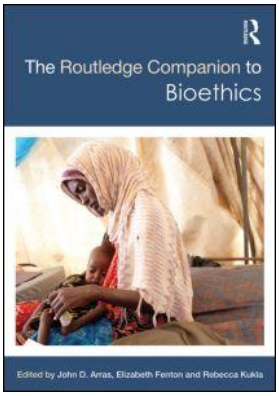

The Routledge Companion to Bioethics

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The Right to Health Care

Publication details
https://test.routledgehandbooks.com/doi/10.4324/9780203804971.ch1
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Published online on: 12 Dec 2014

Part I

JUSTICE AND HEALTH DISTRIBUTION

Considerations of justice are inseparable from many of the most challenging issues in contemporary bioethics; indeed one of the central aims of this volume is to draw out these considerations in debates in which they may otherwise have been obscured or overlooked. Justice is particularly salient in debates over access to and distribution of health care, and more broadly of the social, economic, and political conditions that make it possible for people to live healthy lives. The chapters in this section explore the general theme of how resources relevant to health can be fairly and justly distributed.

The first chapter in this section explores the contours of the longstanding debate over the right to health care. The debate is complex, including philosophical questions about the nature and function of rights in political and moral discourse; it is also contentious, with significant theoretical commitments on both sides. John Arras examines four leading moral and political theories (libertarianism, utilitarianism, liberal egalitarianism, and communitarianism) and the implications under each for the right to health care. Arras's chapter also importantly situates this debate in the contemporary context of the landmark 2010 U.S. health care law known as the *Affordable Care Act*. In bringing the debate into the current health policy context, Arras pays particular attention to the growing understanding among bioethicists of the role of social, economic, and political factors in creating the conditions necessary for health. He notes that in light of this growing understanding many bioethicists have eschewed the language of a right to health care in favor of a right to *health*, which encompasses access not only to health care services but also to the conditions necessary for health. These conditions, and their relevance to social justice, are the subject of Sridhar Venkatapuram and Michael Marmot's chapter on the social determinants of health and health inequalities. Health inequalities in populations often persist because of unjust distributions of other goods within society, such as income and education. This chapter outlines the increasingly strong evidence for the ways in which social, economic, and political conditions influence health and engender, and sometimes entrench, health inequalities. It also draws attention to the extent to which bioethics as a field (with notable exceptions) has been slow to comprehend the moral significance of the social determinants literature, and is an important reminder that bioethics must be expansive in its disciplinary scope if it is to be a force in addressing health injustice.

A deeper understanding of population-level health trends and the factors that influence them is critical to anyone engaging in contemporary bioethics. No less critical is an understanding of the ways in which health resources are allocated and prioritized in a community. The chapters by Dan Callahan, Greg Bognar, and Norman Daniels and Keren Ladin explore the ways in which health resources can be allocated more or less justly. Callahan discusses the ethics and politics of rationing health resources in an era of increasingly expensive health care and increasingly limited resources. Though many of his examples come from the U.S. context where "rationing" remains a dirty word, they are relevant to all health systems where demand outstrips supply, which is to say all health systems. Bognar's chapter provides an excellent introduction to two concepts widely used in health resource allocation, quality-adjusted life years (QALYs) and disability-adjusted life years (DALYs). These concepts have been criticized for promoting distributions of resources that are insensitive to individual health needs and particularly complex health needs, but they remain fundamental to the strategies of many health systems seeking to spend limited budgets both efficiently and fairly. The final chapter by Norman Daniels and Kerin Ladin unifies the themes of this section by asking what we owe in terms of health resources to people who enter a society as immigrants, whether legally or illegally. The authors ask whether immigration status is morally relevant to the provision of health-related goods, based on considerations of reciprocity and the rights of states.

1
THE RIGHT TO HEALTH CARE

John D. Arras

For many people in the world today, access to health care is unattainable. In the developing (i.e., poor) countries, yearly public expenditure on public health and health care often amounts to less than $10 per person (Pogge 2008). In the U.S. before the *Affordable Care Act* (ACA) took effect in 2010, estimates placed the number of uninsured individuals at roughly 48 million, with another 60 million underinsured (Centers for Disease Control and Prevention 2013). The passage of the ACA promised to place access to health insurance within the reach of just about every citizen, but the weakening of that Act by the Supreme Court and the refusal on the part of many states to implement the expansion of Medicaid under the Act have left millions without access to affordable insurance. Indeed, roughly half of the uninsured in the U.S. reside in states whose political leaders have refused to extend Medicaid to them (Tavernise and Gebeloff 2013). The promise of universal access thus remains unfulfilled for the foreseeable future.

What are we to think of this state of affairs? For those of a libertarian persuasion, premature mortality and untreated morbidity due to a lack of health insurance are viewed as "unfortunate but not unjust" (Engelhardt 1996, 1997). The world might be a better place were everyone's health needs somehow met, but this, libertarians argue, is an issue of charity, not justice. Many others contend that lack of access and its contributions to ill health are indeed an injustice, a wrong perpetrated on the poor that cries out for political redress. For these critics, access to health care is a right, not a privilege underwritten by significant wealth.

These two polar opposite interpretations of the moral valence of lack of access to health insurance framed much of the recent debate in the U.S. regarding health reform. Many proponents of the ACA ("Obamacare") stressed the moral importance of achieving universal access, while many opponents downplayed access in favor of an emphasis on cost containment and limited government. This essay will explore and scrutinize some of the arguments on both sides of this debate. I shall conclude that powerful moral arguments can buttress the case for a right to health care, but I shall also stress the limited (albeit important) role for such a right in debates over health policy.

As we shall see below, the notion of a right to health care is controversial. Some on the political right view it as morally unjustifiable, while others on the political left often view a focus on health care alone as excessively narrow. For these latter critics, a theory of justice in health should consider not just access to health *care*—what Norman Daniels has dubbed "the ambulance waiting at the bottom of a cliff" (Daniels 2008: 79)—but

also all those so-called social determinants of health, such as public health provision of clean water and air, safe working conditions, and the social bases of self-respect on the job and in society generally (Wilkinson and Marmot 2003). Following the lead of these critics, I shall focus here on what I call access to health-related goods, not just to health care services.

Some Special Features of "Rights Talk"

First, if someone claims a "right to X," they are saying a lot more than something like "the world would be a better place if everyone had X." Consider this scenario inspired by philosopher Judith Thomson (1971): You are languishing in a New York City hospital, wasting away from some dread, lethal disease. The only prospect for a cure would miraculously require that the actor Matt Damon fly out from Hollywood to place his cool hand on your fevered brow. Since your life depends upon him, wouldn't you have a right to Matt Damon's time and efforts? Thomson's answer is, No. Although it would be "terribly nice" if Matt were to go to all this trouble, you certainly have no right that he do so. It would, however, be a different story had Matt promised you that he'd come, or if he were your father. Hence, the first important defining feature of rights: They are justified claims, demands, or entitlements that we make *vis-à-vis* others. Failure to respect or grant someone's right constitutes an injustice calling for redress; it is not the mere falling short of a social goal or ideal (Buchanan 1984; Wenar 2011).

Second, we must distinguish between moral and legal rights. Some rights—such as the right to be secure in your person or property, or the right of poor people to legal counsel in criminal cases—are carefully articulated and delimited by legal statutes, constitutions, or evolving case law. In the vast majority of cases, if there's any doubt about the existence of such a right, you can just go look it up. By contrast, moral rights are discovered, created, or justified by moral arguments. We say that Joan has a moral right to X if sound and convincing arguments can be given showing that she has a justified entitlement to X. To say that Joan has a moral right to something leaves the legal question open. In many, but not all, cases we say that the existence of a moral right provides us with a good reason for turning that claim into a legal entitlement. So when we debate the existence of health care rights, we are making moral arguments that might later be cashed out as legal arguments.

Another distinction in the topography of rights separates negative from positive rights (Wenar 2011; Holmes and Sunstein 1999). The former are entitlements, *inter alia*, to be let alone, to speak or write freely about political matters in public, to gather with others in voluntary civil and religious associations, all without the interference of others, including the government. Put in a negative mode, these include the right not to be assaulted, not to have our property taken, not to be politically muzzled or imprisoned without good cause, and so on. Putative positive rights, by contrast, are entitlements to certain goods or services, such as legal representation, food, shelter, and, yes, health care.

Just how important this distinction between negative and positive is depends upon one's larger philosophical commitments. Those of a predominantly libertarian persuasion place great stock in this distinction (Cranston 1967). They note that each of us can respect the negative rights of all other persons 24 hours a day, 7 days a week just by refraining from acting upon them in prohibited ways (e.g., stealing their property or killing them). Negative rights thus correlate with the duties of all others to refrain at all times from intervening against them. While negative rights are thus arguably cost free,

positive rights obviously require that other people provide the goods and services to which we are allegedly entitled, usually by means of taxation. If we have a right to health care, then someone or some institution must have a corresponding duty to provide it to us, and this raises a fundamental problem: Exactly how are we entitled to the money or labor of others? It is thus often concluded that negative rights are much easier to justify and fulfill than positive rights, which risk encroaching on the negative rights of others to be free to keep or spend their resources as they see fit (Cranston 1967). As we shall see momentarily, non-libertarians place much less weight on this distinction.

A final distinction concerns the weight or demandingness of various rights. Some people claim that some rights, such as the right to life of innocent people, are absolute; they cannot or should not be violated for any reason. Others argue that all or at least most rights are *prima facie* only (or *pro tanto*)—i.e., they hold for the most part or at first blush, but they can be overridden if countervailing rights or interests are sufficiently powerful. Philosopher Ronald Dworkin famously wrote that serious legal rights (e.g., to free speech) function like trumps in the game of bridge—i.e., they are claims that outrank most other claims, such as social utility (Dworkin 1978). Although he argued that most moral and legal rights should function as trumps in political argument, Dworkin conceded that they can occasionally be limited or outweighed by countervailing social considerations of great importance—e.g., shouting "Fire!" falsely in a crowded theater. Thus, if there is a right to health care, the logic of rights would disallow arguments against it merely on grounds of efficiency, social utility, or public opinion. If, however, a putative right claim would have the likely effect of "breaking the bank" or of using up most social resources for the benefit of a few, that right could legitimately be curbed or overridden.

Rights and Correlative Social Duties

We have seen above that rights are justified claims that generate correlative duties in others to either respect our persons and property or provide us with various goods. They are thus said to be "socially guaranteed" (Mill 1863/2001). But guaranteed by whom or what? Skeptics about positive rights often assume that the duties correlating to them must be lodged against individuals, possibly those in the best position to help. This assumption then leads to worries about placing excessively onerous duties upon individuals who would bear the burden of providing food and health care, for example, for all in need—a burden that would supposedly exhaust our resources and preclude our ability to chart the direction of our own lives. One problem with this assumption is that it ignores an important role for social institutions in the securing of rights. According to one influential theory, rights can generate "waves of duty" that might include individuals, to be sure, but also local, state, and regional governments, as well as the United Nations and non-governmental organizations (NGOs) like the World Bank (Shue 1996). Duties spread around such institutions might be much more manageable for individuals to bear.

Contributors to the literature on universal human rights have further specified what these duties linked with rights entail. First, they involve duties to avoid violating negative rights. These duties apply to each of us all the time. Second, they entail a duty to protect vulnerable parties against deprivation of their rights. This is the function of police departments and of military intervention against states that systematically violate the rights of their citizens. Third, there are duties to assist those whose rights have

already been violated. This is the function of courts and, for example, of NGOs of health care workers, such as *Médecins Sans Frontières*, who attend to the needs of refugees from state-sponsored tyranny (Shue 1996).

The second and third of the above rights clearly require the investment of resources, and thus tend to blur the distinction between negative and positive rights. Even citizens' negative rights require significant public investments in institutions such as police and courts of law, without which our cherished rights to be let alone would be under constant assault. Viewed from this angle, negative rights can often be just as problematic as positive rights, raising questions about who shall pay, the appropriate level and scope of provision, and so on (Holmes and Sunstein 1999).

Finally, any theory of rights must be attentive to the sorts of burdens that ascriptions of rights might entail for those footing the bill. Failure to attend to such burdens is a common failing of many theories of rights, which consequently often yield "wish lists" with little likelihood of ever moving the great mass of humanity into action. Ruth Macklin once called attention to the claim on the part of Canadian welfare recipients to a "right to own a pet" (Macklin 1976). Not only is such a putative right not exactly high on the list of the most important interests of human beings, but Canadian taxpayers might justifiably be unwilling to make the requisite sacrifice of their own resources to pay for it. Any plausible theory of rights, including a right to health care, would have to seriously consider the "supply side" of rights—i.e., who will bear the burden of paying for them (Lomasky 1981).

The Functions of Rights in Moral Discourse

We can easily imagine a world of political discourse that had no use for the concept of rights (Feinberg 1970). Indeed, rights as we currently deploy them were unknown to the ancient and medieval worlds. What then is the function (or functions) of rights talk within our own political culture? We can make a start on this question by noting that the ascription of rights allows political discourse to "take the victim's side." In contrast to appeals to charity or benevolence, rights allow the individual to speak in his or her own name, to make claims against others without shame or embarrassment. There's no need to beg and scrape for the generosity or beneficence of courtiers and bureaucrats; we can stand up, heads held high, and claim our rights as equal citizens.

More specifically, there are two general approaches to the nature of rights in contemporary political theory: namely, the "will theory" and the "interest theory" (Wenar 2011). The will theory grounds rights in appeals to human dignity. As Kant argued, we human beings derive our dignity or special worth from our capacity for moral agency or ability to make free moral choices. Incursions into our agency—e.g., by means of unjust restrictions on our liberty, property, civil liberties, etc.—threaten our status as free and equal persons. Rights thus help define our social status and opportunities as dignified persons in much the same way as the rules of chess define the roles of the various pieces. As Warren Quinn once put it, rights make us all into "small scale sovereigns" (in Wenar 2011: 30). According to this view, the main function of rights is thus to give us control over our actions and property, and over the actions of others with regard to our person and belongings. In short, rights protect our status as autonomous persons.

The rival interest theory of rights is much more concerned with individual and social consequences. On this view, rights are concerned not with our garden-variety interests—e.g., in maintaining a hobby or pet—but rather with protecting our most

important interests (Mill 1863/2001; Buchanan 2010). Many of these interests will map nicely onto the territory protected by the will theory; both will want to protect our person from unjustified physical interference, our liberty to hold and enjoy property, and to enjoy the standard roster of civil liberties. But the interest theory will more naturally want to protect any and all human interests viewed as essential to our flourishing as human beings. Thus, if freedom from chronic pain is crucial to our flourishing, advocates of the interest theory might posit a right to palliative care in our health-related institutions.

What might the will theory and the interest theory of rights say about a right to health care? On the surface, we might imagine these two theories as aligning themselves with opposing stances on the right to health care. The will theory, ostensibly more concerned with external encroachments upon individual moral agency, might tend to side with libertarians who argue, as we shall see shortly, that all positive rights constitute a violation of agency and human dignity. It is unethical, they might claim, to coerce some people to pay for the needs of others. The interest theory, by contrast, easily supports a right to health-related goods insofar as such goods are required for satisfying one of our most important interests in a healthy body and mind.

On closer inspection, however, these two rival conceptions of the function of rights might well agree on the importance of a right to health-related goods. Proponents of the will theory of rights could argue, first, that there are many different kinds of threats to human agency and dignity, of which encroachments upon our liberty by individuals or governments only count for one (Nagel 1975; Sen 1999). How much agency or dignity can we expect from a starving Bangladeshi child whose brain is deprived of nutrients by drought and famine? Second, proponents of the will theory could argue that our dignity as human beings resides in our ability to enjoy all the central human capabilities, including health, so powerfully endorsed by philosophers Martha Nussbaum and A.K. Sen (Nussbaum 2011). Like our capacities for free thought, imagination, and association with others, our capacity for health is central to human flourishing, and thus ultimately to our dignity as human beings.

Finally, a proponent of the will theory of rights might contend that a great deal of individual autonomy is consistent with a moderate amount of state-enforced taxation to support the needs of others. Notwithstanding the inflated, hyperventilating language of some libertarians—"All taxation is theft"—one can lead a perfectly autonomous, self-directed life while at the same time cheerfully paying taxes to support the basic needs of others.

Four Theories of Rights to Health-Related Goods

The literature on rights to health care and health-related goods is both voluminous and highly contentious. I shall content myself here with thumbnail sketches of some of the most influential political theories with relevance for our subject, including libertarianism, utilitarianism, Rawlsian liberal egalitarianism, and some versions of communitarianism. As a pluralist with regard to ethical theory, I believe that each of these accounts should be viewed not, to adapt a phrase from the *Lord of the Rings*, as "one theory to rule them all," but rather as a source of valuable but limited insights into the nature of moral problems. I shall address each theory with two pivotal questions in mind: (1) What kind of good is health care (and other health-related goods)? (2) What does each theory say about a putative right to health care?

Libertarianism

In the context of discussions regarding health care ethics, libertarian political philosophy assumes two somewhat different forms. On one hand, there's what we might call "hard-core" libertarianism, which advances an absolutist conception of negative rights, denies any positive rights, and claims that the right to health care is actually an unjust claim to the resources of others (Nozick 1974). The softer side of this theory is exhibited by "soft-core" libertarians, who focus primarily, not on an absolutist theory of negative rights, but rather upon a policy-level preference for individual choice and free markets in the design and delivery of health services, as opposed to centralized state-sponsored health systems (Lomasky 1981). The focus here will be on the hard-core variant, which is more philosophically fundamental.

The pivotal concept in hard-core libertarianism is the rational agent's right to life, to self-ownership, and to choose values in furtherance of one's own purposes (Sade 2008: 466ff). Sometimes libertarians express their fundamental commitments in terms of Kantian language bearing on the right to be treated as an end in oneself, not as a mere means to the ends of others. For such theorists the supreme value is rational agency, or the ability of rational individuals to make their own decisions. This conception of individual liberty overrides all other considerations. In response to those who would on occasion subordinate individual liberty to other pressing interests, such as forcing taxpayers to feed that starving Bangladeshi child, hard-core libertarians claim that liberty alone can ensure the very possibility of human flourishing (Sade 2008: 468). Libertarians of this stripe thus align themselves against statism or any submersion of the rational individual into the larger social body. Borrowing language they could take from a liberal of a different stripe, John Rawls, libertarians stress the "separateness of persons." There is no over-arching social body or organism whose overall utility or welfare is of any concern to us. There's nobody here but us individuals, and the one life we all have to live.

Hard-core libertarianism thus leads to the conclusion that the only rights we have are negative, and that negative rights take up the entire space of rights. It might be a good, charitable thing for someone to feed that Bangladeshi child, but no one, including the modern state, has the right to coerce some for the benefit of others.

The implications of this view for a putative right to health-related goods are easy to imagine. There simply is no such right because there can be no legitimate positive rights. Health care is not special; it should be treated like any other good—e.g., beer and video games—available on the free market for those willing and able to pay for it. Libertarians do believe, however, that we have negative rights to contract with others to provide for our health care, and they believe we have negative rights to health in the narrow sense that others have duties to refrain from injuring our health. But the key point here is that they view a positive right to health-related goods to be a threat to the negative rights of taxpayers and others.

Utilitarianism

Whereas hard-core libertarianism is all about negative rights, utilitarianism is all about consequences. Utilitarians believe that morality exclusively has to do with improving human welfare; they are not fundamentally interested in agents' motivations, natural rights, or the will of god (Goodin 1995). One theoretical problem with libertarianism, in fact, is its insouciance with regard to consequences. No matter how many Bangladeshi

children are starving, hard-core libertarians would condemn any attempt to solve that problem through coercive taxation, even at very low, laughably affordable rates. Many people find this to be an unacceptable result for a moral theory. But utilitarians have the opposite problem: They can easily justify coercion in the name of the greater good, but they have trouble (as we shall see, not insuperable trouble) justifying rights.

The basic structure of utilitarian theory is simple: Figure out what the good is for human beings (and other sentient creatures), then attempt to maximize the amount of that good in our actions and social policies (Mill 1863/2001). For purposes of this drastically truncated discussion, we shall assume that utilitarians focus on maximizing human *welfare*, rather than (mere) pleasure or unfiltered personal preferences. At first glance, then, utilitarianism would seem to have trouble with the concept of rights since, as we've seen above, rights are supposed to function as trumps with regard to the achievement of good social consequences. Even if medical science could advance by leaps and bounds if only researchers were permitted to dragoon unwitting subjects into medical experiments, such violations of freedom are not permitted, at least by our common understanding of morality.

Utilitarians respond to this and other difficulties by stressing the importance of rules and publicity in social policy (Goodin 1995). Were any society to permit this kind of license on the part of researchers to draft unwilling and unwitting subjects into research for the sake of the greater social good, the consequence would be massive social anxiety. It would be hard to plan one's day, let alone one's life, knowing that one could be drafted at any moment into the protracted war against disease. Note that this argument against coercion is based on the likely social consequences, not on some notion of natural human rights. Still, the social rules that utilitarians follow in attempting to maximize the social good often exhibit the same functions as individual rights. Even though in a particular case it might be utility maximizing to dragoon poor Jones into a study of malaria drugs, the long-term welfare of individuals and society will be best served by following publicly promulgated rules that require informed consent and so do not permit this kind of assault on individual liberty. For utilitarians, then, there is room for rights in moral theory, but these rights are equivalent to rules formulated to maximize welfare.

This so-called "rule utilitarian" conception of rights falls neatly into the category of "interest theories" of rights. For utilitarians rights are not mystical emanations from nature or god; they are simply rules erected by humans to protect our most important interests (Mill 1863/2001). One of these paramount interests is good health. In contrast to libertarians, who believe that health care goods are nothing special, utilitarians point to the great importance of access to health-related goods for both individual and social welfare. For individuals, health care can rescue us from premature death, disability, and unrelenting pain. For society, healthy citizens will be more productive workers, soldiers, and participants in democracy.

Because health services are so urgent and special, utilitarians think it makes perfect sense to posit a right to health care. They would, however, insist on an important caveat: We would have a right only to those health-related goods that are instrumental in maximizing human welfare. Some modalities of health care are essential—they produce major improvements in welfare at relatively low cost (e.g., prenatal care)—while others are outrageously expensive and offer only marginal results (e.g., high-tech cancer drugs that cost over $100,000 and yield only a couple of additional months of life). Thus, a utilitarian theory of health care rights would most likely encompass prenatal care while excluding some of those new cancer drugs.

Another way to express this would be to say that the utilitarian right to health-related goods only includes those treatments and diagnostics that pass the test of cost-effectiveness analysis (see Chapter 4 in this volume). Utilitarians sensibly worry constantly about the "opportunity costs" of all proposed medical interventions; they wonder whether more welfare could be achieved by spending our limited health-related dollars on other interventions that yield more bang for the buck. So we are left with a very different approach to health care rights. In contrast to the "will theory" of rights, which views rights as trumps against social utility, the utilitarians' "interest theory" restricts genuine health care rights to those that actually promise to maximize social utility.

Liberal Egalitarianism

Although utilitarianism offers an arguably more satisfying response to the Bangladeshi child than libertarianism, it is notoriously vulnerable to the criticism that it allows for some individuals' rights and welfare to be sacrificed for the greater social good. True, many of these charges can be successfully rebutted by stressing the important role of social rules and publicity within moral theory, but many critics remain skeptical of any theory that would make individual rights dependent upon maximizing social utility. Utilitarianism claims to be a liberal, individualistic theory by insisting that "everyone counts for one, nobody for more than one" (Bentham 1907; Mill 1863/2001: Chapter 5); but critics point out that no sooner does utilitarianism count an individual's welfare than it plunges her into an aggregate social utility function in which her rights may be subjected to political bargaining. Hence the worry that utilitarianism is insufficiently attentive to the "separateness of persons" (Rawls 1971).

The most famous critic of utilitarianism in this vein is the late John Rawls, who was arguably the greatest political theorist of the twentieth century. For Rawls, political morality should be all about fairness—i.e., about what rules and principles free and equal citizens could accept as fair to them—not about achieving a maximal amount of anything. Although Rawls was mostly silent about matters of health, disease, and access to health-related goods, his student, Norman Daniels, has provided us with the most sophisticated and powerful non-utilitarian theory of "just health" available (Daniels 1985, 2008).

Daniels begins by providing an answer to our first guiding question: namely, What kind of good is health care? Is it in some sense special? Whereas utilitarians claimed that the specialness of health-related goods resides in their ability to advance human welfare, Rawlsian liberals like Daniels call attention to the close connections between access to health-related goods, normal human functioning, and opportunity within democratic societies. Daniels argues that health care isn't just some garden-variety good (along with beer and video games) as claimed by some libertarians (Engelhardt 1996); it is rather a special good that can correct for deficiencies in "normal species functioning." If we have an untreated compound fracture of the leg, diabetes, HIV, or frightful dental caries, we and our body parts are not functioning in the normal ways that human organisms function. (For a robust critique of Daniels' account of health and normal species functioning, see Chapter 39 in this volume.)

This shortfall from normal species functioning can have serious implications for the lives we can choose to live. If we have disfiguring dental caries, we won't be able to land a job as a receptionist; if we have an untreated compound fracture of the leg, we won't be able to train for the Olympics; and if we have untreated diabetes or HIV,

we won't live much longer. Daniels thus points to the important connection between normal species functioning and equal opportunity. Untreated illness or disability closes the doors of opportunity.

It is noteworthy that even hard-core libertarians could agree with Daniels' analysis thus far. They could concede that people in ill health usually cannot take advantage of all the opportunities their society offers to those who can function within the normal range. However, the next step in his argument is crucial: Whereas libertarians would say that this illness-induced inability to compete is unfortunate but not unfair, Daniels responds that in a democratic society governed by a normative principle of equal opportunity, such inequalities are definitely unfair and cry out for social remediation. In making this key theoretical move, Daniels is rehearsing traditional liberal theory. Each of us has a big stake in being able to chart our own life course, and to change that course from time to time depending upon our capabilities and interests. We will thus want access to the full range of social opportunities compatible with our own natural capabilities.

In addition, Daniels argues that, to a great extent, none of us is personally responsible for our place in either the natural or social lotteries. Just as we are not responsible for being born on the wrong (or right) side of the tracks, so we are largely not responsible for much ill health, especially for that which is caused by our genetic inheritance or industrial pollution. (Accounting for illnesses caused by our own negligent behavior, such as reckless driving or obesity, is, of course, another matter, which I cannot address here; see Segall 2009.) Egalitarian liberals are largely reconciled to significant inequalities of outcome within society, but they insist on fair equality of opportunity in striving for such outcomes. For Daniels, access to health-related goods, like access to education, is crucial for securing equality of opportunity. The function of health-related institutions is thus to help compensate for social disadvantages due to social or medical bad luck. Untreated illness in this theory is thus both unfortunate *and* unjust.

For Daniels, then, a theory of liberal equality gives rise to a theory of rights to health-related goods. These are not natural or God-given rights; they are derived from philosophically prior rights to equal opportunity. Just as utilitarians worry about opportunity costs in health policy debates, Daniels would limit the right to health care by weighing and balancing various claims within the category of equal opportunity. Health-related services aren't the only contributors to opportunity. Some services are more important than others within the sphere of health care, just as some opportunity-based social institutions, such as education and public health, might sometimes take priority over health services.

Communitarianism

All of the political philosophies we've canvassed so far constitute big tents housing lots of individual differences among likeminded scholars. It may be that the political theory of communitarianism can boast the largest, most encompassing tent of all, making room for all sorts of theorists on both the political right (Hegel 1821/1991) and left (Walzer 1984), united only in their common rejection of individualist liberalism of the sort we've seen in Rawls and the libertarians. Communitarians fault liberalism on a number of important grounds, including the latter's alleged disembodied, deracinated conception of the person or moral agent, its alleged "asocial" individualism, its concomitant neglect of important community interests, its aspiration to universalism in moral theory,

and, finally, its alleged neutrality concerning the good (Mulhall and Swift 1996). Indeed, the heterogeneity of communitarian thinkers makes placing them all somewhere on a map of health care justice a very daunting undertaking (Kuczewski 2004).

We might begin with communitarians' enthusiasm for a politics of the common good. In contrast to libertarians and Rawlsians, who leave the search for the good up to individuals, and the role of referee among competing visions of the good to the liberal state, communitarians often posit a common good that would function as the wellspring of norms in ethics and social policy. Libertarians and Rawlsians alike, in spite of their vast differences, focus on the individual as the proper subject, the alpha and omega, of political philosophy; communitarians like Daniel Callahan, however, urge us to focus instead on what kind of society we want to live in. As he argues in his aptly titled book, *What Kind of Life?*, Callahan claims that liberals start out in the wrong place, with individual interests and rights, and will therefore end up with a bottomless pit of individual needs and desires, with no available breaking mechanisms or limits to the notion of a right to health care. Instead, Callahan asks us to start with the question of what kind of society we wish to inhabit, and derives answers to health-related questions from that starting point. For example, he claims that the point of health care institutions should be to get everyone to a decent old age (say, 75 years), beyond which point the goals of health care should dramatically shift, away from high-cost, high-tech life-sustaining interventions, and toward more modest goals of palliative care and just plain caring. The contrast with liberalism could not be clearer: Liberals eschew the goal of establishing the "true aims" of health care and how health care should nest within larger, publicly founded conceptions of the good life and good society. Many (but not all) communitarians claim that progress on such issues as the ethics of allocation depends upon a publicly shared conception of the good life.

Another major communitarian thinker, Michael Walzer, proposes a kind of *methodological* approach to communitarianism (Walzer 1984). Instead of searching for political truth in some luminous, transcendent realm of theory in a manner reminiscent of the philosopher in Plato's famous allegory of the cave, Walzer's political thinker examines the actual concrete meanings of various important goods forged by actual historically situated men and women—i.e., the writings on the cave wall. By understanding the meaning of any given good in any given society, we can discern how that good should be properly distributed.

Applied to health-related goods in contemporary well-off Western societies, this approach yields the conclusion that health care should be conceived as a "public need"—right up there with police, fire protection, and education—and distributed universally according to need, not ability to pay. In the middle ages, Walzer notes, physicians' services were regarded as the perquisites of the rich and powerful, but access to the sacraments was regarded as crucially important for each person's salvation—hence, a priest in every parish. By contrast, in the modern era the primacy of the soul has been replaced by the primacy of the body and of good health—hence, the quest for universal health care.

Interestingly, Walzer sees an intimate connection between access to health care and citizenship. Whereas utilitarians stress the contributions of health services to individual (and social) welfare, and whereas Rawlsians stress the connections between health and fair equality of opportunity, Walzer locates the specialness of health care goods in their political symbolism. Lack of access to health services, he claims in a riveting dictum, is not only dangerous, it's degrading, signaling a lack of full citizenship (see also Chesleigh 2004).

Walzer wrote about health care justice in the mid-1980s. A contemporary application of his communitarian method is provided by philosopher Paul Menzel, who eschews high philosophical theory in favor of a careful reading of commitments we have already made as a society that provide, he argues, a compelling justification for the central pillars of President Obama's ACA. In brief, Menzel points to our agreement (1) that there should be universal access to emergency room care; (2) that insurers should not be permitted to deny coverage due to preexisting conditions; (3) that those who get uncompensated care from emergency rooms "free ride" on the rest of society's paying customers; and (4) that the solution to this problem is to bring everyone into the system from the very start via a public policy of insurance mandates and subsidies—also known as the ACA. Space does not permit an adequate fleshing out of this argument here; suffice it to say that Menzel's method is Walzerian and communitarian in spirit, and generates a bounded right to health-related goods (Menzel 2011).

What the Right to Health Care Isn't

Although a great deal of ink has been spilled on the existence or non-existence of a right to health care, the "cash value" of this notion is actually quite limited in our public debates over health policy. Make no mistake, it matters a lot whether we acknowledge such a right in the first place. It matters greatly whether we view access to health services as a mere privilege or an entitlement, and whether we view the uncorrected results of the natural and social lotteries as merely unfortunate or also as unjust. Those who would proclaim a right to health care must, then, grapple seriously with the libertarian challenge.

Importantly, however, the notion of a right to health care does not tell us exactly to what health-related goods and services we are entitled; the right does not yield univocal clues to its substantive content (Brody 1991; Arras and Fenton 2009). In other words, the right to health care tells us that some health-related services are indeed special and should not be subject to the vagaries of the free market, but it does not provide straightforward answers to the hard choices we must make every day in health policy. True, it's easy to predict that some treatments will be included within the ambit of a health care right—e.g., prenatal care and ordinary primary care—but beyond that, it's tough slogging. Simply because some treatments might mean the difference between life and death for some (currently identifiable and unidentifiable) patients doesn't mean that they would have to be covered by an entitlement to health care. Consider again those enormously high-cost, low-benefit cancer treatments that provide constant fodder for heated public debate today (Kolata and Pollack 2008).

Whether society should foot the bill for such treatments cannot simply be read off the surface of a putative right to health care. Among a host of other factors, we need to know the cost-effectiveness ratio of such interventions (see Chapter 4 in this volume), whether they target those who are "medically worst off," whether they should be disseminated in largely urban areas where more people can be reached or in rural areas where people already face significant barriers to care, and so on. One helpful way to think about the proper role of health care rights within the larger ambit of health policy is thus to think of them as establishing for each of us a justifiable claim that certain health-related *institutions* be established within which the tough allocation questions will be debated and resolved in a fair and equitable way (Shue 1996). And this, of course, raises the issue of what a just *process* would be for deciding such questions, an important topic I cannot discuss here (Daniels 2008; Fleck 2006).

One obvious implication of this view of rights needs to be brought out into the open. Some people apparently believe that if there is a right to health care, then any explicit rationing of health care must be morally impermissible. Nothing could be further from the truth. If we define "rationing" as the denial of potentially beneficial care on grounds other than the welfare of the patient—i.e., on grounds of cost, opportunity costs, fairness to others, etc.—then health care rationing is both inevitable and morally justified (Ubel 2001; see Chapter 3 in this volume). Indeed, one philosopher contends that rationing isn't just a necessary evil; it is, rather, morally required of us if everyone is to obtain a just share (Dworkin 2002).

In addition to the libertarian challenge from the political right, the notion of rights to health care is also vulnerable to contestation from the political left. As we saw at the beginning of this essay, the concept of a right to health *care* turns out to be too narrow a claim. If we have learned anything from the burgeoning literature on the social determinants of health during the past two decades (Wilkinson and Marmot 2003; see also Chapter 2 in this volume), it is that health *care* actually plays a relatively minor role in the achievement of health itself, especially at the population level. We've known for a long time that major historical shifts in the health status of populations owe more to various public health interventions—such as safe water systems, better nutrition, and safer working conditions—than to the often admittedly spectacular achievements of modern medicine (McKeown 1980). What we've learned more recently is that factors such as social inequality, lack of status, and stress on the job may also contribute significantly to ill health (Marmot 2005). Conversely, we've learned that if we really want to improve people's health at the population level, we should invest, not necessarily in more, better, and ever more expensive individualized health care, but rather in massive expenditures in education, jobs, the protection of human rights, and the leveling of savage income inequalities.

Related Topics

Chapter 2, "Social Determinants of Health and Health Inequalities," Sridhar Venkatapuram and Michael Marmot

Chapter 6, "Bioethics and Human Rights," Elizabeth Fenton

Chapter 39, "Medicalization, 'Normal Function,' and the Definition of Health," Rebecca Kukla

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