

In the "Readings" section of Ch. 11 we see two essays that support a broad implementation of healthcare in our society. Select one of the essays, by Daniels or Buchanan, for analysis. You must also use our library to find an essay that argues against the positions found in the textbook essay that you select.

For your term paper analyze the essays (one from chapter 11 and the one from your research) and present an argument either for or against universal healthcare based on the arguments and information found in the essays.

The term paper should be 2,000 words. You may select a third essay (from your own research, not the textbook) to include for analysis in your term paper. If you do so, you will get extra credit on the term paper (worth 1/2 of a letter grade on the assignment).

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Dividing Up Health Care Resources

In this land of plenty, many are rich; many are poor. Many are healthy; many are not. Many who are afflicted by disease, disability, or injury can get the health care they need; many cannot— and they suffer and die for its lack. For any sensitive observer (and any decent society), these cold inequalities are surely cause for concern, dismay, even alarm. They also raise ethical questions of the most basic kind. To what are the less fortunate entitled, and what is society obligated to give? Are the needy due only the health care they can afford to buy for themselves, even if they can afford nothing? Or is society obligated to provide more? Is society obliged to provide everyone with access to health care regardless of ability to pay? Or is the claim on society's resources even stronger: Do people have a *right* to health care? If so, to what exactly are they entitled? To a guarantee of a state of well-being equal to that of everyone else? To an equal share of health care resources? To the best health care available? Or to something more modest—a decent minimum amount of health care? And what, exactly, is a decent minimum?

These are moral concerns on a larger scale than most of those we have grappled with in previous chapters. Here we ask not what is right or good in the person-to-person dramas of moral conflict; rather, we ask what is good or right in the policies and actions of society or government. The central issue is: Who should get health care, who should provide it, and who should pay for it? In other words, *what is just?* In the painful, complicated task of dividing up society's health care resources (including medical treatment, disease prevention, emergency care, and public health measures), what does justice demand?

Whatever answer is devised, it must take into account some hard realities. No system can provide maximum health care for everyone; there are limits—sometimes severe—to what any system can provide. Costs restrict how much health care can be delivered and how much can be obtained, and they can rise rapidly enough to destroy the best laid plans for fair access. Moreover, a society's finite resources must be allocated to satisfy many needs besides health care—education, defense, transportation, law enforcement, and others. Some kinds of health care can increase the well-being of more people to a greater degree than others, so considerations of efficiency will have to shape the allocation of resources. And somehow these quantitative factors must be reconciled with freedom of choice. In a free society, this value is paramount and cannot be entirely discarded for the sake of a more rational distribution of health care.

Most careful thinkers on the subject believe that a just apportioning of health care is possible. But how?

health care in trouble

The question is both grave and urgent because the current system for allocating health care is widely believed to be not only unjust but also ineffective and unsustainable. Many claim that, by several measures, it has failed or is failing.

Regardless of their political views, most tend to think that in this free and prosperous nation, all citizens should somehow have access to health care. But many people go without. Health care is so expensive that few can afford it unless they have some type of health insurance, which is itself

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expensive—so expensive in fact that the high cost is the main reason for lack of coverage. In 2010, almost 49 million people under the age of 65 were uninsured, and almost 8 million of those were children. Nearly a third of the under-65 population—almost 90 million people—had no health insurance for at least part of 2006 or 2007.¹ From 2010 to 2014, as the economy improved and the main provisions of the Affordable Care Act (the ACA, or “Obamacare”) took effect, the number of uninsured among people under 65 dropped to 32 million. But the reasons for lack of coverage remain the same: high cost of insurance, the absence of coverage acquired through employment, and ineligibility for public coverage.²

The consequences of going without health coverage are just what you might expect. The uninsured are less likely than the insured to get needed medical treatment, prescription drugs, preventive tests (pap smears and prostate exams, for example), and follow-up care when they do manage to see a doctor. Not

surprisingly, researchers have estimated that the risk of death is 25 percent higher for the uninsured than the insured, resulting in about 18,000 more deaths in 2000 among those aged 25 to 64.³

Traditionally most people under age 65 got health coverage as a benefit of employment, but a smaller percentage of them are now obtaining insurance this way—69 percent in 2000 down to 56 percent in 2011. Fewer employers are offering this benefit, and even when they do, many employees are either not eligible for it or cannot afford to pay their portion of the insurance premium. Over 75 percent of the uninsured are members of families with full-time workers.⁴

People who are age 65 and older and some adults under 65 with permanent disabilities are covered by the public health insurance program known as Medicare. It collects payroll taxes from workers during their employment years and provides coverage when they turn 65, paying many health care expenses including physician and hospital services and prescription drugs. Medicaid, another publicly supported program, covers some under-65 low-income

people including children and the disabled. But coverage varies from state to state and, because of eligibility rules, does not extend to millions of people below the federal poverty level.

Critics of the U.S. health care system point to discrepancies between the huge expenditures for health care and surprisingly low grades on standard measures of national health. According to 2007 data, the country's per capita spending on health care was \$6,102—more than twice as much as the average amount spent by the richest nations in the world. (The list of the richest comprises 30 democracies in the Organization for Economic Cooperation and Development [OECD], including France, Germany, Switzerland, Denmark, Canada, the United Kingdom, Norway, and Japan.) The country coming closest to that level of spending was Luxembourg at \$5,352; Canada spent \$3,326; the United Kingdom, \$2,724; and Japan, \$2,358. Yet in the United States, life expectancy at birth (77.8 years) was lower than the average for the OECD countries (78.6 years) and lower than that of other economically advanced nations such as Canada, France, Japan, the United Kingdom, Switzerland, Iceland, Australia, and Spain. The infant mortality rate in the United States was also higher than the OECD average—6.8 deaths per 1000 live births compared to 5.4. In fact, it was higher than the rate of any of the other developed countries.⁵

Though the United States spends more on health care than any other country, the quality of the care is not obviously better overall than that of other countries. The U.S. system outshines them in some ways, but lags behind in others. For example, it excels in the development and use of medical technologies and has lower wait times for non-emergency surgeries. But it also has higher death rates from medical errors and fewer physicians per capita, and Americans have more trouble getting treated on nights and weekends and obtaining same-day appointments with doctors.⁶ Research shows that for almost half of people who do receive care, that care is inadequate—that is, it does not meet established standards of recommended care.⁷

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Research has established that many minorities have much poorer health and higher mortality than the rest of the population.

At the same time, they are also likely to receive lower-quality health care. According to the Institute of Medicine, “Racial and ethnic minorities tend to receive lower-quality health care than whites do, even when insurance status, income, age, and severity of conditions are comparable.” The CDC’s Office of Minority Health and Health Disparities has detailed many of the differences between the health of minorities and that of others:

Current information about the biologic and genetic characteristics of minority populations does not explain the health disparities experienced by these groups compared with the white, non-Hispanic population in the United States....

- Even though the nation’s infant mortality rate is down, the infant death rate among African Americans is still more than double that of whites. Heart disease death rates are more than 40 percent higher for African Americans than for whites. The death rate for all cancers is 30 percent higher for African Americans than for whites; for prostate cancer, it is more than double that for whites. African-American women have a higher death rate from breast cancer despite having a mammography screening rate that is nearly the same as the rate for white women. The death rate from HIV/AIDS for African Americans is more than seven times that for whites; the rate of homicide is six times that for whites.

- Hispanics living in the United States are almost twice as likely to die from diabetes as are non-Hispanic whites. Although constituting only 11 percent of the total population in 1996, Hispanics accounted for 20 percent of the new cases of tuberculosis. Hispanics also have higher rates of high blood pressure and obesity than non-Hispanic whites. There are differences among Hispanic populations as well. For example, whereas the rate of low birth weight infants is lower for the total Hispanic population compared with that of whites, Puerto Ricans have a low birth weight rate that is 50 percent higher than the rate for whites.
- American Indians and Alaska Natives have an infant death rate almost double that for whites. The rate of diabetes for this population group is more than twice that for whites. The Pima of Arizona have one of the highest rates of diabetes in the world. American Indians and Alaska Natives also have disproportionately high death rates from unintentional injuries and suicide.
- Asians and Pacific Islanders, on average, have indicators of being one of the healthiest population groups in the United States. However, there is great diversity within this population group, and health disparities for some specific segments are quite marked. Women of Vietnamese origin, for example, suffer from cervical cancer at nearly five times the rate for white women. New cases of hepatitis and tuberculosis also are higher in Asians and Pacific Islanders living in the United States than in whites.
- From The National Academies, “Minorities More Likely to Receive Lower-Quality Health Care, Regardless of Income and Insurance Coverage,” 20 March 2002, <http://www8.nationalacademies.org/onpinews/newsitem.aspx?RecordID 10260> (14 June 2008); CDC, Office of Minority Health & Health Disparities, “About Minority Health,” 6 June 2007, <http://www.cdc.gov/omhd/amh/amh.htm> (14 June 2008).

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Fact File U.S. Health Care

- In 2014, 32 million Americans under age 65 had no health insurance; in 2013, the uninsured rate for this group was 16.7%.
- In 2014, 48% of uninsured adults said the main reason they were uninsured was because the cost was too high.
- Enrollment in ACA (Affordable Care Act) coverage corresponds with large declines in the uninsured rate. Between 2013 and 2014, the uninsured rate dropped significantly, from 16.2% in the last quarter of 2013

to 12.1% in the last quarter of 2014. Declines have continued into 2015, with preliminary data indicating an uninsured rate of 10.7% in the first quarter of 2015.

- Many people do not have access to coverage through a job, and some people, particularly poor adults in states that did not expand Medicaid under ACA, remain ineligible for public coverage.
- In 2014, over 80% of uninsured people were in a family with a worker.
- In 2010, there were almost 8 million uninsured children—over 10 percent of all children.
- According to data published in 2007, per capita spending on health care in the United States
- was \$6,102; in Canada, \$3,326; and in the United Kingdom, \$2,724.
- Infant mortality in the United States was 6.8 deaths per 1,000 live births, higher than that of all
- other developed countries.
- Almost half of the health care that people receive in the United States does not meet
- established standards of recommended care.
- From Kaiser Family Foundation, “Key Facts about the Uninsured Population,” 5 October 2015, <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/> (3 November 2015); the Kaiser Commission on Medicaid and the Uninsured, “The Uninsured: A Primer,” Kaiser Family Foundation, October 2010, <http://www.kff.org/uninsured/7451.cfm> (21 March 2008); the National Coalition on Health Care, “Health Insurance Coverage,” the National Coalition on Health Care, undated, 2008, <http://www.nchc.org/facts/coverage.shtml> (21 March 2008); Organization for Economic Cooperation and Development, OECD Health Data 2007, July 2007, <http://www.oecd.org> (27 March 2008); E. A. McGlynn et al., “The Quality of Health Care Delivered in the United States,” *New England Journal of Medicine*, vol. 348, no. 26 (2003), pp. 2635–45; S. Asch et al., “Who Is at Greatest Risk for Receiving Poor-Quality Health Care?” *New England Journal of Medicine*, vol. 354, no. 11 (2006), pp. 1147–56.

In the United States most health care is allocated through **managed care**, a system for providing care to a particular group of patients (members of the system) using regulatory restraints to control costs and increase efficiency. People who enroll in a managed care plan—such as a health maintenance organization (HMO) or a preferred provider organization (PPO)—get health care at discounted prices from the plan’s network of providers (physicians, hospitals, etc.). Managed care plans try to control costs by influencing the kind and amount of care that providers offer and by restricting the choices that members have. Though

cost control and efficiency are laudable goals, many critics worry that they are at odds with patient welfare. The concern is that for the sake of economical medicine, providers may cut corners, decide not to order necessary tests, pay less attention to patients’ needs, or refuse to treat certain serious health problems. Some charge that managed care as it is currently practiced forces physicians to try to serve both the patient and organizational efficiency, an impossible task that weakens the patient’s trust in the physician.

In 2010 this troubling picture of American health care began to change with President

Barack Obama’s signing into law of the Patient Protection and Affordable Care Act (ACA). It was an attempt to provide health coverage to many more Americans and to contain the insidious rise of health care costs. Getting the law through Congress was a wrenching ordeal of high-stakes partisan brawling that seemed to arise largely from diverging answers to fundamental philosophical questions: What duties does the state have towards its citizens? How much should the state do to ensure the well-being of its people? What benefits do citizens have a right to expect from a government that’s supposed to “promote the general welfare”?

Here's a rundown of the legislation's major provisions summarized by a nonpartisan foundation:

- Most individuals will be required to have health insurance beginning in 2014.
- Individuals who do not have access to affordable employer coverage will be able to purchase coverage through a health insurance exchange with premium and cost-sharing credits available to some people to make coverage more affordable. Small businesses will be able to purchase coverage through a separate exchange.
- Employers will be required to pay penalties for employees who receive tax credits for health insurance through the exchange, with exceptions for small employers.
- New regulations will be imposed on all health plans that will prevent health insurers from denying coverage to people for any reason, including health status, and from charging higher premiums based on health status and gender.
- Medicaid will be expanded to 133 percent of the federal poverty level (\$14,404 for an individual and \$29,327 for a family of four in 2009) for all individuals under age 65.
- The Congressional Budget Office estimates that the legislation will reduce the number of uninsured by 32 million in 2019 at a net cost of \$938 billion over ten years, while reducing the deficit by \$124 billion during this time period.⁸

The provisions of the law are to be implemented over the next few years. In the meantime it has been repeatedly challenged in the federal courts, and the partisan divide over it remains as wide as ever.

In 2012, in the case of *National Federation of Independent Business v. Sebelius*, the Supreme Court held that the ACA was constitutional but that states could opt out of the law's requirement to expand Medicaid. In 2014 the Court ruled that under the law, employers with religious objections are not required to cover contraceptives. In 2015, the Court upheld the legality of the ACA's mandate to provide health insurance subsidies to all qualifying Americans.

theories of justice

All these difficulties bring us around again to the question of what is just. Justice in the most general sense refers to people getting what is fair or what is their due (see Chapter 1). At the heart of every plausible notion of justice is the principle that equals should be treated equally—that people should be treated the same unless there is a morally relevant reason for treating them differently. When we ask what justice demands in society's allocation of health care, we are dealing with matters of **distributive justice**—justice regarding the fair distribution of society's advantages and disadvantages, or benefits and burdens, including income, property, employment, rights, taxes, and public service.

Debates about ethical allocations of health care resources rely heavily on general theories of justice. To justify a particular scheme of allocation, philosophers, politicians, and others may appeal to a theory of justice, and those who criticize the scheme may do so by arguing against that underlying theory of justice or by offering an alternative theory they believe to be superior. Three types of theories have had—and continue to have—an enormous impact on the discussions: libertarian, utilitarian, and egalitarian.

According to **libertarian theories of justice**, the benefits and burdens of society should be

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Overall, how would you rate the quality of health care you receive—as excellent, good, only fair, or poor?

Do you think it is the responsibility of the federal government to make sure all Americans have health coverage, or is that not the responsibility of the federal government?

Is Is Not 45% 52%

Gallup Poll, November 6–9, 2014; adults nationwide.

Do you approve or disapprove of the health care law called the Affordable Care Act?

Approve Disapprove 47% 44%

CBS News/*New York Times* Poll, June 10–14, 2015, adults nationwide.

fit. The libertarian would accept a system of health care only if it is freely endorsed and financed by those who participate in it. So health insurance acquired through free choice by a group of private citizens to meet their own health care needs is acceptable. State-supported health insurance financed by taxes is not. But none of this would rule out voluntary charity by well-off citizens to provide health care for the poor.

In **utilitarian theories of justice**, a just distribution of benefits and burdens is one that maximizes the net good (utility) for society. Some allocations (or principles of allocation) of society's resources are more beneficial overall than others, and these are what utilitarian justice demands. A utilitarian may grant some principles of allocation the status of rights—rules that can be enforced by society and that can override considerations of utility in specific situations. But the ultimate justification of the rules is utilitarian (actually, rule-utilitarian): Consistently following the rules may maximize utility generally, although

Excellent Good 35% 44%

Only Fair
15% 5%

Poor

Gallup Poll, November 6–9, 2014; adults nationwide.

Most urgent U.S. health problem:

Access Costs Government Obesity Cancer

Involvement

24% 19% 10% 14% 12%

Gallup Poll, November 6–9, 2014; adults nationwide.

distributed through the fair workings of a free market and the exercise of liberty rights of noninterference. The role of government is to protect the rights of individuals to freely pursue their own interests in the economic marketplace without violations of their liberty through coercion, manipulation, or fraud. Government may use coercion, but only to preserve liberty. Beyond these protections, the government has no obligation to adjust the distribution of benefits and burdens among people; the distribution is the responsibility of free and autonomous individuals. People may have equal rights or equal worth, but that does not entitle them to an equal distribution of society's benefits. The government acts unjustly if it coercively redistributes those benefits.

On this view, no one has a right to health care, and a government program using tax dollars to provide universal health care or even health care only for low-income families would be unjust. Such a program would be a coercive violation of people's right to use their resources as they see

rule adherence in some instances may not produce a net good.

On a utilitarian view, a just allocation of health care can take several forms depending on the facts about society's resources and needs and the likely effects of various allocation policies and programs. Thus, depending on calculations of net benefits, a utilitarian might endorse a system of universal health care insurance, or a qualified right to health care, or a two-tiered plan (like the U.S. arrangement) in which government-supported health insurance is combined with the option of privately purchased health coverage for those who can afford it.

Egalitarian theories of justice affirm that important benefits and burdens of society should be distributed equally. To achieve greater equality, the egalitarian (unlike the libertarian) would not be averse to mandating changes to the distribution of society's goods or to interfering in the workings of a free market. And the egalitarian (unlike the utilitarian) would not allow utility to be the ultimate overriding consideration in a system of distribution. From egalitarian premises, theorists have derived several schemes for allocating health care, including systems that give equal access to all legitimate forms of health care, that offer a guaranteed minimal level of health care for everyone, or that provide care only to those most in need.

Besides these familiar theories of justice, there is another entirely different perspective on justice and health care: the *human rights approach*. The idea is that we can best achieve just distributions of health and health care by ensuring that human rights in general are respected. Respecting human rights (which encompass fair treatment, freedom from coercion, nondiscrimination, protection from abuse, equality, and other entitlements) contributes to well-being and health (including access to health care), and these positive contributions to health depend on respect for human rights. According to proponents of this view,

Health and human rights are not distinct but intertwined. Viewed as a universal aspiration,

the notion of health as the attainment of physical, mental, and social well-being implies its dependency on and contribution to the realization of human rights. From the same perspective, the enjoyment by everyone of the highest attainable standard of physical and mental health is in itself a recognized human right. From a global normative perspective, health and human rights are closely intertwined in many international treaties and

declarations supported by mechanisms of monitoring and accountability (even as their effectiveness can be questioned) that draw from both fields.⁹

a right to health care

No matter what theory of justice people accept, they are likely to agree that it would be good for everyone to have adequate health care, or that beneficence may justify society's providing health care to the neediest, or that making particular kinds of health care available to certain groups may produce a net benefit for society. But some assert a much stronger claim: People have a moral *right* to health care. A right is an entitlement, a bona fide claim, to something. A person's rights impose duties on others—either (1) duties not to interfere with that person's obtaining something or (2) duties to help that person in her efforts to get something. Rights entailing the former obligations are called *negative rights*; those entailing the latter are called *positive rights*. Those who insist that an individual has a right to health care are referring to a positive right and are claiming that society has an obligation to provide that benefit in some way.

Libertarians are likely to deny that there is a right to health care, for generally they accept negative rights and disallow positive rights. Utilitarians can admit a right to health care, though it would be what some have called a *derivative right*, a rule ultimately justified by assessments of utility. Others, including egalitarians, can accommodate a right to health care and interpret it in the strong sense of being an entitlement that

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ultimately outweighs calculations of maximized utility.

But what reasons are there for believing that there is such a strong right to health care? Norman Daniels believes that such a right can be derived from one of the principles of justice articulated by John Rawls, specifically the right to "fair equality of opportunity."¹⁰ Rawls maintains that everyone is entitled to an equal chance to obtain the basic goods of society, though there is no guarantee of an equal share of them (see the discussion of Rawls' theory in Chapter 2). A just society would ensure equal opportunities to its citizens. Daniels argues that disease and disability diminish people's "normal species functioning" and thus restrict the range of opportunities open to them. But "health care in all its forms, whether public health or medical, preventive or acute or chronic, aims to keep people functioning as close to normally as possible....Health care thus preserves for us the range of opportunities we would have, were we not ill or disabled, given our talents and skills."¹¹ Since people are entitled to fair equality of opportunity, and adequate health care can protect or restore their normal range of opportunities, they have a positive right to adequate health care.

A pivotal question that confronts every serious advocate of a moral right to health care is what health care resources it includes. Some have thought the right encompasses universal equal access to all available health care resources. But this arrangement is not technically or economically feasible; a right to health care, it seems, must have limits. Recognizing this, many have argued for a weaker right to a "decent minimum" level of health care. On this view, everyone would have access to a minimal, basic array of health care resources. This tier of care would be universally available, publicly supported, and guaranteed for all in need. A second tier of additional health care services (elective or nonessential therapies, for example) would be available in the free marketplace for those who can afford them.

Allen Buchanan rejects the idea of a right to a decent minimum of care, but he understands its attractions:

First, the notion that people have a right to a decent minimum or adequate level, rather than to *all* health care that produces any net benefit, clearly acknowledges that, because not all health care is of equal importance, allocational priorities must be set within health care and that resources must also be allocated to goods other than health care. Second, this [decent minimum] position is also consonant with the intuitively plausible conviction that our obligations to the less fortunate, although fundamental enough to be expressed in the language of rights, are nonetheless *not unlimited*. Third, the decent minimum is a floor beneath which no one should be allowed to fall, not a ceiling above which the better-off are prohibited from purchasing services if they wish.¹²

But the implications of the decent-minimum standard have been extremely difficult to specify in a plausible way. What is, after all, a *decent minimum* of health care? We may assume it includes such things as immunizations, annual physical exams, and “routine” medical care. Should it also include heart transplants, treatments for rare or orphan diseases, cosmetic surgery, expensive but marginally effective care for very elderly or dying patients, and costly lifelong therapies for mentally impaired persons who will never reach “normal” functioning?

Buchanan believes that although there is no right to a decent minimum of health care, there are good reasons for supposing that society should nevertheless provide the kind and amount of health care that a decent-minimum right would demand. That is, there is no individual right, but there may be a societal duty. Among these reasons are arguments that people have special rights (as opposed to universal rights) to health care—rights of restitution to certain groups for past wrongs, rights of compensation for “those who have suffered unjust harm or who have been unjustly

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Public health is bioethics on a large scale. Most of the time bioethics concerns ethics as it applies to individuals and personal morality, but it also encompasses morality as it pertains to the health of whole populations. This is *public health*. It focuses on communities, from neighborhoods to countries to the world, working to prevent disease and disabilities, promoting health and well-being, tracking the incidence of illness, and intervening when the health of a community is imperiled.

Public health involves agencies of the government but also many professionals and nonprofessionals in the community. It can function locally, nationally, or globally. Public health programs provide vaccinations, promote healthful habits such as handwashing and not smoking, guide the treatment of wastewater, distribute condoms to prevent the spread of sexually transmitted diseases, help insure the safety of food and water, investigate pandemics and other disease outbreaks, provide early warning of emerging public health hazards, prevent epidemics after natural disasters, and much more.

exposed to health risks by the assignable actions of private individuals or corporations,” and rights to health care for honorable service to society (for wounded soldiers, for instance). There are also prudential arguments, Buchanan says, such as that “the availability of certain basic forms of health care make for a more productive labor force or improve the fitness of the citizenry for national defense.” Arguments for what he calls “enforced beneficence” can also be made out. To maximize the practical

effect of our moral obligations of charity or beneficence regarding health care for those in need, “an enforced decent minimum principle is needed to achieve coordinated

Public health ethics, like any other area of applied ethics, deals with the application and reconciliation of moral norms. The same moral principles and concepts that inform the whole field of bioethics also do work in the subfield of public health. In public health, we still must strive to respect autonomy, avoid harming others, act with beneficence, maximize utility, behave justly, protect privacy and confidentiality, deal honestly with others, and keep promises. The proper balancing of these demands— a job that falls to both professionals and ordinary citizens—is often difficult and controversial. Implementing these ideas is a separate job that is frequently even more challenging.

Moral norms can conflict in public health ethics just as they do in personal ethics. Suppose public health officials quarantine or treat a man against his will because he has contracted a deadly communicable disease. Here respect for the man’s autonomy clashes with the need to protect the public from harm. In other cases the need to protect the public might conflict with people’s right to privacy or with fairness or with confidentiality. Suppose the state mandates that all adults must be vaccinated against a lethal, spreading infection. A key issue is whether the government is wrongfully infringing on the population’s personal liberty. Disputes like these can (and do) happen in nearly every public health endeavor, and disagreement is frequently widespread.

joint effort.”¹³ Thus, for example, the government could levy taxes to provide health care to the poor—not in the name of egalitarian justice, but for the sake of beneficence.

the ethics of rationing

Rationing has been a dirty word in debates about health care, laden as it is with images of extreme measures of last resort for managing a dearth of resources. But in health care, rationing—in the broad sense of parceling out important limited goods—has always been with us and probably always will be. People’s health care needs are

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virtually boundless, yet the supply of health care resources is ever limited. So we ration: Medicare and Medicaid allot health care to the elderly and the poor; HMOs limit medical procedures, tests, and access to doctors to control costs; hospitals restrict the use of intensive care units (ICUs), cardiac surgical teams, emergency departments, hospital beds, and expensive drugs; organ transplants are doled out to the few because of shortages of usable organs; and the health care system as a whole rations a great deal of care by people’s ability to pay for it.

Thus the tough choices of rationing fall hard upon us, and we are forced to ask: Who should get what share of limited health care goods and services? In countless troubling instances, the question reduces to this: Who should live and who must die? In nearly the same breath we have to ask: On what ethical grounds do we make these choices? The fundamental issue of the proper allocation of insufficient resources troubles on several levels at once. It arises both on the scale of the total health care system (concerning what portion of society’s resources should go to health care and how this allotment should be used—so-called *macroallocation*) and on the scale of individual patients and providers (regarding who should receive specific resources— known as *microallocation*).

Let's consider just a few of the smaller scale (microallocation) questions raised by one of our scarcest life-saving resources—organ transplants. Transplant operations are incredibly expensive, organs are in very short supply, and transplants are desperately needed by far more people than can be accommodated. The waiting list for transplants is long, and thousands die every year for their lack. Screening committees at transplant centers decide whether someone should be placed on the waiting list and what ranking they should receive. They use various criteria to make these decisions, some explicit, some informal or unspoken, some plausible (such as the patient's need and likelihood of benefit), and some controversial (such as ability to pay, social worthiness, and health habits).

But what criteria *should* be used? What rationing policy for transplants is morally justified? Many proposed criteria are utilitarian, concerned with maximizing benefits to the patient and society. Many are egalitarian, focusing on justice and the moral equality of persons. Some philosophers propose rationing policies that emphasize one or the other, while some try systematically to accommodate both.¹³ No policy is completely satisfactory, but some seem to capture our moral intuitions better than others.

One utilitarian approach to rationing care to patients is to measure objectively the benefits that a treatment is likely to give each patient, then selectively treat particular patients or conditions to maximize total benefits. The objective measure of benefits that has often been used in such calculations is known as QALY, or quality-adjusted life year. One QALY is equivalent to one year of life in good health, and a year of life in poor health is equal to less than 1 QALY. The lower the quality of life for a person in poor health, the lower the QALY value. A transplant operation that allows a patient to live seven years without disability or suffering is worth 7 QALYs; if it results in the patient's living seven years burdened by severe pain, it is worth less than 7 QALYs. Thus QALYs gauge a treatment's impact by, plausibly, trying to take into account both the length of life and its quality. Intuitively this seems right because both quality of life and length of life matter to people. Most would probably rather enjoy a few years of good health than suffer through many years of terrible illness or disability. Suppose, then, that three people are awaiting heart transplants, without which they will die within six months, and only two transplants are possible. Two of the potential recipients are young, so a transplant for either one of them would yield 10 QALYs. The third person is much older; a transplant for her would yield only 5 QALYs. So a transplant selection committee using the QALY standard alone would likely allocate the available transplants to the two younger patients, maximizing total benefits.

The utilitarian purpose behind using QALYs is to do the most good with the resources available. But critics have charged that relying on QALYs to allocate or ration health care can lead to morally unacceptable decisions. John Harris argues, for example, that QALYs discriminate against older people:

Maximizing QALYs involves an implicit and comprehensive ageist bias. For saving the lives of younger people is, other things being equal, always likely to be productive of more QALYs than saving older people. Thus on the QALY arithmetic we always have a reason to prefer, for example, neonatal or paediatric care to all "later" branches of medicine. This is because any calculation of the life-years generated for a particular patient by a particular therapy, must be based on the life expectancy of that patient. The older a patient is when treated, the fewer the life-years that can be achieved by the therapy.¹⁴

QALYs, he says, are also unfair to the disabled:

Suppose for example that if an accident victim were treated, he would survive, but with paraplegia. This might always cash out at fewer QALYs than a condition which with treatment would give a patient perfect remission for

about five years after which the patient would die. Suppose that both candidates wanted to go on living as long as they could and so both wanted, equally fervently, to be given the treatment that would save their lives. Is it clear that the candidate with most QALYs on offer should always and inevitably be the one to have priority? To judge so would be to count the paraplegic's desire to live the life that was available to him as of less value than his rival's.¹⁵

Harris and others contend that a crucial failing of QALYs is that these objective measurements cannot accommodate the subjective nature of people's assessments of the value of their own lives. A paraplegic may value his life and think its quality extremely high despite his disability. A perfectly healthy person may think her life

miserable despite a lack of physical ailments. The subjective valuation seems to be the important one; the objective measurement seems to be beside the point.

Policies for rationing transplants to a particular group of patients generally try to take into account the probability of transplant success or the urgency of the patients' needs. Both factors can be morally relevant. Regarding the former, because transplants are a scarce resource, fairness seems to demand that they be given to those who are likely to benefit from them—otherwise the resource will be wasted, and people will be deprived of a treatment that could have saved them. Regarding the latter, giving transplants to those who cannot survive for much longer without them fulfills a duty to preserve lives.

Nevertheless, some maintain that allocating resources in light of one of these considerations while disregarding the other is a mistake:

For example, although heart-transplant surgeons sometimes list their patients as urgent priority candidates for an available heart because the patients will soon die if they do not receive a transplant, some of these patients are virtually certain to die even if they do receive the heart. High quality candidates are passed over in the process. A classification and queuing system that permits urgent need to determine priority exclusively is as unjust as it is inefficient.¹⁶

Neither probability of success nor urgent need seems to be as controversial as another kind of criterion: the *social value* of people's lives. Here the question is which potential recipients—if given the chance to live—are expected to contribute most to the good of society. To state the issue concretely: All things being equal, should the medical student get the transplant instead of the poet or prostitute? Nicholas Rescher thinks this question of social utility important and morally relevant:

In "choosing to save" one life rather than another, "the society," through the mediation of the particular medical institution in question— which should certainly look upon itself as a

Christine deMeuriers

The era of managed care has changed health care in the United States radically—for the worse, many say. Whatever the case, it has surely set off a host of

California. They got the insurance through their employer (they both were teachers at the same school) and had opted for the least expensive coverage.

conflicts that were previously unimagined: clashes between patients and their insurance companies, between physicians and their cost-conscious managed care employers, and between the physicians' duty to put the patient's welfare first and the economic incentives to put it last. Out of this maelstrom many unsettling stories have come, including this one.

In 1992 Christine deMeurers—a 32-year-old wife, mother of two, and schoolteacher—found out that she had breast cancer. She fought back promptly and aggressively, enduring a radical mastectomy, radiation therapy, and chemotherapy. But in May 1993, a bone scan revealed that the cancer had spread and now rated the ominous label of Stage IV metastatic breast cancer. Every standard therapy available had been used against her disease with no apparent effect. She was running out of time.

Christine and her husband, Alan, were subscribers in an HMO, Health Net of Woodland Hills,

trustee for the social interest—is clearly warranted in considering the likely pattern of future *services to be rendered* by the patient (adequate recovery assumed), considering his age, talent, training, and past record of performance. In its allocations of [exotic life-saving therapy], society “invests” a scarce resource in one person as against another and is thus entitled to look to the probable prospective “return” on its investment.¹⁶

Others reject this line altogether, arguing from an egalitarian or Kantian perspective that all persons have equal worth. Morally, the medical student is not worth more than the poet or prostitute, and vice versa. Education,

After the standard treatments failed, the deMeurers thought they had no options left, but Christine's oncologist, Dr. Mahesh Gupta, was hopeful. He held out the possibility that she could benefit from a promising new treatment, a bone marrow transplant. Its effectiveness against Christine's type of cancer was unproven, but it had been used successfully on other kinds of malignancies. In violation of Health Net rules on referrals, Dr. Gupta referred Christine directly to an expert he knew, an oncologist at the Scripps Clinic in La Jolla.

According to the deMeurers, the Scripps doctor was reluctant to help them or even to provide them with information about the bone marrow transplant. So they flew to Denver, where Christine was examined by Dr. Roy B. Jones at the University of Colorado. He told them that the bone marrow procedure might be beneficial to Christine. But about the time that the deMeurers consulted with Dr. Jones, Health Net

achievement, occupation, and the like are not morally relevant.

Nevertheless, while generally taking this view, some philosophers maintain that in very rare cases, social worth can outweigh egalitarian concerns. It seems reasonable that in a natural disaster involving mass casualties, injured physicians or nurses should be treated first if they can aid the other survivors. We can imagine analogous situations involving organ transplants, says Walter Glannon:

Suppose that Nelson Mandela needed a liver transplant in 1992. This was the time when he was leading the transition from apartheid to democracy in South Africa. The transition turned out to be peaceful; but the political situation was potentially

Increasingly desperate, the deMeurers started trying to raise the thousands of dollars needed to pay for the procedure, and they hired a lawyer to appeal Health Net's ruling. They also got permission to see another oncologist. He too encouraged Christine to consider the bone marrow transplant and referred her to the UCLA Medical Center, where Dr. John Glaspy presented the operation as an option and agreed to perform it.

This encounter between the deMeurers and Dr. Glaspy was strained by mutual ignorance of some significant facts. Wary of possible interference from Health Net, they did not tell Dr. Glaspy that they were Health Net subscribers and told him instead that they would pay for the transplant out of pocket. At the same time the deMeurers did not know that Dr. Glaspy was on the Health Net committee that had voted recently not to cover bone marrow transplants for Stage IV breast cancer patients.

volatile. Mandela was essential to maintaining social stability. Suppose further that a younger individual also needed a liver and would have at least as good an outcome with a transplant. In the light of the political and social circumstances, Mandela should have been given priority over the younger patient in receiving a liver. His survival would have ensured the social stability of the country. It would have ensured that many people would not suffer a loss of welfare or life from the social instability that might have resulted otherwise. Mandela's social worth was a function of the dependence of many people's welfare and lives on his survival. That worth would have been a decisive factor in giving the organ to him rather than to another person with the same need.¹⁷

flicting loyalties. As the deMeurers' physician, he felt a responsibility to help Christine get the transplant. But as a Health Net physician, he was required to uphold the regulations of the HMO, some of which he had helped make. Discussions ensued between Health Net administrators and UCLA physicians and officials. Finally, a way out of the conflict appeared when UCLA agreed that it would pay for Christine's operation.

Christine began the treatment on September 22, 1993, at UCLA Medical Center. She died March 10, 1995. Health Net officials expressed doubt that the treatment helped much. Alan deMeurers said that it gave Christine four disease-free months.

Eventually an arbitration panel ruled that Health Net should have paid for Christine's transplant and that the company had improperly interfered in the doctor-patient relationship.

key terms

distributive justice egalitarian theories of justice libertarian theories of justice managed care
utilitarian theories of justice

summary

The U.S. system of health care has been ailing—or failing, as some would say—for years. Its most obvious symptoms are 47 million uninsured people under age 65, soaring costs, and low grades on some measures of national health, such as infant mortality rates.

Debates about ethical allocations of health care resources often reduce to clashes between

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resolved that the company would not pay for the transplant because it was disallowed under the investigational clause in Christine's contract.

Later, news came that Health Net had rejected the appeal filed by the deMeurers' lawyer.

Dr. Glaspy found himself caught between con-

theories of distributive justice—that is, theories regarding the fair distribution of society's benefits and burdens. Libertarian theories of justice say that the benefits and burdens of society should be

distributed through the fair workings of a free market and the exercise of liberty rights of noninterference. The role of government is to protect the rights of individuals to freely pursue their own interests in the economic marketplace without violations of their liberty through coercion, manipulation, or fraud. On this view, no one has a right to health care. In utilitarian theories of justice, a just distribution of benefits and burdens is one that maximizes the net utility for society. Depending on calculations of net benefits, a utilitarian might endorse a system of universal health care insurance, or a qualified right to health care, or a two-tiered plan. Egalitarian theories of justice say that important benefits and burdens of society should be distributed equally. To achieve greater equality, the egalitarian would not be averse to mandating changes to the distribution of society's goods or to interfering in the workings of a free market. Egalitarian theorists could consistently endorse several schemes for allocating health care, including systems that give equal access to all legitimate forms of health care, that offer a guaranteed minimal level of health care for everyone, or that provide care only to those most in need.

Some theorists assert the strong claim that people have a positive moral right to health care. Libertarians would reject this view, utilitarians could endorse a derivative right to health care, and egalitarians could favor a bona fide entitlement to a share of society's health care resources. Some of the latter argue for a right to a decent minimum of health care.

Because people's health care needs are virtually limitless and the supply of resources is always bounded, rationing of health care in some form is ever with us. The dilemmas of rationing arise most visibly and acutely on the level of individual patients and providers who must contend with scarce life-saving resources such as organ transplants. The central moral

issue in these cases is what criteria should be used to decide which patients get transplants and who should make the decisions.

Cases for Evaluation

CASE 1

Black Market in Organ Transplants

(*San Francisco Chronicle*)—Tears well up in P. Guna's eyes as he stares at a long scar running down his side. A year ago, he attempted to stave off mounting debt by swapping one of his healthy kidneys for quick cash.

"Humans don't need two kidneys, I was made to believe," he said. "I can sell my extra kidney and become rich, I thought."

At the time, an organ trader promised Guna, 38, a motorized-rickshaw driver with a fourth-grade education, \$2,500 for the kidney, of which he eventually received only half. Since then, he has experienced excruciating pain in his hip that has kept him from working full time and pushed him deeper in debt.

In recent years, many Indian cities—like Chennai in southern India—have become hubs of a murky business in kidney transplants, despite a 1994 nationwide ban on human organ sales (the Transplant of Human Organ Act states only relatives of patients can donate kidneys).

An influx of patients, mainly foreigners, seeking the transplants has made the illicit market a lucrative business. Some analysts say the business thrives for the same reasons that have made India a top destination for medical

tourism: low cost and qualified doctors. In fact, medical tourism is expected to reach \$2.2 billion by 2012, according to government estimates.

Not surprisingly, an organized group of organ traders in cahoots with unscrupulous doctors is constantly on the prowl for donors like Guna.

In Gurgaon, a posh New Delhi suburb, police last month busted an illegal organ racket, which included doctors, nurses, pathology clinics, and

hospitals. In the past 14 years, the participants allegedly removed kidneys from about 500 day laborers, the majority of them abducted or conned, before selling the organs to wealthy clients.

Police say the doctor believed to be the mastermind behind the operation, Amit Kumar, searched for donors by cruising in luxury cars outfitted with medical testing machines, and kept sophisticated surgical equipment in a residential apartment. In his office, police found letters and e-mail messages from 48 people from nine countries inquiring about transplants.

On Thursday, police arrested Kumar in Chitwan, a Nepalese jungle resort. Local news reports said he was identified by a hotel employee who recognized him from Indian television broadcasts seen in Nepal. "I have not duped anybody," Kumar later told reporters in Kathmandu, according to the Associated Press.

Nepalese authorities say they won't extradite Kumar until they finish an investigation on whether he violated currency laws by not declaring \$230,000 in cash and a check for \$24,000 that he was carrying when arrested. He is scheduled to appear in a Nepalese court Sunday.

In another high-profile arrest, a renowned Chennai surgeon, Palani Ravichandran, was arrested in October in Mumbai for involvement in a kidney racket. He admitted to arranging organ transplants for wealthy foreigners—mainly from Persian Gulf states and Malaysia, whom he charged up to \$25,000. Mumbai police say Ravichandran had performed between 40 and 100 illegal transplants since 2002.

Police say kidney donors can earn between \$1,250 and \$2,500, while recipients pay as much as \$25,000, according to ActionAid India, an anti-poverty organization that has worked with kidney trade victims in the southern state of Tamil Nadu.

The same procedure can cost as much as \$70,000 in China and \$85,000 in the United States.

"These middlemen act more like cut-and-grab men whose only interest is to hack out the organ," said Annie Thomas, a field co-coordinator for ActionAid in Chennai, formerly known as Madras. "This is a reprehensible abuse of the poor, and this practice needs to be curbed."

Thomas says many middlemen typically masquerade the donors as relatives to circumvent the law while many foreigners in need of a kidney arrive on tourist visas rather than the required medical visas; some resort to false documents.*

Is it morally permissible to sell your own organs? Is it morally permissible to buy organs from consenting adult donors? Should organ selling be illegal in all cases? Are the Indian organ donors described in this article being exploited? How? Give reasons for your answers.

*Anuj Chopra, "Organ-Transplant Black Market Thrives in India," *SFGate*, 9 February 2008, <http://www.sfgate.com> (11 April 2008).

CASE 2

Expensive Health Care for a Killer

(*Statesman Journal*)—Oregon taxpayers are shell- ing out more than \$120,000 a year to provide life- saving dialysis for a condemned killer.

Horacio Alberto Reyes-Camarena was sent to death row six years ago for stabbing to death an 18-year-old girl and dumping her body near the Oregon Coast.

At the Two Rivers Correctional Institution in Eastern Oregon, Reyes-Camarena, 47, gets hooked up to a dialysis machine for four hours three times a week to remove toxins from his blood.

Without dialysis, he would die because his kid- neys are failing.

Each dialysis session costs \$775.80 for treatment and medication, according to Corrections Department figures. At that rate, his dialysis costs \$121,025 a year.

As the state keeps Reyes-Camarena alive, thou- sands of older, poor, sick and disabled Oregonians are trying to survive without medications and care that vanished amid state budget cuts.

Some Oregon hospitals are considering closing di- alysis units because of Medicaid-related reductions.

Reyes-Camarena said he wants to sever his ties to the dialysis machine. The convicted killer wants

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to be the first Oregon inmate to receive a taxpayer- financed organ transplant.

“It’s much better for me, and them, too,” Reyes- Camarena said, referring to his desire for a kidney transplant, a procedure sought by nearly 57,000 Americans.

The prisoner cited medical reports indicating that transplant costs prove to be cheaper than dialy- sis in the long run.

Even so, transplant surgery is costly: \$80,000 to \$120,000. It also requires \$500 to \$1,200 a month in lifelong drugs to keep the recipient from rejecting the new organ.

Studies have found that the death rate for dialy- sis patients is about 23 percent a year. A successful transplant reduces that risk to about 3 percent a year.

But the number of transplants is severely limited by a national scarcity of available organs. As of this month, 56,895 Americans, including 192 Orego- nians, were waiting for kidney transplants, accord- ing to the Virginia- based United Network for Organ Sharing, which maintains the nation’s wait- ing list for organs.

Because the waiting list is long and there aren’t enough organs to go around, some people die before a transplant becomes available.

Overall, 86,157 Americans are waiting for organ transplants—mostly kidneys, livers, pancreases and lungs. Officials estimate that about 700 will die this year while waiting.

Lifesaving care for Reyes-Camarena raises ques- tions about the bounds of medical treatment for prisoners.*

Is society obligated to prolong the life of felons like Reyes-Camarena? As thousands of dollars are spent each year by the state to provide him with health care, many lawful citizens cannot afford critical care and die as a result. Is this arrangement just? Do pris- oners have a right to health care? Does anyone have a right to health care? Explain your answers.

*Alan Gustafson, "Death Row Inmate Seeks Organ Transplant," *Statesman Journal*, 28 April 2003, <http://news.statesmanjournal.com/article.cfm?i=59756> (11 April 2008).

CASE 3

Should We Have Universal Health Care?

(TCU360)—Since the dawn of the twentieth century, a debate over health care has raged in America.

The debate centers around the argument over whether the federal government is obligated to ensure that its citizens have health care, thus preventing them from economic headaches associated with rising costs of basic medical care.

Historian and sociologist Paul Starr wrote in his book, *Remedy and Reaction: The Peculiar American Struggle over Health Care Reform*, that efforts to "provide all Americans access to medical care and protect them from economic ruin" have long been a "liberal inspiration."

Beginning in the early decades of the twentieth century, reform from the Progressive Era gave Americans antitrust laws, labor legislation, the Federal Reserve and workers' compensation, but reforming health care proved to be more challenging.

Reform has come slowly. After the New Deal, Social Security was passed to give seniors a fiscal safety net in their later years. Along with Social Security came the GI Bill and the minimum wage.

For decades liberals sought a system of universal health care that would protect all Americans from the pain of illness and burdensome medical bills.

With the establishment of Medicare and Medicaid, progressives hoped they had broken through— not so.

Starr wrote that "if Americans came to know one thing about the history of battles over health insurance, it was that a government program to make health care a right of citizenship had always been defeated."

Early ideas for government-led health insurance programs came from Europe.

British national health care and German sickness funds were unpopular and never gained traction in America. Workers compensation shows similarities to German sickness funds, but the idea of national health care similar to Britain was, to the chagrin of progressives, politely frowned upon in the States.

In 1912, progressives within the Republican Party established the Progressive Party that included in its platform support for social health insurance.

Canada boasts a single payer system with striking similarities to the United States' Medicare system. Progressives had hoped that the Medicare system would serve as a precursor to a more wide-reaching program to establish a system for all Americans, offering insurance akin to the coverage offered to seniors by Medicare. . . .

In reality, none of the proposals in the United States even closely resembles true government health care like Britain's universal health care system.

Reality shows that Democrats largely played on Republican turf.

Coupling reform with deficit reduction, championing the originally Republican idea of the individual mandate and dropping advocacy for a government-run "public option" meant that Democrats sought compromise on the bill.

They sought agreement on one of the most divisive issues in America's history. Agreement may have been sought, but discord was found.

Perhaps the fact that the debate requires Americans to draw upon deep-seated ethical principles precludes agreement.

Or perhaps the problem is deeper.

Perhaps Americans are truly divided over the role government should play in people's lives.*

Should the United States establish a system of universal health care? Why or why not? What moral principle seems to underpin opposition to such a system? What moral principle seems to favor it? What would be the negative effects of having universal health care? What would be the positive effects?

*Alex Apple, "Universal Health Care Debate a Controversial Topic for the United States," *TCU360* (Texas Christian University), 22 November 2012, <https://www.tcu360.com/> (21 January 2016).

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Daniels argues for a strong right to health care, deriving it from John Rawls' justice principle of "fair equality of opportunity." He reasons that disease and disability diminish people's "normal species functioning" and thus restrict the range of opportunities open to them. Since people are entitled to fair equality of opportunity, and adequate health care can protect or restore their normal range of opportunities, they have a positive right to adequate health care.

Is There a Right to Health Care?

Legal Versus Moral Rights to Health Care

One way to answer this question is to adopt the stance of legal positivists, who claim that there are no rights except those that are embodied in actual institutions through law. We would then be able to reply that in nearly every advanced industrial democracy in the world, there is a right to health care, since institutions exist in them that assure everyone

From *A Companion to Bioethics* edited by Helga Kuhse and Peter Singer, pp. 316–25. Copyright © 1998, 2001 by Blackwell Publishing Ltd. Reprinted with permission.

access to needed services regardless of ability to pay. The notable exception is the United States, where many poor and near poor people have no insurance coverage for, and thus no assured access to, medically necessary services, although by law they cannot be denied emergency services.

The legal right to health care is embodied in a wide variety of types of health-care systems. These range from national health services, where the government is the provider of services, as in Great Britain, to public insurance schemes, where the government finances services, as in Canada, to mixed public and private insurance schemes, as in Germany

and the Netherlands. Despite these differences in the design of systems, there is a broad overlap in the scope or content of the legal right to health care in these countries. Most cover “medically necessary” services, including a broad range of preventive, curative, rehabilitative and long-term care for physical and mental diseases, disorders and disabilities. Most exclude uses of medical technologies that enhance otherwise normal functioning or appearance, such as purely cosmetic surgery. The legal rights vary in significant ways, however, for example, in the degree to which they cover new reproductive technologies, or in the types of mental health and long-term care services that are offered.

In the context of rising costs and the rapid dissemination of new technologies there is growing debate in many countries about how to set limits on the scope of a right to health care. This debate about the scope of rights to health care pushes moral deliberation about such a right into the forefront, even where a legal right is recognized. Legal entitlements, most people believe, should reflect what society is morally obliged to provide by way of medical services. What, then, is the basis and scope of a moral right to health care?

Positive Versus Negative Rights

A right to health care is a *positive* as opposed to a *negative* right. Put quite simply, a positive right requires others to do something beneficial or enabling for right-bearers, whereas a negative right requires others to refrain from doing something, usually harmful or restrictive, to right-bearers. To say that others are required to do something or to refrain from doing something is to say they must so act or refrain even if they could produce more good or improve the world by not doing so (Thomson, 1990). For example, a negative right to free expression requires others to refrain from censoring the expression of the right-bearer even if censoring this speech would make a better world. Some public-health measures that protect people against interference with their health, such as environmental protections that protect people against polluters of air, water and food sources, might be construed as requirements of a negative right. More generally, however, a right to health care imposes an obligation on others to assist

the right-bearers in obtaining needed and appropriate services. Specifically, claiming a right to health care includes these other claims; society has the duty to its members to allocate an adequate share of its total resources to health-related needs; society has the duty to provide a just allocation of different types of health care services, taking into account the competing claims of different types of health-care needs; each person is entitled to a fair share of such services, where a “fair share” includes an answer to the question, who should pay for the services? (Daniels, 1985). Health-care rights thus form a part of a broader family of positive “welfare” rights that includes rights to education and to income support. Because positive rights require other people to contribute

their resources or skills to benefit right-bearers, rather than merely refraining from interfering with them, they have often been thought more difficult to justify than negative rights, and their scope and limits have been harder to characterize.

Theories of Justice and Rights to Health Care

If we are to think of a right to health care as a requirement of justice, then we should look to more general theories of justice as a way to specify the scope and limits of that right. On some theories of justice, however, there is little basis for requiring people to assist others by meeting their health care or other needs. Libertarians, for example, believe that fundamental rights to property, including rights to personal assets, such as talents and skills, are violated if society coerces individuals into providing “needed” resources or skills (Nozick, 1974). Libertarians generally recognize an “imperfect” duty to act beneficently or charitably, but this duty involves discretion. It can be discharged in different ways that are matters of choice. People denied charity have no right to it and have no complaint against people who act charitably in other ways. Though some have argued that the difficulty of coordinating the delivery of charitable assistance might justify coercive measures (Buchanan, 1984), and others have tried to show that even libertarians must recognize some forms of welfare rights (Sterba, 1985), most libertarians resist any weakening of the property rights at the core of their view (Brennan and Friedman, 1981).

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A spectre sometimes raised by libertarians against the idea of a right to health care is that such a right is a “bottomless pit.” Since new technologies continuously expand the scope of “medical needs,” a right to health care would give rise to unlimited claims on the resources of others (Fried, 1969; Engelhardt, 1986). Protecting such an expansive right to health care would thus not be compatible with the function of a libertarian “minimal state” to assure the non-violation of rights to liberty and property.

Though there remains controversy about whether utilitarians can provide a basis for recognizing true moral rights, there are strong utilitarian arguments in favour of governments assuring access to at least some broad range of effective medical services. Preventing or curing disease or disability reduces suffering and enables people to function in ways that contribute to aggregate welfare. In addition, knowing that health-care services are available increases personal security and strengthens the ties of community. Utilitarians can also justify redistributing the burden of delivering these benefits to society as a whole, citing the decreasing marginal utility of money to support progressive financing of health-care services (Brandt, 1979).

Beneath these quite general arguments, however, there lies a more specific controversy about the scope of utilitarian entitlements to health care. There seems to be little utilitarian justification for investing resources in health care if those resources would produce more net welfare when invested in other things, yet many people believe they have moral obligations to assist others with their health-care needs even at a net cost in utility. For example, some highly expensive and effective medical treatments that most people believe should be offered to people might not be “cost beneficial” and thus not defensible on utilitarian grounds. Similarly, many forms of long-term care, especially for those who cannot be restored to productive social activity, are also difficult to defend on utilitarian grounds, yet we insist our health-care systems are obliged to provide such services.

Lack of moral acceptance of the distributive implications of utilitarianism makes many uncomfortable with the use of methods, such as cost-effectiveness

analysis, that are intended to guide decisions about resource allocation in health care. For example, an assumption of cost-effectiveness analysis is that a unit of health benefit, such as a quality-adjusted life year (QALY), is

of equal value or importance regardless of where it is distributed. But this assumption does not capture the concerns many people have about how much priority to give to the sickest patients, or when aggregating modest benefits to large numbers of people it outweighs the moral importance of delivering more significant benefits to fewer people (Nord, 1993; Daniels, 1993).

Two points about a utilitarian framework for a right to health care are worth noting. Recognizing a right to health care is compatible with recognizing limits on entitlements that result from resource scarcity and the fact that there are competing uses of those resources. Consequently, recognizing a right to health care need not open a bottomless pit. Second, just what entitlements to services follow from a right to health care cannot be specified outside the context of a *system* properly designed to deliver health care in a way that promotes aggregate utility. For the utilitarian, entitlements are *system-relative*. The same two points apply to other accounts of the foundations and limits of a right to health care.

Because many people reject the utilitarian rationales for health care (and other welfare) rights, theorists have explored other ways to ground such rights. Some claim that these rights are presupposed as enabling conditions for the exercise of other rights or liberties, or as practical presuppositions of all views of justice (Braybrooke, 1987) or as a way of avoiding vulnerability and exploitation (Goodin, 1988). One approach that has been developed in some detail views a right to health care as a special case of a right to equality of opportunity (Daniels, 1985). This approach shows how the most important contractarian theory of justice, Rawls' (1971) account of justice as fairness, can be extended to the problem of health care, since that theory gives prominence to a principle protecting equality of opportunity (Rawls, 1993). Without endorsing that account here, we shall use it to illustrate further the complexity surrounding the concept of a right to health care.

Equal Opportunity and a Right to Health Care

The central observation underlying this account of a right to health care is that disease and disability restrict the range of opportunities that would otherwise be open to individuals. This is true whether they shorten our lives or impair our ability to function, including through pain and suffering. Health care in all its forms, whether public health or medical, preventive or acute or chronic, aims to keep people functioning as close to normally as possible. Since we are complex social creatures, our normal functional capabilities include our capabilities for emotional and cognitive functioning and not just physical capabilities. Health care thus preserves for us the range of opportunities we would have, were we not ill or disabled, given our talents and skills.

The significant contribution health care makes to protecting the range of opportunities open to individuals is nevertheless *limited* in two important ways. It is limited because other things, such as the distribution of wealth and income and education, also profoundly affect equality of opportunity. It is also limited because health care, by restricting its aim to protecting normal functioning, leaves the normal distribution of talents and skills unmodified. It aims to help us function as "normal" competitors, not strictly equal ones.

Some argue that an equal opportunity account of health care should abandon the limit set by a focus on normal functioning (see Arneson, 1988; G. A. Cohen, 1989; Sen, 1992). They claim our concerns about equality, including equality of opportunity, require us to use health-care technologies whenever doing so would equalize opportunity for welfare or equalizes capabilities. For example, if through medical intervention we can "enhance" the otherwise normal capabilities of those who are at a competitive disadvantage, then our commitment to equality of opportunity requires us to do so. Obviously, this version of an equal opportunity account would vastly expand the moral requirements on medicine, yielding a right to health care much more expansive than any now embodied in actual systems and, arguably, one that would make administration of a health-care system unwieldy (Sabin and Daniels, 1994).

This expansive version of the appeal to equal opportunity ignores an important fact about justice: our concern for equality must be reconciled with considerations of liberty and efficiency in arriving at the overall requirements of justice (see Sen, 1992; Cohen, 1995; Daniels, 1996). Such a reconciliation seems to underlie the limits we commonly accept when we appeal to equality of opportunity. We generally believe that rights to equal opportunity are violated only if unfair social practices or preventable or curable diseases or disabilities interfere with the pursuit of reasonable plans of life within our society by making us lose competitive advantage. We accept, however, the fact that the natural distribution of talents and skills, working in an efficient market for them, will both enhance the social product and lead to inequalities in social outcomes. A just society will try to mitigate the effects of these inequalities in competitive advantage in other ways than by eliminating all eliminable differences in capabilities. For example, on Rawls' account, transfers that make the worst off as well off as they can be mitigate the effects on equality of allowing the natural distribution of talents and skills to enhance productivity. In what follows, the account of a right to health care rests on a more limited appeal to equal opportunity, one that takes the maintenance of normal functioning as a reasonable limit.

What Does a Right to Health Care Include?

System-Relative Entitlements

By making the right to health care a special case of rights to equality of opportunity, we arrive at a reasonable, albeit incomplete and imperfect, way of restricting its scope while still recognizing its importance. The account does not give individuals a basic right to have all of their health-care needs met. At the same time, there are social obligations to design a health-care system that protects opportunity through an appropriate set of health-care services. If social obligations to provide appropriate health care are not met, then individuals are definitely wronged. For example, if people are denied access—because of discrimination or inability to pay—to a basic tier of services adequate to protect normal functioning, injustice is done to them. If the basic tier available to people omits important

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categories of services without consideration of their effects on normal functioning, for example, whole categories of mental health or long-term care or preventive services, their rights are violated.

Still, not every medical need gives rise to an entitlement to services. The scope and limits of rights to health care, that is, the entitlements they actually carry with them, will be relative to certain facts about a given system. For example, a health-care system can protect opportunity only within the limits imposed by resource scarcity and technological development within a society. We cannot make a direct inference from the fact that an individual has a right to health care to the conclusion that this person is entitled to some specific health-care service, even if the service would meet a health-care need. Rather the individual is entitled to a specific service only if, in the light of facts about a society's technological capabilities and resource limitations, it should be a part of a system that appropriately protects fair equality of opportunity. The equal opportunity account of a right to health care, like the utilitarian account, makes entitlements to health care system-relative.

Effective Treatment of Disease and Disability

The health care we have strongest claim to is care that effectively promotes normal functioning by reducing the impact of disease and disability, thus protecting the range of opportunities that would otherwise be open to us. Just what counts as "effective," however? And what should we do about hard cases on the boundary between treatment of disease or disability and enhancement of capabilities?

It is a common feature of public and private insurance systems to limit care to treatments that are not “experimental” and have some “proven effectiveness.” Unfortunately, many services that count as standard treatment have little direct evidence about outcomes to support their use (Hadorn, 1992). They are often just customary treatment. Furthermore, it is often controversial just when new treatments or technologies should count as “safe and efficacious.” What counts as “reasonably effective” is then a matter of judgement and depends on the kind of condition and the consequences of not correcting it. We might, for example, want to lower our standards for effectiveness when we face a treatment of last resort, or raise them if resource scarcity is very great. On the other hand, we do not owe people a chance to obtain miracles through whatever unproven procedures they prefer to try.

By focusing a right to health care on the maintenance of normal functioning, a line is drawn between uses of medical technologies that count as legitimate “treatments” and those that we may want but which do not meet our “health-care needs.” Although we may want medical services that can enhance our appearance, like cosmetic (as opposed to reconstructive) plastic surgery, or that can optimize our otherwise normal functioning, like some forms of counselling or some uses of Prozac, we do not truly need these services to maintain normal functioning. We are obliged to help others achieve normal functioning, but we do not “owe” each other whatever it takes to make us more beautiful or strong or completely happy (Daniels, 1985).

Though this line is widely used in both public and private insurance practices, it leaves us with hard cases. Some of the hardest issues involve reproductive technologies. Abortion, where there is no preventive or therapeutic need, does not count as “treatment” because an unwanted pregnancy is not a disease or disability. Some nevertheless insist that requirements of justice, including a right to control one’s body, means that non-therapeutic abortion should be included as an entitlement in a health-care system. Some national health-insurance schemes do not cover infertility services. Yet infertility is a departure from normal functioning, even if some people never want to bear children. Controversy may remain about how much social obligation we have to correct this form of impaired opportunity, especially where the costs of some interventions, such as in vitro fertilization, are high and their effectiveness is modest. Different societies will judge this question differently, in part because they may place different values on the rearing of biologically related children or on the experience of child-bearing.

Hard cases involve non-reproductive technologies as well. In the United States, for example, many insurers will cover growth hormone treatment only for children deficient in growth hormone, not for those who are equally short but without any

pathology. Yet the children denied therapy will suffer just as much as those who are eligible. Similar difficulties are involved in drawing a line between covered and non-covered uses of mental health services (Sabin and Daniels, 1994). As in the cases of reproductive technologies, there is room for different societies to “construct” the concept of mental disorder somewhat differently, with resulting variation in decisions about insurance coverage.

Rights and Limits on Effective Treatments

Even when some health-care service is reasonably effective at meeting a medical need, not all such needs are equally important. When a disease or disability has little impact on the range of opportunities open to someone, it is not as morally important to treat as other conditions that more seriously impair opportunity. The effect on opportunity thus gives us some guidance in thinking about resource allocation priorities.

Unfortunately, the impact on our range of opportunities gives only a crude and incomplete measure of the importance or priority we should give to a need or service. In making decisions about priorities for purposes of resource allocation in health care, we face difficult questions about distributive fairness that are not answered by this measure of importance. For example, we must sometimes make a choice between investing in a technology

that delivers a significant benefit to few people or one that delivers a more modest benefit to a larger number of people. Sometimes we must make a choice between investing in a service that helps the sickest, most impaired patients or one that helps those whose functioning is less impaired. Sometimes we must decide between the fairness of giving a scarce resource to those who derive the largest benefit or giving a broader range of people some chance at getting a benefit. In all of these cases, we lack clear principles for deciding how to make our choices, and the account of a right to health care we are discussing does not provide those principles either (Daniels, 1993). Some methodologies, like cost-effectiveness analysis, are intended to help us make appropriate resource allocation decisions in these kinds of cases. But these methodologies may themselves embody controversial moral assumptions about distributive

fairness. This means they cannot serve as decision procedures for making these choices and can at best serve as aids to decision-makers who must be explicit about the moral reasoning that determines the distributive choices they make (Gold et al., 1996).

In any health-care system, then, some choices will have to be made by a fair, publicly accountable, decision-making process. Just what constitutes a fair decision-making procedure for resolving moral disputes about health care entitlements is itself a matter of controversy. It is a problem that has been addressed little in the literature. Our rights are not violated, however, if the choices that are made through fair decision-making procedures turn out to be ones that do not happen to meet our personal needs, but instead meet needs of others that are judged more important (Daniels and Sabin, 1997).

How Equal Must Our Rights to Health Care Be?

How equal must our rights to health care be? Specifically, must everyone receive exactly the same kinds of health-care services and coverage, or is fairness in health care compatible with a “tiered” system? Around the world, even countries that offer universal health insurance differ in their answers to this question. In Canada and Norway, for example, no supplementary insurance is permitted. Everyone is served solely by the national health-insurance schemes, though people who seek additional services or more rapid service may go elsewhere, as some Canadians do by crossing the border. In Britain, supplementary private insurance allows about 10 per cent of the population to gain quicker access to services for which there is extensive queuing in the public system. Basing a right to health care on an obligation to protect equality of opportunity is compatible with the sort of tiering the British have, but it does not require it, and it imposes some constraints on the kind of tiering allowed.

The primary social obligation is to assure everyone access to a tier of services that effectively promotes normal functioning and thus protects equality of opportunity. Since health care is not the only important good, resources to be invested in the basic tier are appropriately and reasonably limited, for example, by democratic decisions about how

much to invest in education or job training as opposed to health care. Because of their very high “opportunity costs,” there will be some beneficial medical services that it will be reasonable not to provide in the basic tier, or to provide only on a limited basis, for example, with queuing. To say that these services have “high opportunity costs” means that providing them consumes resources that would produce greater health benefits and protect opportunity more if used in other ways.

In a society that permits significant income and wealth inequalities, some people will want to buy coverage for these additional services. Why not let them? After all, we allow people to use their after-tax income and wealth as they see fit to pursue the “quality of life” and opportunities they prefer. The rich can buy special security systems

for their homes. They can buy safer cars. They can buy private schooling for their children. Why not allow them to buy supplementary health care for their families?

One objection to allowing a supplementary tier is that its existence might undermine the basic tier either economically or politically. It might attract better-quality providers away from the basic tier, or raise costs in the basic tier, reducing the ability of society to meet its social obligations. The supplementary tier might undermine political support for the basic tier, for example, by undercutting the social solidarity needed if people are to remain committed to protecting opportunity for all. These objections are serious, and where a supplementary tier undermines the basic tier in either way, economically or politically, priority must be given to protecting the basic tier. In principle, however, it seems possible to design a system in which the supplementary tier does not undermine the basic one. If that can be done, then a system that permits tiering avoids restricting liberty in ways that some find seriously objectionable.

A second objection is not to tiering itself but to the structure of inequality that results. Compare two scenarios. In one, most people are adequately served by the basic tier and only the best-off groups in society have the means and see the need to purchase supplementary insurance. That is the case in Great Britain. In the other, the basic tier serves only the

poorest groups in society and most other people buy supplementary insurance. The Oregon plan to expand Medicaid eligibility partly through rationing the services it covers has aspects of this structure of inequality, since most people are covered by plans that avoid these restrictions (Daniels, 1991). The first scenario seems preferable to the second on grounds of fairness. In the second, the poorest groups can complain that they are left behind by others in society even in the protection of their health. In the first, the majority has less grounds for reasonable resentment or regret.

If the basic tier is not undermined by higher tiers, and if the structure of the inequality that results is not objectionable, then it is difficult to see why some tiering should not be allowed. There is a basic conflict here between concerns about equality and concerns about liberty, between wanting to make sure everyone is treated properly with regard to health care and wanting to give people the liberty to use their resources (after tax) to improve their lives as they see fit. In practice, the crucial constraint on the liberty we allow people seems to depend on the magnitude of the benefit available in the supplementary tier and unavailable in the basic tier. Highly visible forms of saving lives and improving function would be difficult to exclude from the basic tier while we make them available in a supplementary tier. In principle, however, some forms of tiering will not be unfair even when they involve medical benefits not available to everyone.

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The Right to a Decent Minimum of Health Care

ALLEN E. BUCHANAN

In this article Buchanan argues that the notion of a universal right to a decent minimum of health care cannot justify a mandatory decent minimum policy. But the combined weight of other arguments, he says, can establish that the state should provide certain individuals or groups with a decent minimum. The necessary arguments are from special rights, from the prevention of harm, from prudential considerations, and from enforced beneficence.

The Assumption That There Is a Right to a Decent Minimum

A consensus that there is (at least) a right to a decent minimum of health care pervades recent policy debates and much of the philosophical literature on health care. Disagreement centers on two issues. Is there a more extensive right than the right to a decent minimum of health care? What is included in the decent minimum to which there is a right?

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Preliminary Clarification of the Concept

Different theories of distributive justice may yield different answers both to the question “Is there a right to a decent minimum?” and to the question “What comprises the decent minimum?” The justification a particular theory provides for the claim that there is a right to a decent minimum must at least cohere with the justifications

it provides for other right-claims. Moreover, the character of this justification will determine, at least in part, the way in which the decent minimum is specified, since it will include an account of the nature and significance of health-care needs. To the extent that the concept of a decent minimum is theory-dependent,

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then, it would be naive to assume that a mere analysis of the concept of a decent minimum would tell us whether there is such a right and what its content is. Nonetheless, before we proceed to an examination of various theoretical attempts to ground and specify a right to a decent minimum, a preliminary analysis will be helpful.

Sometimes the notion of a decent minimum is applied not to health care but to health itself, the claim being that everyone is entitled to some minimal level, or welfare floor, of health. I shall not explore this variant of the decent minimum idea because I think its implausibility is obvious. The main difficulty is that assuring any significant level of health for all is simply not within the domain of social control. If the alleged right is understood instead as the right to everything which can be done to achieve some significant level of health for all, then the claim that there is such a right becomes implausible simply because it ignores the fact that in circumstances of scarcity the total social expenditure on health must be constrained by the need to allocate resources for other goods.

Though the concept of a right is complex and controversial, for our purposes a partial sketch will do. To say that person A has a right to something, X, is first of all to say that A is entitled to X, that X is due to him or her. This is not equivalent to saying that if A were granted X it would be a good thing, even a morally good thing, or that X is desired by or desirable for A. Second, it is usually held that valid right-claims, at least in the case of basic rights, may be backed by sanctions, including coercion if necessary (unless doing so would produce extremely great disutility or grave moral evil), and that (except in such highly exceptional circumstances) failure of an appropriate authority to apply the needed sanctions is itself an injustice. Recent right-theorists have also emphasized a third feature of rights, or at least of basic rights or rights in the strict sense: valid right-claims “trump” appeals to what would maximize utility, whether it be the utility of the right-holder, or social utility. In other words, if A has a right to X, then the mere fact that infringing A’s right would maximize overall utility or even A’s utility is not itself a sufficient reason for infringing it.³ Finally, a universal (or general) right is one which applies to

all persons, not just to certain individuals or classes because of their involvement in special actions, relationships, or agreements.

The second feature—enforceability—is of crucial importance for those who assume or argue that there is a universal right to a decent minimum of health care. For, once it is granted that there is such a right and that such a right may be enforced (absent any extremely weighty reason against enforcement), the claim that there is a universal right provides the moral basis for using the coercive power of the state to assure a decent minimum for all. Indeed, the surprising absence of attempts to justify a coercively backed decent minimum policy by arguments that do *not* aim at establishing a universal right suggests the following hypothesis: advocates of a coercively based decent minimum have operated on the assumption that such a policy must be based on a universal right to a decent minimum. The chief aim of this article is to show that this assumption is false.

I think it is fair to say that many who confidently assume there is a (universal) right to a decent minimum of health care have failed to appreciate the significance of the first feature of our sketch of the concept of a right. It is crucial to observe that the claim that there is a right to a decent minimum is much stronger than the claim that everyone *ought* to have access to such a minimum, or that if they did it would be a good thing, or that any society which is capable, without great sacrifice, of providing a decent minimum but fails to do so is deeply morally defective. None of the latter assertions implies the existence of a right, if this is understood as a moral entitlement which ought to be established by the coercive power of the state if necessary. . . .

The Attractions of the Idea of a Decent Minimum

There are at least three features widely associated with the idea of a right to a decent minimum which, together with the facile consensus that vagueness promotes, help explain its popularity over competing conceptions of the right to health care. First, it is usually, and quite reasonably, assumed that the idea of a decent minimum is to be understood in a society-relative sense. Surely it is plausible to assume that, as with other rights to goods or services, the

content of the right must depend upon the resources available in a given society and perhaps also upon a certain consensus of expectations among its members. So the first advantage of the idea of a decent minimum, as it is usually understood, is that it allows us to adjust the level of services to be provided as a matter of right to relevant social conditions and also allows for the possibility that as a society becomes more affluent the floor provided by the decent minimum should be raised.

Second, the idea of a decent minimum avoids the excesses of what has been called the strong equal access principle, while still acknowledging a substantive universal right. According to the strong equal access principle, everyone has an equal right to the best health-care services available. Aside from the weakness of the justifications offered in support of it, the most implausible feature of the strong equal access principle is that it forces us to choose between two unpalatable alternatives. We can either set the publicly guaranteed level of health care lower than the level that is technically possible or we can set it as high as is technically possible. In the former case, we shall be committed to the uncomfortable conclusion that no matter how many resources have been expended to guarantee equal access to that level, individuals are forbidden to spend any of their resources for services not available to all. Granted that individuals are allowed to spend their after-tax incomes on more frivolous items, why shouldn't they be allowed to spend it on health? If the answer is that they should be so allowed, as long as this does not interfere with the provision of an adequate package of health-care services for everyone, then we have retreated from the strong equal access principle to something very like the principle of a decent minimum. If, on the other hand, we set the level of services guaranteed for all so high as to eliminate the problem of persons seeking extra care beyond this level, this would produce a huge drain on total resources, foreclosing opportunities for producing important goods other than health care.

So both the recognition that health care must compete with other goods and the conviction that beyond some less than maximal level of publicly guaranteed services individuals should be free to purchase additional services point toward a more

limited right than the strong access principle asserts. Thus, the endorsement of a right to a decent minimum may be more of a recognition of the implausibility of the stronger right to equal access than a sign of any definite position on the content of the right to health care.

A third attraction of the idea of a decent minimum is that since the right to health care must be limited in scope (to avoid the consequences of a strong equal access right), it should be limited to the "most basic" services, those normally "adequate" for health, or for a "decent" or "tolerable" life. However, although this aspect of the idea of a decent minimum is useful because it calls attention to the fact that health-care needs are heterogeneous and must be assigned some order of priority, it does not itself provide any basis for determining which are most important.

The Need for a Supporting Theory

In spite of these attractions, the concept of a right to a decent minimum of health care is inadequate as a moral basis for a coercively backed decent minimum policy in the absence of a coherent and defensible theory of justice. Indeed, when taken together they do not even imply that there is a right to a decent minimum. Rather, they only support the weaker conditional claim that if there is a right to health care, then it is one that is more limited than

a right of strong equal access, and is one whose content depends upon available resources and some scheme of priorities which shows certain health services to be more basic than others. . . .

My suggestion is that the combined weight of arguments from special (as opposed to universal) rights to health care, harm-prevention, prudential arguments of the sort used to justify public health measures, and two arguments that show that effective charity shares features of public goods (in the technical sense) is sufficient to do the work of an alleged universal right to a decent minimum of health care.

Arguments from Special Rights

The right-claim we have been examining (and find unsupported) has been a *universal* right-claim: one that attributes the same right to all persons. *Special* right-claims, in contrast, restrict the right in question to certain individuals or groups.

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There are at least three types of arguments that can be given for special rights to health care. First, there are arguments from the requirements of rectifying past or present institutional injustices. It can be argued, for example, that American blacks and native Americans are entitled to a certain core set of health-care services owing to their history of unjust treatment by government or other social institutions, on the grounds that these injustices have directly or indirectly had detrimental effects on the health of the groups in question. Second, there are arguments from the requirements of compensation to those who have suffered unjust harm or who have been unjustly exposed to health risks by the assignable actions of private individuals or corporations—for instance, those who have suffered neurological damage from the effects of chemical pollutants.

Third, a strong moral case can be made for special rights to health care for those who have undergone exceptional sacrifices for the good of society as a whole—in particular those whose health has been adversely affected through military service. The most obvious candidates for such compensatory special rights are soldiers wounded in combat.

Arguments from the Prevention of Harm

The content of the right to a decent minimum is typically understood as being more extensive than those traditional public health services that are usually justified on the grounds that they are required to protect the citizenry from certain harms arising from the interactions of persons living together in large numbers. Yet such services have been a major factor—if not *the* major factor—in reducing morbidity and mortality rates. Examples include sanitation and immunization. The moral justification of such measures, which constitute an important element in a decent minimum of health care, rests upon the widely accepted Harm (Prevention) Principle, not upon a right to health care.

The Harm Prevention argument for traditional public health services, however, may be elaborated in a way that brings them closer to arguments for a universal right to health care. With some plausibility one might contend that once the case has been made

for expending public resources on public health measures, there is a moral (and perhaps Constitutional) obligation to achieve some standard of *equal protection* from the harms these measures are designed to prevent. Such an argument, if it could be made out, would imply that the availability of basic public health services should not vary greatly across different racial, ethnic, or geographic groups within the country.

Prudential Arguments

Prudent arguments for health-care services typically emphasize benefits rather than the prevention of harm. It has often been argued, in particular, that the availability of certain basic forms of health care make for a more productive labor force or improve the fitness of the citizenry for national defense. This type of argument, too, does not assume that individuals have moral rights (whether special or universal) to the services in question.

It seems very likely that the combined scope of the various special health-care rights discussed above, when taken together with harm prevention and prudential arguments for basic health services and an argument from equal protection through public health measures, would do a great deal toward satisfying the health-care needs which those who advocate a universal right to a decent minimum are most concerned about. In other words, once the strength of a more pluralistic approach is appreciated, we may come to question the popular dogma that policy initiatives designed to achieve a decent minimum of health care for all must be grounded in a universal moral right to a decent minimum. This suggestion is worth considering because it again brings home the importance of the methodological difficulty encountered earlier. Even if, for instance, there is wide consensus on the considered judgment that the lower health prospects of inner city blacks are not only morally unacceptable but an injustice, it does not follow that this injustice consists of the infringement of a universal right to a decent minimum of health care. Instead, the injustice might lie in the failure to rectify past injustices or in the failure to achieve public health arrangements that meet a reasonable standard of equal protection for all.

Two Arguments for Enforced Beneficence

The pluralistic moral case for a legal entitlement to a decent minimum of health care (in the absence of a universal moral right) may be strengthened further by non-rights-based arguments from the principle of beneficence.⁷ The possibility of making out such arguments depends upon the assumption that some principles may be justifiably enforced even if they are not principles specifying valid right-claims. There is at least one widely recognized class of such principles requiring contribution to the production of "public goods" in the technical sense (for example, tax laws requiring contribution to national defense). It is characteristic of public goods that each individual has an incentive to withhold his contribution to the collective goal even though the net result is that the goal will not be achieved. Enforcement of a principle requiring all individuals to contribute to the goal is necessary to overcome the individual's incentive to withhold contribution by imposing penalties for his own failure to contribute and by assuring him that others will contribute. There is a special subclass of principles whose enforcement is justified not only by the need to overcome the individual's incentive to withhold compliance with the principle but also to ensure that individuals' efforts are appropriately *coordinated*. For example, enforcing the rule of the road to drive only on the right not only ensures a joint effort toward the goal of safe driving but also coordinates individuals' efforts so as to make the attainment of that goal possible. Indeed, in the case of the "rule of the road" a certain kind of coordinated joint effort is the public good whose attainment justifies enforcement. But regardless of whether the production of a public good requires the solution of a coordination problem or not, there may be no *right* that is the correlative of the coercively backed obligation specified by the principle. There are two arguments for enforced beneficence, and they each depend upon both the idea of coordination and on certain aspects of the concept of a public good.

Both arguments begin with an assumption reasonable libertarians accept: there is a basic moral obligation of charity or beneficence to those in need. In a society that has the resources and technical knowledge to improve health or at least to ameliorate important health defects, the application of this

requirement of beneficence includes the provision of resources for at least certain forms of health care. If we are sincere, we will be concerned with the efficacy of our charitable or beneficent impulses. It is all well and good for the libertarian to say that voluntary giving *can* replace the existing array of government entitlement programs, but this *possibility* will be cold comfort to the needy if, for any of several reasons, voluntary giving falters.

Social critics on the left often argue that in a highly competitive acquisitive society such as ours it is naive to think that the sense of beneficence will win out over the urgent promptings of self-interest. One need not argue, however, that voluntary giving fails from weakness of the will. Instead one can argue that even if each individual recognizes a moral duty to contribute to the aid of others and is motivationally capable of acting on that duty, some important forms of beneficence will not be forthcoming because each individual will rationally conclude that he should not contribute.

Many important forms of health care, especially those involving large-scale capital investment for technology, cannot be provided except through the contributions of large numbers of persons. This is also true of the most important forms of medical research. But if so, then the beneficent individual will not be able to act effectively, in isolation. What is needed is a coordinated joint effort.

First argument. There are many ways in which I might help others in need. Granted the importance of health, providing a decent minimum of health care for all, through large-scale collective efforts, will be a more important form of beneficence than the various charitable acts A, B, and C, which I might perform *independently*, that is, whose success does not depend upon the contributions of others. Nonetheless, if I am rationally beneficent I will reason as follows: either enough others will contribute to the decent minimum project to achieve this goal, even if I do not contribute to it; or not enough others will contribute to achieve a decent minimum, even if I do contribute. In either case, my contribution will be wasted. In other words, granted the scale of the investment required and the virtually negligible size of my own contribution, I can disregard the minute

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possibility that my contribution might make the difference between success and failure. But if so, then the rationally beneficent thing for me to do is not to waste my contribution on the project of ensuring a decent minimum but instead to undertake an independent act of beneficence; A, B, or C—where I know my efforts will be needed and efficacious. But if everyone, or even many people, reason in this way, then what we each recognize as the most effective form of beneficence will not come about. Enforcement of a principle requiring contributions to ensuring a decent minimum is needed

The first argument is of the same form as standard public goods arguments for enforced contributions to national defense, energy conservation, and many other goods, with this exception. In standard public goods arguments, it is usually assumed that the individual's incentive for not contributing is self-interest and that it is in his interest not to contribute because he will be able to partake of the good, if it is produced, even if he does not contribute. In the case at hand, however, the individual's incentive for not contributing to the joint effort is not self-interest, but rather his desire to maximize the good he can do for others with a given amount of his resources. Thus if he contributes but the goal of achieving a decent minimum for all would have been achieved without his contribution, then he has still failed to use his resources in a maximally beneficent way relative to the options of either contributing or not to the joint project, even though the goal of achieving a decent minimum is attained. The rationally beneficent thing to do, then, is not to contribute, even though the result of everyone's acting in a rationally beneficent way will be a relatively ineffective patchwork of small-scale individual acts of beneficence rather than a large-scale, coordinated effort.

Second argument. I believe that ensuring a decent minimum of health care for all is more important than projects A, B, or C, and I am willing to contribute to the decent minimum project, but only if I have assurance that enough others will contribute to achieve the threshold of investment necessary for success. Unless I have this assurance, I will conclude that it is less than rational—and perhaps even

morally irresponsible—to contribute my resources to the decent minimum project. For my contribution will be wasted if not enough others contribute. If I lack assurance of sufficient contributions by others, the rationally beneficent thing for me to do is to expend my “beneficence budget” on some less-than-optimal project A, B, or C, whose success does not depend on the contribution of others. But without enforcement, I cannot be assured that enough others will contribute, and if others reason as I do, then what we all believe to be the most effective form of beneficence will not be forthcoming. Others may fail to contribute either because the promptings of self-interest overpower their sense of beneficence, or because they reason as I did in the First Argument, or for some other reason.

Both arguments conclude that an enforced decent minimum principle is needed to achieve coordinated joint effort. However, there is this difference. The Second Argument focuses on the *assurance problem*, while the first does not. In the Second Argument all that is needed is the assumption that rational beneficence requires assurance that enough others will contribute. In the First Argument the individual’s reason for not contributing is not that he lacks assurance that enough others will contribute, but rather that it is better for him not to contribute regardless of whether others do or not.

Neither argument depends on an assumption of conflict between the individual’s moral motivation of beneficence and his inclination of self-interest. Instead the difficulty is that in the absence of enforcement, individuals who strive to make their beneficence most effective will thereby fail to benefit the needy as much as they might.

A standard response to those paradoxes of rationality known as public goods problems is to introduce a coercive mechanism which attaches penalties to non-contribution and thereby provides each individual with the assurance that enough others will reciprocate so that his contribution will not be wasted and an effective incentive for him to contribute even if he has reason to believe that enough others will contribute to achieve the goal without his contribution. My suggestion is that the same type of argument that is widely accepted as a justification for enforced principles requiring

contributions toward familiar public goods provides support for a coercively backed principle specifying a certain list of health programs for the needy and requiring those who possess the needed resources to contribute to the establishment of such programs, even if the needy have no *right* to the services those programs provide. Such an arrangement would serve a dual function: it would coordinate charitable efforts by focusing them on one set of services among the indefinitely large constellation of possible expressions of beneficence,

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resources to these services will become effective.