Health Care in a National Health Program: A Fundamental Right

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Do or should Americans have a right to health care or some appropriate level of it? To explore this difficult and complex question, we must say something about rights and ways to justify them; about considerations which favor a right to health care; about what level and kind of care the right may involve; and about what can be said against such a right. We believe that a right to a decent level of health care should be recognized and enacted in public policy.

RIGHTS

Health Care as a Claim Right

To say that people have a right to have or do something implies that whether they have it or not, or do it or not, is *their choice*; it is up to them. They have a legitimate and strong claim to choose to have or to do. Some rights are best described as "liberties." A person may choose to do something, but others do not necessarily have to allow him or her to do it. For example, a basketball player is "at liberty" to score a basket but the opponent does not have to permit this. Other rights—those we will focus on—are stronger; they are not mere liberties but are claim rights. This means that if a person has such a right, others have a correlative obligation or duty not to interfere. When a basketball player is awarded a foul shot, those on the opposing team may not try to block it—they have a duty to let the player shoot. Our most important legal and constitutional rights are claim rights. I have a right to free speech, which means that neither private parties nor the government may stop my speech.

Health Care as a Positive Right

The right to health care we have in mind, then, is a claim right, a right which is also the basis of duties in others. What are the duties? To answer this, we must distinguish between negative and positive rights. A right is a negative right when the correlative duties of others are duties of noninterference only. Thus my right of free speech is a negative right if the only duty others have with respect to that right is to not interfere with my attempts to speak, to leave me alone to speak as I choose. It is not difficult to respect negative rights. All one has to do is leave other people alone and mind one's own business. Negative rights—to life, to liberty, to the acquisition of property—have historically played a large role in the American political tradition.

Positive rights, on the other hand, require more than noninterference. They require aid; they require that one help others obtain what they have a right to. My right to life is a negative right if not killing me is all that others must do to respect it. But if they must come to my aid when I am in danger of dying, by providing or paying to provide needed health care, then my right is a positive right. Positive rights are sometimes called welfare rights, for they involve positive contributions to the welfare of others. It is not enough simply to leave people alone; one must also help them when they are unable to help themselves.

The social enforcement of both negative and positive rights is expensive, but that of positive rights is usually more expensive. To protect an individual's negative rights, for example, to free speech or security of property, a police force, courts, and prisons are required to deter those who would invade these rights. It is also important for the state to restrain its own tendency to violate negative rights. All this is not cheap, as we know from the cost of the judiciary and the correction system. But though expensive, negative rights are less costly to maintain than positive rights, which require both programs to provide the help mandated by the right and agencies to administer these programs. Since such programs and agencies are funded from tax revenues, they are in reality transfer payments from those who have much to those with little. For this reason, such programs and the positive rights they secure are less popular in the United States than negative rights and the judicial institutions they require.

It is safe to say that the right to health care as a negative right is recognized in this country as part of one's general right to liberty. If you choose to seek medical help and have the money or insurance to

pay for it, no one may stop you. The current issue has to do with health care as a positive right—not only something which people can claim as their due but something which society must provide to those unable to secure it by themselves. The obligation of citizens correlative to this right is that they provide the tax revenues to fund the needed programs. It is this right and set of correlative obligations that we will examine.

Health Care as an Inherent Moral Right

Before concluding this discussion of the nature of rights, it is important that we distinguish legal from moral rights. A right is a legal right when it exists as a matter of law and is enforced by the judicial authorities. A right is a moral right when it exists as a matter of moral principle, when moral reflection and argumentation are the grounds for its validity. A society may fail to give legal recognition to moral rights, as happens in regimes which either deny or do not protect what are generally accepted to be basic human rights. When we argue for a right to health care, we are arguing *both* for health care as a moral right and for its recognition as a legal right.

Within the domain of legally recognized rights one can distinguish those rights which exist prior to policies which secure them, and those which are the creatures of and dependent on policy. Suppose that a policy is thought desirable and enacted into law—for example, the practice of allowing elderly persons to pay only half-fare for public transportation. Once this law is enacted, senior citizens have a valid legal entitlement, a legal right, to pay half-fare for travel. There is, however, no fundamental moral right which existed prior to the enactment of the policy that made its passage morally mandatory. The policy is "a good idea," a desirable way to promote the common good, but not a mandatory demand of justice. The right is therefore the effect of the policy and comes into being only when it is enacted. Such a right is a *conventional* right.

Consider, on the other hand, a right to nondiscrimination in matters of public education. *Brown v. Board of Education* recognized and secured this right, but it seems reasonable to propose that the right preceded Brown. It existed not solely as a result of the policy or practice Brown announced but as the basic *reason* for that legal decision. Let's call such legal rights, which are based on prior moral right, *inherent* rights. The right to health care we wish to defend is an inherent right.

Rights and Self-Respect

Our final general point about rights is that when one has a right to something, one can "stand up and demand it as one's due." One need not beg for it or convince others of its desirability on a case-by-case basis. Receiving the aid to which one has a right is a different thing from receiving aid that has been gratuitously offered as a matter of charity. For this reason, it has been suggested that having rights is importantly connected with self-respect and social status.[1] To be a rights-holder with regard to certain things is to have a social recognition which promotes one's sense of worth and equality with others. A right is thus desirable not only for what is received through its exercise but also for its further effects on securing respect and status.

JUSTIFYING RIGHTS

Claims that people have certain rights require justification. Rights have typically been justified three different ways. The first holds that certain rights are natural and self-evident—basic propositions whose truth everyone is compelled to admit and which require no further defense. The Declaration of Independence invokes such a view when it holds as "self-evident" the truths "that all men are created equal [and] endowed by their creator with . . . inalienable rights" to life, liberty, and the pursuit of happiness. The problem with claims to self-evidence is that people may differ in what they accept as self-evident, and this view provides no grounds for adjudicating among conflicting claims. Further, and more important, there must surely be some reasons why certain things are legitimately demanded as rights and others are not. But this view is silent here.

The second theory remedies this by basing the recognition of rights on their tendency to promote general human well-being. On this *utilitarian* basis, rights are not simply self-evident but are justified by their consequences, their results. Since rights to health care meet urgent human needs, there is reason to think that the recognition of such rights might well be utility-maximizing. But there is a well-known problem of appeals to utility which weakens this argumentative ground. Utilitarian justification relies on the total quantity of human happiness or welfare that a particular system or policy produces, and it chooses that alternative which produces the greatest

[1]For a discussion of this idea, see Joel Feinberg, "The Nature and Value of Rights," *Journal of Value Inquiry* 4 (1970): 243–57.

total amount. The net happiness of each person is added together to achieve a sum total; it is this sum which plays the justificatory role. Utilitarianism is thus not directly concerned with the *distribution* of welfare among people. The distribution matters only insofar as it affects the general total. A system of unequal rights could receive utilitarian preference over equal rights if the improved welfare of those with greater rights under the system outweighs the losses of those with lesser rights such that the total benefit is greater than what a system of equality produces. To defend a right of *equal* access to health care, the utilitarian perspective is inadequate.

The third perspective is, unlike utilitarianism, inherently distributive. Its basic idea is that there are certain individual human interests which are of such fundamental importance to the ability to lead a decent life that *each* and *every* individual person should be able to satisfy those interests. This distributive perspective involves four elements, as follows:

1. First is the claim that people have fundamental interests such as the need for food, shelter, and clothing.

2. Second is the claim that it is a good and desirable thing that people are able to satisfy these fundamental interests. People are happier and lead better lives when they can do so, and it is difficult to deny that this is better than the frustration of such interests.[2]

3. Third is the idea that *if anyone is able to have these interests met, all should be able to do so.* This is an explicitly egalitarian premise, requiring that such interests be satisfied for each and every person, if they are satisfied for any. This differentiates this view from utilitarianism in requiring the satisfaction of the interests and well-being of *each* and *every* individual, not the highest sum total. It is concerned with the human welfare of *each*, not the general welfare of *all.*

4. Fourth, there is the idea that the only way to secure each and every one's fundamental interests is by attributing to individuals both moral and legal rights to the satisfaction of those interests and/or to the means necessary for their satisfaction. To accept these interests as rights makes their satisfaction a matter of particular moral urgency. Such fundamental interests need special defense against two strong opponents: the reality of the social and economic system, which results in some people being unable to satisfy these interests through

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[2]This perspective shares with utilitarianism both the idea that it is a good thing to promote human well-being and the grounding of rights not on self-evident truths but in fundamental interests.

their own efforts, and the legislative enactment of social and economic policies that promote the general welfare at the expense of the poor—for example, by cutting taxes to promote the well-being of the middle classes and the affluent at the expense of social services for those unable to afford them. A socially recognized claim of right counters both tendencies. It underlies a demand that society act positively to correct the vagaries of economic fortune and directs legislation to give priority to the fundamental interests of the least fortunate.[3]

THE RIGHT TO HEALTH CARE AS A RIGHT TO AN ADEQUATE LEVEL OF CARE

While using this scheme to justify a right to health care, we want to make clear that the right to health care we wish to defend and put on a secure basis is not the right to any care anybody might want but *a right to an adequate or basic or decent level of care.* Many people in our society are unable to secure even this level of care.[4] How has this come about? Historically, physicians have been a primary source of health care, and in the past were able and willing to meet the need for health care as a positive right by directly providing uncompensated care to those unable to pay for it. This was, and in many cases still is, a well-accepted and widely practiced obligation of the medical profession. The delivery of health care, however, has changed dramatically during the past thirty years, and physicians are no longer the sole caregivers. Physicians personally account for only 20 percent of actual care delivery. The remainder, although to varying degrees directed by or influenced by physicians, is actually delivered by hospitals, nursing homes, extended-care facilities, home health agencies, and a multitude of other health care organizations and individuals. In many instances, the care delivered by these other entities is directed or influenced by third-party payers (insurance, business, and government) as much as by physicians, or even more so.

Along with the shift in control of health care from physicians to third-party organizations has come a corresponding change in the perception of physicians and other health care professionals about

[3]This way of seeing rights and justice as giving special emphasis to the needs of the least fortunate is firmly defended by John Rawls in his well-known work *A Theory of Justice* (Cambridge, Mass.: Harvard University Press, 1971).

[4]For a chilling description of this, see "Health Problems of Inner City Poor Reach Crisis Point," *New York Times*, December 24, 1990.

their profession(s) and their professional ethics. Many physicians have accepted the premise that health care is a business. Medicine is now operated as a business by large health care corporations managed by highly paid administrators (many of whom are also physicians), and by solo- or small group-practice physicians/small businessmen. The ethics of medicine require that "a physician shall be dedicated to providing competent medical service with compassion and respect for human dignity."[5] The ethics of business are less grounded in respect for human dignity and more concerned with financial survival and success.

This poses a difficulty, in that physicians appropriately recognize that guaranteeing a positive right to health care imposes a specific obligation to be sure that care is provided. When the question then arises concerning on whom the obligation falls to provide that care, the answer is muddled because both practical and financial limits preclude physicians from providing it all, and the "business" managers of health care delivery can provide it only as long as their ability to generate profits and continue operations is not threatened. The best way out of this dilemma is a societal consensus that the obligation to provide the degree of health care for which there is a right should be borne by society in general, including physicians and health care managers, through funding by the government.

But how much health care should government underwrite for all? Given the ever-inherent limitation of financial resources, for example, it is difficult to say that everyone should have an equal right to every expensive health technologic procedure, such as an organ transplant or magnetic resonance imaging scans, when by so doing the resources used in those cases would then not be available to provide more basic or less costly care to a greater number of people. The resolution of this problem is that there should be an "adequate level" or "basic level" of health care to which everyone has a right. Health care services which exceed this basic level would then be distributed as they currently are, on the negative-rights basis that those who are able to afford or provide additional services for themselves will purchase them.

How should this basic level of care be defined? There have been many attempts by interested groups to provide such a definition. These range in scope and underlying motivations from the "ideal" defined in the Organizational Charter of the World Health Organiza-

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[5] *Principles of Medical Ethics* (Chicago: American Medical Association, 1980).

tion, through the Minimum Benefits Plan recently adopted by the American Medical Association (AMA), which defines the maximum amount of worthwhile services that can be funded with a set amount of per-capita expenditures.[6] They include also the Basic Benefits Package outlined with perhaps the most broadly based input by the Health Policy Agenda for the American People;[7] and perhaps the most controversial, the plan currently being developed by the state of Oregon to distribute Medicaid funds more equitably.[8]

Another possible way to define a basic level of care might be to agree that society has a responsibility to provide *needed* care to all members of society, and then prioritize and define the *need* by establishing specific criteria with which to match this responsibility with available limited resources. Criteria for provision would in a sense be society's definition of who are most in need of societal resources, and thus who (or what services) would represent a less urgent use of those resources. The criteria might also be agreed-upon equivalent *needs*. The criteria could be many potential factors. Age or potential longevity could be used, for example, basing decisions on the presumed length of life prolonged in an individual case per unit of resource spent. Various attempts have been made to quantify these factors under such terminology as "Quality-Adjusted Life Years."[9]

An adequate level of health care might also be defined as that which can maximize individual well-being and opportunity to the extent that available resources would allow. Relative individual and societal benefits of the health care service could be incorporated (that is, greater weight placed on immunizations, which benefit the individual *and* the society in general). Such a definition does not limit choices to *all* needed care, or *all* available care but would allow flexibility. What is considered "adequate" could change as additional knowledge develops concerning outcomes or opportunity, or as societal resources available for health care change. The underlying

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[6]American Medical Association Board of Trustees, *AMA's Minimum Benefits Plan*, Report Y (Chicago: American Medical Association, June 1990).

[7]Health Policy Agenda for the American People, *Basic Benefits Package*. Ad Hoc Committee on Basic Benefits (Governor Scott M. Matheson, Chair), June 1988.

[8]"Oregon Puts Bold Health Plan on Ice," *Science* 249 (1990): 468–71.

[9]J. LaPuma and E. F. Lawlor, "Quality-adjusted Life Years: Ethical Implications for Physicians and Policy Makers," *Journal of the American Medical Association* (hereafter *JAMA*) 263 (1990): 2917–21.

consensus that an adequate level of health care should be provided would still remain.

We want to reemphasize that we do not wish to define exactly what an appropriate "adequate" level of health care should be. Quite the contrary, since much of the debate and effort which has historically tried to do so has thus far only impaired the development of a consensus that *any* level of health care is an inherent right. The attitudes of many segments of society (or their representatives) have instead been that unless a basic amount of health care can be defined and agreed upon in advance, they are not willing to accept the responsibility for providing it. We thus reemphasize that our goal is to justify that the inherent right to health care exists. If society can agree that a right to health care exists, then the tone of the ongoing debate changes significantly. It is no longer necessary to struggle with defining specifically that one health care service is a right and another is not (in an endless succession of such services) before being able to agree that there is a right to *any* such service. Rather, the debate can more appropriately and likely more effectively focus on determining whether a particular service improves individual (or societal) well-being or opportunity, and thus can be considered within the overall health care framework as part of "adequate" care. In the case of expensive technology, the debate can also focus on whether the potential for individual well-being or opportunity provided by the service or procedure justifies the expense enough to be considered adequate, or does it, in fact, fall into a realm of "heroic" care. These debates would also be able to change with changing resources and knowledge, while still focusing on whether, considering that change in resource or knowledge, the health care item should still be "adequate" or not.

Similar uncertainties about an adequate level of provision have characterized the public education system without disturbing the consensus which has long existed that education is a fundamental right which society has the obligation to provide for all its members. In actual practice, the amount of public education provided, and the identification of which members of society it will be provided for, have varied (and continue to do so) in response to societal resources and to changing interpretations of need. Most states currently agree that public education must be provided to all children from first through twelfth grades. Some also include kindergarten, based both on a societal recognition of its importance and on available

resources. In the early years of our country's history, secondary education was not felt to be as necessary a right, and thus was not always provided at taxpayers' expense. It has only been in recent decades that the "right" to an adequate level of education has been extended to the developmentally or physically disabled segments of our society, through federal statutes developed by consensus as societal attitudes and resources change. Some states have even recognized a societal responsibility to provide higher education by allowing tuition-free college attendance for in-state residents, as California did through the 1970s. Many states still recognize that responsibility by having lower tuition levels for state residents attending state-supported colleges and universities; but as societal resources have diminished, even in-state residents have had to assume some of the financial burden.

Nevertheless, throughout all these changes in scope, the fundamental consensus has always remained: society has an obligation to provide an education for its members. Few will argue against this premise, although debate will always continue on what the current level of provision for that obligation should be.

JUSTIFYING A RIGHT TO AN ADEQUATE LEVEL OF HEALTH CARE

We return now to an attempt to justify a right to a basic level of care, using the "distributive/utilitarian" scheme discussed earlier. There are strong and persuasive arguments favoring the right to a basic level of care which we believe are generally accepted and not highly controversial. Objections to the right to health care tend to be based on counterarguments; that is, they do not reject the arguments *favoring* the right, but hold, instead, that there are reasons *against* it which are stronger and more weighty. We will therefore dwell only briefly on the reasons favoring such a right and spend the bulk of our time refuting the major counterarguments.

The first strand of our framework for justifying rights involves the claim that people have certain interests whose satisfaction is necessary for them to lead minimally good lives. Defining such interests can be done "subjectively," by identifying interests whose satisfaction is necessary for people to reach a tolerable level of happiness or contentment. Or it can be done "objectively" by reference to what an ideal of the good life [or lives] for humans re-

quires.[10] In either case, it is likely that life itself, adequate nutrition, shelter, the minimizing of pain and suffering, and self-determination will all be considered elements of the good life. Health care thus also becomes an element of the good life, since it is an essential means to achieve or maintain these basic interests. Briefly, health care does or can do the following: save life, restore complete health, bring a person to as healthy a state as is physically possible, prevent ill health, relieve pain, suffering, and distress, restore or secure opportunities, and provide information necessary for exercising informed choice.[11] All these things meet fundamental interests and so it makes sense to think that health care will be an urgent good in any plausible theory of the good life. Of course, not all health care meets such urgent needs. Some forms of therapy, such as some cosmetic surgery, satisfy wants, not needs. That does not vitiate the case for the urgency of much health care. It simply again emphasizes that we must better distinguish what health care can do and secure a right to that "adequate" level of care which meets the most urgent or accepted needs.

Given that health care meets such essential interests, it is also clear—in accord with the second strand of our framework—that widening access to health care will promote the general welfare. But we argue that access to adequate care should be provided to all as a matter of right. This requires appeal to the egalitarian distributive premise that people should be treated equally with regard to basic health care. *Every* individual should be able to secure an adequate level of care. Although a full-scale defense of this egalitarian claim is beyond the scope of this essay, we point out that equality is a deeply held value in our political system. Although it can mean different things, surely most would agree that with respect to the means necessary for meeting our most urgent interests, inequality is acceptable only if there are morally important differences between people that justify the inequality. The most familiar and persuasive reason for inequality is that people *merit* or *deserve* different goods on the

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[10]For an astute discussion of these alternatives, see T. M. Scanlon, "Preference and Urgency," *Journal of Philosophy*, 72 (1975): 655–69.

[11]For a discussion of what health care does for us, see the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Securing Access to Care* (Washington, D.C.: Government Printing Office, 1983). For a view which stresses opportunity see Norman Daniels, *Just Health Care* (Cambridge: Cambridge University Press, 1985) especially chapters 1–3.

basis of positive personal achievements or on the basis of wrongs they have intentionally committed. Thus, high salaries may be rationalized on the basis of superior social contributions, and punishments on the basis of voluntary criminal acts. But surely, with regard to basic health care, the inability of the bulk of those who are unable to secure it by their own efforts is *no fault of their own.* They have not committed a crime or been otherwise irresponsible in such a way that they are no longer deserving of health care. They are simply poor. Thus, the most plausible grounds for inequality do not apply here, and justice seems to demand universal access to this basic good. It seems plausible, further, that the only way such access can be secured is by a legally recognized right to a basic level of care.[12]

Much of what we have argued may seem obvious. But, if so, why is a right to a basic level of care resisted as much as it is in this country? We suggest three reasons for the popular resistance to such a right. The first is a concern about government inefficiency. If government is authorized to secure basic care for all, it will do this inefficiently and ineffectively. Government bureaucracies will grow and red tape will multiply. Tax money will be wasted. Better not to recognize a right to basic health care than increase government ineptitude. These claims, it must be said, are empirical claims, claims about the facts. They may or may not be true and they may be more true in some contexts then in others. They do not vitiate the idea of a universal right to basic health care, but they warn us of the difficulty of developing effective institutions to secure that right. But the right survives this critique.

We would also argue that the economic costs of *not* providing adequate health care may already be a greater burden on society than the costs of providing such care. Evidence is continuing to accumulate, for example, that infants and children are paying a large part of the human costs for inadequate health care. Newborns who are uninsured are more likely to be of low birth weight and malnourished than those who are insured and are consequently more likely to have such adverse outcomes as prolonged hospital stays (including stays in intensive care units), transfer to specialized facilities, and deaths.[13] If the poor and uninsured child is able to overcome or survive its increased likelihood of perinatal morbidity and mortality, it still

[12]See the final paragraph of the section "Justifying Rights," above, for reasons why this interest needs to be recognized as a right.

[13]P. Braveman et al. "Adverse Outcomes and Lack of Health Insurance among Newborns in an Eight-County area of California, 1982 to 1986," *New England Journal of Medicine* (hereafter *NEJM*) 321 (1989): 508–13.

must face an increased risk for childhood trauma, accidental poisonings, tuberculosis, learning disability, mental illness and alcoholism, nutritional deficiency, lead poisoning, anemia, and other chronic illnesses and handicaps.[14]

Many of these problems will require ongoing, acute care as the child grows to adulthood, not just in the health care area specifically but also in education or other social systems. More important, when one recognizes that nearly 40 percent of the estimated thirty to thirty-seven million uninsured Americans are children, the economic consequences of diminished or lost productivity over lifetimes of lost opportunity become tremendous. We suggest that the investment early on in adequate health care will pay returns in later years of improved productivity in the overall society, which more than justifies the initial economic commitments.

The second and perhaps most fundamental reason for resistance to a right to a basic level of care rests on the individualism inherent in American political culture. A right to health care for all can be secured only by transfer payments from some groups to others through taxation. But to many, this transfer violates people's basic property rights, rights to earn what they can through their own efforts and to use what they earn as they please. This objection, then, is on the grounds of liberty. Those who are taxed to provide access to care for others are having their freedom violated, a freedom which must take precedence over the equality demanded by an equal right to care. This libertarian-type argument is, we believe, very persuasive to many Americans who resist a right to a basic level of care; it is a premise implicit in their resistance.

One response to this argument is that the appeal to equality in favor of such a right is more important than the liberty it takes away. But this raises the complex question of the worth of liberty versus that of equality, a question we cannot adequately address here. A more direct objection is, however, possible. A law that prohibits people from doing something imposes a *restriction* on their liberty. If this restriction is unjustified, there is a *violation* of liberty. Not all restrictions are violations. In most countries, for example, driving on the left side of the road is not permitted. This is a restriction that few would see as a violation. Even those most zealous about liberty agree that many other restrictions are not violations; for example, restrictions against injury, force, fraud, and theft do not violate liberty.

[14]D. M. Berwich and H. H. Hiatt, "Who Pays?" (Editorial), *NEJM* 321 (1989): 541–42.

Whether a restriction is a violation depends on whether the restriction is reasonable. The contention that transfer payments to underwrite health care for those who cannot provide it for themselves is a violation of liberty, as opposed to a reasonable restriction of it, requires argument. Merely *saying* that such redistribution violates liberty is *not* providing an adequate argument.[15] On the surface, it does not seem unreasonable to restrict the ability of the members of a society to use their earned income on things they want but do not need in order to fulfill the basic and urgent needs of those too poor to do so for themselves. The appeal to liberty per se does not refute the claim that this is a reasonable and just social aim.

One may respond, however, by arguing that the reasonableness of such a transfer does not show that it is morally required or permissible. A rich person will not act unreasonably if he or she donates half of his or her wealth to a charitable cause, but it does not appear that he or she, morally, *must* do so. Analogously, it might be reasonable and nice if those who can afford basic health care provide it (through taxes) for those who cannot, but must they do so? This question—and its implied negative answer—makes sense only on the assumption that people have a strong claim to their own income, so that transferring some part of it to others is morally problematic. People are typically taken to have this strong claim because they have earned their income through their own efforts, through hard work and the development and effective use of their talents. In other words, people are responsible for their abilities and therefore *deserve* the rewards they bring; and this desert, furthermore, is the basis of their right not to have their wealth "taken" (or even "stolen") to help others, unless there is a morally weighty reason to do so, such as the protection of everyone's security.

This picture of human endeavor raises very complex and fundamental issues of political theory which we cannot do justice to in this space. We simply point out that the picture is problematic because of the highly individualistic idea that people can claim sole responsibility for their efforts and abilities, and thus sole title to the reward these bring. In contrast, an individual's success is often highly dependent on their community and its structure of social and economic institutions. A person could not "strike it rich" through his or her develop-

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[15]Readers familiar with Robert Nozick, *Anarchy, State, and Utopia* (New York: Basic Books, 1974), will rightfully see this criticism as directed at a libertarian theory such as his.

ment and use of talents were it not for the willingness of others to cooperate in the legal, economic, and social institutions which make such rewards possible. Furthermore, one's ability to develop his or her talents depends a good deal on educational support heavily subsidized by the public, and often on family and social circumstances over which a person has had no control. There are also elements of sheer luck frequently involved in how one fares. One is born with the capacity to develop certain talents and not others, and over this one has no choice. Further, and more important for our argument, whether one's talents will be rewarded in the society one happens to be born into is also a matter of chance—frail economic entrepreneurs, for example, would probably not be at the head of the pack in Homeric Greece. And, last but not least, our tastes and values, thoughts and preferences, aims and efforts, are heavily influenced by our society. We are social and interdependent members of communities, heavily dependent on the restraint and efforts of others for our own well-being and social and economic position. From this perspective the idea that much of what we earn results from good fortune and is best used to meet the most basic needs of those in our community who have lost out in this lottery is compelling. Americans may well resist recognizing a right to health care because they resist this community perspective, but in our view, interdependence cannot be justly denied, nor can the implication that justice requires ensuring that everyone's basic needs are met through universal access to health care.

The third reason for resistance to a right to health care has to do with an important feature of positive rights. Negative rights can be respected by leaving people alone. But positive rights require providing people with some good. In a market economy, however, the typical way people come to possess most goods is through earning income through work and buying them. The recognition of a positive right, then, implies giving people certain goods for free. With regard to health care, it means that everyone should be given such care without having to do anything by way of labor to earn it. That this goes against the American grain is obvious. And that is why negative rights are so much more respectable. They do not mean giving people things they have not earned but simply leaving them alone.

This understanding of positive rights, however, is mistaken. Suppose we wanted to guarantee everyone a decent standard of living. The most efficient and natural way to do this would be to have a set of social and economic institutions in which everyone has an opportu-

nity to get a job and earn enough income to live up to that standard. In other words, we can ensure people's positive rights by making it possible for them to earn the wherewithal they need if only they choose to put in a reasonable effort.[16] The problem occurs when those institutions fail to provide every individual with that opportunity. Then some people, through no fault of their own, cannot provide for themselves. It is in this case *and only in this case* that concern for positive rights mandates help. So respect for positive rights does not mean giving people "something for nothing." It means helping those who need help because they cannot help themselves. It means, in other words, benevolence and being a good Samaritan. What we might call the "free-riding" objection is unpersuasive.

THE CONSTITUTIONAL STATUS OF A RIGHT TO HEALTH CARE

At the time of the drafting of the United States Constitution, and during most of the two centuries since, there has been neither a legal nor constitutional presumption that a right to a minimum level of health care services exists. Such a right has not been considered to be an inherent right, and thus is not part of the seventeenth-century political and legal philosophy on which the United States Constitution was based.

One of the widespread movements to establish a nationwide health care system occurred in the mid-1960s. During this time, much discussion was devoted to the concept of a right to a minimal level of health care services, which ultimately led to the establishment of the Medicare program to provide health care for the elderly, and the Medicaid program to provide health care to the poor. Despite that progress, however, there has been very little in the way of litigation or court action which would address the concept of a *legal* right or a *constitutional* right to a minimal level of health care, even to the current time.

The justices of the Supreme Court have held in two separate cases that state and federal legislatures are not obligated to fund abortion services for indigent or poor women.[17] These rulings support current

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[16]This is argued by James W. Nickel, *Making Sense of Human Rights* (Berkeley: University of California Press, 1987).

[17]*Maher v. Roe*, 432 U.S. 464, 1977; *Harris v. McRae*, 448 U.S. 297 (1980).

federal law, which denies Medicaid funding to states for abortion services except in the case of a life-threatening pregnancy.[18] In an additional decision of the Supreme Court, however, Justice Thurgood Marshall made the observation that access to medical care of a nonemergency nature was a basic necessity of life for the poor, equivalent to general welfare assistance.[19]

These decisions served as the foundation for perhaps the most important case heard by the Supreme Court; in that case the plaintiffs forced a direct examination of the issue of a basic entitlement to health care services by bringing suit against a county government under federal civil rights statutes. A patient had experienced severe abdominal pain during her fourth month of pregnancy. She contacted her physician, who instructed her to meet him at the hospital. The patient then dialed the emergency number for ambulance service (provided by the county) and was taken by the ambulance to another hospital, where the county had a contractual arrangement, despite her protestations that she needed to see her own physician at her own hospital. At the hospital where she was taken, there was a long delay before she was seen. After finally being evaluated, she was then transferred to the original hospital where her primary physician was still waiting for her, but by this time it was essentially too late. She was well into premature labor and subsequently delivered a stillborn premature infant.

The woman's attorneys argued that the patient had a constitutional right to medical services provided by her own physician at her own hospital, and the county had interfered with that right by taking her to a different hospital. The United States Court of Appeals for the Eleventh Circuit ultimately ruled, with extensive background justification, that municipalities have no constitutional obligation to provide even the most basic protective services; not only health care, but also police, fire protection, and sanitation. The only exception seen by the Court of Appeals occurs when the municipality has entered into a "special relationship" with the person or persons involved, which results in that person being placed under a substantial degree of forced confinement or in custody of the municipality. Thus, this case established that persons who are in jail or prison, or in police custody in a courthouse or a hospital, are guaranteed basic levels of health care. Everyone else is not. The key element defined by

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[18]"Hyde Amendment," Public Law no. 96–123, sec. 109.

[19]*Memorial Hospital v. Maricopa County*, 415 U.S. 250 (1974).

the court was whether or not there is present "the exercise of coercion, dominion, or restraint."[20]

Two other special groups must be recognized; no legal or constitutional precedent for their right to health care exists, but there appears to be substantial societal consensus that they do or should have such a right. These two groups are military-service veterans, for whom there is a nationwide system of health care, and pregnant females and infants. In the ongoing discussions concerning the establishment or existence of a right to health care, consideration of a constitutional amendment to guarantee such a right must be made. There is precedent for this in constitutions of other Western hemisphere nations.[21] Such an action would surely serve as a means to focus societal consensus to determine if there is indeed agreement over whether this right truly exists. If successful, such an amendment would then again focus the debate (now through court interpretations) on what specifically should constitute "adequate" health care.

CONCLUSION

The shift over the last three decades from medicine as a profession, controlled and practiced by physicians, to medicine as a business, controlled by businessmen (many of whom are also physicians), insurers, and government, has been accompanied by a major change in how medical care is delivered, in how that care is paid for, and in who may have access to that care. It has also been accompanied by a rapidly increasing reliance on high-cost technology, which then generates further expectations and costs by allowing less room for human fallibility in delivering care.

Unfortunately, there is little sympathy or flexibility within a business and high-technology framework for the poor and the disadvantaged. A growing segment of our society have thus been denied access not only to the high-cost health care system but to even a minimal level of care. We have argued that it is time for us as a society to recognize that a right to basic health care exists and that society has an obligation to secure that right. We must refocus our debate not on *whether* health care should be provided to all society members but rather on what the adequate level of health care should be and how we can prioritize our needs and our resources to provide that level of care.

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[20] *Wideman v. Shallowford Community Hospital, Inc.*, 826 F 2d 1030 (1987).

[21] W. J. Curran, "The Constitutional Right to Health Care," *NEJM* 320 (1989): 788–89.