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# A Right to Health Care — Fact or Fiction?

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The notion of a right to health care is a relatively recent concept. The importance of considering such a concept has increased because of changing human experience and parallel societal developments. Ideas on social justice have, at the same time, evolved, reflecting a new and different reality. What medicine can and does do differently than it did 50 or 100 years ago is part of the change. Since the 1970s cataclysmic developments in medical technology as well as radical changes in health care delivery patterns have left much of American society with a tenuous grasp of what they perceive as necessary to assure for them a healthful life. This insecurity is most prevalent among those who, especially when ill, are the most disadvantaged — the poor, the young, the elderly and the marginally employed. In the 1980s, the importance of examining the subject of social justice and health care has become even more crucial because of growing economic influences in health care delivery. In this context, this paper will examine the meaning, track and history, and consider the implications of the term “right to health care”.

There are several ways to approach the question of whether there is a right to health care. A basic distinction might be to examine the question of whether health care is a basic human right, or natural right, such as “life, liberty and the pursuit of happiness”, or whether it is a right coming out of social contract. Rights typically involve the question of entitlement or the right to “something”. Although the rights **language** has its origin in the late Middle Ages, it is not clear at all what the concept of entitlement was like even in the time of Aristotle. Although the language is of relatively recent origin, this does not exclude the possibility that the concept of entitlement and right is an ancient one. It is possible, if we examine the claim to a specific right in contemporary society, that historical changes may have occurred which make it, because of the changes in society, something which

is seen as necessary for the fulfillment of individuals. Because of that, it may now be seen as a basic human right, even though it was not in the past.

### A Clarification of 'Rights'

The topic of rights has been raised, and at this point, a clarification of what is understood by rights is in order. By natural fundamental rights is meant those rights which belong to man **qua man**, and which are included in the words of the Declaration of Independence: "life, liberty and the pursuit of happiness". Some argue that these are the only "fundamental" rights, and that a **fundamental** right is "an inalienable right without which life as a human people would be untenable".<sup>1</sup> Lesser, a physician, contrasts these fundamental rights with "qualified rights", which are derivative rights. He would allow one to exercise these qualified rights only if they did not interfere with other persons' rights. Lesser bases this position on social contract theory. It would appear, however, that our society, at least, does not make even fundamental rights absolute, contrary to Lesser's contention. That is, we condone capital punishment (limiting right to life) and there are certain circumstances under which freedom of speech (for instance, yelling "fire" in the theatre) or liberty (almost all societies accept some degree of imprisonment whether stockades or penitentiaries) are restricted. Even fundamental rights, it would appear, can be qualified in the same way that Lesser's qualified rights are qualified. That is, rights certainly in Western society, appear to be relative and typically modified, depending on the rights and liberty of others.

Although we can consider rights in the context of health care and ask whether they are **natural** human rights, or rights **coming out of a social contract**, there is a second way in which we can examine the subject — by asking whether we are talking about **opportunities** for access, or a "right to obtain" health. That is, is health something to which access must be provided, or is there actual entitlement to health care as a product or resource?

Arthur Caplan has suggested that in the 19th century, except for veterans of the Civil War who were felt to have entitlement because of their military service, there was no general sense of societal obligation to provide health care. Caplan and Jennings<sup>2</sup> describe health care in 19th century America as being "viewed as both a luxury and a personal responsibility". It also should be noted, considering the marginal level of medicine available to most citizens during the 19th century in the United States,<sup>3</sup> that there was little perception of health care as something very desirable. Concern about human rights centered around such questions as slavery, the right to property, freedom of speech, and exploitation of the working man. A living wage, the right to unionize, and humane working conditions were major concerns during the latter part of the 19th century. Until well into the 20th century, the vast majority of health care was delivered by physicians with marginal training, who had little scientific

expertise, and by practitioners of alternative forms of healing, including folk medicine and homeopathy. There was a small professional elite to whom the wealthy had access, but this certainly did not involve, at least in the United States, the larger body of medical practitioners. It might be argued that 100 years ago, given the limitations of the medical profession, universal health care (as we know it today) was **impossible**, hence it was not obligatory. "Ought" implies "can" and therefore the right to health care was not only not sought, but was not possible.

### Papal Statements and Pastoral Letters

The question of whether there is a right to health care was one which I suggest, was not asked a century ago because it was not a meaningful question in our society. That would have indicated that at that time it was not considered a **fundamental** human right. Papal encyclicals are often a reflection of the concerns present in the broader society and can be important historical markers. With that in mind, let us examine some documents covering the last 100 years. In the encyclical *Rerum Novarum* (1891),<sup>4</sup> Pope Leo XIII did talk of rights, but his emphasis was on the importance of property rights. He called for the use of the "power and authority of the law"<sup>5</sup> if working conditions did not provide sufficient opportunity for performing religious duties or resulted in harm to human personality, to morals, or to human dignity. He touched on the subject of health if it became impaired because of "immoderate work." His approach was essentially corrective or retributive where harm was done. If harm had been done, he called on employers for **limited** aid which, he suggested, involved removal of the danger or remedy of the evils. There is no indication that Leo XIII saw any type of positive right involving entitlement to any other types of health care, either from employers or from the government. Leo XIII did express concern for the common good and called for the worker to be "housed, clothed and secure".

The primary emphasis in "Rerum Novarum" was on humane working conditions. The role of institutions or organizations (not the state) is mentioned in the context of "associations for giving mutual aid".<sup>6</sup> The role of "agencies established by the foresight of private persons to care for the worker, and likewise for his dependent wife and children in the event that an accident, sickness or death befalls him . . ." is mentioned. However, "associations of workers" are given "first place" and are compared with traditional guilds of artisans.<sup>7</sup> Leo calls upon the workers to adapt and meet the changing needs, not the state. Rather than giving the state the mandate to provide benefits, the encyclical is concerned with protecting the rights of the workers to form organizations which can provide the benefits.

A series of changes have taken place in the 20th century which are important in evaluating the question of whether health care is **now**, even if it was never before, a right. Prior to the 20th century, it was not a question

to be asked; there was no question of right and therefore none of entitlement. People had access to many alternative modes of care and retained within their own hands much of the control of what they saw as necessary to provide health. Rights did not become a question since there was no desire for entitlement. Rights raise the question of access to resources. When specific resources are virtually universally available, and particularly if their value is relatively low (as grains of sand on the beach), then the question is not one which is posed. Such was the status of health care prior to this century. Everyone was essentially equal in regard to health care which was not considered something dependent on how advantaged one was. To have been given equal access to the benefits available from health care was not perceived as a benefit because of several factors. In part, the ability was freely available (as grains of sand) either in the family or the community. In part, health care was not seen as a benefit or goods on which one placed value, such as they might in humane working conditions or free speech. In part, if it seemed to be a sought-after benefit, it was ranked far below those other rights and benefits including the "offices and positions" which were not open to all.

### **Wealthy's Financial Resources**

For a few wealthy members of society, home visits, servants and access to certain (often harmful) procedures, such as bleeding, were obtainable because of financial resources. Such care was available only to a small segment of the population, and primarily in urban centers. For the vast majority of people, health care was not something controlled by the government (like liberty in the 18th century). It was not like economic opportunities thwarted by 19th century industrialism. It was not, like bread and potatoes, essential for survival. It was not a limited resource which, if one were deprived of it, did not allow for an ordinary existence. For most individuals, health care was not limited by government, the profession or ability to pay. From the 19th century perspective, health care, such as it was, was virtually universally available.

However, when something is perceived as essential to the fulfillment of man, and when there is difficulty in acquisition or retention of it, or when entitlement is not clear, the question of rights can become an appropriate one. The changes which have taken place in the 20th century in American health care have made this an appropriate question. With scientific development, the effectiveness of medicine and its ability to provide significant improvement in health has expanded significantly. With this has come at least a perception, which some would attribute to the institutionalization of health care and the medicalization of many aspects of our life,<sup>8</sup> that health care is now perceived as something necessary for man's fulfillment. Modern media and marketing not only have fostered this perception, but have suggested that without this entitlement, men are impotent, unequal, and not truly capable of fulfillment. There were some

tentative moves, especially by labor unions in the early 20th century, to add health benefits to union contracts, but such an agenda was not generally supported until after the Second World War. In the 1950s, it did become a major plank in liberal political movements. With changes in our culture, man perceives that he cannot provide adequate health care by himself, nor even by the mutual associations which Leo XIII suggested.

Forty years after “Rerum Novarum”, there were major changes both in social conditions and in health care. “Quadragesimo Anno” (1931) is an important next marker in our historical narrative.<sup>9</sup> In this document on social conditions, there is still no specific mention of a right to health care. The document adds few specifics and, in fact, is less explicit on health than “Rerum Novarum”. The document does recognize social changes and an increased role of the state. It indicates that the “function of the rulers of the state . . . is a watch over the community and its part; . . . in protecting private individuals and their rights, chief consideration ought to be given to the weak and the poor.”<sup>10</sup> It identifies new laws “wholly unknown to the earlier time” which are directed to “protect vigorously the sacred rights of the workers that flow from their dignity as men and as Christians. These laws undertake the protection of life, health, strength, family, homes, workshops, wages and labor hazards . . .” The document which updated social concerns still does not speak explicitly of the need to include, in the framework of the social structure, entitlement to health care.

### John XXIII's Encyclical

Some 30 years later (1963)<sup>12</sup> Pope John XXIII issued his Encyclical “Pacem in Terris.” Contained in it was the most forthright papal statement as yet on the right to health care:

The right to life and a worthy standard of living.

11. Beginning our discussion of the rights of man, we see that every man has the right to life, to bodily integrity, and to the means which are suitable for the proper development of life; these are primarily food, clothing, shelter, rest, medical care, and finally the necessary social services. Therefore a human being also has the right to security in cases of sickness, inability to work, widowhood, old age, unemployment, or in any other case in which he is deprived of the means of subsistence through no fault of his own.<sup>13</sup>

The American Catholic bishops, in a pastoral letter of 1981, reaffirmed this position stating:

1. Everyone has a right to adequate health care. This right flows from the sanctity of human life and the dignity that belongs to all human persons . . . . It implies that access to that health care which is necessary and suitable for the proper development and maintenance of life must be provided for all people, regardless of economic, social or legal status. Special attention should be given to meeting the basic health needs of the poor. With increasing limited resources in the economy, it is the basic right of the poor that are frequently threatened first . . .

2. . . . Any comprehensive health system that is developed . . . should use the

cooperative resources of both the public and private sectors, voluntary, religious and profit sectors.<sup>14</sup>

3. The benefits provided in national health care policy should be sufficient to maintain and promote good health as well as to treat disease and disability. Emphasis should be placed on the promotion of health, the prevention of disease, and the adequate protection against environmental and other hazards to physical and mental health. If health is viewed in an integrated and comprehensive manner, the social and economic context of illness and health care must be an important focus of concern and action . . . Public policy should provide incentives for preventive care, early intervention and alternative delivery systems.

The American Bishops emphasized that these and other principles developed in this pastoral letter were based on their "belief in health care as a basic human right", and called for a "national health insurance program", which was seen to be a responsibility of the federal government to establish. It called for the provision of a **basic** level of health care for all Americans. Hence, in some 90 years, the papal encyclicals and pastoral letters on health care had moved from a policy which recognized a need to avoid harm to the health of the worker and a retributive approach to the damages done. They now call for a very broad policy which includes not only a right to health care, but also a call for an entitlement program which the American federal government would have the mandate to undertake as its moral responsibility. The provision of a health care system which would provide for basic or adequate needs, was to be available to all, and would emphasize especially the provision of entitlement for those least advantaged in society. In 1982, Pope John Paul II again insisted on the "primary right of every individual" to have "what is necessary for the care of his health and therefore (a right) to adequate health care."<sup>15</sup>

### Scene Changes

By 1963, the political as well as the health care scene had changed. National health insurance existed in Britain, and in 1964, with a new Democratic Congress, the American Medicare Law was enacted. This law was a reflection of the recognition and distress of the reality faced by people with sickness. They no longer prepared their own remedies and resorted, instead, to physicians and hospitals. This shift in medical care was associated with an alteration in the social and economic relationships of illness. A market economy with a loss of autonomy, necessary or not, results. Charles Fried has commented on the changes and notes that a careful analysis of the notion of a right to health care is crucial:

Nevertheless, it is worth noting that at least in American public discourse, the idea of a right to health care developed into something which had the appearance of inevitability only recently, in what might be called the intermediate, perhaps golden, age of modern medicine. This was a period when advances in treating acute illness, advances such as the antibiotics could really make a large difference in prolonging life or restoring health; but the most elaborate technologies which may make only marginal improvements in situations previously thought to be

hopeless and had not yet been generally developed. In this recent "Golden Age" we could unambiguously afford a notion of a general right to health care because there were a number of clear successes available to medicine, and these successes were not unduly costly. Having conquered the infectious diseases, medical science has undertaken the degenerative diseases, the malignant neoplasms, the diseases of unknown etiology; and one must say that the ratio between expense and benefit has become exponentially more unfavorable. So it is really only now that the notion of a right to health care poses acute analytical and social problems.<sup>16</sup>

We moved from a time (the 19th and early 20th century) when a right to health care was not considered, to a time (the 1950s and 1960s) when it was assumed to be a right. Now we have moved to a time when the concept is questioned. It is questioned now because the entitlement which was, in general, a reality, is now, for many, elusive.

Let us next consider how the foregoing discussion will fit into certain theoretical frameworks of rights and justice. Major contemporary theories of justice include utilitarianism, and those of Robert Nozick, and John Rawls. I will review these theories and relate them both to the encyclicals and to the questions which have been raised about the issue of a right to health care.

### Nozick on Justice

Robert Nozick, a libertarian, argues that the most fundamental element of life in our society is liberty, and that liberty should not be limited except for extremely serious social reasons. He argues that each individual has the right to what he/she possesses as long as he/she has acquired it justly. This acquisition can be by discovering something, by gift, or through exchange. The world he envisions is one in which every individual is free to make use of his/her status in whatever way possible. Although clearly, in Nozick's scenario, the individual must refrain from murder and robbery, he has no obligation to redistribute income or anything else of value to the less needy. One's liberties are inalienable and personal. The state, in this libertarian view, has a very limited role which primarily involves providing protection against unjust appropriation by others. Individuals, voluntarily and out of the goodness of their hearts, might choose to act charitably towards the less fortunate, but they are under no obligation to do so. It follows, under Nozick's theory, that the state has a corresponding limited duty which would not require that citizens be taxed in order to provide special services such as health care to those who are in need.

Nozick does allow for contractual relationships, and if one chooses freely to enter into such an arrangement in which one would agree to give certain benefits to others in return for something, this would be acceptable. Nozick would appear to grant no **right** even to access to health care to other members of the community or even other basic needs such as food, clothing and shelter. If one had the ability to access health care, Nozick would defend the right to retain that ability. Nozick rejects the idea of



“distributive justice” and is concerned with “holdings”. Holdings designate what individuals have lawfully acquired, and because of that lawful acquisition, they have entitlement. The fact of just holding determines just distribution. This approach is in no sense egalitarian.

It is unlikely that Nozick would acknowledge an individual’s right to acquire even “adequate” health care. It is possible that he might extend his ideas to include “very minimal health care” if it were absolutely necessary to ensure life. This might be similar to Nozick’s example of a man who controls a waterhold in a desert. He should not be allowed to deny that lifesaving water to others.

Lesser supports Nozick’s argument with specifics and acknowledges that a parallel in health care would be that “no one should be denied access to penicillin for pneumococcal pneumonia in a time of surplus”.<sup>17</sup> He then compares penicillin with water, as being lifesaving in a very specific situation. Lesser, like Nozick, argues that the “right to health care should be strictly limited to lifesaving, basic necessities”. He argues that restraints comparable to Nozick’s waterhole example should be considered. Lesser, who is a physician, further argues that one should be careful “not to proliferate the concept of rights”. It appears that his concern is the extension of the obligation which would then require someone (presumably health care professionals) to provide a product or service.

### **Don’t Threaten Society**

Lesser, in the language of Nozick, further argues that needs should not be met in such a way as to threaten society. As an example of a situation in which needs should not follow the most qualified rights in contrast to the penicillin, Lesser argues that rehabilitation after a stroke should not be a health care right because it would place a burden or obligation on those who provide the service, and it is not “lifesaving”. The niceties of society such as “better housing, better transportation, safer jobs, better food, and to be more beautiful”, are, in the libertarian view, expecting too much. It is not clear that Nozick would accept even Lesser’s specific example, but their line of reasoning is similar. Looking at the qualifying adjectives which we have seen in the papal encyclicals, the libertarian view is very protective of individual property, but would not extend the concept of justice to provide “adequate or necessary”, but only “lifesaving”, health care and then probably only in the instance that it did not impose a significant, perhaps even measurable, burden on those who would be required to give up something from their resources.

The libertarian view argues strongly for an older historical situation which sees social benefits (such as hospitals, hospices etc.) arising from a sense of charity and compassion rather than from a sense of rights and obligations. It would follow then, under libertarian principles, that either private resources or privately purchased insurance would fund virtually all health care. Those without recourse to either one of these would be

dependent on individuals and institutions functioning on the basis of compassion. Inherent is the premise that sufficient funds would be available in excess of the amount needed to sustain the health care system in a strongly entrepreneurial economic environment. The high cost of maintaining our current health care system without cost shifting to those with considerable wealth, expensive insurance or to governmental entities, makes such a solution virtually impossible to envision. Not only is voluntarism less pervasive than in the past for many social reasons, but it has been altered by institutionalization which often functions in a context of entitlement rather than compassion. Alternative resources available to those in need are considered when services are delivered. Even charitable donations are strongly influenced by potential favorable tax advantages which, in contemporary society, are seen as an entitlement. The libertarian approach to health needs of the less fortunate, which is based on voluntarism, seems unworkable in today's milieu. Some modification which would provide limited catastrophic care (the desert water hole approach) would also seem unworkable since it would exclude preventive and basic health care. Both would remain effectively unattainable for many. Many would flounder in the sands of modern society and die of thirst on the way.

### **Utilitarianism**

The utilitarian argument which in its simplest form argues "for the greatest good for the greatest number", is rooted in the writings of John Stewart Mill. From a policy standpoint, utilitarianism is one which is very attractive in light of the problems of the limits on resources which our society typically allocates to health care. However, in the context of insuring individuals of the right of access to even a minimum, much less the necessary, level of health care, a utilitarian approach does not satisfy principles of social justice laid down, for instance, in either Rawls or the papal encyclicals. The least advantaged may and, typically in our society, do suffer. On the other end of the spectrum, the impact which very expensive procedures have, although not a direct part of the formula, may adversely affect the outcome even for the greatest number. This can occur because if resources are directed into very expensive procedures for a relatively small number without restriction, then the greatest good for the greatest number may not be served. This is, in part, what is happening in our contemporary scene. As more expensive technology and associated costs have concentrated the expenditures on a relatively small number who are either seriously ill or who are affluent, the total allocation to health care after the cost for these procedures is significantly less than if we did not have these procedures. Therefore, the residual resources, or residual good, when reallocated, either becomes too expensive for most individuals or not accessible to them. In practice then, although the United States has, in terms of public policy, tended to follow utilitarian principles, there is

significant stratification of the benefits. This has led people such as Robert Veatch to argue for a distribution of access to health care on the basis of needs.<sup>18</sup>

### Veatch's Proposal

Veatch has developed a theory of medical ethics which he applies to the question of the level of health care which should be given to patients. Veatch lists four principles, two of which are "patient centered" (i.e., user-oriented), and two which operate at the social level. The two patient-centered principles are "patient-centered beneficence" and autonomy. We will use the term "user-oriented beneficence" for the former. These two principles act to benefit the user and allow the user the right of self-determination. For Veatch, paternalistic acts which place constraints on autonomy would be excluded, even if the individual benefitted.

The two principles which operate at the social level are justice and "full beneficence". These principles require that access or distribution be on an equal basis and that the resources be used to do the most good.

Since Veatch's two principles of full beneficence and justice are presumed to be based on rights, it is appropriate to apply them to health care. It follows that consumers of health care should be free to choose from available (or predictable) resources in a manner beneficial to them. According to Veatch's principles, they should be distributed so as to provide an opportunity for equal access and to do the most good. This appears to combine utilitarian principles and preserves the rights of the disadvantaged.

There apparently are not any significant problems in applying Veatch's principles of autonomy and patient-centered beneficence to health care. Although individual agents may thwart autonomy in general, we operate with the principle of autonomy as a general standard of action. Although aberrations may occur in the implementation of patient (user) centered beneficence (particularly adverse reactions and therapeutic misadventure in medicine), the standard is clearly patient-centered beneficence.

(Although it is possible to make a case that a system based on patient-centered beneficence is not feasible in the light of the recent major increase in entrepreneurship in health care, cost considerations are still not the **major** determinant of the standards for **individual** medical interventions. It may be necessary to implement public policy decisions which remove entrepreneurship if a plan such as Veatch's is to work. This, in all probability, would involve a National Health Service.)

As for Veatch's two principles which operate at the **social** level (justice manifest as equal access opportunity and maximum good), it is not apparent that they can be accepted as easily. Determination of the maximum good would seem to require policy decisions which might well deprive some individuals of access. It also might prevent autonomous acts on the part of those individuals who could be excluded on the presumption

that their access (and associated presumed utilization) might prevent application of the maximum good requirement.

It appears feasible to apply three of Veatch's principles to health care. Autonomy, consumer-centered beneficence and equal distribution of access do not appear to conflict. To avoid conflict, it appears that maximum good must be monitored and presumably, it will be limited by available resources allocated.

What happens if we include the concept of limits in the principle of full beneficence? (This presumes a limit on various kinds of resources, so that what is available is in adequate but not limited supply for everyone.) If access to health care is considered in the same context as access to food (when there is abundance), what result does this give?

A special problem in health care is that user expectations often exceed the effectively available (or reasonably affordable) supply.<sup>20</sup> If total expectations are matched by total available resources, then this problem can be resolved. This is a two-sided equation which can be modified by changing either expectations or resources. Applying our social-oriented principles requires a societal allocation of resources which allow equal access to the basic needs. This satisfies the requirement of justice and full beneficence. It does leave problems for autonomy and user-centered beneficence. It would deprive individuals of the access to esoteric resources, in part, perhaps, frustrating their autonomy and limiting their possible benefit. The challenge, of course, is to have user expectations which allow both limits and adequate resources.

Applying the principle of "full beneficence", it seems a reasonable application that procedures and resources in health care should be developed which can do the most good and avoid any type of "elitism."

### **Rawls's Theory of Justice**

The next theory I would like to apply is that of John Rawls.<sup>21</sup> Rawls's theory is based on distributive justice, and has been applied particularly to health care by Norman Daniels.<sup>22</sup> Rawls presents a concept of justice in which fairness is the center, but argues that fairness and justice are not the same. In Rawls's concept, all persons "participating in a practice are affected by it as an equal right to the most extensive liberty compatible with a like liberty for all others", and secondly, that "inequalities are arbitrary unless it is reasonable to expect that they will work out for everyone's advantage, and provided that positions in offices to which they attach or from which they may be gained are open to all". For Rawls, justice involves a triad of liberty, equality, and a reward for service which contributes to the common good. Although health care is not given a special place in society by Rawls, Daniels suggests it clearly occupies, or should occupy, a special place. As noted earlier, this is now true, although it may not have been in the past. This is due to social, medical and economic changes which have taken place in recent years. As Veatch has

argued, the major problem with assigning Rawlsian principles to health care is that the needs are much more diverse for health care than they are for such things as food, shelter and clothing. Illness is not uniformly distributed throughout society. Some people, throughout their entire life, have virtually no need for access to health care, while others may require either extensive health care from birth to death (which may occur in few or many years), and still others may have catastrophic episodes of intermittent major need. Bread, water, vegetables, and the few basic foods may sustain one throughout life; the pattern for food intake is relatively uniform for the vast majority of people, but the distribution of illness and the variety of illnesses is so diverse that no close parallel exists.

It is possible that a Rawlsian approach which recognizes limits is feasible. It may require a modification of expectations of those who seek entitlement, and a restructuring of benefits so that they accrue to the least advantaged (the person in the original position) and not to the entrepreneur. One such system meeting that condition is a national health service.

Health care is a right in the context of our current historical setting. A major dilemma which remains is that under current patterns of care, there is inadequate access to many members of American society. These individuals are typically the least advantaged and often, because of the standing in society, the most needy. It is apparent that neither a libertarian nor utilitarian theory will result in equality of access to basic needs. That access to basic health care is a fundamental right must be recognized. Solutions, even if they require fundamental changes in health care and its delivery, must be found. Justice requires that.

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19. *Ibid.*, p. 33.

20. Drummond et al. have pointed out that in their experience in Canada and the United Kingdom, free market principles do not work in health care. Some of their basic tenets are that human wants are unlimited, but resources are finite and that health care choices involve value judgments. They also notice the arguments that "recent advances in health care have had little impact on life expectancy, compared with improvements in nutrition, sanitation and general economic wealth." They indicate, in passing, that: "Perhaps we have to accept that health is traded, by persons and governments for **other benefits**"; (bold face added). These authors mention fast cars, climbing mountains and cigarettes. (See: Drummond, M. et al., "Health Economics: An Introduction for Clinicians", *Annals of Internal Medicine*, 1987 (07:8892).

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