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Rights to Health Care

A basic human right to the delivery of health care, even to the delivery of a decent minimum of health care, does not exist. The difficult with talking of such rights should be apparent. It is difficult if not impossible both to respect the freedom of all and to achieve their long-range best interests. Rights to health care constitute claims against others for either their services or their goods. Unlike rights to forbearance, which require others to refrain from interfering, rights to beneficence require others to participate actively in a particular understanding of the good life. Rights to health care, unless they are derived from special contractual agreements, depend on the principle of beneficence rather than that of autonomy, and therefore may conflict with the decisions of individuals who may not wish to participate in realizing a particular system of health care. If the resources involved in the provision of health care are not fully communal, private owners of resources may rightly have other uses in mind for their property than public care….[T]he principles of autonomy and beneficence that lie at the foundations of justice will spawn conflicts within any portrayal of a just allocation of health care resources.

THE LIMITS TO JUSTICE AS BENEFICENCE

These fundamental conflicts between respecting the freedom and achieving the best interests of persons are made worse by commitments to goals that, if pursued without qualification, lead to even more elaborate tensions within any concrete vision of a just health care system. Consider the following four goals that are at loggerheads.

1. The provision of the best possible care for all
2. The provision of equal care for all
3. Freedom of choice on the part of health care provider and consumer
4. Containment of health care costs

One cannot provide the best possible health care for all and contain the cost of health care. One cannot provide equal health for all and maintain freedom in the choice of health care provider and consumer. For that matter, one cannot maintain freedom in the choice of health services while containing the costs of health care. One also may not be able to provide all with equal heath care that is that same time very best care because of the limits on the resources themselves. These tensions spring not only from a conflict between freedom and beneficence, but from competing views of what it means to pursue and achieve the good in health care (e.g., it is more important to provide equal care to all or the best possible care to the least well-off class?)….

JUSTICE AND INEQUALITY

Interests in justice as beneficence are sustained in part because of inequalities among persons. That have some little while others have so much properly evokes

moral concerns of beneficence to provide help for those in need….[T]he moral authority to use force to set such inequalities aside is limited. These limitations are in part due to the fact that the resources one could use to aid those in need are often already owned by other people. One is forced to examine the very roots of inequality to determine whether such inequality and need constitute a claim against those in a position to aid.

THE NATURAL LOTTERY

Natural lottery is used to identify changes in individual fortune that are the result of natural forces, not the actions of persons. It is not used to identify the distribution of natural assets. The natural lottery contrasts with the social lottery, with is used here to identify chances in individual fortune that are not the result of natural forces but the actions of persons. The social lottery is not used to identify the distribution of social assets. The natural and social lotteries together determine the distribution of natural and social assets. The social lottery is termed a lottery, though it is the outcome of personal actions, because of the complex interplay of personal choices. They are both aptly termed lotteries because of the unpredictable character of their out comes, witch do not conform to an ideal pattern.

All individuals are exposed to the brutal vicissitudes of nature. Some are born healthy and by chance remain so for a long life, free of disease and major suffering. Others are born with serious congenital or genetic diseases, others contract serious crippling fatal illnesses early in life, and yet others are injured and maimed. These natural forces, insofar as they occur outside of human responsibility, can be termed the natural lottery. They bring individuals to good health or disease through no merit or fault of their own or others. Those who win the natural lottery will not be in need of medical care. They will live extraordinarily full lives and die painless and peaceful deaths. Those who lose the natural lottery will be in need of health care to blunt their sufferings and, where possible, to cure their diseases and to restore function. There will be a spectrum of losses, ranging from minor problems such as having bad teeth to major tragedies such as developing childhood leukemia, inheriting Huntington's chorea, or developing amyelotrophic lateral sclerosis.

These tragic outcomes, as the blind deliverances of nature, are acts to God for which no one is responsible (unless, that is, one wishes to impeach divine providence). The fact that individuals are injured by hurricanes, storms, and earthquakes is often simply no one's fault. Since no one is to blame, no one can be charged with the responsibility of making those whole who lose the natural lottery on the ground that they are accountable for the harm. One will need a special argument to show that the readers of this [article] should submit to the forcible distribution of their resources in order to provide health care for the individuals injured. It may very well be unfeeling or unsympathetic not to provide such help, but it is another thing to show that one owes such help in a way that would morally authorize state force to redistribute resources, as one would collect funds owed in a debt. The natural lottery creates inequalities and places individuals at disadvantage without creating a straightforward obligation on the part of others to aid those in need.

THE SOCIAL LOTTERY

Individuals differ in their resources not simply because of outcomes of the natural lottery, but also due to the actions of others. Some deny themselves immediate pleasures in order to accumulate wealth or to leave inheritances to others. Through a complex web of love, affection, and mutual interest, individuals convey resources, one to another, so that those who are favored prosper, and those who are ignored languish. Some will grow wealthy and others will grow poor, not though anyone's maleficent actions or omissions, but simply because they were not favored by the love, friendship, collegiality, and associations through which fortunes develop and individuals prosper. In such cases there will be no fairness or unfairness, but simply good and bad fortune. In addition, some will be advantaged, disadvantaged, rich, poor, ill, diseased, or disabled because of the malevolent actions of others. Such will be unfair circumstances, which just and beneficent states should try to prevent and to rectify through retributive justice and forced restitution. Insofar as the injured party has a claim against the injurer to be made whole, not against society, the outcome is unfortunate from the perspective of society's obligations to make the actual restitution. Restitution is owed by the injurer.

When individuals come to purchase health care, some who lose the natural lottery will be able in part at least to compensate for that loss through their winnings at the social lottery. They will be able to afford expensive health care needed to restore health and to regain function. On the other hand, those who lose in both the natural and the social lottery will be in need of health care and without the resources to acquire it.

THE RICH AND THE POOR: DIFFERENCES IN ENTITLEMENTS

If one owns property by virtue of just acquisition or just transfer, then one's title to that property will not be undercut by the needs of the others. One will simply own it. On the other hand, if one owns property because such ownership of goods (e.g., the greatest balance of benefits over harms for the greatest number, the greatest advantage for the least-well-of class), one's ownership will be affected by the needs of others. [There are] reasons why one should suspect that property is in part privately owned in a strong sense that cannot be undercut by the needs of the others. In addition, it would appear that all have a general right to access to the fruits of the earth, if not the universe, which would constitute the basis for a form of taxation as rent in order to provide for fungible payments to individuals, whether or not they are in need. Finally, there are likely to be resources held in common by groups that will need to find reasonable and equitable means for their distribution. The first two forms of entitlements will exist independently of medical or other needs; that last form of entitlement, through the decision of a community, may be conditioned by need.

The existence of any amount of private resources is basis of an inequality among persons. Insofar as one owns things, one will have a right to them, even if others are in need, and even if the taxation as rent on one's resources is far from excessive or onerous. The test of whether one should transfer one's goods to

others will not be whether such a redistribution will prove onerous or excessive for the person subjected to the distribution, but whether the resources belong to that individual. Goal-oriented approaches to the just distribution of resources will need to be restricted to commonly produced and commonly owned goods. Therefore, one must qualify the conclusions of the President's Commission that suggest that excessive burdens should determine the amount of tax persons should pay to sustain an adequate level of health care for those in need.[1] One will need to face a more complicated moral world with three sources of goods for the support of health care.

DRAWING THE LINE BETWEEN THE UNFORTUNATE AND THE UNFAIR

How one regards the moral significance of the natural and social lotteries and the moral force of private ownership will determine how one draws the line between circumstances that are simply unfortunate and those that are unfortunate and in addition unfair in the sense of constituting a claim on the resources of others. Life in general and health care in particular reveal circumstances of enormous tragedy, suffering, and deprivation. The pain of illness and disease and the despair of deformity call upon the sympathy of all to provide aid and give comfort. Injuries and diseases due to the unconsented-to actions of others are unfair. Injuries and diseases due to the forces of natural are unfortunate. As noted, unfortunate outcomes of the unfair actions of others are not necessarily society's fault. The horrible injuries that come every night to the emergency rooms of major hospitals may be someone's fault, if they are not society's. Such outcomes, though unfair with regard to the relationship of the injured with the injurer, may be simply unfortunate with respect to society. One is thus faced with drawing the difficult line between acts of God and acts of malicious individuals that do not constitute a basis for societal retribution and injuries that provide such a basis. Such a line was drawn by Patricia Harris, the former secretary of the Department of Health, Education, and Welfare, when she ruled that heart transplantations should be considered experimental and therefore not reimbursable through Medicaid.[2] To be in need of a heart transplant and not have the funds available would be an unfortunate circumstance but not unfair. One was not eligible for a heart transplant even if another person had intentionally damaged one's heart. From a normal point of view, things could change if the federal government had in some culpable fashion injured one's heart. So, too, if promises of treatment had been made. For example, to suffer from appendicitis or pneumonia and not receive treatment reimbursable through Medicaid would be unfair, not simply unfortunate.

The line between the unfair and the unfortunate can be drawn because it is difficult if not impossible to translate all needs into claims against the resources of others. First it is hard to distinguish needs from mere desires. Is the request of an individual to have his life extended through a heart transplant at great cost and perhaps only for a few years a desire for an inordinate extension of life, or is it a need to be secure against a premature death?...Outside a particular view of the good life, needs to not create rights to the services or goods of others. Finally, there is a certain impracticality in seeing such circumstances as needs that generate claims. Attempts to restore health could indefinitely deplete societal

resources in the pursuit of ever-more incremental extensions of life of marginal quality. A relatively limited amount of food and shelter is required to preserve the lives of individuals. But an indefinite amount of resources can be committed to the further preservation of human life. One is forced to drawn a line between those needs that constitute claims on the aid of others and those that do not.

BEYOND EQUALITY

The line between the unfortunate and the unfair justifies certain social and economic inequalities. In particular, it justifies inequalities in the distribution of health care resources that are the result of differences in justly acquired resources and privileges. To this one must add that the very notion of equal distribution of health care is itself problematic, a point recognized in *Securing Access to Health Care,* the report of the President's Commission.[3]

1. Though in theory at least one can envisage providing all with equal levels of decent shelter and nutrition, one cannot restore all to or preserve all in an equal state of health. Health needs cannot be satisfied in the same way in which one can address needs for food and shelter.
2. If one provided all with the same amount of funds to purchase health care or the same amount of services, the amount provided would be far to much for many and still insufficient for some who could have always used more investment in treatment and research in the attempt to restore them to a level of function that would ensure equal opportunity.
3. If one attempts to provide equal health care in the sense of allowing individuals to select health care only from a predetermined list of available therapy, which would be provide to all so as to prevent the rich from having access to better health care than the poor, one would have confiscated a portion of the private property of individuals and have restricted the freedom of individuals to join in voluntary relationships. That are fortunate in having more resources is neither more nor less arbitrary or unfair than some having better health, better looks, or more talents. If significant restriction were placed on the ability to purchase special treatment with one's resources, one would need not only to anticipate that a black market in health care services would inevitably develop, but also to acknowledge it as a special bastion of liberty and freedom of association.

CONFLITING MODELS OF JUSTICE

We will [now] turn to a comparison of to radically different understandings of what counts as justice in general and what should count as justice in health care in particular: justice as primarily procedural, a matter of fair negotiation, and justice as primarily structural, a pattern of distributions that is amenable to rational disclosure. As examples of these two contrasting approaches, John Rawls's *A Theory of Justice* and Robert Nozick's *Anarchy, State, and Utopia,* will be briefly examined. Rawls presumes that there is an ahistorical way to discover the proper pattern for the distribution of resources, and therefore presumably for the distribution of health care resources. Moreover, he presumes that societally based entitlements are

morally prior to privately based entitlements. Nozick, in contrast, provides a historical account of just distributions. Justice in patterns for the allocation of goods, including health care services, depends on what individual men and women have agreed to do with and for each other. Nozick holds that privately based entitlements are morally prior based entitlements. In contrast with Rawls, who argues that one can discover a proper pattern for the allocation of societal resources, Nozick argues that such a pattern cannot be discovered and that instead one can only identify the characteristics of a just process for fashioning rights to health care….

This contrast between Rawls and Nozick can be appreciated more generally as a contrast between to quite different principles of justice, each of which would have remarkably different implications for the allocation of health care resources.

1. Freedom-based justice is concerned with those distributions of goods made in accord with the notion of the moral community as a peaceable community. It will therefore require the consent of the individuals involved in a historical, cultural nexus of justice-regarding institutions in conformity with the principle of autonomy. The principle of beneficence is pursued within constrains set by the principle of autonomy.

2. Goals-based justice is concerned with the achievement of the good of individuals in society, and where the pursuit of beneficence is not constrained by a strong principle of autonomy. Such justice will vary as one attempts to (a) give each person an equal share; (b) give each person what that person needs; (c) give each person a distribution as a part of system designed to achieve the greatest balance of benefits over harms for the greatest number of persons; and (d) give each person a distribution as a part of a system designed to maximize the advantage of the least-well-off class within conditions of equal liberty for all and of fair opportunity….

[A] market approach maximizes free choice in the sense of minimizing interventions in the free associations of individuals and in the disposition of private property. In not intervening, it allows individuals to choose as they wish and as they are able what they hold to be best for their health care. It makes no pretense at cost containment. Health care will cost as much and will receive as much commitment of resources as individuals choose. The percentage of the gross national product devoted to health care will rise to a level determined by the free choices of health care provides and consumers. If some element of health care becomes too expensive or not worth as much as competing possible expenditure, individuals will engage in cost containment through not purchasing such health care, and its price will tend to fall. Finally, there will be no attempt to achieve equality, though there will be considerable room for sympathy and for the loving care of those in need. A free market economy, through maximizing the freedom of those willing and able to participate, may create more resources than any other system and thus in the long run best advantage those most harmed through the natural lottery. By creating a larger middle class, the market may tend to create greater equality at a higher standard of living and of health care than would alternative systems. Further, charity can at least blunt severe losses at the natural and social lotteries.

Whether one accepts a free market approach will depend on one's moral views regarding (1) the rights of individuals to create free associations, as occur in the market with physician-patient contracts; (2) the moral significance of the natural and social lotteries; and (3) the character and scope of private and communal ownership, as well as one's understanding of (4) the factual circumstances, that is, if and to what extent the market is in the long run the best provider of a high standard of living and of health care. If one holds that individuals and society have an obligation to provide a certain level of health care, which conforms to a particular market and that the obligation overrides rights to free choice and the use of one's property, one will need to abandon market mechanisms either in whole or in part….

A two tired system of health care is in many respects a compromise. On the one hand, it provides at least some amount of health care for all, while on the other hand allowing those with resources to purchase additional health care. It can endorse the provision of communal resources for the provision of a decent minimal amount of health care for all, while acknowledging the existence of private resources at the disposal of some individuals to purchase better care. This compromise character of a two-tiered system can find a number of justifications. The utilitarian may in fact find that this approach maximizes the greatest good for the greatest number because it is a compromise. In allowing free choice while providing some health care for all, the system supports two important human goals and sources of satisfaction (i.e., liberty and wellbeing). A two-tired system can also be justified in Rawlsian terms insofar as health care is to be treated under the difference principle, that is, to the extent it is to be regarded as justly distributed if the distribution redounds to the benefit of the least-well-off class. One would then allow that amount of additional health care to be purchased by the affluent, which would maximize the quality of care for the least-well-off, or the general status of the least-well-off class.

[My] analyses of the principles of autonomy and beneficence and entitlements to property support a two-tiered system of health care. Not all property is privately owned. Nations and other social organizations may invest their common resources in insuring their members against losses in the natural and social lotteries. On the other hand, . . . not all property is communal. There are private entitlements, which individuals may freely exchange for the services of others. The existence of two-tiered system (whether officially or unofficially) in nearly all nations and societies reflects the existence of both communal and private entitlements, of social choice and individual aspiration. A two-tiered system with inequality in health care distribution would appear to be both morally and factually inevitable.

The serious task will be to decide how to create a decent minimum as a floor of support for all members of a society, while allowing money and free choice to fashion a special tier of services for the advantaged members of society. The problem will be to define what will be meant by a "decent minimum" or "minimum adequate amount" of health care….

[T]he concept of adequate care will not be discoverable outside of an appeal to a particular view of the good life and a particular understanding of the charge of medicine. In general, smaller social groups, insofar as they share a common view

of the good life, may be able to appeal to such a vision in order to discover what should count as a decent minimum of health care within that understanding. In nations encompassing numerous communities an understanding of what one will mean by adequate level of health care or a decent minimum will need to be created through open discussion and fair negotiation. In some communities such as the BaMbuti, there may be little commitment of resources to the endeavors of modern health care. For such communities, a decent level of such care will be not care at all. In nations such as United Kingdom, the decent minimum of care may not include hemodialysis over the age of fifty-five or coronaly bypass surgery for any but the most promising candidates for surgical treatment (or at least there are informal ways of discouranging such treatment). For many, such a minimal level of investment may not count as a decent level. But on must remember that one creates through negotiation an amount of health care that becomes de facto the decent amount for the community as a whole, though it always remains open to further critique, discussion, and alteration….

Rights are fashioned in terms of the content given to the duty to be beneficent to those in need. It is in terms of such visions of proper beneficent action that communities join together as nations to fashion large-scale webs of entitlements to health care and thus give content to beneficence through a system of rights to health care delivery. As always, however, particular communities may not wish fully to participate or may wish in various ways to have special health care systems with special rights and entitlements of their own (e.g., one might imagine Roman Catholics arguing that the provision of contraceptive, abortion, and sterilization procedures should not be provided through a national health insurance; on the other hand, one can easily imagine other communities wishing to provide such services through their communal insurance plans).

A web of concrete expectations in thus woven through the endorsement and negotiation of the men and women who constitute moral communities and who span moral communities through undertakings such as large-scale nations. In their weaving of patterns of commitment, they include certain goals and exclude others. Particular systems of health care are particular in choosing certain goals but not others, in ranking some goals higher and others lower. That patients in one system will receive care that they would not in another, that patients who would be saved in one system die for lack of care in another, is not necessarily a testimony to moral malfeasance. It may as well be the result of the different choices and visions of different free men and women. As we have seen, there are limits to our capacity as humans to discover correctly what we ought to do together. We humans must instead settle for deciding fairly what we will do together, when we cannot together discover what we ought to do. Even gods and goddesses must choose to create one world rather than another. So, too, must we.

NOTES

1. President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Securing Access to Health Care* (Washington, D.C.: Government Printing Office, 1983), Vol.1, pp.43-46.

2. H. Newman, “Exclusion of Heart Transplantation Procedures from Medicare Coverage,” Federal Register 45 (Aug. 6, 1980): 52296. See also H. Newman, “Medicare Program: Solicitation of Hospitals and Medical Centers to Participate in a Study of Heart Transplants,” Federal Register 46 (Jan. 22, 1981): 7072-7075.

3. President’s Commission, Securing Access to Health Care, vol. 1, pp. 18-19.