law supervision within the *Human Rights Act*, for example whether the state has undertaken a statutory responsibility for seeing that a service is provided, the public interest in having that task undertaken at public expense, whether funding for the service is provided by public sources, and whether the authority

<sup>67</sup> *Human Rights Act 1998* (U.K.), 1998, c. 42 [*Human Rights Act*].

<sup>68</sup> (2007), 96 B.M.L.R. 1 [*YL*].

<sup>69</sup> *Supra* note 67, s. 6(3)(b).

<sup>70</sup> *Ibid.*, s. 6(5). As Lord Neuberger said in *YL*, *supra* note 68 at para. 130,

[s]ection 6 is, at least in some respects, not conspicuous for the clarity of its drafting [especially as to the] distinction between 'acts' and 'functions' in the section. In my view, both as a matter of ordinary language and on a fair reading of the section, there is a difference between 'functions', the word used in section 6(3)(b), and 'act[s]'.... The former has a more conceptual, and perhaps less specific, meaning than the latter.

includes coercive powers of restraint. Thus, in *YL*, Baroness Hale, dissenting, said: “This was a function performed for the appellant pursuant to statutory arrangements, at public expense and in the public interest. I have no doubt that Parliament intended that it be covered by s 6(3)(b)... The company is potentially liable to the appellant ... for any breaches of her convention rights.”<sup>71</sup>

I do not suggest that if the *Human Rights Act* had applied to *YL*, the applicant should have been entitled to remain in the nursing home. After all, the *Act* consistently requires the courts to have regard to the interests of others;<sup>72</sup> there may be circumstances in which the removal of an individual or the closure of an entire home can be justified in the interests of (respectively) the other residents of the home or the viability of other nursing homes operated by the owner. The point is that the *Human Rights Act* requires the court to address the public dimension of the dispute by balancing the interests of others, rather than responding as if it were a matter arising only between private parties to a commercial contract.

What trends do these authoritative cases suggest for rights claims within the New Governance of public services located in market-based systems of reward and incentives? Arguably, they demonstrate that the new framework of rights has become less cohesive and more individualistic, less public and more economic. We have noted the post-War concern with personal insecurity and the need for collective insurance to protect against it. For the theorists of the public domain, such as William Henry Beveridge, John Maynard Keynes, and Richard Titmuss, social needs “take precedence over market wants; the long-term health of the social organism is to be prioritized over the satisfaction of short-term wants through the market mechanism.”<sup>73</sup> Yet this post-War commitment may be undermined by arguments for individualism and freedom from interference. In the U.S., for example, where a culture of individual responsibility for personal welfare is more entrenched, it has been said that

[i]t is as though, by some unspoken consensus, constitutional lawyers, unlike political and moral liberal theorists, have tacitly agreed that American constitutionalism somewhere along the line simply turned its back on the bedrock tenet of both classical and modern liberal theory.... That we should take individual rights seriously, in other words, does not imply that we should not take legislative duties seriously as well.<sup>74</sup>

Should these concerns now trouble the New Governance environment developing elsewhere (especially within the E.U.)? If we continue to value Marshall’s post-War idea of social citizenship, we may need a clearer commitment to preserve it which recognizes the role of public/positive/procedural rights.

#### CONCLUSION

In the E.U., the contradiction between the *political* aspiration to preserve social welfare and the *economic*, market-oriented, fundamental freedoms has been described as a “constitutional asymmetry.”<sup>75</sup> We are all concerned with concepts of social solidarity and the

<sup>71</sup> *YL*, *ibid.* at para. 73. See also Leslie Turano, “Charitable Trusts and the Public Service: The Public Accountability of Private Care Providers” (2007) 18 *King’s Law Journal* 427.

<sup>72</sup> For example, the right to “family and private life” exists “except such as is in accordance with the law and is necessary in a democratic society in the interests of ... the protection of the rights and freedoms of others” (*Human Rights Act*, *supra* note 67, s. 8(2)).

<sup>73</sup> David Marquand, *Decline of the Public: The Hollowing Out of Citizenship* (Cambridge, U.K.: Polity Press, 2004) at 60.

<sup>74</sup> Robin West, “Unenumerated Duties” (2006) 9 *U. Pa. J. Const. L.* 221 at 223, 240. She continues, this Dworkinian drenching of law ... with moralism can likewise limit our moral sense, obfuscate our moral intuition, and dangerously dull our capacity for moral criticism.... And surely, a part of what the Constitution might be faulted for is its understatement with respect to the affirmative moral duties of legislatures (*ibid.* at 253-54).

<sup>75</sup> Fritz W. Scharpf, “The European Social Model: Coping with the Challenges of Diversity” (Max Plank Working

need to protect weaker members of society. Yet economic rights have advanced in ways that favour the (articulate) consumer and those who compete most effectively for market share. Markets react quickly and efficiently to the pressures of supply and demand, but they respond less well to recondite concepts of public interests and the general good. They take a disengaged view of the normative aspirations of equality and solidarity by respecting rights negotiated in a free market. This concept of “market citizenship,” it is said, is “embedded within an ideological paradigm which undertheorizes collective agency and debate and overemphasizes individual choice and models of economic determinism.”<sup>76</sup>

The danger of these approaches is that they undermine a sense of solidarity and social cohesion. In the E.U. context, for example, market citizenship may have developed to engage individuals with the personal benefits of free-market values. But a policy of promoting citizen self-interest will not necessarily generate a sense of allegiance.<sup>77</sup> At the national level, too, if consumerism comes to dominate the concept of social welfare rights, it would not be surprising if patients felt diluted concern for the institutions that provided their care, or for the welfare of their fellow citizens. Perhaps unwittingly, the New Governance ideology undermines traditional concepts of social welfare. Its “consumer orientation directs attention away from the political context. The bright light that is made to shine upon the consumer [casts] a gloomy shadow upon the citizen and the broader consequences of personal choice remain undisclosed in those very same shadows.... This attitude and solidarity do not go well together.”<sup>78</sup> If this view is correct, Marshall’s analysis of the evolutionary forces within the concept of citizenship requires re-evaluation to accommodate a less cohesive, more individualistic notion of the market, or consumer citizen.

Some may say these concerns are overstated; solidarity, after all, is so emotive and intangible and, in any case, people should recognize the limitations of the modern welfare state and become more self-sufficient and independent. Indeed, compared to the allure of individualism, “solidarity begins to appear both ugly and unkind.”<sup>79</sup> But a competitive market implies the existence of winners and losers, and the sections of the population most at risk of a dilution of “community” tend to be the latter. They are likely to be the least articulate, least “popular” groups of patients with limited pressure group support. Elderly, infirm, and disabled (especially mentally disabled)<sup>80</sup> patients are most likely to be left behind. For example, a recent report of the House of Lords on the human rights of older people found “historic and embedded ageism” within the NHS and demanded “an entire culture change in the way that healthcare services for older people are run.”<sup>81</sup> This goes to the root of the modern challenge to social welfare: to reconcile the tendency of market-based incentives to focus on the individual with the culture of social citizenship in order to foster solidarity and social cohesion. Unless we can develop a system of rights capable of recognizing both, the benefit of encouraging “equalization between the more and less fortunate” that Marshall valued so highly is unlikely to thrive as a political value.

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Paper 02/08, Max Planck Institute for the Study of Societies, July 2002).

<sup>76</sup> Root, *supra* note 1 at 152.

<sup>77</sup> “Being instrumentalized, the market citizen had no choice but to become instrumentalist ... Europe ... has given rise only to a self-interested ‘citizen’ whose allegiance to Europe may not simply be taken for granted” (M. Everson, “The Legacy of the Market Citizen” in Jo Shaw & Gillian More, eds., *New Legal Dynamics of the European Union* (New York: Clarendon Press, 1995) at 88).

<sup>78</sup> Stjerno, *supra* note 18 at 338.

<sup>79</sup> Somek, *supra* note 18 at 816.

<sup>80</sup> See U.K., Healthcare Commission, *A Life Like No Other: Specialist Healthcare Services for People with Learning Difficulties in England* (London: U.K. Commission for Healthcare Audit and Inspection, 2007), online: British Institute of Learning Disabilities <[http://www.bild.org.uk/hcc/LD\\_audit\\_report1.pdf](http://www.bild.org.uk/hcc/LD_audit_report1.pdf)>.

<sup>81</sup> U.K., H.L., “Human Rights of Older People in Healthcare”, 156-1 in *Sessional Papers*, vol. 18 (2006-07) at para. 59. See also U.K., Healthcare Commission, *Caring for Dignity: A National Report on Dignity in Care for Older People in Hospital* (London: U.K. Commission for Healthcare Audit and Inspection, 2007), online: Healthcare Commission <[http://www.healthcarecommission.org.uk/\\_db/\\_documents/Caring\\_for\\_dignity.pdf](http://www.healthcarecommission.org.uk/_db/_documents/Caring_for_dignity.pdf)>; David Oliver, “What’s Wrong with the NHS?: Well, If You Are Old or Frail...” (2007) 335 B.M.J. 1059.