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The Foundation and Content of a
Moral Right to Health Care

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ABSTRACT

This thesis addresses the question "Is there a moral right to health care, and, if so, what does it entail?" In nearly all Western countries except the United States, the idea of a right to health care is taken for granted. However, since a right to health care has been assumed in most countries, the foundation of that right is unclear, and today, as health care systems are feeling ever-tightening budget constraints, difficult rationing decisions face all countries. Without a clear foundation for the right, countries are left with little guidance in these rationing decisions. A clear foundation should assist in the prioritization of health care interventions. The elements of health care which make it morally special and secure us a human right to it should be reflected in the prioritization of services.

Chapter two attempts to clarify the concept of rights. The right to health care being discussed is a moral, positive in rem right, i.e., a morally-justified, resource-intensive entitlement to health care which can be claimed against society at large. Rights have been given considerable moral status, and they are entrenched in our system of moral justification such that considerations of rights "trump" all non-rights considerations. However, positive rights are dependent on scarce resources to be fulfilled. As a result, the content of a positive right is dependent on the amount of resources available to a given community. Thus, positive rights entail different things in a developed nation than in a developing one.

Chapter three examines several theories of justice for strengths and weaknesses vis-à-vis health care, and three arguments are identified as stronger than rest: the right to a decent minimum, Robert Veatch's egalitarianism, and Norman Daniels' Just Health Care. Chapter four presents Jack Donnelly's constructivist theory of human rights and applies it to health care. The priority setting mechanisms of the three main rival theories are compared to those of the constructivist theory. The central concept of the constructivist theory, dignity, contains the subtlety to yield a sensible prioritization of services. The moral importance of health care lies in its ability to maintain and enhance the dignity of individual lives. The constructivist theory suggests that health care interventions should be prioritized by their relative ability to allow individuals to live a life of dignity which calls for a community definition of dignity.

Chapter five examines several rationing tools. Because low priority services also make some contribution to dignity, it is not enough to prioritize condition/treatment pairs and effortlessly fund the list as far as the budget allows. We should labour to fund as much of the list as possible by controlling costs high on the list. The concept of dignity assists us in this task: of each rationing device (e.g., waiting lists, technology assessment, etc.) we must ask "Does this method, as being applied, assist or detract from the health service reaching its goal of enhancing the dignity of individuals' lives?"
PREFACE

I would like to thank my supervisors, Grant Gillett and Alastair Campbell, for their helpful guidance and encouragement throughout the year. I am also indebted to Andrew Moore, John McMillan, and Grant Vallance. These five spent considerable time reading and discussing this thesis with me both while it was separate chapters and as it became more cohesive. They assisted me in clarifying my message when my writing was not clear, and they pointed out the spots where my writing was clear but my thinking had gone wrong. Their input is heavily reflected in this final version. Of course, the problems that remain are attributable to me alone.

Thanks also to Christine Cooper for always remaining cheerful while helping me to sort so many things out. My wife, Mary, deserves special thanks for her endless patience throughout the entire project.

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"Is there a moral right to health care, and, if so, what does it entail?" is the specific question I have undertaken to answer. In nearly all Western countries except the United States, the idea of a right to health care is taken for granted; certainly, the concept is taken as a given in New Zealand. Most health care delivery systems have grown-up with this as a basic tenet. Inasmuch as this is correct, an analysis of a right to health care may seem dull or common. However, since a right to health care has been assumed in most countries, the foundation of that right is unclear, and today, as all health care systems are feeling ever-tightening budget constraints, difficult rationing decisions face all countries. Without a clear foundation for the right to health care, countries are left with little guidance in these rationing decisions. Hence, an analysis of the right to health care is useful to those involved in rationing. The question of a right to health care is far from mundane for an American--in fact, it is central to many resource allocation decisions. Unfortunately, demonstrating a right to health care leaves its content inadequately defined, although the foundation will necessarily be reflected in the content. Thus we are faced with the two-pronged question: Is there a right, and what is its content? A clear foundation for the right to health care should assist in the prioritization of health care interventions. The elements of health care which make it morally special and secure us a human right to it should be reflected in the prioritization of services. If it is health care's ability to save lives, for example, which makes it morally important, then life-saving medical care should get highest priority.

I found my way to medical ethics with the question of whether there is a moral right to health care because it was obvious to me that there was something ethically wrong with the system of health care financing and delivery in the United States. I wanted to ferret out the problem, and demonstrate where the system had gone wrong. On one hand, it seemed people should be able to claim a right to health care in many situations. On the other hand, many proponents of the right to health care were claiming too much. Many have used this as evidence against a right to health care: since we cannot possibly afford to pay for all desirable health care it is nonsensical to speak of a right to health care, the
argument goes. How can one establish a right and maintain reasonable limits on it? Further complicating the picture, problems with health care delivery are multifactorial: economic and political, as well as ethical. It is not simply ethical inadequacies that have lead to the current undesirable situation. This chapter will highlight what is at stake in the discussion of a right to health care by describing issues in US delivery with brief mention of analogous problems in other western countries. This initial discussion will be largely factual with little attempt to separate ethical from economic or political difficulties. After all, good applied philosophy should be planted firmly in the real world. Then the layout for the remainder of the thesis will be sketched.

My early research in this area lessened the sense of urgency.

The United States...is on the verge of a 'massive crisis' in health care. The nation devotes a greater share of resources to health care than do other countries. Yet it lags behind several large industrialized societies in primary indices of health. There is a growing shortage of doctors. Medical services are unevenly distributed. Costs are spiraling.¹

Although it sounds like a pretty desperate situation and it looks like something out of a recent newspaper or periodical, it was written in 1970. This initially had a calming effect. After all, if people have been preaching imminent doom for 25 years and doomsday has yet to come, then it is probably all blown out of proportion. Unfortunately, closer inspection of the doom being preached shows that most of it is coming true. In 1970 the foreboding future for health care was that the (already too high) bill of US$63 billion might "reach $100 billion in the next five years and may even double and reach $200 billion in the early 1980s."² US health expenditure was $248 billion in 1980 and $323 billion by 1982! Despite these expenditures, the problems of uneven distribution of health care and poor rankings in the primary indices of health persisted. Although I was initially assuaged, on further consideration, perhaps things have been


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in a state of crisis for some time. Predictions for the future have the USA total health expenditure exceeding $1.5 trillion by the turn of the century.3

What is wrong with health care delivery in the United States?

As suggested in the quote above from 1970, there is a combination of problems in American health care that is particularly difficult. American health care is inadequate in terms of cost, access and quality; hence it is difficult to repair or improve one of the areas without further damaging another area. This fact has thwarted many attempts at reform. By emphasising the negative impact on other areas, reforms which address only one of the problems are argued to be terribly inadequate. And reforms which encompass all areas are so broad as to be accused of "not retaining the strengths of the American system." As the system deteriorates in the background, the great majority of reform plans are cast aside for one of these reasons.

The easiest problem to elucidate is that costs are out of control. As is illustrated in figure one, the United States spends far more per capita on health care than any country in the world.

Per Capita Health Expenditure
Selected Countries, 1989

- United States: $2,384
- Canada: $1,798
- Japan: $1,586
- Australia: $1,211
- New Zealand: $872
- United Kingdom: $854

Source: Comparison of Health Expenditure in OECD Countries

**FIGURE 1:** Per Capita Health Expenditure, Selected Countries, 1989

American health costs totalled US$752 billion in 1991, and they are projected to reach US$1 trillion in 1994. However, the US has spent more on health care than other countries for a long time; the real concern is that the gulf between what the US spends and what other countries spend is widening. Expenditures on health care are threatening the US economy. Health care is gobbling up a progressively larger chunk of the total economy as is illustrated in figure two by health care's growing percentage of gross domestic product.
Some argue that health care is draining funds from police, schools, and other social programs because between 1965 and 1992 health costs rose from 2.6 to 16 percent of the federal budget. Health care is definitely draining money out of individuals' pockets: since 1972, rising health insurance costs have eaten up half of workers' increased compensation (pay plus fringe benefits including insurance).

The US system is primarily employment based, that is, employers pay the lion's share of health insurance premiums. Thus, the high cost of health care is adversely affecting America's ability to be competitive in the global economy. In 1989, US health care costs per capita were 40% higher than Canada's, 91% higher than West Germany's, 127% higher than Japan's, and 182% higher than the United Kingdom's.4

This expansion in costs has been in the face of unprecedented cost containment efforts such as utilisation review, second surgical opinions before surgery, co-payments, and diagnosis related groups (DRGs). Left unchecked, we can only speculate what health expenditures would be. This has lead many to the conclusion that health care demand is a "black hole"—that, if allowed to, health care could consume infinite resources.

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without eliminating demand much the way infinite matter and even light are sucked into a real black hole.

Although the increasing expenditure on health care is economically frightening and demands political attention, the most ethically difficult issue is the poor access to health care in the USA. At any one time about 33 million people (15% of the population under age 65) are without health insurance in the United States, and millions more have inadequate coverage for catastrophic illness. Perhaps the most significant fact is that full-year, steadily employed workers and their families, account for two-thirds of people with no health insurance (in a system that is employment-based). This fact says different things to different people. Some ask why these working folk do not buy their own health insurance. Why should we feel guilty and compelled to overhaul the health delivery system because some people are not prudent? Others reply this is evidence of how expensive health insurance has become; even full-time workers cannot afford health insurance. There is truth in both positions. Not all of the uninsured are without insurance because they cannot afford it; about 23 percent of the uninsured had annual incomes of at least US$30,000 in 1986 (well above the 1986 median household income of $24,897). However, there are also a large number of Americans who simply cannot afford health insurance and are not eligible for the government programs (Medicare or Medicaid). Compared with insured people, the uninsured are less likely to have a regular source of care, to see a physician in any given year, to obtain immunisations, and to receive adequate prenatal care. The uninsured are more likely to delay obtaining needed services, thereby compounding health problems.

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8 Reinhard Priester, "Biomedical Ethics Reading Packet #5: Distributing Limited Health Care Resources." (Minneapolis, MN: Center for Biomedical Ethics, April 1991) p. 2.
The US health care system is also attacked by some for being of low quality. At least, people question whether health care is good value for money. The problem was clear in 1970: despite massive expenditures on health, the US lagged behind several large industrialised societies in the primary indices of health. In 1970, the US ranked 13th in infant mortality, 18th in male life expectancy, and 11th in female life expectancy. Not much has changed. In 1989, the US ranked 22nd, 13th and 14th. Obviously, these are crude measurements of the health of a nation. Expensive health care with a significant impact on quality of life--like hip replacements and cataract surgery--would have little, if any, impact on these indices. And non-medical care factors like life-styles, environment and genetics play a significant role in these rankings. Still, though, these poor rankings are an indictment of the US health care system.

**How can a nation sustain such a system?**

Sketches of the US system as I have made above, although factual, are incomplete, and by omission they paint a worse picture than reality. Those Americans for whom the health system works well (a large majority of citizens) enjoy a level of health care available only to relatively few elsewhere in the world. Hospitals are superbly equipped with all of the latest technology, and most physicians are specialists with long years of training. These elements, of course, add to the high cost of health care, but from the well looked-after individual's perspective there is no better health system in the world. Things are not as bad as they seem for the uninsured, either. They have "access" to this same high tech system; access in the sense they are not barred from using it. Hospitals, on average, devote about 5 percent of their budget to charity care which pays for treating the uninsured indigent. The non-indigent uninsured are left with large medical bills to pay. Uninsured, acutely ill patients are not left untreated to die.

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Are these exclusively American problems?

Are there problems with rising costs, poor access and quality in other Western countries? The short answer is yes, but it must be admitted that the 'health care crisis' is more acute in the US than anywhere else. The following graph demonstrates that other countries also are having difficulties with health care inflation.

![Total Health Expenditure as a Percentage of Gross Domestic Product, Selected Countries](image)

Although this graph is admittedly difficult to read, the tendency is clear: health care is consuming a progressively larger portion of the economy of each of these five major nations. The upward trend (i.e. the slope of the line) is less dramatic than in the USA, but the pattern is the same. And these nations are not isolated examples: health care as a percent of GDP is increasing in all OECD countries.

The US does have an exclusive hold on the problem of access, in the sense of universal insurance coverage. All other industrialised nations (except South Africa) provide universal access to care for their citizens, and, at the same time, spend less per capita on health care than the United States. Universal insurance coverage, however, does not eliminate differential access: there are many examples of unequal access to health care in countries with public health services. The inadequate access of Maori in New Zealand is well documented. Pomare reports that Maori have an infant mortality rate which is 60% higher than non-Maori,
Introduction and in 1982 Maori life expectancy at birth was 7 years less for males and 8 years less for females than their non-Maori counterparts. Coronary artery disease is a particular health problem for Maori with age specific death rates far higher than for non-Maori; however coronary artery bypass graft (CABG) surgery rates are shockingly low. In 1983 and 1984, 822 and 825 CABG surgeries were done in New Zealand, but only 10 and 14 of these surgeries were on Maori patients, respectively.\(^{11}\) Rates for heart valve operations are slightly higher among Maori (13.6 versus 12 per 100,000), but the difference in indication for the surgery is alarming. Rheumatic heart valvular disease is caused by rheumatic fever which is easily prevented by treating strep throat infections with penicillin. Green Lane hospital (which does 57 percent of all heart valve surgeries) statistics reveal that 84 percent of Maori operations are for rheumatic valvular disease, compared with 25 percent for European New Zealanders.\(^{12}\) These examples are not meant to imply New Zealand has a particularly poor health system; similar examples can be demonstrated for the lower socioeconomic groups of most countries. However, these examples demonstrate that differential access is not a problem for the US alone, a fact that is overlooked by most critics of the US health system and used by proponents of the status quo. The argument is simple: if this is the kind of equity a national health service can give us, then we should stick with what we have.

As noted above, problems with health care delivery are complex, containing difficult economic, political as well as ethical elements. From all these angles, though, it would seem the most elementary question that must be answered before attempting to reform the health delivery system is whether universal access is a priority. Is access to health care a basic right? As illustrated with the Maori examples, providing universal insurance coverage is only one of the obstacles that must be removed to get equal access, but clearly it is the starting point. Legislation has been passed in the US to increase the access to health care for certain groups (Medicaid for the indigent and Medicare for the elderly), but universal health insurance has never been official policy. Furthermore, an

\(^{11}\)All of these statistics are from EW Pomare, "Groups with Special Health Care Needs." *New Zealand Medical Journal*. 101 (1988): 711-713.

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employment-based approach to health care, like the US system, is not designed to provide universal health insurance coverage. Universal coverage can only be achieved by special arrangements to cover the non-employed.\(^{13}\) Although it was not a statement of official government policy, the 1983 President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research argued that Americans have no right to health care, but there is a social obligation to provide a decent minimum of health care.\(^{14}\) Many bills mandating universal coverage have been put before Congress during several administrations from Nixon through Clinton, but none has had a serious chance of becoming law. The importance placed on universal access has far reaching implications for the whole system. The question of a right to health care will be addressed from an ethical perspective leaving aside all pragmatic economic and political concerns except one. The fact that health care must get by within a limited budget will be an integral part of the argument. We simply do not have the resources to pay for all desirable, beneficial health care interventions. Thus our moral argument for a right to health care must contain the ability to set priorities and ration health care if it is to be useful.

Rationing, unfortunately, has become an emotive word in health care. It seems to conjure up callous and inhumane images. Rationing is defined here as limiting the availability of beneficial care (an uncontroversial definition). Rationing by this definition includes all examples of patients not receiving "the best" treatment, all examples of withholding treatment that would yield a net benefit (benefits minus harms) to the patient. This includes providing treatment at a later date that is indicated today (i.e., waiting lists). As you can see, rationing does not contain any explicit reference to costs. (Something that is overlooked by many who think rationing is offensive.) Thus rationing includes some quite uncontroversial decisions as well as some more controversial acts. For uncontroversial examples, we treat uncomplicated infections with

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\(^{13}\)For a complete discussion see Peter Budetti, "Universal health care coverage—pitfalls and promise of an employment-based approach." *Journal of Medicine and Philosophy.* 17 (1992): 21-32.

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cheaper antibiotic when more expensive antibiotics with broader antibacterial spectrums would give marginally better cure rates; we do not order chest x-rays on everyone with respiratory complaints; and we do not send everyone with a sprained ankle for physiotherapy. In all these cases, the benefits of the additional treatment (however small) would outweigh the harms, but the treatment is seen as unnecessary. Few would find problems with these examples. Partly, these examples arise from attempts to control costs, but our ease in rationing here has much to do with the additional benefits gained being small. Of course, rationing includes more contentious examples also, but the examples given above demonstrate rationing should not be considered inherently evil. Furthermore, as the economists remind us, rationing medical care is nothing new: "the United States has always rationed medical care, just as every country always has and always will ration care."15 Rationing is a reality with which we should become comfortable.

The resources that can be devoted to health care are scarce; that is, we cannot afford to pay for all possible beneficial health care. This is a premise that is accepted much more readily in New Zealand than in the United States. Much of the American medical literature on the topic of resource allocation argues against the need for systematic rationing. Consider the following passage by Arnold Relman, former editor-in-chief of the New England Journal of Medicine:

This, in essence, is the health policy debate of the 1990s. Can we improve our health care system sufficiently, and soon enough, to avoid either systematic rationing or more restriction of access through pricing?...I am convinced we can. In a country that spends as much as we do on health care, there should be no need to deny medically necessary services (including the best of modern technology) to anyone....All the evidence suggests that there are vast savings to be made through the elimination of unnecessary services and facilities.16

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I would like briefly to address the two main arguments invoked in support of the "we do not need to ration health care" thesis.

First is the efficiency argument. Much of the American literature emphasises the need to trim the "fat" from our system. America needs to eliminate unnecessary medical care, and eliminate inefficiencies in the delivery of necessary care. The underlying assumption is that we could avoid rationing by having a more efficient health care machine. A good starting point is to define efficiency. Pareto gives us the conventional definition of economic efficiency: a Pareto-improvement is a change that benefits someone and injures no one and a situation is efficient if it cannot be Pareto-improved, i.e., efficient arrangements are Pareto-optimal. Eliminating health care of no benefit or replacing interventions with less expensive alternatives and equal benefits are ways to increase the efficiency of the health care system. There are many examples of such efficiencies. One study showed that laboratory tests in a teaching hospital could be cut by 47 percent without any apparent loss in the quality of patient care. Eliminating these lab tests would be a Pareto-improvement: the money saved would benefit someone and no one would be injured. I agree that the New Zealand and especially the American health care systems have a long way to go in increasing efficiency. However, health care resources would still be scarce even in an ideally efficient system (leaving aside the low probability of reaching 100 percent efficiency). As Aaron and Schwartz point out, efficiency gains are a one-time savings, and the upward trend of expenditures would consume even a large one-time savings in a few years. Say, for example, we are spending $1 trillion on health care this year, and, say, we can achieve an impressive 25 percent reduction in costs by eliminating all inefficiencies. Expenditure is reduced to $750 billion, but, after adjusting for inflation, total health expenditure has risen at 5.5 percent per year since 1950. After six years at that rate (it would be likely to take less time as

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health expenditures have been increasing more rapidly in recent years),
total (efficient) expenditure is well over $1 trillion, and we return to the
question of rationing.

There is another less technically precise, though more common,
usage of "efficient." This usage seems to follow from the physics
definition of efficiency: the ratio of the work done by a machine to the
work equivalent of the energy supplied to it. Some authors are referring
to elimination of all high-cost or all low-yield interventions when they
speak of "efficiency." Some argue we should eliminate expensive
procedures, like liver transplants, to increase our efficiency. Others argue
that the system would be more efficient if all low efficacy interventions
were eliminated, say all treatments with less than 10 percent effectiveness.
The argument is that if we can buy greater health gains in another area by
forgoing these interventions, then efficiency is improved because greater
health gains are purchased with the same resources. These propositions
are not Pareto-improvements (regardless of whether they seem like good
ideas). In both cases many people stand to gain from the changes but some
people are also injured. Although the money saved by not funding liver
transplants may be able to bring necessary health care to many people,
those forced to forgo transplants are injured, gravely injured. Both of
these purported efficiency gains are actually modes of rationing: the first
is rationing by cost of care; the second is rationing by net benefit of care.
These approaches are both rationing techniques, not efficiency gains (by
Pareto's technical economic definition).

The second argument is that we simply need to devote more
resources to health care. Many claim there are so many examples of
extravagant, wasteful, ridiculous expenditures in our society that it is
obvious we should shunt more of our resources toward health care
because health care serves such a vital function in society. Marcia Angell,
for example, writes: "In a country that is this year [1985] spending about
$300 billion on defense and $25 billion on tobacco, and in which $500,000 is
spent for a 30 second television advertisement during the Super Bowl, we
should be prepared to argue for spending whatever is necessary for
effective medical care."20 The argument to spend more labours under the

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20Marcia Angell, "Cost Containment and the Physician." Journal of the American
dual delusion that more health care is tantamount to better health and that life is infinitely valuable. In America this argument should carry little weight. The US already spends a great deal more on health care than the rest of the world, and our health is no better. And normal behaviour suggests life is not infinitely valuable. Anyone who smokes and believes smoking is bad for his/her health is deliberately trading health for the pleasure of smoking. Indeed, anyone who spends time or money on anything that does not increase life expectancy while there remains an expenditure that does--better food, more exercise, safer car--is demonstrating that life, while it may be valuable, is not infinitely valuable in comparison to other things.

Perhaps the argument to spend more on health care has some merit in New Zealand. Consistently, the average percentage of GDP spent by OECD countries on health care has been above that spent by New Zealand.

![Health Expenditure as a Percentage of Gross Domestic Product (1980-1989)](image)

**FIGURE 4:** Total Health Expenditure as a Percentage of GDP, OECD Mean and New Zealand, 1980-1989

However, Scott and Scott "concluded that New Zealand's spending on health, although below the OECD average (as a percentage of GDP), was in line with the level of GDP per capita"21 (i.e., New Zealand's expenditure

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on health was similar to other nations with similar GDPs). Thus, Scott and Scott argued New Zealand was spending roughly the appropriate level on health care. Regardless of whether New Zealand should increase its expenditure on health, the US and Canadian experiences suggest that not all health care needs could be met even by a dramatic increase in expenditure. Hence, the need to ration care would remain.

I will attempt to maintain the focus on the specific question of whether there is a moral right to health care, although explication will require frequent (sometimes lengthy) references to general ethical theories. The objective is not to devise a new general ethical theory. It is simply to answer the question of whether or not a moral right to health care exists. Moulding a right to health care should have wider implications for other moral rights. It is my goal to explain my thoughts regarding health care well, and to sufficiently (but not thoroughly) suggest implications for other moral rights. This may leave my thoughts regarding resource allocation and justice outside health care unsatisfactorily vague, but I hope not. One point to make clear, though, is that health care is not properly viewed alone; it belongs within a complete system of moral rights. Examining only health care can lead to unsatisfactory conclusions, and that has been the error of many who have approached the topic. I hope I succeed in conveying the inter-relatedness of all moral rights without losing the focus of my argument on justice in health care.

The idea of a right to health care is taken for granted in most Western countries. An analysis of the foundation of the right to health care is important because the foundation of that right is unclear. As all health care systems are facing increased budgetary constraints, all countries are confronted with difficult rationing decisions. A clear foundation should assist in the prioritization of health care interventions; hence, even those who take the right to health care for granted may profit from a clear explication of the foundation of that right. One objective of this thesis is to provide a cogent argument that many proponents of a right to health care envision too broad a right. Arguments that do not expressly address our obligations to other moral rights tend to overvalue health care. Most accounts make little contribution to the necessary rationing decisions that confront us both within health care and between health care and other moral rights (social goods). We require a
philosophical foundation that points to a content for the right to health care that allows us to avoid the black-hole problem (infinite demand for health care). It must contain the subtlety to distinguish between health care needs that entail a right and those which do not entail a right, and the foundation should allow us to make comparisons between health care and other moral rights.

This thesis is in six chapters. In chapter two the concept of a right is explored and the necessary precision is added to the kind of right to health care we are discussing. A great deal has been written on the different aspects of a right to health care, and we must be precise about the right we are discussing lest we find our subject shifting awkwardly beneath us. In chapter three various possible foundations for the right to health care are critically examined. Several theories of justice—egalitarianism, utilitarianism, merit theory, Rawls's theory, and libertarianism—are examined for strengths and weaknesses vis-à-vis justice in health care. None of the standard accounts of justice seems to yield what we expect of justice in health care. In chapter four the approach from a constructivist human rights theory is mapped, and offered as a new alternative standard of what we want from health care. The human rights approach is better at assisting us with the necessary rationing decisions than are the standard conceptions of justice in health care. In chapter five an attempt is made to spell out the content of a right to health care. The tendency to overvalue health care is discussed, and emphasis is placed on ways to limit the right to health care. Finally, chapter six briefly summarizes the conclusions.
CHAPTER 2: WHAT KIND OF RIGHT?

In bioethics we often discuss rights. Patients have a right to confidentiality. Patients have a right to informed consent. Patients have a right to refuse treatment. Women have a right to abortion. Foetuses have a right to life. Animals have certain rights that should not be violated by medical science. We are also frequently confronted with rights in political discussions: gay rights, women's rights, prisoner's rights, right to vote, right to die, right to an education, right to practice any religion we choose, etc. Rights are the buzzword in moral debates--both in medicine and elsewhere. What are rights? How can the same word be used in so many seemingly different contexts? This chapter will attempt to clarify rights language.

"Does a right to health care exist?" is the question at hand. It seems the majority of people in Western society have an intuitive sense that people are entitled to some level of health care. For example, a 1987 survey showed that 63% of New Zealanders agreed or strongly agreed with the statement "medical care should be available free-of-charge to those who need it." In America, the Harris survey from roughly the same time found an impressive 91% agreed with "everybody should have the right to get the best possible health care--as good as the treatment a millionaire gets." Both of these surveys, however, contained several questions and the degree of public enthusiasm for a right to health care varied with each question. At the very least, we can agree most people are disturbed by examples where good people have come to harm by the denial of basic health care. Unfortunately, this gut feeling that it is wrong when people are denied needed health care is insufficient in a systematic discussion of health care as a right. In fact, before the discussion can proceed with any precision one needs to work through exactly what rights are and what sort of a right to health care is being proposed.

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As Jack Donnelly points out, "right" is a multifaceted word in the English language, especially within the language of philosophy. To this point, an important usage of "right" has been neglected. We often discuss what is and what is not right. It is not right to violate a patient's autonomy. Paternalism is not right in most situations. It is right to tell patients the truth regardless of what you might think they want to hear. In all of these contexts the verb to be is used with right, and the discussion is moral righteousness. Above, the verb to have was always used with a right. Surely, there is an important distinction between "having a right" and "being right," but how are these two related? It would not be right to deny necessary health care to a child, but can this be turned around to say the child has a right to such health care? More on this distinction and relation below, but for the remainder of this section we will be classifying rights in the sense of "to have a right."

RIGHTS AS ENTITLEMENTS

Rights are traditionally understood as entitlements a person possesses to some good, service or liberty. As entitlements, rights are to be contrasted with privileges, personal or group ideals and acts of charity. Only a person with a valid claim has a right. A rights bearer is in a position to make demands because of his/her entitlement. The philosophical foundation of any right is located in a justifying reason that directly supports the claim of entitlement. A clever argument for X does not always amount to an entitlement to X, and passionately arguing that one ought to receive a good or service is not adequate grounding for a rights claim. For example, while it may be a good idea to provide all school children with a personal computer for a myriad of reasons (e.g., preparation for the job market, increase their learning potential, etc.), it does not follow that school children have a right to a computer. It may even be possible to show that giving school children a computer would eventually increase the economic output of a nation so much as to exceed greatly the initial cost of the computers; still the children have no right to a computer. When arguable cases or claims turn out to be invalid, then one has no right. The notion of a moral right is usually translated into the language of justice. The language of rights is used to specify an area of

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justified claims that are well guarded against political tradeoffs because they are rooted in moral principles. 4

**CLASSIFICATION OF RIGHTS**

There are several distinctions that need to be made with regard to rights. The first is between conferred and moral rights. *Conferred* rights are those granted by institutions, both legal and non-legal. *Moral* rights are rights that exist prior to and independently of any social conventions or legal or institutional rules. Moral rights are essentially human rights. 5 They are the rights claimed on behalf of all men and women in all situations. There is considerable overlap between conferred and moral rights, but neither group is a subset of the other. There are moral rights that are not conferred and conferred rights that are not moral. 6

Another distinction is between legal rights and moral rights. Legal rights are justified within a system of legal principles, and moral rights are justified within a framework of moral principles. Once again, there would be three subgroups: legal rights merely, moral rights merely, and both legal and moral rights. Although a conferred right need not necessarily be a legal right, this distinction is less important in philosophical discussion. For example, it could be the conferred right of a member of a certain private club to use the club’s facilities before a club guest although there may be no such law. This "extra layer" in the description of rights unnecessarily complicates things. Particularly with the issue at hand—whether there is a moral right to health care—I cannot think of a scenario where the right would be conferred but not legal. For simplicity’s sake, the conferred/legal/moral distinction will be reduced to the legal and/or moral distinction. Discussing that which will be

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5Obviously, one could argue there are moral rights that are not human rights—extra-human moral rights, if you will (e.g., animal rights)—but this section is to frame a discussion of a human right to health care. I make human rights tantamount to moral rights not necessarily to deny extra-human moral rights, but rather to emphasise the importance of moral rights. The concept of human rights is further explicated in chapter four.

6It is important to notice here that "not moral" is different than "immoral." Of course, a conferred right could be immoral (e.g., the right of slave owner to beat a slave in eighteenth century America), but it could also be not moral in the sense that it is petty (e.g., cars should stop at a red light even when there is no cross-traffic).
eliminated is informative, though, to the extent it illustrates the complexity of the concept of rights.

The next feature of rights to elucidate is the difference between negative and positive rights. The difference has long been pointed out by theorists. Wesley Hohfeld, the American attorney, distinguished between "liberties" and "claim-rights," and British philosopher Jeremy Bentham drew a similar distinction. A simpler and more contemporary word choice—and the choice used henceforth—is to call the two types of rights negative and positive, respectively. The crux of the distinction is whether recognising the right requires a specific action and resources or whether it does not. Positive rights require a specific action (e.g., the right to be repaid a debt), and negative rights require an omission of action, i.e., negative rights protect against interference (e.g., the right not to be assaulted). Furthermore, positive rights typically require resources in order to be fulfilled whereas negative rights do not. Presumably all that must be done to honour negative rights is to leave people alone. Thus the right to liberty is a negative right because no one has to do anything to honour it; it is just that certain actions are prohibited by a right to liberty. Positive rights, on the other hand, are rights to receive goods and services. A right to food requires someone to give food (i.e., a specific action and a specific resource) to the needy person.

CORRELATIVITY OF RIGHTS AND OBLIGATIONS

What is the relationship between rights and obligations? From the preceding discussion, it should be clear that a right entails the imposition of an obligation on others either not to interfere (negative right) or to provide something (positive right). Consequently, rights establish obligations, but do


9 It is worth noting that some authors have used positive rights to mean two separate things. Positive rights can mean rights conferred only on those who fall under the jurisdiction of a particular system of positive law. These positive rights are contrasted with human rights or moral rights which can be claimed on behalf of all men/women in all situations. For this distinction I have used conferred/moral. Within different contexts, these same authors use positive rights to denote rights logically correlated with other people's action. This can be confusing when reading the literature, so I have purposely avoided the dual usage.
all rights establish obligations? That is to say, are there rights without corresponding obligations?

Bentham claims that all rights assign obligations: "For every right which the law confers on one party, whether that party be an individual, a subordinate class of individuals, or the public, it thereby imposes on some other party a duty or obligation." This is the prevailing view.

Rights without obligations?

While all seem to agree the great majority of rights entail obligations, a few authors have posited that there are some rights without obligations. Feinberg argues that there are positive rights without obligations in situations where the goods in question are so scarce that there is no hope of fulfilling all the valid claims. During a severe famine, for example, it would be impossible to see that all receive sustenance, and after an earthquake which levels the local hospital it is impossible to fulfil a right to hospital care. Feinberg argues that the "deprived claimant in conditions of scarcity remains in a position morally to make a claim, even when there is no one in the corresponding position to do anything about it...But where there is no other person with a duty to fulfill the claim, its validity does the claimant no good." While this is a persuasive example, it seems what is lacking is not duty obligation but anyone capable of carrying out the obligation. This problem of extreme scarcity is discussed further below.

David Lyons argues that many negative rights entail no obligations. (Interestingly, he concedes that positive rights entail obligations.) To paraphrase, he takes the familiar example of the right to free speech, and argues it does not entail any obligations to forbear which do not already exist. What does the right to free speech guarantee us? It allows us to air our views without risk of physical assault or coercive measures from individuals or government. Lyons says, "Since others are prohibited in general from (e.g.) assaulting, threatening, coercing, and forcibly restraining" other individuals, then the right to free speech guarantees us nothing new. Lyons challenges the


correlativity of certain negative rights and obligations; he appears to think it is an argument against the right to free speech implying certain obligations that the obligations in question exist anyway. The argument seems to hinge on the obligations of a right to free speech being redundant. David Braybrooke, however, argues that superfluity does not mean the right to free speech entails no obligations.13 While it may be untidy that many or all of the obligations entailed by the right to free speech are simultaneously guaranteed by other rights, we need not invoke the other rights to exercise our right to free speech. Moreover, the right to free speech mandates a full package of subtle and not-so-subtle forbearance obligations that may be superfluous, but it is more efficient to exercise the right to free speech than to invoke the multitude of other relevant forbearance rights. Braybrooke maintains that all rights entail obligations.

**Obligations without rights?**

Looking at the correlativity thesis from the opposite perspective, we ask the question "Do obligations have corresponding rights?" Bentham says not all obligations have corresponding rights: obligations "may be either extra-regarding or self-regarding: extra-regarding have rights to correspond to them: self-regarding, none."14 Tom Beauchamp agrees, and distinguishes between two senses of obligation--weak obligations and strong obligations.15 Strong obligations are correlative with rights, but weak obligations have no corresponding rights. There are numerous examples of weak obligations that do not entail rights. Obligations of charity, love, and conscience, for example, do not correspond to rights. My obligation to be charitable is not correlated with the right of any particular needy recipient. If I choose to donate to a homeless shelter, a food bank, and the Cancer Society instead of my alma mater, the local church or the Red Cross, it is my prerogative. It fulfils my obligation to be charitable. In so donating, I do not fulfil the rights of the worthy recipients of the homeless shelter, the food bank or the Cancer Society. Furthermore, I do not violate any right of Wabash College, the local


church or the Red Cross. Even if I were particularly affluent and notably generous to, say, the homeless shelter for ten years running and the shelter came to depend on my donation in order to stay open, I would not violate any right of the shelter if I decided to make the donation to another cause.\textsuperscript{16} Strong obligations, on the other hand, have correlative rights, and are not a matter of prerogative. If I owe you a debt, I am obliged to repay it—even if I do not want to.

Thus, by this paradigm there are three levels of morally correct actions: required acts (with strong obligations), expected acts (with weak obligations), and supererogatory acts (with no obligations). Examples of each would be refraining from harming others, doing some charitable works and risking your own life to save another, respectively. Only required acts entail rights. Expected actions (like being charitable) are likewise important to a moral life, but they involve considerable discretion. Supererogatory acts go beyond even weak obligations. Obviously, these actions are arranged from least to most morally laudable.

To summarise, rights always entail obligations, but in some circumstances it is impossible to fulfil the obligations and in others the obligations already exist. Nevertheless, all rights have corresponding obligations. Obligations, however, do not always have corresponding rights. Many aspects of the debate over a right to health care turn on whether the obligation to provide health care goods and services is a weak obligation or a strong obligation. This debate was touched upon above, when discussing the difference between being right and having a right. It would not be right to deny health care to a child, but can this be turned around to say the child has a right to health care? There is certainly a weak obligation to provide health care to a needy child, and the morally righteous (in the sense of being right) would do so. The weak obligation and righteousness of the act, however, do not necessarily entail a right to health care for the child.

\textsuperscript{16}It has been pointed out to me that relationships develop and change over time, and perhaps the ten-year benefactor would be wrong to stop his annual donation unexpectedly. This is a point I do not dispute; weak obligations are strengthened by long-term associations, and the benefactor’s obligation is stronger in the eleventh year than it was during the first. However, even a weak obligation that has been nurtured by a ten-year relationship is a different sort of obligation than a strong obligation.
WHO IS OBLIGATED?

We can add to the concepts of moral/legal and positive/negative by specifying upon whom the obligation is placed. *In rem* indicates that the right is logically correlated with the duties of other people generally, i.e. society at large. For the purposes of this thesis, *in rem* is meant to extend to the bounds of one's political community. Essentially, arguments for a government-funded health system are at issue here; thus, *in rem* extends as far as a country's government would have it—a city-funded program to the city's boundary, a nationally-funded program to the nation's boundary, etcetera. There may, or may not, be valid moral claims against a broader *in rem* community, but the argument will be limited to the more modest conception of *in rem*. *In personam* indicates that the right is logically correlated with the duties of specific, nameable persons or entities. Any given right can be described with precision by assigning one term from each of the three descriptive pairs to it. For example, moral positive *in rem* rights are a specific subset of rights including moral rights that require resources to fulfil which can be claimed from society at large.

Now we find ourselves with a number of ways to categorise rights—in fact, twelve in total. First, all rights can be merely legal, both legal and moral, or merely moral. Beyond this, any of those three categories can be subdivided into four subcategories, viz., positive *in personam* rights, negative *in personam* rights, positive *in rem* rights, or negative *in rem* rights.¹⁷

What Kind of Right?

### TABLE 1: Schema of Rights

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<thead>
<tr>
<th>Legal Rights</th>
<th>Legal and Moral Rights</th>
<th>Moral Rights</th>
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<tbody>
<tr>
<td>Negative <em>in personam</em></td>
<td>Negative <em>in personam</em></td>
<td>Negative <em>in personam</em></td>
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<tr>
<td>Negative <em>in rem</em></td>
<td>Negative <em>in rem</em></td>
<td>Negative <em>in rem</em></td>
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<tr>
<td>Positive <em>in personam</em></td>
<td>Positive <em>in personam</em></td>
<td>Positive <em>in personam</em></td>
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<tr>
<td>Positive <em>in rem</em></td>
<td>Positive <em>in rem</em></td>
<td>Positive <em>in rem</em></td>
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What are some examples of these various rights? The majority of legal rights are either positive *in personam* (e.g., a person's right to the terms of a contract entered into voluntarily) or negative *in rem* (e.g., a person’s rights not to be interfered with or attacked by anyone). The familiarity of these examples has lead some legal commentators to suppose that the other two classes are empty. That is, it has been suggested all *in rem* rights are negative, and all *in personam* rights are positive. The other areas cannot be excluded so easily, though. The negative *in personam* category is a small one that exists under narrow circumstances. One example would be if a specific businessperson agreed to not compete with another businessperson in a particular area. It is positive *in rem* rights that are the most interesting to our discussion.

Positive *in rem* rights basically include rights to the things we can call social goods. Education, employment, housing, nutrition, retirement benefits and even health care are the things of positive *in rem* rights. Individuals can claim these rights from society in general (i.e., from the state) if the individuals meet the requirements of the various programs. These are the
things that together work to make our society a better place to live, utopian aspirations if you will.

Where do human rights fit into this scheme? It was suggested above that moral rights are essentially human rights, but now we can be more precise. They are the rights claimed on behalf of all men and women in all situations. Closer examination of the kinds of things claimed as human rights will demonstrate where they fit into the proposed framework. Are human rights legal, moral or both legal and moral? Clearly they need not be legal; in fact, we most often hear about human rights when a nation is not recognising them. There is no legal right in a totalitarian regime not to be tortured, but this is the kind of human rights violation which draws the most attention. Are human rights positive or negative in content? There are many examples of both. Many claim the positive in rem rights in the preceding paragraph as human rights, and many also claim freedom of speech, freedom of religion, the right to vote and other negative rights (liberties) as human rights. Are human rights in personam or in rem? While individuals can help ensure the enjoyment of human rights, all of the above examples are things claimed from the state, from society at large—in rem rights. In summary, human rights are moral, positive and negative, in rem rights.

Having constructed this framework for rights, one would hope it would now be a simple task to pigeonhole any "right" imaginable into one of the twelve slots. However, like most such constructed frameworks, the lines of division are not so fine and black as would be ideal. In fact, some "rights" do not even sit in the grey zone: they appear to fit into two categories. For example, negative in rem rights usually require governmental interventions using public revenues, a fact that obscures any neat positive/negative distinction. Freedom from harm is one of the core liberties we expect the State to protect. This is the sacred liberty which justifies such things as a strong national defence and law enforcement agencies. Freedom from harm extends to health care as well. Consider various rights to have one's health protected. On the surface this seems a right to liberty, a right to be free of interferences that will negatively impact one's health, a negative in rem right.

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18 In the particular example of the right not to be tortured, this human right is enshrined in international law. Thus, in a sense, most human rights are indeed legal rights. Nevertheless, the point is that we assert that citizens of all countries have basic human rights regardless of the positive law of their country or whether their country has signed the relevant international treaty.
But one is really asserting more than a negative *in rem* right here; one expects the state to protect citizens from pollution or the spread of contagious diseases via publicly funded state agencies—a positive *in rem* right. These rights to health protection contain both negative and positive elements within their broad scope. Likewise, the right to be protected from harm, a basic liberty, entails many positive entitlements.

**THE POSITIVE/NEGATIVE DISTINCTION**

Philosophers have often drawn a distinction between positive and negative rights as outlined above. Presumably all that must be done to honour negative rights is to leave people alone. The same is not true for positive rights. To honour positive rights someone has to provide something. The association of liberal individualism with negative rights is clear. Libertarians emphasise the individual's freedom from government and the protection of zones of privacy. However, positive rights require at least one person to yield some of his/her resources to advance the welfare of another person (or group of persons). In the case of positive *in rem* rights, all members of the community give up some of their resources to help either all members of the community or a subgroup of the community (e.g., a fire service potentially benefits everyone while a provision for the poor only benefits the impoverished). There is an inherent tension between positive and negative rights: the more resources society demands from each individual to honour positive rights, the more society infringes on the liberties of the individuals. To elucidate the point further, any moral framework with an extensive set of positive or negative rights is not going to leave much room for the other type.

This inherent tension has lead to reductionist arguments that only positive or only negative rights are truly moral rights. Take, for example, Maurice Cranston's defence of the priority of negative rights.\(^{19}\) He claims that negative rights are "universal, paramount, categorical moral rights" while positive rights are neither universal, practical, nor of paramount importance. Therefore, he concludes, positive rights actually "belong to a different logical category"; they are not truly moral (human) rights. From the other extreme,

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\(^{19}\)Maurice Cranston, *What are Human Rights?* (New York: Basic Books, 1964), 36-54. Cranston actually argues for the priority of civil and political rights over economic and social rights, so he avoids any problems with the positive aspects of most negative rights. However, this is not far removed from arguing for only negative rights.
there is the argument that negative rights are essentially an instrument of the privileged to maintain the status quo. This side argues negative rights are useless without positive rights. After all, how many starving people are concerned with their right to free speech?

Like many reductionist arguments, both of these seem to go too far. Certainly, there is something wrong with a libertarian argument that will not allow minimal levies against the rich to bring great gains for the poor. But it is equally unappealing to picture a society that takes positive rights so seriously as to greatly infringe on core negative rights. Further complicating the distinction is the argument (outlined above) that seemingly negative rights usually contain a large positive component of enforcement. Moreover, a formal statement of what a right is a right to simply does not tell us whether the right is positive or negative. Whether a particular right, as held by a particular person at a particular time, is positive or negative depends at least as much on circumstances as on the essential character of the right. Even straightforward examples of negative rights like one's right not to be tortured and positive rights like the right to adequate nourishment are subject to circumstances. Protection from torture is negative in New Zealand whereas it is quite positive in Haiti today. And a right to food is essentially negative on a Southland dairy farm where a small number of individuals could eat quite well without appreciably decreasing the output of the farm. This same right to food is somewhat more positive in Dunedin where arrangements would have to be made for cartage of the food and distribution; and a right to food is very positive indeed in Rwanda where the masses cannot be fed despite a resource-intensive international effort. Thus, even with rights that seem clearly positive or negative in character, particular circumstances result in a wide variation of positiveness. Less extreme circumstances would have an impact on the character of rights which are more mixed by nature.

Where does this leave us with the positive/negative distinction? Are there too many problems for it to be useful? First, there is nothing theoretical that demands exclusion of one class from true moral rights; solid individual arguments can be made for a number of positive and a number of negative rights. Second, it must be conceded that the positiveness or negativeness of a right is not set in stone; depending on changing circumstances, the same right can be considerably more or less positive. However, amid these theoretical difficulties, an important distinction remains.
I am hesitant to discuss positive and negative in rem rights as though they are two species of a common genus. It is a widely held opinion that there are no absolute rights, i.e., there are no rights which apply to all people in all situations and cannot be overridden. Obviously, only one right could be absolute because one right must yield to another in conflicting traffic, and, hence, only one right could always have the right of way. Perhaps the most promising candidate to be an absolute right is the right not to be killed. However, even the right not to be killed—one of the most basic negative rights, the right to life—can be overridden under specific conditions. There are moral arguments for the just war, and soldiers have their lives taken during war; and some argue criminals forfeit their right to life by the nature of their crimes. Thus, all rights must be limited. The important difference between positive and negative rights lies in the way they are limited. Negative rights must be limited as to not infringe on the liberties of others. But positive rights require more robust limits. They are dependent on resources that are (although not by definition, but in point of fact always have and always will be) scarce. Positive rights can only be as extensive as resources will allow.

Rights cannot be absolute. Negative rights must be limited; positive rights are more severely limited. So what? Both positive and negative rights are rights, and as such deserve to be taken quite seriously. To emphasise the prima facie priority of rights over other justifying principles, Ronald Dworkin writes of rights as "trumps." Rights as trumps succinctly carries a lot of meaning and has been widely used since Dworkin wrote it. This implies that rights are not on a level playing field with other types of moral or social goals. Rights have been entrenched in our system of justifications giving them priority over other considerations such as utilitarian calculations; rights considerations outweigh any amount of any non-rights consideration. One of the most powerful functions of rights is to protect individuals from claims based on principles such as utility. Rights carve out a protected area for the individual; they guard the individual against manipulations by the powerful state. To fail to respect an individual's rights is not simply a failure to discharge a duty. It is a particularly harmful affront to the individual.


Although they are both rights, the difference in the way positive and negative rights are limited is still important.

We return to the problem of extreme scarcity. Several integral features of rights have been discussed: 1) rights are entitlements, 2) rights entail obligations, and 3) valid right-claims trump non-rights considerations. Positive rights in conditions of scarcity pose theoretical difficulties for rights which challenge these integral features. During extreme conditions, for example a famine, it is impossible to fulfil some very basic positive right-claims. It is difficult to explain how one can have a valid claim which one cannot reasonably expect to be fulfilled. There are at least three responses to this theoretical quandary, and each should be examined for its ability to deal with both extreme scarcity and more moderate scarcity.

Firstly, some conclude that positive rights are not rights at all. This, seemingly, avoids the problem of what to do when right-claims cannot be met: negative rights are not scarce. Perhaps there are moral claims to goods and services, but they do not amount to rights. It is ridiculous to say one's rights were violated because one was not fed during a famine. This is similar to Cranston's defence of the priority of negative rights discussed above. While this stand avoids the problem of right-claims which are impossible to fulfil, it goes too far. As discussed above, both positive and negative rights are valid, and changing circumstances have a significant effect on the positiveness of a right.

Secondly, some philosophers argue that rights and obligations can become disconnected in conditions of scarcity. As outlined above, Feinberg argues that nothing can be done when resources are insufficient to fulfil a valid right claim, and that no one has an obligation to fulfil the claim. The unfulfilled claim remains valid and society should fulfil it when conditions change and resources become adequate. Furthermore, the unfulfilled right claim, as the argument goes, highlights to the relevant authorities that something needs to be done to alleviate the scarcity. While this approach has some intuitive appeal in very extreme circumstances like natural disasters, it is not particularly useful when its application is broadened. The instance of extreme scarcity is analogous to the ordinary scarcity which is a part of everyday life: they are only differences of degree. Indeed, resources are

scarce even in the richest of countries. Broadening the idea that obligations are removed in conditions of scarcity disregards the danger of routinely leaving "moral" rights unfulfilled. It was illustrated in the introduction that, despite tremendous expenditure, not all medical needs can be met. We require a moral standard for the right to health care which considers that resources are scarce and provides attainable moral goals for health care. A standard which is doomed to leave many "valid" claims unfulfilled due to scarcity is insufficient. The moral standard ultimately accepted must distinguish between health care needs which entail a right and health care needs which do not.

Thirdly, one can argue that positive rights have to be framed in the context of how much resources are available in a given society. Making the content of rights dependent on the very shifting sands of resource availability seems not to give rights the "trump" status some proponents ascribe to rights. Unfortunately, this implies that one's right to adequate nourishment disappears in conditions of famine. Obviously this is not a desirable conclusion, and perhaps the answer lies in broadening the conception of in rem to include the global community during very extreme conditions (which seems to correspond to actual practice). However, this conclusion will not be further explored because this approach works well under more moderate conditions.

Despite its weaknesses, the idea of the content of positive rights being subject to resource constraints is advocated as a better alternative than denying all positive rights or claiming that not all rights entail obligations. The inherent exhaustability of positive rights needs to be addressed; a theory that neglects this feature would be inadequate. Common sense demands that positive rights be limited in their content. How do we decide the content of a positive right? The exact content of these positive in rem rights will necessarily be under constant discussion. All of these social goods are worthy causes, but they each have an infinitely--or at least immensely--expandable appetite. Since a given society will only have so much wealth to redistribute on these items, there will be constant discussion of how big each program's piece of the pie will be. Further complicating the discussion, the pie itself will shrink or grow from year to year. Hence, society (or its representative members) has to make the difficult decisions about what items it can afford and what things it must deny its citizens, and this list will be constantly changing. Negative rights, too, are limited, but their content is not subject to
such constant re-evaluation. The content of a positive right is necessarily less fixed than that of a negative right.

**RIGHT TO HEALTH CARE**

Now that we have an explicit framework within which to discuss rights, we can return to the question at hand, "does a right to health care exist?"

**Negative Rights**

Negative *in personam* rights are a category that is seldom important, and they play little (if any) role in a right to health care.

Is there a negative *in rem* right to health care? Of course, there is a negative right to health care in the sense that no one should prevent an individual from accessing the health service. Everyone would agree it is wrong for, say, an ambulance team to leave victims at an accident site for prejudicial reasons. Society at large is obligated to not interfere with individuals' attempts to use the health system.

There is a more encompassing conception of the negative *in rem* right to health care which is more contentious. Some argue that the sort of collective protection we all take for granted logically could be extended to include a number of health care services. As Tom Beauchamp writes, this argument starts from the position that the general range of protection rightly afforded by government—and already afforded in most nations—naturally extends to health care. The government is constituted to protect citizens from risk to the environment, risk from external invasion, risk to public health, risk from crime, risk from fire, the risk of highway accidents, and the like. We do not ask people to have their own firefighters, crimefighters, jet pilots, etc. It seems a natural extension that government would protect against risks to health and thereby would meet health care needs, especially given the significance of this benefit to individuals and to society.23

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This argument is an important way to get our foot in the door, so to speak, with those who see the right to health care as a liberty only. Protecting citizens from public threats would entail many positive entitlements. Exploring the conclusions of a broadly conceived negative right to health presents irrefutable evidence to those who wish to deny any entitlements to health care. As emphasis is increasingly placed on social and environmental factors in the aetiology of disease, it would seem the entitlements which flow from a negative right to health care are growing.

However, while this approach is persuasive and it builds upon already-present institutions, Beauchamp goes on to point out that it leaves unacceptable gaps. Unfortunately, there are many health care needs that are completely private needs and in no measure the result of a public threat. That is to say, even if we extend a negative in rem right to health care to its logical extreme to include treating all diseases with an infectious or environmental component, important diseases will be left out. In fact, some of the diseases overlooked in this account are ones we are intuitively most sympathetic to—for example, genetic diseases like Tay-Sachs disease, cystic fibrosis and Duchenne's muscular dystrophy. Furthermore, this approach creates markedly different entitlements within the same disease category. Consider atherosclerotic heart disease. The man whose heart disease is a result of socially determined lifestyle factors would receive full treatment while the sufferer with familial hypercholesterolaemia would have no entitlement to health care. Thus, while a health service based on a broadly conceived negative in rem right would treat many conditions, it inherently falls short of the ideal vision of a health service. I concur with Beauchamp, that "an exclusively negative conception of the right to health invites chaos in health policy and is unsatisfactory both on theoretical and practical grounds." Nevertheless, this is an important argument. In the business of setting priorities for a positive right to health care it may be that many of the diseases which are a collective threat should receive high priority.

Positive Rights

In the USA (as in New Zealand), many people have a right to health care through specific contractual agreements with private insurance companies. These are legal, positive in personam rights—legally guaranteed.

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What Kind of Right?

rights to health care goods and services which can be claimed from specific, nameable insurance companies.

In a much celebrated article, Robert Sade argues passionately against the right to health care conceived as a moral, positive in personam right. Sade's first mistake is defining a right as "a freedom of action," neglecting all positive rights. The argument starts from what is called man's primary right—the right to his own life—and then extends to a strong claim of individual property rights. To quote Sade, "In a free society, man exercises his right to sustain his own life by producing economic values in the form of goods and services that he is, or should be, free to exchange with other men who are similarly free to trade with him or not." The conclusion is that health care services are the property of the doctor to distribute as he/she sees fit without interference or coercion from the government. To do otherwise, as the argument goes, would break the chain of natural rights which starts with the right to one's own life, and hence would be anti-life.

Although the article takes several wrong turns, not the least of which is morally undervaluing positive rights in general, it does have one strong point. Sade makes an analogy between health care services and doctors and a loaf of bread and bakers. He argues that it is wrong to take bread from the baker without compensating her/him, and that it is a similar situation to give patients a right to health care and allow them to take services from the doctor without compensating her/him. To this point, the argument has merit: surely, it is not the sole responsibility of individual doctors to fulfill a right to health care. After all, medicine is a career and it is fair for doctors to want to earn a living. But Sade's conclusion does not follow from this line of thought. He argues that because it would be wrong to "steal" the doctor's services there can be no right to health care whatsoever; however, his argument only suggests that health care is not a positive in personam right. Contrary to Sade, there may be other ways of conceiving the right.


26Ibid., p. 1289.

27Sade makes too strong a claim of individual ownership for health care services. Doctors rely on communal resources during training and the accumulated knowledge of medicine, so health care resources cannot be strictly owned by them. This flaw in his argument is briefly addressed in chapter 3.
What Kind of Right?

In New Zealand there is also a legal right to public health care, a legal, positive *in rem* right. Although the exact content of the "core services" is not specified in law, the Health Acts mandate the provision of a public health system. No such right exists in the United States. The prevailing *legal* view in the US seems to be that there are no constitutional restrictions against enactment of a right to health care, but a right to health care is not constitutionally guaranteed. 28 The USA does have examples of legal, positive *in rem* rights, however. The right to an education is a legally guaranteed right that an individual can claim from society in general. It is widely held that congressional enactments of health care programs are constitutionally permitted: Chapman and Talmadge have documented an extensive history of discussions about rights to health care in the US dating from the quarantine laws of 1796. 29 Presumably, it would take nothing more than a bill from the legislature signed by the President to create a universal legal, positive *in rem* right to health care in the USA.

A more difficult question is whether there is a *moral* positive *in rem* right to health care in New Zealand, the USA, or anywhere. This is the most direct way to approach the problem. There are a number of ways to argue for this moral right; usually it is based on an overarching theory of justice. The remainder of this thesis will be devoted to answering the question of whether there is a moral positive *in rem* right to health care and what its content might be. Although important, questions of the scope of a negative *in rem* or positive *in personam* right will not be addressed further.

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CHAPTER 3: FAMILIAR TERRITORY

Having specified the kind of right to health care being discussed, possible foundations for the right should be examined critically. In this chapter several theories of distributive justice will be examined for strengths and weaknesses vis-à-vis health care, and a few non-justice approaches to a right to health care will be outlined also. As Norman Daniels states, "We are justified in claiming a right to health care only if it is derivable from an acceptable, general theory of distributive justice. Taken this generally, the point borders on a philosophical commonplace, despite the more general 'lay' practice of claiming rights wherever strong interests are felt."1 Thus we can answer affirmatively to the question "Is there a moral positive in rem right to health care?" if we can demonstrate that a general theory of justice demands it.

Indeed, deriving a right to health care from a general theory of distributive justice is the most common approach. Distributive justice is such a far-reaching area that piecemeal adjustments (hopefully improvements) are possible, but comprehensive restructuring of health care resource allocation proves very difficult.2 The right to health care should follow the general theory in which it is based. Unfortunately, theories that seem to treat large portions of resource allocation well fall apart in some or many specific areas, i.e., no established theory of distributive justice seems adequate for all resource allocation situations.

Difficulties arise because general theories of justice are blunt tools that have been developed to deal with human and societal inadequacies. Some have persuasively argued that a good society is simply one that provides necessary goods and services such as food, shelter and health care to those in need (regardless of their ability to pay).3 Certainly, all other


2Here I do not mean that restructuring is difficult for political reasons while I am well aware that this, too, is the case. My point is that purely (some would say merely) theoretical restructuring proves difficult.

3Mark Siegler, "A Physician's Perspective on a Right to Health Care." Journal of the American Medical Association. 244 (1980): 1591-1596. Siegler rejects the idea of a right to health care while embracing the idea that "every person receive competent, efficient, and
things being equal, a society where everyone has something to eat, somewhere to sleep, and where people get the health care they need is a more desirable and more virtuous society than one where members cannot always get food, shelter or health care. These comparative judgments are made with no reference to justice or individual rights. However, this is not a new concept; David Hume made the point clear over 250 years ago:

Justice takes its rise from human conventions...and these are intended as a remedy to some inconveniences, which proceed from the concurrence of certain qualities of the human mind with the situation of external objects. The qualities of the mind are selfishness and limited generosity; and the situation of external objects is their easy change, join'd to their scarcity in comparison of the wants and desires of men....Increase to a sufficient degree the benevolence of men, or the bounty of nature, and you render justice useless, by supplying its place with much nobler virtues, and more favourable blessings.4

Unfortunately we find ourselves in the conditions of justice: today's state of affairs is marked by a scarcity of public resources and an abundance of self-interest (or a shortage of benevolence). With nobler virtues in short supply we are forced to turn to justice.

Alastair Campbell and Grant Gillett instructively point out that "theories of justice tend either to be process oriented or outcome oriented."5 Their division of theories of justice into two groups will be employed: interventionist theories (outcome-oriented) and liberal
theories (process-oriented). Common to all theories of justice is the following minimal principle: like cases should be treated alike unless there is a relevant difference between them. Obviously, no two situations are identical; however, it is what the various theories of justice regard as a relevant difference that separates each of them. When examining theories of justice we must retain and apply our own intuitive sense of justice. Many agree an important test of a moral theory is whether it matches our intuitive responses to moral situations. In this chapter I will use this technique to discuss briefly several theories of distributive justice trying to point out each theory's strengths and weaknesses with respect to health care. It should be noted there is considerable diversity of opinion even within the broad classifications; however, due to space considerations, each theory will be dealt with only generally.

Justice is roughly synonymous with fairness. It applies in an economic sense where individuals compete for scarce resources, but also in human actions in general where these affect others. Distributive justice is concerned with the way resources ought to be allocated in general and for specific things—like health care. It is helpful to think of resource allocation decisions as falling along a continuum from macro allocation to micro allocation. At the extreme macro-end of the scale we find decisions to questions like "How much public resources—the total allocated to all public goods—will be redistributed?" and "How much of the total resources is health care to receive?" Slightly less extreme we find "Given health care's slice of the total pie, how is that money to be divided up among various health services?" On the other hand, at the extreme micro-end of the scale we find questions like "Keeping in mind the range in cost of the drugs and the range of benefit provided by the drugs, which antihypertensive drug should this patient receive?" or "When should aggressive treatment be withdrawn in a case?" or "Who gets the final intensive care bed?"

Whether a resource allocation decision is considered macro- or micro- is not inherent to the decision; it is relative to some other consideration. Hence, whether or not to have a cardiac unit in Christchurch is a microallocation decision when compared with how

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much to allocate to Vote: Health, but it is a macroallocation decision when compared with who to operate on from the waiting list this month. Some call allocation decisions from the middle of the spectrum "meso-" allocation decisions, but the relative nature of the description persists.

Reflection on the range of resource allocation decisions reveals some things. First, tough decisions on either end of the scale make the decisions at the other end less difficult. For example, if all (or nearly all) microallocation decisions were made very carefully to minimise expenditures, then resources would be less scarce for the macro- decisions. Conversely, if certain health services are removed from the system and certain expensive drugs are removed from the formulary by macroallocation decision makers, then (as unsatisfying as it may be) there is no microallocation decision to be made (in those excluded areas). Second, the exercise of resource allocation is a very different endeavour at either extreme of the scale. The microallocation decisions seem to be the domain of health professionals (either individual clinicians or a team of professionals involved in a patient's care), patients and families (where appropriate) alone. Whereas macroallocation decisions lend themselves to input from a variety of people including taxpayers, politicians, business experts, health professionals, and patients. The area in-between is less clear. At what point along the continuum are decisions the exclusive domain of health professional and patient?

Failure to consider the full continuum of resource allocation decisions is the shortcoming of the various general theories of justice. The theories which treat macroallocation decisions quite well are less adequate in microallocation decisions and vice versa. Most ethicists committed to distributive justice have concentrated, perhaps unduly, on intra-medicine injustices: differences in access between rich and poor or urban and rural citizens, inadequacies in allocations to women's health, insufficient resources in mental health. These microallocation issues clearly warrant careful consideration; however, in addition one would like to see further consideration of macroallocation decision making, viz., public allocation decisions between various social goods. Paul Ramsey, in *The Patient as Person* thinks that the larger questions of how to choose

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*I have already tried to illustrate that macroallocation decisions affect microallocation decisions. In that sense doctor and patient are never alone, but presumably there would still be some latitude within which to operate in individual cases. My point is simply that input from "the rest of society" is inappropriate in microallocation decisions.*
between medical and other societal priorities is "almost, if not altogether, incorrigible to moral reasoning." To be sure, it is a difficult task, but 'incorrigible to moral reasoning'? Thinking such as this and the writing that corresponds to it will long guarantee that philosophy does not have a seat at the public policy making table. To be fair, it would seem Ramsey's point is that public policy decisions are based on things so unrelated to theories of distributive justice that it is nearly impossible to apply sound moral reasoning to those decisions; and with that point I raise no objection. However, to even suggest that resource macroallocation decisions between various societal priorities are outside the purview of moral philosophy is absurd. Such a view denies the discipline of philosophy the abilities of any adult who has ever read the paper or watched the evening news. We all have an intuitive sense of what is just or unjust. The political cries of news conscious taxpayers can be heard at most dinner tables: "New Zealand can't afford to continue to subsidise tertiary education to the extent it used to." "Taxes should be raised to better fund the public health system." "New Zealanders won't stand for a two-tiered health system." "Primary and secondary teachers should have pay parity." Certainly Ramsey would not have us think these amateur libertarians and egalitarians are capable of intuitive reasoning that methodical moral philosophers are not. To the contrary, I propose that well-reasoned macroallocation arguments are where ethicists have the most to offer (with respect to resource allocation). And the ethicist's most important role is in the allocation decisions between society's various priorities—e.g., roads, education, museums and health care—the same area Ramsey seems to shun. If someone does not endeavour to "get the big picture" of public resource allocation, then that potentially allows for the biggest injustices to be perpetrated. After all, poor decisions on the more micro end of the macro-micro spectrum of resource allocation are often brought to our attention (e.g., specific patients who have been denied specific treatments because of lack of resources), but ethicists can fill a void by pointing out inconsistencies in society's allocation to various things (like defence and education). A well founded right to health care would take into account the full spectrum of allocation decisions.

INTERVENTIONIST THEORIES (OUTCOME-ORIENTED)

As the division suggests, interventionist theories are more concerned with the ultimate outcome of resource allocation than the process by which that outcome is achieved. If the outcome is not in fitting with the theory of justice, then the interventionist would have the state intervene to create a just distribution. For example, if the goal of a theory is simple equality of income and two people do not have equal incomes (regardless of the reasons that brought about their unequal incomes), then the state would equalise the two people's incomes. While outcome-oriented theories contribute much to the discussion of resource allocation, most members of Western society would agree that State intervention should be held to a reasonable minimum. State intervention conjures a negative, heavy-handed, totalitarian image in Western society regardless of the ends that are being sought. For this reason, interventionist theories meet strong opposition by libertarians no matter how noble the goal of the specific theory.

Egalitarianism

The first theory to be examined is egalitarianism which purports to hold that no individual differences are relevant. To be sure, all good egalitarians realise that all people are unique and different, but they deny that the differences are relevant to resource allocation decisions. In egalitarianism's pure form, all cases are to be treated equally out of respect for our common humanity. The most prolific contemporary advocate of egalitarianism, at least as it applies to health care, is Robert Veatch. Veatch advances the following principles as the basic tenets of egalitarianism:

1. Human beings are of equal moral worth in the sense that no human deserves a claim to more than or less than an equal share of available resources.
2. The natural resources of the world should be seen as always having had moral strings attached to their use. They have never been 'unowned' and available for appropriation and use without conditions attached.

For my understanding of egalitarianism—to the point which I grasp it--I am indebted to Andrew Moore. Discussions with him pointed out important errors on my part.
Egalitarianism attempts to emphasise the sameness of individuals, and treat differences as irrelevant. As Veatch says, egalitarians strive for an equal distribution of resources. Minimal reflection, though, reveals that any attempt to equalise individuals in any one area encourages or even demands inequalities in other areas. The first question for any egalitarian is "Equality of what?" A few health examples make the case clear. If we aim for equality of health status, then justice mandates we direct resources (health care) to those who have sub-standard health. The individual differences in health status become highly relevant to allocation, and there are resultant inequalities in resources received. If we target equality of life span, then justice demands we direct resources to the young: despite similar health needs, young receive treatment preferentially to the elderly. Deciding what is to be equalised implicitly entails deciding what differences will be relevant and creates inequalities in other areas.

Egalitarianism comes in at least two forms which will be referred to as: 1) strict egalitarianism and 2) pseudo-egalitarianism.

While quite equitable on the surface, strict egalitarianism is easiest to criticise. While the question "equality of what?" remains, strict egalitarians want exact equality. Assume, for instance, the goal is an equal share of available resources. If all members of society are allocated an equal share of health care, the fortunate ones who live long, healthy lives as well as the unfortunate ones who die premature but sudden deaths (e.g., automobile accident, fall from a great height, suicide or homicide) will be allocated a share larger than they would use. On the other hand, unfortunate members of society with chronic illnesses and/or illnesses that are particularly expensive to treat would not have a large enough share of resources to meet their needs. If we modify the position so that the goal is equality of overall resources, the sick could devote their share of resources from other areas to health care; and the well could use their

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health care allocation on something else. One must ask if we wish to penalise the sick by requiring them to forfeit resources from other areas. In either form (an equal share of health care resources or an equal share of overall resources) strict egalitarianism is an inadequate, and at times irrational, theory.

Pseudo-egalitarianism is a stronger, more applicable version, but notice how many inequalities it endorses. The pseudo-egalitarian wishes to distribute resources according to the most relevant and appropriate criterion in each area. For example, access to the finest educational institutions should be by intelligence and not by the income of one's parents. With regard to health care, Bernard Williams rightly states: "Leaving aside preventive medicine, the proper ground of distribution of medical care is ill health: this is a necessary truth."12 To each person according to individual need becomes the health care policy. The problem of the person with great health care needs—needs that far exceed that person's equal share—is alleviated in this construction. This is a particularly strong theory at the microallocation end of the scale: it adheres to an intuitive sense of justice that says sick people should be treated. It is consonant with the Hippocratic tradition which emphasises the responsibility of the doctor for the needs of the individual patient. The impact of the individual's treatment choice on the distribution of health care resources or its effects on the interests of others is irrelevant.

However, the theory weakens when applied to the entire resource allocation scale. The most common criticism of this theory is that it denies the conditions of justice. Indeed, to each according to his need looks more like a principle describing distribution that would be possible if there were no problem of scarcity than a prescriptive principle of distributive justice designed to cope with the problem of scarcity. After all, the explosive health care expenditures of the USA outlined in the introduction are driven by health needs. Critics claim that this kind of egalitarianism would place a great strain on public coffers. In response to this criticism, some egalitarians further qualify the statement: "to each

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according to his essential needs." Critics reply that even this standard would be more expensive than society can afford. Another proponent of egalitarianism, Gene Outka, carries the qualification one step further to "similar treatment for similar cases." This seems to abandon egalitarianism and return to the general concept of justice (like cases should be treated alike), but Outka's case actually embraces the ideals of egalitarianism (no personal differences are relevant to resource allocation decisions) while allowing for non-treatment in some instances where there is an essential need. Outka is willing to admit that resources may be too scarce to treat in all cases where need can be demonstrated: "the formula of similar treatment for similar cases may serve to modify the application of a need conception of justice in order to address the insatiability problem and limit frivolous use....The goal of equal access then retains its prima facie authoritativeness. It is imperfectly realised rather than disregarded."

Defining need is not straightforward, and further qualifying it is even more difficult. What separates a need from a mere preference or want? Perhaps in health care we could develop some objective criteria of well being which if not met would demonstrate a need. I am sceptical such a list of criteria with proper weighting can be developed, but for argument's sake let us assume it can. As outlined above, many critics claim we cannot afford to meet all objective health care needs; hence, some egalitarians have added qualifiers such as 'essential' needs. Even if we can arrive at a useful definition of need, modifying it is elusive because there is such a wide variation in what is considered 'essential'. Furthermore, what is required to 'meet' a need is a topic of debate. Consider surgery for cancer. Criteria for needing surgery for, say, bowel and prostate cancer could be developed relatively easily, but what it means to meet that need varies. In New Zealand, waiting lists for these elective operations are acceptable, but in the USA waiting lists would not be tolerated. For less urgent conditions, long waiting lists are accepted in


15Ibid., p. 93.
New Zealand, but not in the USA. Need, essential need, and what it means to meet these needs are not simple concepts.

Veatch is aware of the difficulty of using need as the unqualified criterion of health care resource allocation: the most ill (i.e., the most needy) will wind up with all the resources. His stand is qualified to reflect the fact that some unfortunate people are incurably ill as well as the fact some people will not take advantage of opportunities they are given. For medical examples of the latter, many people (indeed most people to some extent) refuse to treat their bodies well with regard to diet, smoking, drinking alcohol, exercise, etc., and some people refuse preventative measures (e.g., immunisations) despite their availability. Veatch's final egalitarian statement is: "Justice requires everyone has a claim to health care needed to provide an opportunity for a level of health equal, as far as possible, to other persons' health."\(^\text{16}\)

Obviously, if sufficient qualifiers are added to the egalitarian ideal the resulting allocation could be within the resources of society. That is, the idea that health care is a resource allocation black-hole sucking in infinite resources can be avoided. However, the reasonable, sufficiently qualified egalitarian theory still makes no contribution to macroallocation decisions. It offers no way to compare needed health care with other social goods, other positive in \textit{rem} rights.

Egalitarians resist any two-tiered delivery system as unjust. The egalitarian right to health care requires that no one is to have access to any health care that is not also available to everyone else in similar need. From here a difficult problem arises. Either the level of health care to which everyone is entitled is set as high as technology allows or it is set at a level lower than that. In the former scenario (max tech care for everyone--levelling all care up) we are back to the problem of health care being more expensive than society can afford. In the latter scenario where the equal level of care is set at a point such that the overall expense of that care is within society's budget (levelling some care down and some care up), ill citizens with private resources are prohibited from buying high tech, beneficial health care that the public system does not offer and citizens are banned from advancing their health beyond a certain point.

Surely something is amiss in a society where one can purchase luxury goods like yachts and expensive artwork but one cannot buy high tech health care.

That leads to a final criticism of egalitarianism. Some feel that everyone would readily agree to an unequal system as long as the worst off citizens were better off than they would be under a system of equal distribution. According to the critics, if the wealthy were allowed to pay for certain surgical procedures unavailable to the poor and this arrangement increased general surgical skill to a point where surgical outcomes improved significantly for the poor (as well as the rich), then everyone is ahead and no injustice is done. Another example is allowing the wealthy to avoid surgical waiting lists by paying for private surgery: this would benefit the worst off citizens, too, by shortening the waiting list. Egalitarians would respond that it is far more complex than that: the psychologically negative effects of different levels of health care for different classes of society far outweighs the benefit of any small improvement in outcomes.

I do not take egalitarianism very seriously. I unfortunately cannot divorce myself from my context, and I do not see egalitarianism as a useful theory of justice in our society. "All men were created equal" or more mildly stated we all deserve equal treatment because of the moral value of our common humanity or humanness seems only to extend to a few things in our capitalistic democracy. Certainly we all deserve an equal voice in the running of our government and justice demands equal treatment under the law, but, these issues aside, egalitarianism has little place in our society. We all were not created equal, and our society makes little if any attempt to reverse the inequalities that have come about by luck of birth, natural endowment, individual initiative, or personal misfortune. Sure, there are many examples of laws written to blunt the impact of bad fortune, e.g., bankruptcy laws, unemployment benefits, provision for public education, but in none of these instances are we attempting to equalise the individuals of society. Education would come

17cf. Rawlsian justice below.

18I have been accused of an inductive fallacy in the following three paragraphs. Just because our society is a certain way does not mean that it ought to be that way. My point is that society ought to perpetuate certain inequalities for the benefit of all, and health care is not a special area where equality must reign.
the closest, but even there it is obvious that the rich and/or particularly talented have access to institutions that are an order of magnitude better than the public system.

Some egalitarians would respond that this complaint is irrelevant. They might say the fact that our society tolerates, in fact encourages, so many inequalities is testimony to how immoral the society is. With these consistent egalitarians I can only disagree. Others, though, would agree that our society is not egalitarian. They might even agree that many inequalities are necessary and beneficial to an optimal society. A straightforward example is the inequalities of power that are necessary: a society requires a small number of people to be leaders, and the most effective leaders should hold those positions. This latter group of "egalitarians" would make a special case for the egalitarian treatment of health care. With regard to this group I agree with Charles Fried:

For as long as our society considers that inequality of wealth and income are morally acceptable--acceptable in the sense that the system that produces these inequalities is in itself not morally suspect--it is anomalous to carve out a sector like health care and say that there equality must reign.19

I think Americans' reluctance to admit they do not take egalitarianism seriously is one impasse in the health care delivery system debate. In contrast to elsewhere in our society, we seem to want egalitarianism when it comes to health care. Many people are outraged when a treatment is available to one person but not another solely on the basis of ability to pay. Why? We cannot afford to pay for everything for everyone; should something not be available to those who can pay when we cannot provide it for those who cannot? I dare say the "levelling down" scenario would be the more repugnant of the two to Americans, but why are we hanging on to a desire to "level up" and provide everything to everyone?

**Utilitarianism**

The second outcome-oriented theory is utilitarianism which operates with the maxim "the greatest good for the greatest number." The relevant difference between individual cases in utilitarianism is how

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much good consequences (utility) or bad consequences (disutility) would result from following either course. Utilitarianism attempts to maximise aggregate utility (and minimise aggregate disutility) in a system where each person counts as one and no one counts as more than one; all units of happiness and sadness are summed. Utility is defined as pleasure, satisfaction, happiness, or the realisation of preferences. Alleviating two units of sadness is equal to causing two units of happiness. Hence, utilitarian justice mandates that decisions be made to maximise utility. There are several different versions of utilitarianism, but the largest distinction is between two varieties: 1) act utilitarianism and 2) rule utilitarianism. The discussion will be limited to these two broad forms.

Act utilitarianism is considered the more extreme as well as more difficult version because the act utilitarian always asks, "What will be the consequences of this action in this individual circumstance?" Rule utilitarians, on the other hand, justify actions by referring to general rules which have been calculated to increase overall utility if universally followed; however, in an individual circumstance the outcome of following a rule may increase or decrease utility. Rule utilitarians adhere to the principle of utility less strictly, but the difficulty of weighing the consequences of each and every action is obviated. In fact, a utilitarian moral theory can include rules that prohibit appeals to utility maximisation in individual cases (as long as the system of rules is shown to maximise overall utility).

Utilitarianism is a powerful theory in which to ground a right to health care. Although the principle of utility does not explicitly include a right to health care, common sense says health care would be one of the goods that significantly contributes to maximising utility: utilitarian calculations would highly value medicine's ability to restore functioning, alleviate pain and suffering and prevent premature death. Although there are serious difficulties with utilitarianism that are discussed below, it is an influential theory that underpins many judgments considered intuitive or obvious. For example, few would argue that we should not, on the whole, attempt to maximise the health benefit brought about from public resource expenditure. And few people disagree with the concept of triage, based in utility. In triage, battle or disaster victims (patients) are divided into three groups: those requiring immediate treatment, those who can wait, and those who are beyond help. If doing the greatest good
for the greatest number is one's goal, then this is a quite just approach: the
most victims are likely to have maximal recoveries (in context of their
initial injuries). However, in a need based theory of justice it is
questionable whether justice is served as all of the victims have needs.
Other influential applications of utilitarianism in health care include
quality adjusted life years (QALYs), cost-effectiveness analysis, and cost-
benefit analysis.

Utilitarianism is particularly strong at the macroallocation end of
the scale. Consider the following from H. Gilbert Welch:

[W]e should remember that expenditures not
directly related to health may be extremely
important to the well-being of the poor. We must
gain an appreciation of the value of other services,
take a broad view, and be willing to ask ourselves
hard questions. Are we sure that annual
mammography is more important than a Head
Start program? Is treating drug addiction more
useful than job training? Is one liver
transplantation worth the price of housing for four
families? The tradeoffs between health care and
other social goods require careful consideration.
When it is appropriate, we ought to be willing to
advocate expenditures for food, housing, or
education over those for medical care.20

Most would consider Welch's questions reasonable, and they are patently
utilitarian. If egalitarianism were a hands down better theory than
utilitarianism, then these questions would not seem so reasonable; after
all, the addicted patient and the patient with end stage liver disease both
have legitimate, essential needs. Utilitarians recognise that job training
and housing are important, too--sometimes more important than needed
health care. Having praised utilitarian considerations, though, one must
admit that when it comes to telling the 34 year old mother of four that she
cannot get a liver transplant and she surely will die because the public
resources are being used to build housing, utilitarianism feels a bit harsh.

As suggested, utilitarianism weakens at the microallocation end of
the scale. There is not a special place for the individual in utilitarianism.

20H. Gilbert Welch, "Health Care Ticket for the Uninsured: First Class, Coach, or
Familiar Territory

The objective is to maximise aggregate utility (viz., pleasure, satisfaction, happiness, or the realisation of preferences), but the theory is unconcerned with how the utility is distributed. Two examples illustrate this point. The first is the "Christians and lions" problem. Picture a society where there is a small minority group that is relatively outcast from the rest of society; Rome in the first couple of centuries will do, but take notice there are easy contemporary analogies. In this society the majority are greatly pleased by watching lions devour humans. Utilitarian calculations show that the happiness of the majority far outweighs the suffering of the Christians. Therefore, utilitarian justice mandates that the Christians be thrown to the lions. The repugnance most of us feel when an individual is ruthlessly sacrificed for the sake of a social good s/he cannot share is the strongest case against utilitarianism. A rule utilitarian might avoid the Christians and lions problem by invoking a rule that "Citizens cannot be killed for entertainment" because, although there are examples where utility favours it, on the whole it is a utility decreasing activity. Hence, utilitarianism is not necessarily guilty of cruel treatment of vulnerable minorities, but its critics are wary because it still endorses sacrificing the individual for the general good.

The second example is between "statistical" and "identifiable" lives. Take rescuing a trapped mine worker, for illustration. The resources necessary for an all out rescue party could be demonstrated to save three or four future lives if devoted to improving safety in the mining area. A simple utilitarian calculation might mandate leaving the mineworker for dead and spending the resources on improving safety standards to save more futures lives, but this would agree with few (if any) people's intuitive sense of what is right. Utilitarianism fails to explain the general preference of identifiable individuals over statistical individuals. A more sophisticated utilitarian might say that the calculation was in error. Ensuring to all members of society that a rescue party would be sent for them if they were in the mine does so much to increase overall utility

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that the rescue party must be sent out. Surely the sophisticated utilitarian is correct, but his/her calculations are more difficult and the theory less practical. For a less dramatic illustration, consider intensive care versus preventative care. Clearly, most aspects of good preventative care save more lives per dollar, but are we ready to eliminate life-saving medical care?

Another criticism of utilitarianism is when it is adding up individual preferences it does not distinguish perverse or manipulated preferences. There is something wrong with using preferences to guide a moral theory the critics say. Think of substance abusers or gamblers: even though they prefer to drink alcohol, do drugs or gamble, surely we are right in saying their preferences are morally lacking. Consider the following with regard to manipulated preferences:

If I lived in Huxley's Brave New World, then I would prefer a life of convenient and shallow hedonistic pleasures to any struggle with the uncertainties of 'normal', uncontrolled and sometimes unpleasant human existence. But most of us regard the fact that I would have been conditioned to enjoy Brave New World from before my birth as morally odious. If it is morally odious, then that is not because it goes against my preferences.23

Finally, there is a practical criticism of utilitarianism: how does one do the calculations? how can utility be summed? Since people vary so much in their values it becomes very difficult. Microeconomists are sceptical about intrapersonal comparisons let alone interpersonal preference rankings. Does this leave us hopeless? To be sure, this is a valid criticism of utilitarianism and a real problem for the theory, but it has been overemphasised. All theories face similar problems: how do we measure need? merit? how do we decide who is least advantaged? Much can be learned from the general trends (but not the specific numbers) arrived at from utilitarian questionnaires regarding health care and other public resource allocation. The services people strongly prefer should be provided; the services that get low preference scores should be minimised or eliminated; and the ones in-between should be considered further. The

23Campbell, Gillett, and Jones, Practical Medical Ethics. p. 5.
Utilitarian calculus is not a sharp instrument with which to answer all of our resource allocation questions, but it deserves serious consideration in allocation discussions, particularly at the macro end of the scale.

**Merit Theory**

The third interventionist theory to be examined is merit theory.\(^{24}\) Meritocratic theories hold that the relevant difference between individuals is the amount of energy expended or the type of result achieved by either individual. Meritocratic theories show weaknesses throughout the resource allocation decision continuum, but the general importance of desert criteria in most people’s intuitive thinking about justice should be emphasised. The intuitive logic as well as the practical difficulties of meritocratic theories will be outlined. Meritocratic theories come in at least three forms: 1) to each according to individual effort, 2) to each according to achievement, and 3) to each according to societal contribution.

In some contexts it is worthwhile to separate efforts from achievements. With efforts one focuses on the amount of energy expended by the individual. When assessing achievements one measures actual performance, successes, and productive contributions. There really is a difference. Athletic awards like "most improved player" are given to recognise hard work and improvement, whereas awards like "top scorer" are given for achievement regardless of the amount of effort, good fortune or support work involved. For a scholastic example, the top academic award is given to the student with the best grades, regardless of the amount of work the student had to do. The greatest individual effort may have been demonstrated by a student in the middle of the class.

To each according to his societal contribution has a utilitarian flavour about it. This conception gives moral pride-of-place to the common good and the welfare of the community; it is less individualistic than effort or achievement.

\(^{24}\)A distinction is often made between merit (frequently a forward-looking, consequentialist notion) and desert (typically a historically-based notion). Although there is clearly a difference, neither is particularly helpful in health care, and they are being treated the same for simplicity’s sake.
Gene Outka expresses the general importance of merit considerations well:

These criteria may serve to illuminate a number of disputes about the justice of various practices and institutional arrangements in our society. It may help to explain, for instance, the resentment among the working class against the welfare system. However wrongheaded or self-deceptive the resentment often is, particularly when directed toward those who want to work but for various reasons beyond their control cannot, at its better moments it involves in effect an appeal to desert considerations. 'Something for nothing' is repudiated as unjust; benefits should be proportional (or at least related) to costs; those who can make an effort should do so, whatever the degree of their training or significance of their contribution to society; and so on.\(^{25}\)

Positive examples of how these meritocratic theories would operate in health care are few. One can imagine a person who labours to have optimum health being favoured should s/he become ill. And few would argue that a President or Head of State should not receive treatment with priority to an average citizen. What about the unfortunate ill who are not praiseworthy? Should they receive any health care? What about the huge grey zone of societal contribution? Who gets priority between a city council member and a teacher? What is being compared—past societal contribution or future potential contribution? How does one attribute merit to children? These examples hardly illustrate a theory for resource allocation.

It is in their negative form that meritocratic theories take shape in health care; not only do merit theories highlight the praiseworthy, they point out the blameworthy. Many people feel that along with all rights, especially a right to health care, come responsibilities, and if one is not willing to live up to demands of the responsibilities s/he forfeits her/his

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right. Anyone who believes in a penal system agrees with this line of thought to a point; our society accepts that a person’s right to liberty may be forfeited by his/her criminal activity. Many feel that health needs resulting from what is seen as a voluntary decision to take a health risk are not worthy of public subsidy. Egalitarian Robert Veatch asserts it would be unfair to not treat these risk-takers differently:

...that it is fair, that it is just, if persons in need of health services resulting from true, voluntary risks are treated differently from those in need of the same services for other reasons. In fact it would be unfair if the two groups were treated equally.

One of the most popular examples is the longtime smoker who develops lung cancer many years after public health warnings about the dangers of smoking appeared. As the argument goes, the person with lung cancer "got what he asked for." "Surely she knew it would happen." Unfortunately it is not that clear. If the conclusion is to be that smokers who develop lung cancer have no valid claim to public health care resources, then it must be demonstrated the risk was taken voluntarily.

Smoking is certainly a public health villain. Lung cancer causes over 1200 deaths per year in New Zealand, and clearly the most important causative factor is cigarette smoking. And the negative effects of smoking do not stop there; it plays a large role in heart disease, emphysema, respiratory infections, etc. The world would be a healthier place without smoking. However, comparing smoking’s effect through lung cancer to another, more socially acceptable, public health villain is informative. Let’s compare lung cancer to the morbidity and mortality caused by automobiles. When is the last time you heard someone blame the victim of an automobile accident for his/her own demise? "Surely she knew lots of people are killed in cars every year." Of course, there are a minority of


27 An exception is voluntary health risks taken for public good. For example, firefighters and police officers injured in the line of duty would certainly be worthy of public subsidy.

motor vehicle deaths caused by wanton recklessness, drugs and alcohol, but the majority of accidents are caused by mistakes that are inherent to driving. Strengthening this argument is the fact that it is not always the reckless driver who is killed or injured; indeed, it is often a passenger or an innocent person in another automobile. Even in the "no fault" accidents, it can be said that all drivers (and indeed passengers) know there is a small risk every time one travels in an automobile; it is a calculated health risk. The intuitive retort is that the obvious health risks of smoking far outweigh the minimal risk involved with driving. But the actual numbers paint a different picture. Research has shown that approximately 4% of those who have smoked for 40 years develop lung cancer (is taking a one in twenty-five risk asking for it?). Statistically, someone will die in a motor vehicle crash in one of every eleven New Zealand families. Crashes are the leading cause of death for New Zealanders under age 45.29 Road accident statistics for New Zealand in 1992 show that 16,767 people were injured or killed. That is approximately 0.5% of the population EACH YEAR (the percentage would be higher if those people who never travel by car could be deducted). If minor injuries are deducted, the number of New Zealanders killed (558) or seriously injured (2741) is 3299 which is 0.1% of the population every year.30 Lung cancer takes about 1200 lives each year. The health risks of driving and smoking are not so disparate as the intuitive retort. Granted, lung cancer is only one of several disease states linked to smoking, and the total impact of smoking would be much higher. On the other hand, lung cancer is the disease most directly linked to smoking (in other diseases, heart disease for example, smoking is a culprit but the risk factors are multiple), and if there is any difficulty making a case for blaming bronchogenic carcinoma patients it will only be more difficult for other illnesses. This is not to say we should all avoid our cars and smoke more instead, but rather when blaming victims for voluntary health risks we need to ask, 'Where will we draw the line?' and 'What will the penalty be?'


30Motorcycle statistics were deliberately excluded as they are considered at least as culpable as cigarettes in many circles. However, if motorcycle accidents were included, add 88 fatalities and 673 serious injuries. Statistics from The New Zealand Yearbook 1994.
The punitive side of desert theories has been criticised in four ways. The first argument I have already begun: the slippery slope or where to draw the line. First, smokers and drinkers will be singled out. Then it will be rugby players, trampers, skiers. Will society soon enough penalise those of us who eat too much, exercise too little and have irregular sleeping habits? The critics from this perspective ask if life would be too dull if we first had to assess all of our actions to see if they promoted health. Isn't it punishment enough that the health risk-takers are sick in the first place?

The second criticism asks what the penalty will be, and whether it can be fair. All writers on the subject seem to agree that exclusion from the health system would be too extreme. Many opt for levies or taxes on the risky behaviours. It is a simple enough exercise to put a tax on cigarettes, alcohol and gasoline, but how would those who participate in high risk sports be levied? Would a levy on high risk sports reflect both the health risks and health benefits of exercise? And if we penalise those who play high risk sports (e.g., through ACC levies on sporting organisations), what about those who endanger their health with a sedentary lifestyle? Is it fair to levy easily taxable items and leave other culprits untaxed?

The third criticism is that, while some voluntary behaviour is obviously bad for one's health, there is no practical system of enforcement. That brings to mind a family conversation. While giving one of my relatives the stop smoking routine at a family get together my mother flippantly commented to me that if she smoked she would never tell a doctor about it. Half of her point was to silence me, but the other half is worth thinking about. If we try to implement any sort of a punitive system it would encourage dishonesty between patients and the health service. This certainly would be a negative side effect of such a policy. How would such a system be enforced? Would it require 'health police' or some other Orwellian big brother surveillance?

The final criticism is the strongest, and it asks if human behaviour is truly voluntary. There are a range of viewpoints in this area. The most

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extreme is the social causation model of health and disease. According to Victor Sidel,

...most health and illness are socially determined rather than individually determined. I refer not only to the obvious instance of environmental pollutants and other unhealthy conditions, but also to the fact that most personal health practices are culturally and societally determined.32

Holders of this viewpoint feel that since society failed to prevent the risky activities, society is responsible for the outcomes. At its worst, the punitive side of merit theories actively diverts public attention and governmental responsibility away from addressing the social forces which cause or encourage disease.33 Merit theories can be nothing more than poorly disguised prejudices: it is no coincidence that frowned upon diseases are often concentrated among the lower socioeconomic class. For example, successful, workaholic, middle-aged entrepreneurs who suffer coronary artery disease in their forties are revered as societal heroes while truck drivers or shearers with lumbar back disease are considered malingerers until proven otherwise. A more moderate stance is the multicausal model of health and disease.34 This theory has a place for genetic, psychological, and social causation as well as allowance for voluntary acts affecting health. However, the multicausal model posits that we cannot determine the degree each element contributed to disease; hence, it is not possible or practical to blame the individual for his/her disease. This set of theories recognises that certain diseases and 'voluntary' behaviours have a strong correlation with socioeconomic class, and questions whether we can blame people for their illnesses.

LIBERAL THEORIES (PROCESS-ORIENTED)

In contrast to interventionist theories, liberal theories are more interested in having a just process of resource allocation than in the


eventual outcome of the distribution. Obviously, the procedural principles that a theory endorses are intimately associated with a vision of the good. That is, a process is chosen which will presumably lead to a certain vision of society. However, if the process is assiduously followed and the outcome is not in keeping with that vision of the good, then the outcome is unfortunate but not unjust. The process was not violated. Liberal theories do not sanction any State intervention to change the unfortunate outcome. Of course, the process could be amended as necessary to avoid future unfortunate outcomes. Liberal theories are more suited to fit Western democracies than interventionist theories.

**Rawls's Theory Of Justice**

One of the most influential recent works in philosophy is John Rawls's *A Theory of Justice*. Although Rawls's theory has many critics as well as fans, all would agree it is a book of considerable influence which has created much discussion. Rawls's theory is a process-oriented social contract theory with a distinctly egalitarian flavour. Many advocates generally sympathetic to egalitarianism appeal to this theory in part because it avoids heavy-handed government intervention.

Rawls's theory is a direct repudiation of utilitarianism as the grounds of social justice. Rawls's principle objection to utilitarianism is that maximising utility allows a distribution of social goods that violates basic individual liberties and rights that should be guaranteed, regardless of their effect on overall utility. As pointed out above, utilitarianism secures no place for the individual. It is concerned with aggregate utility in a society and is indifferent to the distribution of utility among individuals (recall the Christians and Lions argument).

Rawls's theory uses a novel procedure to arrive at the principles of social justice. The procedure involves an imaginary contract situation which Rawls calls the "original position." The individuals participating in the social contract are to be ordinary, rational citizens who stand behind a "veil of ignorance." The veil prevents the individuals from knowing anything about their eventual station (socioeconomic class, gender, religion, race, occupation, etc.) in society. They are not permitted to know about the society for which they are promulgating rules. Thus they will not decide matters of social justice in a self-serving way; they would not be able to. They are, however, permitted to know true general facts about the
human condition. Although the participants have been equalised to the point where they cannot be self-serving by the veil of ignorance, each participant remains distinct and can defend his/her vital interests. Thus no basic beliefs/values have been assumed by Rawlsian justice.

It could be thought that the veil of ignorance reveals so little to the contract parties that they could not devise any rules for social justice. In response to this, Rawls develops the concept of primary social goods: goods or values that are of instrumental use to virtually any life plan. These are in contrast to primary natural goods (e.g., intelligence) which are certainly important, but beyond the purview of social justice. Thus, from the vantage point of the original position, contractors would seek rules to maximise his/her share of the primary social goods without actually knowing his/her station in society: contractors in the original position have everyone else's interests in common. For Rawls the primary social goods are: 1) basic liberties, 2) diverse opportunities and freedom of movement and choice of occupations, 3) powers and prerogatives of office, 4) income and wealth, and 5) the social bases of self-respect.

Rawls's theory of justice rests on two principles which he asserts would be unanimously agreed to by the social contractors in the original position. First, the principle of greatest equal liberty: each person is to have an equal right to the most extensive total system of equal basic liberties compatible with a similar system of liberty for all. Second, social and economic inequalities are to be arranged so that they are both: a) to the greatest benefit of the least advantaged (the difference principle) and b) attached to offices and positions open to all under conditions of fair equality of opportunity (principle of fair equality of opportunity). Thus, the contractors agree that liberties (negative rights) are to be distributed in an egalitarian manner, whereas the other primary social goods will be distributed equally unless an unequal distribution benefits the worst off individuals. For example, inequalities in income and wealth will be tolerated if the financial rewards for successful entrepreneurs stimulate the economy enough to make the income of the poorest higher than it would be under an equal income system.

Notice that several obvious candidates are missing from the list of primary social goods, e.g., food, clothing and shelter. It is assumed that if everyone receives a just share of income and wealth then these necessities
can be purchased. Health care, too, is missing from the list. How one treats health care in terms of Rawlsian justice leads to different conclusions since Rawls himself was silent on the matter. Hence it is quite possible to read two "Rawlsian" accounts of just distribution of health care resources that are quite different.

In one of his earlier articles\textsuperscript{35}, Norman Daniels explains there are at least four ways to fit health care into the list of primary social goods. In the first two strategies, health care would be added as a sixth primary social good. As pointed out above, one of Rawls's primary social goods—the basic set of liberties—is not subject to the difference principle. In the first strategy, health care is added as a primary good on par with the basic set of liberties. Thus, a right to equal access to health care is generated similar to the right to equal basic liberties. Ronald Green takes this approach. Green writes:

\begin{quote}
Access to health care is not only a social primary good, in Rawls's sense of the term, but possibly one of the most important such goods. I have already indicated the central place Rawls believes contract parties would give to civil liberties. But certainly the same can be said for health care. Even more apparently than governmental interference, disease and ill health interfere with our happiness and undermine our self-confidence and self-respect. Indeed, some who have disputed the priority that Rawls gives to the civil liberties have done so precisely because they believe that other values, especially physical well-being and security, are to be rationally preferred.\textsuperscript{36}
\end{quote}

The conclusion from this application of Rawls's theory to health care is: "each member of society, whatever his position or background, would be guaranteed an equal right to the most extensive health services the society allows." Not surprisingly, this is the egalitarian argument revisited, and it is open to all the same criticisms. If health care is ranked as this centrally important, then how can we assess trade-offs between it and other social


In the second strategy, health care is added as a sixth primary social good, and is distributed according to the second principle. If distributed unequally, then it will be to the greatest benefit of the least advantaged. This construct is compatible with a two-tiered health system where those who can afford it receive max-tech care as long as benefit also accrues to the least advantaged. Obviously, Rawlsian principles are designed for an enduring, dynamic society; thus, there are limits on the gulf that can develop between the most advantaged and the least advantaged. Benefits need to be apportioned so as to guarantee a stable society. Take, for example, plans to build a new, private, state-of-the-art paediatric hospital and research facility. Public approval is needed for such an endeavour, and a freeze-frame application of Rawlsian justice might wrongly conclude that the 'public' benefit from new research at the facility would be sufficient to count as benefiting the least advantaged. However, looking at the private hospital in the context of an ongoing society shows the new research to be inadequate spin-off to the least advantaged. Such a facility would encourage an ever-widening gap between the most and the least advantaged. The hospital could still be built, but a more reasonable benefit to the least advantaged would be requiring some portion of the beds in the hospital to be dedicated to charity care. Thus, the benefit to the least advantaged would be more direct. The difference principle avoids a central criticism of egalitarian theories, viz., that people should be able to spend their private resources on expensive medical care. It leaves a problem with how to weight health care in the primary goods index. Some worry that the urgency of health care needs would give so much weight to health care as to return us to the black hole problem.

The third strategy uses the principle of fair equality of opportunity to put health care on par with education; both provide a critical, necessary background condition for the realisation of other primary social goods. If a person is ill or uneducated, s/he is unfairly disadvantaged in the pursuit of occupations, positions of power and income and wealth. This is the approach Norman Daniels takes in Just Health Care. His account is designed to help answer two important health care resource allocation questions. First, what makes health care morally special? For Daniels the answer is that ill health is a barrier to normal species functioning which is
necessary to pursue opportunities, and (some forms of) health care can return individuals to their normal opportunity range. Daniels states that, the "moral function of the health care system must be to help guarantee fair equality of opportunity." Second, how are various health care interventions ranked relative to one another? Daniels suggests that those interventions which do most to return people to normal species functioning should be ranked highest.

The fourth strategy is simply to leave health care as something to be purchased along with food, clothing and shelter with one's own fair share of income and wealth. This approach to health care is quite similar to the libertarian approach except one's share of income and wealth would theoretically be higher in Rawlsian justice than libertarian justice if one were 'least advantaged.' As in libertarianism, this account provides no guidance for how to treat children or the handicapped; obviously their income will be insufficient to acquire adequate health care. And those who have a low income secondary to their illnesses and inability to work seem to fall through the cracks, too.

On the positive side, Rawls's theory avoids heavy-handed state intervention by being process-oriented. It carves out a special place for the individual not allowing individuals to be merely means to an end. It places liberties, negative \textit{in rem} rights, on their own level above and more sacred than positive \textit{in rem} rights which is roughly the conclusion arrived at in chapter two. However, while advantaging liberties, Rawls does not neglect positive \textit{in rem} rights. And he takes quite seriously the idea that unequal distributions often benefit everyone.

The strongest criticism against Rawls's theory of justice is quite fundamental. Critics ask whether contractors in the original position behind a veil of ignorance would actually choose the difference principle. Are people really so afraid to take a risk that they would demand distribution to the greatest benefit of the least advantaged? This Rawlsian concept of maximising the minimum one could possibly receive in society is questioned. Many feel most contractors would choose a distribution that allowed greater potential maximums with a safety-net minimum (below a Rawlsian maximin). There is certainly empirical evidence that

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people are quite willing to take substantial risks for possible gains. If this criticism is legitimate, then Rawls's theory gives us little guidance.

**Libertarianism**

Libertarianism is a pure process view which holds that the relevant difference between individuals is the entitlement created by past circumstance or actions. Justice to libertarians is confined to free and fair exchanges in the marketplace. It wants nothing to do with redistribution:

> The term 'distributive justice' is not a neutral one. Hearing the term 'distribution,' most people presume that some thing or mechanism uses some principle or criterion to give out a supply of things. Into this process of distributing shares some error may have crept. So it is an open question, at least, whether redistribution should take place; whether we should do again what has already been done once.\(^{38}\)

This theory is so opposed to all welfare rights that it is not useful in a discussion of establishing a right to health care. While I feel libertarianism can be successfully refuted, it would not advance the cause of demonstrating a right to health care. Hence, only a few comments will be made. The argument that a broadly conceived negative right to health care entails many positive entitlements was outlined in chapter two, and libertarians hold negative rights paramount. The case against the libertarian repudiation of welfare rights is strengthened by the argument that both positive and negative rights are legitimate moral rights. In the previous chapter, the error of only recognising negative rights was addressed.

**NON-JUSTICE APPROACHES**

**Societal Investment And Return**

Tom Beauchamp frames an argument based on societal investment and return. The public can claim a right to health care because all of the institutions for health care research and education are heavily publicly subsidised. Beauchamp writes,

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The collective social system that funds the education of physicians and medical research—and not merely the education and research of professionals in public health—is heavily subsidised by public funding. Like any system of protective insurance, investment, and return in which the public is involved, a decent return on one's contribution is anticipated, and that return should come in this case in the form of protection of health or alleviation of illness and injury.39

While it is clear that these institutions are publicly subsidised, it is less clear the subsidy is intended to be in exchange for private medical services. A strong argument could be made that the expenditure is in the name of public health, and the funding is to provide new treatments and sufficient doctors—not medical services. It is unclear what sorts of positive in rem claims could be substantiated with this argument.

While this line of thought may not help to establish a positive in rem right, it makes an important contribution to refuting a popular argument. To quote Robert Sade again, "In a free society, man exercises his right to sustain his own life by producing economic values in the form of goods and services that he is, or should be, free to exchange with other men who are similarly free to trade with him or not."40 Sade argues that health care services are an example of economic values that individual doctors create and should be free to exchange as each sees fit. Doctors, however, do not stand alone. Recognising that the great body of medical knowledge has been accumulated by the individual efforts of many past and present scholars coupled with the fact much of this work was publicly subsidised, makes Sade's view that medical services are the individual property of doctors appear ridiculous.

**Beneficence/Charity: Obligations Without Rights**

Because of the unsatisfactory results of applying general theories of justice to health care and a perception that justice is not the only relevant


moral value in health care, some authors have emphasised beneficence or charity in health care resource allocation. There are two main proponents of this stand. The President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research argued that there is a societal obligation to provide "an adequate level of care without the imposition of excessive burdens." Although far from specific, arguing for an adequate level "acknowledges the need for setting priorities within health care and signals a clear recognition that society's resources are limited and that there are other goods besides health." Allen Buchanan argues for enforced beneficence. The basic premises are:

1. The provision of at least some of the more important forms of health care to the needy can be viewed as collective goods, and strictly voluntary schemes for securing them may succumb to familiar obstacles to successful collective action--in particular, the free-rider problem and the assurance problem.

2. In some cases, enforcement of obligations to contribute is both necessary and sufficient for the successful provisions of collective goods, including important forms of health care for the needy.

3. The fact that enforcement is necessary and sufficient for achieving such a morally fundamental collective good as the provision of the most important forms of health care to the needy is a strong prima facie justification for enforcement, independently of whether the individuals who will receive the good have an antecedent moral right to it.

As outlined in chapter two, our goal is to investigate the foundation for a moral positive in rem right to health care; thus, this approach is inadequate by definition. Beneficence or charitable obligations do not

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42Ibid, p. 561.

entail rights. There are two senses of obligation (also outlined in chapter two): strong obligations are correlative with rights, but weak obligations have no corresponding rights. Beneficence and charity are weak obligations. Bentham would call these self-regarding obligations; it is my duty to be charitable, but no one can make a claim against that duty. This is not to claim the argument is without merit. Indeed, much like the argument that health care is a natural extension of collective protection (i.e., a negative in rem right), this argument from beneficence/charity carries a lot of weight. Hence we should take note of both positions. However, both approaches are destined to fall short of the goal which has been set: to find an appropriate foundation for a positive in rem right to health care which both establishes the right and assists us in rationing decisions.

**The Right To A Decent Minimum**

The right to a decent minimum is somewhat misplaced in this section of non-justice approaches. The advocates of a right to a decent minimum of health care envision it as a matter of justice, and would consider not fulfilling the right an injustice; hence, it is a justice approach, loosely defined. It is placed here because of its lack of a clear philosophical foundation and its lack of roots in any general theory of justice.

As Allen Buchanan observes, a consensus that there is a right to a decent minimum pervades the philosophical literature as well as public policy debate. The concept has at least four strong points which have lead to its popularity. First, it is sufficiently vague as to bring people with significantly differing opinions on the topic under the same umbrella. The vague nature of the principle could also be seen as a weakness. Second, it recognises that some kinds of health care are more important than others; it avoids the excesses of what Buchanan calls the 'strong equal access principle' (exemplified in this chapter by Robert Veatch's egalitarianism and Ronald Green's application of Rawlsian justice). Third, the idea of decent minimum is to be understood in a society-relative sense. Citizens of all nations can expect a decent minimum, but the specifics of the right will be notably different in Australia and

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Bangladesh. Finally, since the right to health care must be limited, the right to a decent minimum suggests it should be limited to the 'most basic' services, those adequate for a 'decent' life. Obviously, this final strength of the theory is also a weakness. What exactly is adequate for a 'decent' life? How do we define 'basic'?

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<tr>
<th>Basic</th>
<th>Non Basic</th>
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<td>inexpensive</td>
<td>costly</td>
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<td>preventative</td>
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<td>low tech</td>
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<td>primary</td>
<td>secondary or tertiary</td>
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<td>acute</td>
<td>chronic</td>
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Robert Veatch illustrates the difficulty in deciding what counts as basic. As shown in the chart, inexpensive, preventative, low tech, primary, and acute care are each thought of as more basic than costly, curative, high tech, secondary or tertiary, and chronic care, respectively. How do we categorise care that cuts across these pairs? Is inexpensive, high tech, tertiary care basic or non-basic? Basic care may very well be the care entailed by a right to health care, but defining it is a difficult matter.

As Buchanan states, "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." Buchanan then offers a hodgepodge supporting theory made up of the combined weight of four less encompassing arguments (prudential arguments and arguments from/for: special rights, the prevention of harm, enforced beneficence). While it seems Buchanan is correct that the idea of a decent minimum has many advantages, this is an inadequate supporting structure. We require a theory that retains the advantages of this concept while being based in a stronger, clearer supporting framework.


CONCLUSIONS

The complexity of resource allocation has been emphasised throughout this chapter. The areas of relative strength as well as weakness have been illustrated in each theory of distributive justice examined. The three most plausible approaches are Robert Veatch's egalitarianism, Norman Daniels' application of Rawlsian justice, and the right to a decent minimum. By plausible I mean these theories are both reasonable (they have some intuitive appeal) and have a significant number of adherents. Still, none of these theories is adequate for all situations. The conclusion is that each theory of justice deserves a voice in resource allocation, but that it would be dangerous to lay the foundation for a right to health care in any one of these theories of justice. After all, one would assume an egalitarian right to health care would demand an egalitarian distribution of resources. A pluralistic approach to resource allocation is suggested giving each theory a voice where appropriate. This is further explored in chapter five.

In his introduction to Rights to Health Care Thomas Bole, III warns us to avoid the "fanaticism of justice". Any canonical ranking of values inherent in a theory of justice is unlikely to be acceptable to someone who does not share that view of justice. There is no theoretical reason why multiple theories of justice cannot be employed to arrive at an acceptable allocation of health care resources. Indeed, it is this type of compromise that is most likely to succeed in gaining public approval.

Where does that leave us with regard to establishing a right to health care? It would seem reasonable to say the total volume of evidence for a right to health care given by the justice and non-justice arguments is enough to persuade us a right to health care exists. I am willing to accept that, but it is wanting in terms of a systematic approach. To say a right to health care exists because the majority of the evidence says one should is a bit weak. In the next chapter the right to health care will be grounded in one version of human rights theory. This foundation is appropriate to allow each theory a voice in resource allocation where appropriate.

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CHAPTER 4: NEW BEGINNINGS

Human Rights theory provides the best foundation for a right to health care. Moreover, human rights theory provides an appropriate foundation for all moral (positive as well as negative) in rem rights. A straightforward initial question is, "What are human rights?" The literalist might reply, "The rights of humans, of course." Further explication of the concept, though, has proven elusive, and has been the subject of many volumes of work. Different authors express widely varying conceptions of human rights. In this chapter, the great range of human rights theories will not be mapped. Rather, attention will be focused on a single theory as the source of an appropriate right to health care (and other moral in rem rights). Several key issues for all theories of human rights will be outlined, and the specific strengths of the constructivist theory will be highlighted. Finally, the content of the right to health care will be addressed by examining the priority-setting mechanisms of the constructivist theory.

First, some preliminary questions should be answered. It could be asked fairly, "Haven't we been discussing human rights throughout this thesis? Why are we just now getting to a theory of human rights? or What is the difference between these human rights and the rights to health care discussed in the last chapter?" To paint with dangerously broad strokes, there are four basic elements which most moral theories account for: duties (what one 'ought' to do), goals (consequentialist reasoning), virtues and rights. Different ethical frameworks place differing levels of importance on each of these elements. Utilitarianism, for example, makes goals paramount, but this is not to say there is no place for rights. Rights could be derivative from the central goals of the theory: a rule utilitarian theory might have a rule that entails a right to (at least some forms of) health care (because, on the whole, it serves to increase utility). Human rights theories, on the other hand, give pride of place to rights. A right in a theory of human rights is central to the theory—not the result of what one ought to do (like a right to health care based in beneficence or charity) or a consequentialist calculation. To be sure, though, rights all give certain entitlements to the right-holders. Furthermore, there is (some) room for rights in most moral theories. The
distinction is the relative importance of rights to the individual theory. In this chapter rights will be central to the moral theory, not derivative as in the rights discussed in the previous chapter.

Doctrines of human rights have a long and impressive history dating from the Stoics and Roman jurists.1 Human rights have enjoyed a particularly important spot in moral thought since John Locke (1632-1704). While important to moral reasoning, human rights are by no means beyond contention: they have been passionately defended and vehemently denied. Albeit debate continues, the importance of human rights to contemporary thought is witnessed by documents such as the Universal Declaration of Human Rights adopted in 1948 by the United Nations.

**NATURAL RIGHTS VERSUS HUMAN RIGHTS**

Occasionally, though not consistently, a distinction is made between natural and human rights.2 John Locke originally wrote of natural rights which were freedoms of the individual from the government in terms of Life, Liberty and Property. For Locke, natural rights were essentially negative rights. Over time, the idea of natural rights expanded and came to include many positive rights as well. When made, this distinction usually means that natural rights are the, essentially negative, rights of the early theorists and human rights are the, positive as well as negative, rights of the more recent theorists.

The matter is complicated, though, by the fact that some use the distinction between natural and human rights to differentiate between the rights discussed by contemporary libertarians (natural rights) and contemporary human rights theorists.3 Clearly, libertarians and human rights theorists share a common heritage in the writings of John Locke. At some point there was a division in this line of thought where one group

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progressively enlarged the concept of natural rights to contain positive, social and economic rights. This group became the human rights theorists. The other group emphatically limited the idea of natural rights to negative, civil and political rights--today's libertarians.

Inasmuch as it is unclear, the distinction between natural and human rights is not important, and, therefore, I will not employ it. The concept of human rights seems to have undergone a natural evolution to include positive as well as negative human rights. As discussed in chapter two, there is an inherent tension between positive and negative rights: the more resources society demands from each individual to honour positive rights, the more society infringes on the liberties of the individual. This tension has lead to reductionist arguments that only positive or only negative rights are truly moral rights. There is the argument that negative rights are essentially an instrument of the privileged to maintain the status quo. This side argues negative rights are meaningless without positive rights. The full-belly argument asks "how many starving people are concerned with freedom of religion?" From the other extreme, many libertarians argue there is simply no need for redistribution, no need for welfare rights at all. Consider Kuenzi's comments.

A 'right' merely defines a freedom of action--free speech, peaceable assembly, press, etc. The only right that a government can guarantee, then, is that of freedom of action in those areas outlined by our constitution. Health Care [by contrast] is a service provided by doctors and others functioning in a free society, to people who wish to purchase it.4

According to Kuenzi and others, the only valid rights are liberties, negative rights. In the atmosphere of free and fair market exchanges, there is no cause for redistributing goods. This, the libertarian argues, smacks of paternalism: if citizens wanted something they would acquire it in the marketplace. Why should society second-guess rational consumers? Both of these arguments seem to go too far. Consider the right to life of a child. Certainly, this encompasses both negative and positive rights like freedom from harm and a right to health care if seriously injured. Thus positive and negative rights are in a delicate

balance with one another: neither should dominate the other, and both are necessary. Both positive and negative rights will be referred to as human rights in this chapter.

WHAT ARE HUMAN RIGHTS?

We return to the question, "What are human rights?" Human rights are the universal rights of humans: they are rights which are claimed on behalf of all people in all situations. Whether or not an individual enjoys her/his human rights, they are rights s/he should enjoy. Human rights are the moral (positive and negative) in rem rights of the second chapter. They are the things individuals can claim from society at large.

Above it was mentioned that the four basic elements of any moral theory are goals, duties, virtues and rights. Can there be a right-based ethic? J.L. Mackie argues that there can and should.\(^5\) We are all familiar with goal-based, consequentialist moral theories—most notably the many forms of utilitarianism. Duty-based, deontological theories (in their many forms) are well-known, too. However, while there are right-based political theories, there are no common examples of complete right-based moral theories. Mackie suggests that Rawls's theory of justice and (portions of) Mill's utilitarianism may be right-based, although neither is explicitly so. At the end of the day, there are no well-developed right-based moral theories, but there are no theoretical prohibitions either. I am not sure I can or will advance beyond the contributions of Mackie in developing a complete moral theory below, but a right-based theory does make an appropriate foundation for a right to health care.

Most authors agree the source of human rights must be our humanity, our common human nature. The problem lies in illuminating human nature and how it gives rise to rights. It has been popular to argue that human rights are based on human needs. This theory is attractive because it avoids the philosophical difficulty of defining human nature in order to promulgate a list of human rights. A simple operational definition of need would be "A needs x if and only if x is essential to the

proper functioning of A."\textsuperscript{6} Presumably a scientifically demonstrated human need entails a human right. This line of thought rests on a narrow biological view of humanity. Thus, one could run a controlled experiment systematically denying humans specific things to see if they are negatively impacted (presumably physiologically or perhaps psychologically). If the lack of a something, \( x \), caused improper functioning (i.e., illness), then there is a human right to \( x \).

However, closer inspection shows this approach to be beset with difficulties, too. The list of scientifically demonstrable needs based on a narrow biological view is short indeed: minimum nutrition, basic shelter, minimal social interaction and life-saving medical care.\textsuperscript{7} Surely, there would be more rights on a complete list of human rights. Notice that both positive and negative rights are inadequate in this biological needs conception of human rights: liberty could be restricted nearly to the point of causing illness. In response, "soft" needs have been added to some theories. For example, Donnelly writes:

\[ \text{[Abraham] Maslow recognises a wide range of hierarchically ordered needs, ranging from survival, safety, love and affection, to higher needs for 'belongingness', esteem and self-esteem, up to 'metaneeds' of truth, goodness, beauty, wholeness, aliveness, uniqueness, perfection, completion, justice, simplicity, richness, effortlessness, playfulness and self-sufficiency.}\textsuperscript{8} \]

Most would agree (at least some of) these things should be included in a list of human rights, but the principle contribution of the need-based theories was their empiricism. With the "soft" needs added the theories lose much of their empirical value. This underscores an important problem with using needs. Need demands either too much or not nearly enough. With a narrowly defined biological view of health needs there


\textsuperscript{7} While it does nothing to support or refute a need-based human rights theory, notice that this sort of reasoning closely resembles the egalitarian distribution of health care based on needs. It would lend itself to the same criticisms. Of course, health care would be the only area where the two theories would be identical: egalitarianism would distribute other goods equally and a needs-based human rights theory would only address goods which are scientifically demonstrated needs.

\textsuperscript{8} Donnelly, \textit{The Concept of Human Rights}. p. 29.
are valid claims to very little. However, if we adopt something akin to the World Health Organization definition of health (viz., "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"9), then there are valid claims to a great deal more than any society could offer. Everyone realises the correct balance is somewhere in-between, but it is unclear how a theory of needs can suggest a reasonable list of human rights. We return to the problem of illuminating human nature and how it gives rise to rights.

Along with the difficulty of explicating human nature there are at least three other problems or strong criticisms that human rights theories run up against. Each will be briefly mentioned here, and discussed further below. First, doctrines of human rights are accused of being too individualistic; some feel they deny community obligations. Second, explaining the universality of human rights is problematic when so many people obviously do not enjoy them. Finally, some denounce human rights as an impoverished moral notion.

Jack Donnelly argues for a constructivist theory of human rights in political philosophy. He argues "the source of human rights is man's moral nature....Human rights are 'needed' for human dignity, rather than health, and violations of human rights are denials of one's humanity rather than deprivations of needs. We have human rights...to those things 'needed' for a truly human life."10 The items on a constructivist list of human rights will be those things necessary to lead a life of human dignity. The rights on the list are not idiosyncratic, however. They apply to all members of a given society. Donnelly envisions a dialectic between politics and ethics. This theory has several strong points.

First, it is a 'constructivist' theory. It says, in effect, if you treat a person like a human, then you will get one. Constructivism is contrasted with essentialism which is defined as a belief in true essence—that which is most irreducible, unchanging and therefore constitutive of a given person or object. Constructivism insists that essence itself is a historical construction, and its proponents attempt to illustrate that many essences

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are in fact the effect of complicated discursive practices. Constructivism has found its largest audience among feminist scholars. Many feminists have brought under suspicion the idea of an irreducible, immutable, metaphysical essence defining "Woman." They have suggested instead that we can speak only of specific "women" constructed by variable and historically specific sets of social relations. Donnelly is applying this line of thought to man's (and woman's) moral nature. The institution of slavery provides an example that our moral judgements are indeed, in some measure, constructed. Slavery in its least heinous form—in which slaves were well fed, not beaten and treated with some respect (although still treated as slaves)—was an institution accepted by many otherwise right-minded individuals in its time. Today we find it difficult to fathom an acceptable form of slavery. Our society has had an impact on our moral judgements. The constructivist theory has a clear place for the effect of society on human nature and vice versa. It recognises that human nature can reach its greatest potential with a little nurturing.

The constructivist theory of human rights is not excessively individualistic. K.R. Minogue explains a standard criticism of human rights:

The idea of an independent individual pursuing his own self-generated purposes has often been taken as an implausible account of human beings, because they are more realistically to be understood as the creatures of their society, framing purposes they draw from its traditions in a language they inherit from its collective creativity.12

The constructivist theory of human rights accepts the societal heritage of the individual, but it also welcomes the idea that people differ radically about the type of life they elect to pursue. It embraces pluralism in the spirit of "we would not be where we are today without our history and our

11Diana Fuss, Essentially Speaking: Feminism, Nature & Difference. (New York: Routledge, 1989). Fuss argues that feminists have been too eager to cast aside essentialism, and that most of the theories aimed to refute essentialism actually make important essentialist assumptions. Ultimately, she is pro-constructivism, but she envisions a place for essentialism also. This argument plays little role in our discussion, but her book defines the issues well.

society, but each individual deserves to be treated with dignity." Admittedly, community concerns are secondary to individual concerns. If human rights were exercised viciously, it could negatively impact the community. For example, if a right to health care entitled individuals to ambulance services and 24 hour emergency care (as most would feel it should), it is easy to envision abuse. Individuals with non-urgent illnesses might utilise ambulance and emergency services as a matter of convenience. Clearly, this would be an abuse of the system. We accept that it is the individual who must decide if his or her illness requires immediate attention, and with this as a premise it is difficult to construct a system that could prevent abuse. If we accept the patient's perspective there is no practical way to differentiate a misperceived symptom from abuse of the system (e.g., an individual could perceive non-cardiac chest pain as a possible heart attack or he/she could just want something to help him/her sleep). Respect by the individual for the system is required to avoid wasting resources. The constructivist theory holds that, on the whole, individuals will respect society's institutions if society treats the individuals with dignity. Human rights theorists hold that it is more important to insulate the individual from a potentially vicious community than to protect the community from a potentially vicious individual. All the while, the constructivist emphasises that human nature and society are in dialectic. An important, though secondary, place for the community remains.

The constructivist theory does not rely on an abstract vision of human nature. It makes the moral claim that human rights are founded in humanity's moral nature and are needed for human dignity. Any right-based theory has to face the issue of whether the rights it endorses are universally valid and determinable a priori by some kind of reason or are historically determined in and by a particular society. The constructivist straddles the fence: the package of rights needed for dignity are universal but the particular rights in the package only become specific in a society at a specific time. This explains the obvious historical particularity of some things we wish to claim as human rights without denying the universal nature of human rights. The universality of human rights means that all humans anywhere, anytime deserve to be entitled to the things necessary to lead a life with human dignity because they are human. However, different entitlements will be necessary in
different time periods depending on human knowledge, technology and financial constraints.

Take health care, for example. There are differences in what we claim as a right both between societies and across time. The medical interventions necessary for human dignity are considerably more extensive now than they were at the turn of the century, and one could argue that no one would have made a human right-claim for health care just a few hundred years ago. Who would be interested in claiming a right to leeches and bloodletting? Few truly saw these modalities as beneficial—they were just something to try when nothing could be done. Leeches and bloodletting—or any other commonly acknowledged quackery—are not required for a life of dignity. Today things are different. Medicine is seen as an effective science, and much of what it can offer is viewed as necessary for a life of dignity.

Although knowledge and available technology are now essentially constant across the globe at a given time, financial constraints are not. Thus the content of the right to health care will be significantly different between affluent and impoverished societies at the same point in time. Interventions taken for granted in the Western world—like modern intensive care or CT scans—would be completely inappropriate in Rwanda, where potable water is a more pressing and appropriate concern. The differences in health care brought about by differences in wealth between nations does not suggest that the human right to health care is being violated in the poorer country. Such a stand would be absurd; the entitlements demanded for a life of dignity (particularly positive rights) only gain specificity within a given society during a specific time.

The constructivist theory also allows for the less-laudable but undeniable potential of human nature. No one can deny the existence of evil in the world; evil that is often caused seemingly deliberately by humans. Human nature is a complex item made up of humanity's natural, social, historical and moral elements. The source of human rights is humanity's moral nature. While the constructivist theory is optimistic about the resulting moral character if one is treated with human dignity, it provides an explanation for the dark side of human nature. If you do not treat a person with human dignity, it is quite
possible to create something sub-human. The constructivist theory does not demand a rosy image of human nature.

The constructivist theory of human rights is very optimistic: the underlying moral vision of human nature, if expressed and implemented in the form of human rights, will create the envisioned person. Thus human rights represent a special sort of self-fulfilling prophecy. They provide an environment where a truly human being can lead a life of dignity, developing and expressing the moral possibilities of human nature.

Joseph Raz strongly criticises the notion of a right-based moral theory as impoverished.13 Raz says right-based moralities are deficient because rights are the grounds of duties and nothing more. He claims that three things do not enjoy their true moral significance. First, there are things that we ought to do which do not amount to duties; duties are only a subset of oughts. Second, right-based moralities cannot account for the nature of supererogation and its role in moral life.14 Third, right-based moralities do not allow intrinsic moral value to virtue and the pursuit of excellence.

Raz’s misgivings are misplaced; they may apply to some right-based theories, but not to the constructivist theory.15 The constructivist theory is right-based, yet it retains an important place for virtue and the pursuit of excellence as well as considerations of what one ought to do. Recalling the distinction between in personam and in rem, Raz is criticising the constructivist theory for not having in personam characteristics in an area designed for in rem considerations. Human rights are moral (positive and

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14To clarify, there are three levels of morally correct actions (as outlined in chapter two): required acts (with strong obligations), expected acts (with weak obligations) and supererogatory acts (with no obligations). Only strong obligations entail rights. Thus Raz is claiming that right-based moralities have no place for weak obligations (things we ought to do which do not amount to duties) and supererogation.

15In fairness to Raz, his essay was not discussing the constructivist theory. He was addressing the theory sketched by J.L. Mackie. Raz argues for a pluralistic understanding of the foundation of morality. There are, he says, fundamental goal, duty, right and virtue elements. The constructivist theory, as outlined here, may actually be close to what Raz envisioned: it places rights as central to society in general while retaining an important place for other moral elements with regard to the individual.
negative) in rem rights. They are the things required to live a human life of dignity which the individual can claim from society at large. Donnelly is a political philosopher, and hence his attention is appropriately focused on in rem considerations—the area of political relevance. Naturally, there is little consideration of individual ought or virtue in this area of the theory. A complete constructivist theory (one extended beyond political morality), however, is not devoid of these important elements.

A COMPLETE CONSTRUCTIVIST THEORY

At this point, a sketch of the overall moral theory I envision can be made. A complete constructivist theory includes each of the four fundamental moral elements—rights, duty, virtue and goals. The basic underlying assumptions of the complete constructivist theory are:

1) There is a plurality of reasonable visions of the good that are mutually compatible within limits.
2) Everyone should have the freedom to choose how to live (i.e., how to strive for his/her vision of the good).
3) Human rights should guarantee individuals the things necessary to live a life of dignity.

Human rights are central to the theory. Should positive and negative human rights be handled differently by the constructivist theory? Theoretical difficulties (outlined in chapter two) must be conceded. Negative in rem rights usually require governmental enforcement. Take the police and court system, for example. A large portion of what they do is assist people to enjoy their liberties as much as possible. However, the police and the court system require public revenues, a fact that obscures any straightforward positive/negative distinction. One is really asserting more than a negative in rem right when one asks for police assistance; one expects the state to protect citizens from crime with public resources—a positive in rem right. Thus, rights to protection contain both negative and positive rights within their broad scope. Furthermore, the positiveness or negativeness of a right is not set in stone; depending on changing circumstances, the same right can be considerably more or less positive. However, amid these theoretical difficulties, an important distinction remains.

Positive and negative in rem rights are not two species of a common genus. By their very nature (almost by definition) positive rights
cannot be absolute; they must be limited. They are dependent on resources that are scarce, and the inherent exhaustability of positive rights needs to be addressed; a theory that neglects this feature would be inadequate. Negative rights are limited, also, but the constraints are less severe. Liberties are only limited inasmuch as they interfere with the liberties of others.

It follows that negative human rights should be distributed so that everyone enjoys the most extensive total system of equal basic liberties compatible with a similar system for all. Positive human rights should be distributed to allow individuals to lead a life of dignity. Separating the way positive and negative rights are distributed is important when considering human rights in an impoverished nation. While it has already been illustrated that positive rights in these societies will be severely limited without violating human rights, the same can not be said for negative rights. Members of poor societies should enjoy roughly the same liberties as their affluent neighbours. The right to free speech and the right not to be tortured do not shrink along with the right to health care in a developing country.

Beyond social justice, considerations of ought and virtue weigh heavily in the individual’s moral life. Individuals should be concerned with assisting other individuals to live a life of dignity.

Ought and virtue prove important in the *in personam* aspects of the constructivist theory. Due to limited resources and the inevitable variation in personal opinion, individuals will perceive deficiencies in a society’s human rights. That is, some individuals will feel that other individuals are not being enabled by society to live a life of dignity. Though the beneficiary would hold no entitlement to such treatment, individuals would have an obligation to (they ought to—a weak obligation) assist those in need. Those who assist fellow humans are morally praiseworthy, and those who do not are morally culpable. Some of the variation in behaviour, though, will be attributable to an honest, non-vicious difference in opinion. There are many health care examples. Take post-menopausal oestrogen replacement therapy, for instance. The

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16The constructivist theory handles negative *in rem* rights much the same way that Rawls's *A Theory of Justice* does, but the positive *in rem* human rights are treated differently. Both recognise the priority of liberties.
pain and suffering from advanced osteoporosis are easily demonstrable. And the daily administration of oestrogen to post-menopausal women has been demonstrated to slow the progression of osteoporosis. Furthermore there are other benefits from oestrogen for some post-menopausal women. From these facts, two groups of physicians are formed. One feels that oestrogen replacement therapy (ERT) is warranted in all post-menopausal women (for whom there is no contraindication). The other feels that only certain women at high risk for osteoporosis should be given oestrogen. Both stands are reasonable. Hence, within a limited budget, it is reasonable for a health system to fund publicly ERT for high risk women only. Some in the former group might feel this is substandard medicine and endeavour to treat all post-menopausal women. They might argue that life with advanced osteoporosis is a life lacking human dignity; hence, all efforts should be made to prevent advanced osteoporosis. Others would not. While the jury is out on which group is medically correct, both the aggressive and the conservative doctors are acting on their reasonable interpretation of the data. Despite their actions being opposite, neither group is morally superior to the other.

This serves as an example that our incomplete knowledge of the human situation will result in different individuals treating the same people in different ways. This is not to opt for an extreme moral relativism, because some actions are unequivocally morally wrong. Rather it is to highlight that where knowledge of the situation is equivocal, opposite actions can both reasonably be treated as morally virtuous.

I would push the role of virtue in the constructivist theory one step further. Virtue and well-being are intimately connected.\textsuperscript{17} The constructivist theory holds that human nature and society are in dialectic. If a person is treated like a human being (by recognising that person's human rights) then the positive aspects of human nature are fostered and the person becomes a truly human being. The next step is to include the notion that the individual must treat other people with human dignity to foster his/her own human nature. Conversely, if one denies another person something needed for human dignity, then one's moral character

is harmed. Having a regard for what one ought to do, living a virtuous life, is essential to human well-being.

THE CONSTRUCTIVIST THEORY AND HEALTH CARE

Having endeavoured to demonstrate the richness of the constructivist theory, our attention should be focused again on the more narrow problem of how the constructivist theory treats health care, and whether it provides any advantages over rival theories. We are now in a position to answer the question 'Does a moral positive in rem right to health care exist?' As argued in this chapter, we all have human rights to the things that are needed to live a life of human dignity. Clearly, health care meets this standard. The adolescent with a sprained ankle, the elderly person with pneumonia, the middle-aged man having a heart attack, the young adult with acute appendicitis, the young pregnant woman and her unborn child, the elderly man with arthritis, the middle-aged woman with hypertension, and the man with dyspepsia all require medical attention to lead a life of human dignity. There is a human right to health care; without health care individuals are reduced to a pathetic and sometimes hopeless state. Although in no particular order, the above list contains right-claims for health care which merit different priorities. The man with dyspepsia has less of a claim on our resources than his neighbour who is having a heart attack. This is not to trivialise dyspepsia; it may be the early symptoms of a stomach ulcer which may later pose him with a life-threatening problem. However, as has been repeatedly emphasised, no society can afford to pay for all desirable health care interventions. Priorities must be set. Nor is it suggested that dyspepsia should be left untreated, but it does merit a lower priority than a heart attack.

We have examined other justifications for the right to health care. Egalitarian Robert Veatch argues we have a right to health equal to the health of others; health care is necessary to attain this. Utilitarians argue that health care does so much to alleviate pain and suffering that there must be a right to some forms of health care because of its overwhelmingly positive affect on utility. And Norman Daniels applied Rawlsian justice to health care, and argued that health care is necessary to guarantee fair equality of opportunity. Each of these are compelling
arguments, but each must operate under the same budgetary constraints as any other theory. Again, due to limited resources, priorities must be set.

Have we gained anything in applying the constructivist human rights theory to health care? We have another justification for the right to health care, but we still operate under a limited budget. Was it worth the effort? The constructivist approach to the right to health care is superior in setting priorities for health care. As argued in chapter three, there are three arguments for the right to health care which stand out from the rest: Veatch's egalitarianism, Daniels' account of equality of opportunity, and the right to a decent minimum. Utilitarianism has many strong points, but it is an inferior approach because it does not respect the individual. The priority-setting mechanisms of these three main rival theories will be outlined, and then the superior human rights approach will be sketched.

Starting with the simplest case first, the right to a decent minimum suggests that priority be given to the "most basic" services. As pointed out in chapter three, it is a difficult task to define "basic." Veatch has explained that "basic" is thought of as encompassing several different criteria, and health care interventions may be basic by one criterion yet non-basic by another. If the right to a decent minimum were to be employed, much greater specificity would have to be added to the idea of "basic."

Egalitarianism, per Veatch, is much clearer about how to set priorities. Veatch's statement of egalitarian justice in health care is "Justice requires everyone has a claim to health care needed to provide an opportunity for a level of health equal, as far as possible, to other persons' health."\(^{18}\) For Veatch, the worst-off patients get first priority. He writes,

> Those whose health is worst are entitled to enough health care to get them as healthy as others. We should target our efforts on the sickest....The medically worst off have a complete claim of justice on health care resources in order to bring them, as far as possible, up to the level of health of others....the egalitarian claim is that, difficult though it may be, we must include those conditions

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which constitute the greatest assault on one's health.\textsuperscript{19}

While this is lucid, it is not very helpful. We already expend a tremendous amount of resources on the worst off. Consider the following quotes from various American sources over a number of years:

By the early 1980s some 30 to 35 percent of Medicare expenditures were devoted to that 5 percent of the total number of recipients who were in their last year of life, and similar provocative figures were emerging about the cost of care for the dying and critically ill in all age groups.\textsuperscript{20}

In any year, the sickest 1 percent of patients account for about 30 percent of health spending and the sickest 5 percent of patients account for 58 percent of costs, report analysts Alan Monheit and Marc Berk.... The healthiest 50 percent of Americans account for 3 percent of annual costs. Nor are the sickest 1 percent just the very old; slightly more than half are under 65.\textsuperscript{21}

In 1977, per capita expenditures for those over 65 in the US were $1745; they were $661 for those age 16-64 and $253 for those under 19 (Gibson and Fisher 1979:3-16)... One study shows that 50% of all hospital charges are to some 13% of the patients, the seriously chronically ill. About 40% of these 'high-cost' patients are over 65, whereas only 15% of the low-cost patients are (Zook and Moore 1980: 996-1002).\textsuperscript{22}

\textsuperscript{19}ibid., pp. 133, 141.


\textsuperscript{21}The Editors, Newsweek. (October 4, 1993): 35.

Almost 30% of all Medicare expenditures are devoted to the 6% of enrollees who are in the last year of life.\textsuperscript{23}

If we shift priorities to further favour the worst-off, there would be nothing left for anyone else. This is not to advocate abandoning the worst off, but giving them a \textit{complete} claim on health resources does not seem rational. Where do pregnant women fit into this kind of priority list? Surely they cannot be considered among the worst off, but do we want to give maternity care a low priority? How about people with chronic diseases? And because healthy individuals are clearly not the worst-off, prevention does not enjoy its proper place in this prioritization, either.

It is tempting to think this is a misreading of Veatch. The above quotes are approaching twenty years old, and the conclusions flowing from this argument seem too unreasonable. However, Veatch has remained steadfast in his views. Consider his more recent discussion of the infinite demand problem and its effects on preventative medicine:

Surely the blind are not as healthy as others and egalitarian justice would require diverting some resources to try to help them, but if enough resources were diverted so that it cut into the healthy persons' supply of polio vaccine, the healthy would be medically worse off. In fact, if enough doses were diverted, polio could become rampant and all would be at serious risk. At some point the previously healthy would be at a high risk and might actually be worse off than the group of blind persons. Justice would then require diverting resources from the better off blind persons in order to benefit the now least well off persons at high risk for polio. Justice itself sets its own limits to the infinite demand problem.\textsuperscript{24}

If prevention can only merit a high priority as the risk of acquiring a completely avoidable disease increases, there is something faulty with the theory of justice. It would seem Veatch has taken a good idea--giving

\textsuperscript{23}Victor Fuchs, "The health sector's share of the GNP." \textit{Science}. 247 (1990): 536.

some priority to the worst off—and allowed it to destroy the workability of his theory of egalitarianism.

Now we turn to the strongest of the rival theories, Norman Daniels' application of Rawlsian justice. In *Just Health Care* Daniels starts with the assumption that equality of opportunity is an element of justice. He does not argue for that principle, but says that Rawls offers a good account in *A Theory of Justice*. Daniels asserts that, while he draws from Rawls, his work is compatible with any theory of justice which holds equality of opportunity as a principle.

Daniels argues that the moral importance of health care needs lies in their effects on opportunity. Health care needs are analogous to educational needs: "The combination of their unequal distribution and their great strategic importance for opportunity puts these needs in a separate category from those basic needs we can expect people to purchase from their fair income shares, like food and shelter." For Daniels, the "moral function of the health care system must be to help guarantee equality of opportunity." For Rawls, equality of opportunity is connected with individuals' ability to secure jobs and positions of power. As this does not assist us in ascribing value to health care for non-workers (children, retired people, etc.), Daniels broadens equality of opportunity to include all the things individuals want to do, and he adds the idea of an age-relative opportunity range.

Daniels proposes a sensible criterion for setting priorities. He recognises that some kinds of health care are more important than others, and suggests health care interventions should be prioritised by their relative ability to correct impairments of the normal opportunity range. This, of course, does not answer all questions. Do we favour completely effective treatments for mild disorders over significantly (but not completely) effective treatments for serious disorders? Is preventing a disorder preferred to curing it?

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26Ibid., p. 41.
Some of these questions are answered when Daniels lists the following "layers" of health care services:\(^{27}\)

i) preventative services  
ii) curative services  
iii) chronic care  
iv) terminal care and care for the seriously mentally and physically disabled.

This ranking is quite problematic. It runs the risk of overvaluing prevention, undervaluing chronic care, and category iv is inappropriately ranked. Each problem is discussed in turn.

Prevention may be overvalued here. Many of the greatest successes of medicine have been in the area of prevention: immunisations, for the best example, have had a profound impact. However, most prevention is not as effective as immunisations, and some things billed as prevention are simply wasteful. This example will illustrate. Pregnant women with a history of genital herpes require screening to ascertain whether they have an active infection close to the time of birth of their child. If they do, a caesarean section is required to avoid transmitting the infection to the child. Nearly half of neonates who contract herpes die or are left severely disabled from the infection. This obviously is a preventative screen for the child. There are two ways to carry out the screening. The considerably less expensive option is simply undergoing a physical examination. Unfortunately, this will not detect cases of subclinical infection. The second option is to undergo weekly viral cultures in the final weeks of pregnancy. This more expensive approach will detect additional cases of genital herpes and prevent some cases of neonatal herpes (and hence save the lives of some neonates). However, it is very expensive. One study suggests that the cost of each case of neonatal herpes prevented by such screening is US$1,840,000.\(^{28}\) Is this sort of prevention to be ranked above chronic care for hypertension or arthritis?

\(^{27}\)Ibid., p. 48.

The category of chronic care suggests similarities where none exist. Much chronic care merits ranking behind (some) preventative services and curative services, but some chronic care deserves a high ranking. Consider insulin treatment for type I diabetes mellitus. It is a daily, lifelong treatment—certainly chronic, but it is highly effective and life-saving. Without insulin, type I diabetics would die, and with it they can lead a reasonably long, relatively normal life. Surely, insulin treatment should be ranked highly.

While it would seem Daniels' theory could be adjusted to suitably accommodate the previous concerns, it contains a fatal weakness exposed by a final criticism: A theory of justice in health care that rests on equality of opportunity cannot give appropriate consideration to the terminally ill and seriously disabled. Returning these people to "the normal opportunity range" is nonsensical, yet caring for similarly-placed individuals has always been one of the most important things the health system does. Caring for these individuals is an important mission of the health service, and it deserves a much higher relative priority. Daniels is aware of this problem; he writes that treatment of the terminally ill and seriously mentally and physically disabled raises "serious issues which may not just be issues of justice. Indeed, by the time we get to the fourth layer virtues other than justice become prominent."29 A better theory of justice would give caring for these patients its proper priority without appealing to "other considerations."

That brings us back to the constructivist theory of human rights. We have human rights to those things necessary to live a life of human dignity. While all needed health care is important, some kinds of health care are more important than others. This approach holds that health care interventions should be prioritized by their relative ability to allow individuals to live a life of dignity. This approach does not leave the obvious gaps like preventative medicine (for Veatch) and care for the terminally ill (for Daniels). Admittedly, though, the increased usefulness of this approach is purchased at the expense of specificity. Arguing over what dignity entails could be lengthy. Consequently, we require a community definition of dignity in order to set priorities. Consider the following example. We all think that having a dignified death is

29Daniels, Just Health Care, p. 48.
important. Comfort care for the terminally ill would be highly ranked by this dignity standard in every society known to me. However, the setting of the comfort care might be very different for different cultures. Some groups may highly value dying at home in the presence of their extended family, while others may prefer to die in the hospital. In either case the priorities of home care versus hospital care for the terminally ill would be different. Neither is preferred without knowing the values of the society. Setting priorities by this theory and developing community definitions of dignity calls for explicit and public rationing: by now a familiar cry in the medical literature.  

Allowing individuals to live a life of human dignity is the unifying feature of many health care interventions that we hold to be important which seem to have little else in common: the hospitalisation of an acutely psychotic young man, reconstructive surgery following mastectomy for a fifty year old woman, hospice care for a Maori woman with inoperable lung cancer, habilitative services for the congenitally handicapped, nursing home care for the elderly, rehabilitative services for a young man following a serious auto accident. These widely different health care interventions all assist the patients to live a life of dignity. Health care's ability to enhance the dignity of people's lives is more than a least common denominator—it truly gets at the essence of the health care system. Maintaining dignity should be the goal of the health system. It is health care's ability to do so that gives it moral importance. The other theories have only gained a glimpse of the real purpose of the health system. Sometimes maintaining dignity involves saving life; sometimes it is returning individuals to the normal opportunity range; sometimes it is caring for the terminally ill; sometimes it involves providing basic care; and sometimes it can also mean not saving life. The unifying concept is dignity.

Dignity is a concept which requires a communal definition. It is not an "objective" criterion such that we can assign values to various health care interventions and rank them. Discussing openly where community health care priorities lie is valuable both for the community and the health service. The community can become more familiar with the difficulties of rationing, and the health service can be told explicitly which types of services the community wants to be targeted. Community priorities based upon health care interventions' effect on living a dignified life is not a disguised way to discriminate against minority groups. Prioritizing health care interventions would require extensive input from patients and health professionals, as well as the public. Thus very general information as to priorities would be sought from the public not public input about specific diseases. The majority would not be put in a position, for example, to give all HIV/AIDS treatments a low priority simply because they do not agree with the types of lifestyles which often result in transmission of the virus. Rather, public input might result in chronic treatments which improve quality of life being funded and intensive care for the terminally (within so many weeks of death) ill not being funded. Thus, many treatments for HIV/AIDS would receive a high priority, but artificial ventilation for pneumocystis pneumonia would receive a low priority. Community definitions of dignity, properly understood, are not an excuse to victimise minorities.

Dignity is such a lofty standard that it could be asserted that it is not compatible with any forms of rationing. This, of course, would be a perversion of the argument. Although health care rationing is both difficult and painful, it is necessary. Indeed, implicit rationing has been with us for a long time through capped budgets in some countries and prohibitive pricing in others. The constructivist account of the right to health care holds that the moral importance of health care lies in its ability to assist individuals to live a life of dignity. Explicit rationing with this principle in mind should yield far superior results to implicit, random rationing. Thus, to argue that rationing infringes upon dignity entirely misses the thrust of the constructivist argument.

Explicit and public priority setting is better than the alternatives, but it raises two questions with no obvious answer: What if the public does not/will not participate? and What if the input from the public is
unreasonable? Examples of each come from the American state of Oregon's experience with setting priorities.31

The Oregon Medicaid Priority-Setting Project Health Services Commission was established in September 1988, and from the outset the project was headline news. Over a year later (presumably sufficient time to raise public awareness) from January through March 1990, Oregon Health Decisions held 47 public meetings across the state to assess public values in priority setting. Although over a thousand Oregonians attended, it was far from a cross-section of the population. Two-thirds were university graduates and fewer than 50 people were Medicaid recipients (the group being rationed to). More than two-thirds worked in the health care sector! What can be concluded from any consensus reached by such a group? Perhaps the methodology could be improved somewhat, but it did seem, on the whole, to be a fair process. Would a process that forced certain groups (e.g., Medicaid recipients) to represent themselves be any more valid? If representatives are to be chosen, what will be the process? How can we guarantee the public will participate in a public process?

What do we do with unreasonable public input? In an attempt to further elicit public values, Oregon ran a phone survey starting in February 1990. Residents were asked to judge on a scale of 0 (death) to 100 (perfect health) what the impact would be of having to live the rest of their life with some physical or mental impairment or symptom. Some of the results were surprising. For example, wearing eyeglasses was rated 95 out of 100, which is about the same rating assigned to not being able to drive a car or use public transportation and to having to stay at a hospital or nursing home! Can we blame poor methodology for this result? If not, i.e., if this rating reflects actual attitudes, must (or should) we accept it? Those who have experienced any particular disability often give it a higher rating (i.e., indicate it has had a less negative impact on their life) than those who have not. Noting this, whose rating should count as more relevant?

Putting these problems aside, the human rights approach to priority setting calls for explicit and public rationing. Although the criterion of living a life of dignity was not invoked by Oregon, we should briefly examine Oregon as the only example of priority setting to date which has generated a ranked list. Oregon’s prioritization is not being presented as the moral answer to rationing decisions; however, as the only example of an explicit, public ranked list it provides a basis for discussion of the kind of prioritization being advanced here. Furthermore, the list generated in Oregon roughly corresponds to my concept (as a member of a developed nation) of what is required to live a life of dignity.

Oregon generated seventeen categories for condition/treatment pairs, then assigned each condition/treatment pair\textsuperscript{32} to a category. Then the categories were ranked from highest to lowest priority. Next all of the condition/treatment pairs were ranked within each category using an assessment of net benefit and cost, and a list of condition/treatment pairs was generated such that the lowest ranking pair from, say, category seven was immediately above the highest ranking pair from category eight. Finally, the list of pairs was adjusted to a "standard of reasonableness." The final step was required due to the obvious fact that, while one category may generally be above another, individual pairs may merit particularly high or low priority. While this seems a good methodology and Oregon may have benefited from even greater specificity, examining the ranking of categories is detailed enough for our discussion of priority setting. Oregon’s category prioritization is listed in table three.

\textsuperscript{32}Because they are the codes used to bill for third party reimbursement, the Oregon commission used codes from the \textit{International Statistical Classification of Diseases, Injuries, and Causes of Death, Ninth Revision (ICD-9)} to define conditions and codes from \textit{Current Procedural Terminology, Fourth Edition (CPT-4)} to define treatments. While this has administrative benefits, it did limit the specificity of the list.
TABLE 3: Oregon’s Categories

1. Acute Fatal, prevents death, full recovery
2. Maternity Care (including care for the newborn in first 28 days of life)
3. Acute fatal, prevents death, without full recovery
4. Preventative care for children
5. Chronic fatal, improves life span and Quality of Well Being (QWB)
6. Reproductive Services (excluding maternity and infertility)
7. Comfort Care
8. Preventative dental (children and adults)
9. Preventative care for adults (A-B-C)
10. Acute nonfatal, return to previous health
11. Chronic nonfatal, one time treatment improves QWB
12. Acute nonfatal, without return to previous health
13. Chronic nonfatal, repetitive treatment improves QWB
14. Acute nonfatal, expedites recovery
15. Infertility services
16. Preventative care for adults (D-E)
17. Fatal or nonfatal, minimal or no improvement in QWB

This list was developed for the unique American situation in Oregon. These are personal health services for recipients of Medicaid only, and two important categories were exempted: nursing home care for the elderly as well as mental health and substance abuse services. A complete list would need to incorporate these two categories. It is interesting to note that these categories were exempted because they were thought to be important yet likely to be undervalued by the cost-benefit/net benefit analysis Oregon was employing. That is, policy makers felt these areas were more important than a cost-benefit analysis would indicate. Employing a more useful standard like the importance of a given health service to living a life of dignity would yield a high priority for these two categories without giving them special treatment. Another thing to note, especially before criticising the top of the list, is that resources were sufficient to fund through category twelve and well into category thirteen. Accordingly, it was not particularly relevant to Oregon whether a condition/treatment pair was in category three or seven; either way it was sure to be funded.

Here we are discussing priority setting for a human right to health care: a right that all men and women everywhere should be able to claim. As already emphasised, the priority ranking should reflect the conception of dignity in each individual society. Also, different societies will have greatly varying amounts of resources to devote to health care. Consequently, even some of the higher priority categories may not receive funding in all societies. Another point to mention is that sanitary, safe, unpolluted living and working conditions contribute much to health.
While this was not relevant to Medicaid priorities in Oregon, it is important in many countries. As a result of these facts, several adjustments should be made to the list.

From a more global perspective than Oregon needed to apply, comparatively high tech, hospital care is overvalued on Oregon's list. Sanitary living conditions like a safe water supply, edible food and adequate sewage disposal should probably top the list. Then maternity care, preventative care for children (at least immunisations) and comfort care for the dying should probably rank above services which require expensive hospitals and highly trained personnel to operate (like many acute fatal, prevents death, full recovery interventions). To reiterate, these are not criticisms of the list for Oregon, but for Oregon's list for the whole world. Otherwise, the list is reasonably intuitive: the most serious conditions we can treat effectively are ranked above others, and the "caring" and preventative aspects of medicine receive proper priority, too.

CONCLUSION

By holding we have a right to the things necessary to lead a life of dignity, the constructivist human rights theory provides many advantages over rival theories. It outclasses the right to a decent minimum for three reasons. It has a clear philosophical foundation which the right to a decent minimum does not. Our human rights theory tells us how to make macro allocation decisions between health care and other goods: we need to enhance human dignity in our distribution. Finally, the constructivist theory suggests a clearer prioritization than the "basic" care suggested by a right to a decent minimum.

This human rights approach yields a much more sensible priority list than Robert Veatch's egalitarianism. For this reason alone, it represents a great advantage. It also seems stronger with macro allocation decisions. While egalitarianism offers little or no help in comparing allocations to food, shelter and health care, the constructivist theory suggests maximising dignity. Thus, we should not pursue health care to the detriment of food or shelter.

Norman Daniels' theory espoused in Just Health Care is the strongest rival for the human rights theory. Daniels gives reasonable advice on macro allocation decisions: different areas like education, police
protection and health care are funded as to maximise equality of opportunity. No area should be pursued to the detriment of the others. Daniels theory also yields a sensible criterion for prioritization: the effect on the service of guaranteeing equality of opportunity. Daniels, however, undervalues the caring aspects of medical care--those areas where patients cannot be returned to the normal opportunity range. For this reason, the human rights approach is superior. Furthermore, the constructivist approach gives us further guidance with rationing, as illustrated in chapter five, which Just Health Care does not provide.

The constructivist human rights approach posits that health care interventions should be prioritized by their relative ability to allow individuals to live a life of dignity. This approach suggests public and explicit priority setting consistent with the societal conception of dignity. Since funding is limited, priorities must be set and the list will be funded as far as possible within a society. This does not trivialise the health care needs of individuals whose conditions are low on the list, it merely claims that it is better to systematically deny care with less impact on a life of dignity than to randomly deny care. This ranking reflects both the limits of health care and the limits of the budget.

To reiterate, it would be desirable to fund all needed health care, but this is simply not possible. Some beneficial care must be denied. It is not enough to rank condition/treatment pairs and effortlessly fund the list as far as the budget will allow. Every attempt must be made to allow the budget to fund as much of the list as possible. That is to say, simply because a condition merits high priority it does not necessarily receive limitless resources. For example, it was argued that maternity care and preventative services for children merit a high priority for their impact on living a life of dignity. Thus, the example of screening for genital herpes during pregnancy outlined above is a high priority condition. However, this does not require funding the expensive viral cultures; serial physical examinations are adequate to meet the dignity standard. Furthermore, some rationing techniques should be applied to the whole list, regardless of priority ranking. The dignity standard assists in this task also, and these rationing tools are outlined in chapter five.
When approaching the question of a moral right to health care, two main questions were identified at the outset: 1) What is the foundation of a right to health care? and 2) What is the content of the right? As pointed out in the introduction, the philosophical underpinnings of a right to health care would presumably say a lot about the content of the right. The constructivist human rights theory holds that human rights are those things needed for human dignity. Enhancing the dignity of people's lives is what gives health care moral importance and is the foundation of our right. Thus, health care interventions should be prioritized by their relative ability to allow individuals to live a life of dignity. The relative prioritization of services suggested by the dignity standard is consistent with what we want from health care. Health care serves many purposes for us—prevention, cure, chronic care, disability support, and comfort care for the dying—and the dignity standard allows each its proper priority. The human rights approach yields a high priority for important health care services which are undervalued when prioritized by other standards.

If we argue that the standard of health care demanded by the moral right is all health care needed to live a life of human dignity, then it may seem this will not help us to put limits on the right to health care whatsoever. What kind of health care is not dignified? Misconstrued, the dignity standard might suggest society must provide everything. We must admit that ill health is an affront to individual dignity; for the sick individual, all needed health care is required to enhance his/her dignity. However, the constructivist theory does not claim that we have a human right to all possible health care in every situation. The constructivist theory holds that the content of positive rights must be in reference to the resources available. Health care must be rationed, and the treatment that is forgone will be to the detriment of those who do not receive it. This theory is not intended to trivialise the legitimate health needs of individuals whose conditions are low on the list because needed, low priority health care does make a positive contribution to individual dignity. However, health care must be rationed, and it is the community's (not the individual's) conception of dignity that is important in setting
priorities. Certain illness/treatment pairs make a more significant
collection to leading a life of human dignity than others, and, although
important, some illness/treatment pairs will necessarily get a low priority.
Since resources are limited, public and explicit rationing is morally
acceptable because, despite rationing's negative effect on some individuals,
it is morally preferable to deny care (with less impact on living a life of
dignity) systematically than to deny care randomly. Arguing that all
rationing violates dignity misses the point of the constructivist stand.

It is important to see illnesses and treatments as paired. If we
ranked only illnesses or only treatments by their effects on dignity, the
results would be ridiculous. Regardless of the illness, our obligation to
treat is less when the treatment is ineffective (consider further
chemotherapy for terminal cancer). Conversely, some conditions, like
maternity care, demand priority despite the likelihood all will go well
even without medical care. Society finds it unacceptable to put mothers
and infants at risk.

When setting priorities, the initial question is usually: "If we
cannot treat everyone, who should we treat first?" It doesn't take long to
realise, though, that the real question is "Who do we treat last, and why?"
This is the more relevant way to phrase the question because those who
receive lowest priority aren't going to be treated. The dignity standard
does not easily point out services which can be excluded from the right to
health care, although it yields the relative prioritization roughly outlined
in chapter four. The categories near the bottom of the list are obviously in
jeopardy of not being funded.

Assuming that there is a fixed amount of money available to be
spent on health care, a greater portion of the prioritized list could be
funded by saving resources higher on the list. This is where the dignity
standard is additionally helpful in rationing discussions. It has been
argued that it is a smaller infringement on dignity to forego interventions
at the bottom of the priority list than it is to forego interventions high on
the list; however, it is regrettable that the entire list cannot be funded.
Low yield medicine is not no yield medicine, and sick individuals want
every gain that can be offered. Thus, we should attempt to use all of our
resources as wisely as possible to fund as much of the list as possible, i.e,
even for interventions high on our priority list, spending should be
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tightly controlled. The dignity standard assists us on two levels: first, it suggests a prioritization, and, second, it allows us to examine rationing techniques that apply to all interventions. All of the health service should be subjected to similar rationing constraints, but as money runs out it is the low priority interventions that will not be funded. By this system all health care is rationed to some extent and some health care is not available. The concept of dignity is useful to examine all of the rationing tools; all forms of rationing are morally acceptable to the point which they excessively infringe upon the health service meeting its goal of enhancing the dignity of people's lives.

This chapter is in two sections. In the first part, our tendency to overvalue health care is discussed. No exact amount of allocation to health care is mandated, but it is suggested that we can do well with less than we usually think we can. In the second section, various rationing techniques are analysed with the dignity standard. Some of the ways in which it would be ethically acceptable to employ the techniques are outlined, and unacceptable applications are highlighted as well. In chapter three it was argued that the various general theories of justice should have a voice in resource allocation where appropriate; these areas are explored in the second section.

OUR TENDENCY TO OVERVALUE HEALTH CARE

One frequent criticism is that those applying economic analysis and discussing limiting health care have made a fundamental error: they have failed to recognise that life is infinitely more valuable than money. Since medical care is necessary (in some instances) for life, limiting what is spent on it is absurd. As the argument goes, life, and hence medical care as (sometimes) a necessity for life, is infinitely more important than other values. While persuasive, this argument is wrong if we accept our behaviour as any reflection of our true values.

Some people misapply an economic argument to show that life is infinitely valuable. They say the principle of revealed preference demonstrates the value of life. How many people would consent to being killed tomorrow in exchange for a million dollars, or even twenty-five million? This, they argue, demonstrates that our value for life is very high and perhaps infinite. It does not illustrate that at all; it shows that
money is of no value to a dead man. Consider this example. Let us take the value of $25 million, and further consider what revealed preference suggests. Imagine we want to set-up a study of the pharmacokinetics of a new medication. We are going to give the drug at such a subtherapeutic dose that it will have virtually no physiological effect; however, the small risk of fatal allergic reaction to the medication remains. Assume the risk of anaphylaxis one in one hundred thousand (0.001%), and we would offer $250 to be in the study; or that the risk is one in one thousand (0.1%) and we are offering $25,000 to be in the study. In either case, our intuition is that many people would be willing to accept the risk, and both instances place the value of life at $25 million. The value of life is discontinuous; it is not until the risk of death becomes large that we place a large value on it. Unfortunately, we allow our value for the certain loss of life to inflate how much we value low benefit interventions. We adopt the 'spare no expense' mentality even though the interventions may yield very little benefit. The failure to recognise the discontinuous value of life is one cause for overvaluing health care.

A second reason for overvaluing health care is the economics of insurance or risk-sharing. The tendency to use more health care when in an insurance arrangement has been termed "moral hazard." Insurance writers have tended to look upon this phenomenon (of demanding more at zero price than at market price) as an ethical problem, using emotive words such as malingering and hypochondria and lumping it together with fraud. However, it is a result predictable by standard economic theory. Insurance works well when the event being risk pooled is beyond the control of the insured (e.g., insuring one's home against a natural disaster), but health care demand is under the control of the insured. The effect of insurance which covers all medical care expenses is to reduce the price charged to the individual at the point of service from the market price to zero. Thus it is expected that individuals would consume more because the incremental benefit to them for excess use is great, while the

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additional cost of their use is largely spread over other insurance holders. The individual only bears a tiny fraction of the cost of his/her use.

This is not merely economic theory; studies have shown it to be true. A study of nearly 8000 people over several years demonstrated that persons fully covered for medical services spent about 50 percent more than similar people with income-related catastrophe insurance. Full coverage lead to more people using services and more services per user. Both ambulatory services and hospital admissions increased. Insurance increases our tendency to overvalue health care.

I am suggesting that we can obtain acceptable health care results with less resources than demand seems to indicate. There is no convincing moral argument that we should spend 6, 9, 12 or 15 percent of gross domestic product on health care, but comparing countries with themselves across time and comparisons between countries at the same time indicates that more health care is not tantamount to better health. Thus a public health system need not be lavishly funded.

HOW CAN WE RATION ETHICALLY?

Are simple lists acceptable?

The argument until now has been based on generating a priority list and using resources as wisely as possible to fund as much of the list as possible. Consequently, services will either be included or excluded from the public health system. Some call this the 'simple list' approach. The criticism of the simple list is straightforward and valid: not all indications for health services are equal, and, as a result, a simple list would exclude services even for a patient with a pressing indication. Surgery for varicose veins offers a good example. This is a procedure which would be likely to get a low priority on a list because the majority of cases are for softer indications like discomfort late in the day and/or cosmesis. Once again, this example is not to trivialise these individuals' health needs, but to indicate that these indications have a smaller impact on living a life of dignity than many other health needs. However, consider Helen, a 62 year old nurse who spends long hours on her feet. She has a history of severe

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varicose veins and nonhealing venous stasis ulcers. She has been repeatedly admitted to hospital for infections of the ulcers. For Helen, the surgery could bring great benefits, but the procedure is excluded from the public health system by the simple list approach. The simple list is unfair to Helen.

There are two ways to blunt the force of this criticism; both of which are relatively simple to implement. The first is to make the list more sophisticated and specific. Certainly, in this example the softer and harder indications could be considered different diagnoses. The presence of ulcers is a clear distinguishing feature. However, increasing the detail of the list should only go so far. It is no one's desire to create an inflexible excessively bureaucratic list. The second approach is to have an "unusual/atypical indications" fund/committee which clinicians and patients could appeal to when they feel the list had wrongly excluded them. Even with both of these improvements in place, however, the criticism still packs some punch. A list would inevitably exclude some people with greater needs than others whose condition was higher up the list because not all indications are equal. The New Zealand Core Services Committee rejected the simple list approach for this reason. As Core Services Committee Chairman, Lynette Jones says, "A 'yes/no' or 'in/out' list approach is just too simplistic. It would either have to be so broad and lacking in definition as to be meaningless, much the situation the Committee inherited, or its explicitness would make it too arbitrary and inflexible resulting in people being unfairly excluded from services. Either way it would fail."4 But, despite its weaknesses, the simple list remains superior to its alternatives for three reasons.

First, a list is better than forcing the dual role of patient advocate and keeper of societal resources onto physicians. This is a remarkable burden for right-minded clinicians.5 It also should be recognised that this approach lends itself to being remarkably random, far more random than the unequal indications of a simple list. Some doctors will accept this responsibility and attempt to fulfil it well. Others will attempt it with

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(deliberate or unintentional) prejudice; it exposes patients to all the prejudices and ill-conceived notions of less noble health professionals. If all rationing is done by doctors, the results are likely to reflect their respective values. The ageist will ration by age, sexist by gender, racist by race, etc. Finally, some doctors will refuse to ration out of a sense of duty to their patients. Such a system results in a very inequitable distribution of resources.

Second, even if we can assume all individual doctors will carry out rationing decisions well, a list is better suited to administering community agreed rationing decisions because no doctor has an adequate scope of practice to make the appropriate rationing tradeoffs. Health professionals can only encounter a relatively small number of patients in a day, week, or even year. As a result no single professional can make sufficiently informed rationing decisions. Specialists only see cases in their field, and have little basis for deciding relative funding for their field versus another. This would not necessarily result in the specialist overvaluing her field. She might operate by the policy of treating the worst-off patients only while society might decide that the conditions she treats should be funded more broadly. She may not be treating patients for whom treatment would yield a significantly more dignified life when patients in comparatively better positions are being treated in other fields. Generalists, while they see a diverse range of clinical conditions, have less experience with the range of impairment possible from a given condition.

The final reason the simple list approach is superior to abandoning the list and looking at the merits of each individual case is the most important. Abandoning the list seems largely to abandon the public and explicit approach to rationing and return to implicit rationing. Leaving doctors to weigh the individual merits of each individual case is the same sort of implicit rationing we have now. The financial constraints and need to ration remain, but the explicit nature of the rationing is lost. How can community values be adequately assessed and reflected when the rationing is done behind closed doors?

Can we ration by cost?

"Is cost important?" is a question we must ask. Should expensive interventions be given a lower priority than inexpensive interventions? It may seem ridiculous to ask the question: it is obviously the fact that the
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cost of health care has exceeded the resources available which has lead us to a discussion of rationing. However, what underlies the question is an intuition that it might be unfair to single out expensive health care for rationing; perhaps all health care, inexpensive as well as expensive, should be rationed in a similar fashion. Furthermore, most see cost as an incomplete picture of a health care intervention. Our judgment of a health care intervention should have some reference to the benefit gained from that intervention. An expensive drug that brings great benefit to those who receive it seems a better target for funding than a medium-priced drug that brings little benefit.

Responses to the issue of cost tend to be at one extreme or another. Robert Veatch represents one extreme. To quote him:

Historically, health workers have been committed to consequentialist modes of ethical reasoning....It is utilitarian consequentialism that provides the moral foundation for the cost-benefit and cost-effectiveness analysis that has dominated the movement for rationing care....But the question remains whether it is necessarily correct to treat care as basic (morally prior) simply because it is cost-effective. That is what utilitarian ethical theory calls for, but it is at odds with many of the most significant moral traditions of our culture....Among the most conspicuous of such moral considerations [that are lacking in this analysis] are the duties of preserving life, respecting autonomy, and promoting a just or equitable distribution of benefits.6

It is easy to misunderstand this group, and accuse them of being naive for not accepting the need to ration health services. But Veatch and others do recognise the need to ration health care, and want explicit rationing based on the moral priority of the care. However, they question whether cost-effectiveness is the fundamental, morally prior criterion to ration by.

However, if we up the stakes high enough most will agree that at some point costs become relevant. As Peter Pillans writes, "Hospitals or health care institutions fulfil a community service...If a decision to

purchase a new pharmaceutical for an individual patient renders the facility fiscally unsound, it is endangering its larger mission. In such circumstances to forego the drug is regrettable but ethically sound.\textsuperscript{7} Certainly, it would be a rare circumstance where the treatment of a single patient threatened the solvency of a hospital, but should such a situation arise, the costs of treating the patient would indeed be too high.

David Eddy represents the other extreme, the group that emphasises costs:

The central problem that underlies the concept of essential care is that different interventions have different worths, determined by their benefits, harms and costs. While few would debate the importance of benefits and harms, some might object to including costs. But cost is the very problem that drives the concept of essential care. If costs were of no concern, there would be no problem; everyone could get everything that has benefit, and the distinction between essential and 'luxury' care would never arise. To remove costs from the definition of essential care would not only be unrealistic, it would separate the concept of essential care from the problem it is designed to solve.\textsuperscript{8}

Eddy (and others) emphasise cost, but it is clear from this passage that cost is not the only factor. Benefits and harms are also seen as important.

The contrast between Eddy's and Veatch's approaches leads to a more basic question. How do we define costs? Just looking at the price tag of a given intervention is far too simple an account of costs. That is because any single intervention is part of an overall plan of management for a given problem. That plan of management can, artificially, be split into various components but in any moderately comprehensive public health system, the resulting picture is unhelpful in planning services and costing treatment. In order properly to make use of health dollars we need to consider the costs of various packages including in hospital, out-of-

\textsuperscript{7}Peter Pillans, "Control of high cost medicines." \textit{New Zealand Medical Journal.} (26 January 1994): 5.

\textsuperscript{8}David M Eddy, "What care is 'essential'? What services are 'basic'?" \textit{Journal of the American Medical Association.} 265 (1991): 782, 786.
hospital and follow-up care in order to place a given intervention in context. Strictly rationing all health care over X thousand dollars is an ineffective way of keeping health care within its budget. For example, imagine that it was decided to strictly ration the most expensive treatment modalities for all disorders, either by capping the number of expensive modalities within each health service or by eliminating all expensive modalities for which a less expensive alternative exists. The rationale would be that "basic" care should be made available to all, but more expensive care is a luxury. In the treatment of schizophrenia, the drug clozapine (Clozaril®) would likely be singled out. Clozapine is an expensive pharmaceutical indicated for the treatment of resistant schizophrenia. Estimates of the proportion of patients with schizophrenia who are refractory to treatment vary because there are no firm guidelines on what constitutes treatment-refractory schizophrenia, but it is a significant minority of patients (with estimates around 30%). And 30 to 60% of treatment-refractory schizophrenic patients benefit from clozapine therapy. While clozapine is expensive, it reduces the length of inpatient psychiatric care for those patients who respond to it. For those who respond, the costs saved by reduced inpatient care would clearly outweigh the price of clozapine. What is more, clozapine is less expensive in simple financial terms; no value need be assigned to the increased quality of life the patients would enjoy. Therefore, excessive limitation of the availability of clozapine would actually be more expensive for the health service. A more comprehensive view of costs would take into account the cost of alternative treatment as well as the cost of suffering or the value of health for the patient.

Although rationing by cost can be fiscally unwise as illustrated by clozapine, the real ethical problem is that it violates the concept of dignity. Patients with rigorously demonstrated refractory schizophrenia require a trial with clozapine, and those who respond need it to live a life of human dignity. It is dangerous to look for quick fixes to budgetary difficulties exclusively among the expensive health care services. Consider the

9The published dosage range for clozapine is 200-900 mg/day. The acquisition costs thus range from $2226 to $10,019 per year (information from Dunedin Public Hospital Pharmacy). Obviously, this does not include the substantial expense of regular haematological monitoring.

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following real-life example from America. In June 1987 the Joint Ways and Means Committee of the Oregon legislature voted unanimously to discontinue funding for all transplants (except kidneys and corneas). Expanded coverage of basic medical services for low-income children and pregnant women (approximately 1500 people) was substituted in place of transplants. It had been estimated that 34 patients would require transplants (namely, bone marrow, heart, liver and pancreas) during the 1987-89 biennium, at an estimated cost of US$2.2 million. The argument was essentially that the money was better spent on children and prenatal care than transplants.¹¹ The Oregon case is an example of utilitarian reasoning gone badly awry. Many will agree, as I do, that the money was better spent on children and prenatal care than on transplants, but we should not be choosing between the two.¹² Clearly, organ transplants (when rigorously indicated) are required to live a life of human dignity. One should not be asked to die for the cause of better prenatal care. But prenatal care is high priority, also, for its contribution to the dignity of mothers and babies. It was the direct result of this poor decision to curtail funding for transplants that lead to the legislation mandating the prioritization of services outlined in chapter four. As Oregon's subsequent ranking shows, both transplants and prenatal care are highly valued (of seventeen total categories, maternity care is category two and transplants are in category five), and this agrees with the prioritization the dignity standard produces. We should not curtail transplants to better fund child and prenatal care. More appropriate cutbacks to better fund prenatal and paediatric care would be, for example, some types of adult preventative medicine, hernia surgery, hip replacements or cataract surgery. Although these interventions do not cost as much individually as transplants, they are more appropriate trade-offs. Rationing by cost does


¹²Decision making in Oregon is often attacked (as I just did), but we are really criticising Oregon out of context. While Oregon's mistakes are real and provide us all with examples, Oregon, properly seen, is making the most of a bad situation, the unique American situation. Oregon came to this bad decision (to curtail transplant funding) because of the constraints that are placed on it by Federal Medicaid laws. Only certain services are optional (transplants being one), and several obvious better candidates for cutbacks are not optional. Furthermore, transplants cannot be partially funded with, say, a cap on the number funded because the law says patients in similar circumstances must be treated equally. Resource allocation is difficult, and Oregon's situation is made worse by some of the conditions imposed on it.
not advance the cause of the health service. Enhancing the dignity of people's lives is what gives health care moral importance. Cost, on the other hand, is not a morally relevant factor. Rationing by cost ignores any conception of human dignity and is not an ethically acceptable rationing tool.

Is cost effectiveness an acceptable rationing tool?

Cost effectiveness is an improvement over simple cost when looking at health care interventions. Cost-effectiveness analysis (CEA) seeks to determine the least cost solution for a particular objective, or how to maximise beneficial outcomes in a particular program of service within a given fixed budget. Thus CEA is designed to compare different approaches to the same problem: examples would be, the comparative cost of treating end stage renal disease (ESRD) by transplant, hospital haemodialysis or home dialysis; or, the least expensive way to maximise the number of patients with seizure disorder who are seizure-free.

This approach is better than simply looking at the price tag of an intervention, but it has its own deficiencies. CEA makes no contribution to defining the goals of a program. It merely gives us a way to compare approaches to a predetermined goal. Also, CEA does not help us to compare different treatments for different diseases. For example CEA yields no information which would enable us to compare spending limited pharmaceutical resources on erythropoietin for anaemia of ESRD with ondansetron for nausea associated with chemotherapy for cancer.

Moreover, CEA does not take quality of life into consideration. A straightforward example of CEA analysis is comparing open and laparoscopic cholecystectomies.\footnote{K. Kesteloot and F. Penninckx, "The costs and effects of open versus laparoscopic cholecystectomies." \textit{Health Economics}. 2 (1993): 303-312. The analysis was simplified in the text. Hospitals actually must weigh the cost of equipment, increased theatre times, electrocautery or laser, and disposable or reusable equipment against the cost savings of shorter post operative length of stay. Thus, if a certain number of laparoscopic procedures are done, the aggregate savings in post operative stays exceeds the one-time expense of the equipment, and the}
laparoscopic procedure is more cost-effective. For society, clearly the laparoscopic procedure saves cost because patients return to work sooner. But nowhere is the decreased suffering (shorter recovery period) of the patient factored in. A better measurement would differentiate the benefits to the patient of the different methods of removing the gall bladder.

CEA has its underpinnings in utilitarianism, and, although it has weaknesses, it is utilitarianism at its finest. Once the goals of our health system are defined, CEA points us to the least cost solution to reach those goals. If we prioritise our goals, CEA helps do the greatest good for the greatest number by bringing down the cost of the high priority goals thus enabling us to address lower priority goals. CEA is valuable because it uses utilitarian reasoning to help us attain our goals without allowing utilitarianism to infect our goal setting.

Can we ration with cost-benefit analysis?

It is difficult to make decisions when one is comparing things qualitatively. Which should receive priority, ondansetron, an expensive new medicine that significantly decreases nausea and vomiting following cancer chemotherapy, or clozapine, an expensive new drug for the treatment of resistant schizophrenia? Both drugs represent more effective and more expensive alternatives to previous pharmaceuticals, but the illnesses these patients face are quite different. How can we compare the benefits for such different diseases? As outlined above, CEA does not assist us with this problem, and the prospects are not bright for an analysis which will allow us to compare across treatments. The problem of incommensurable gains has bedevilled several attempts to suggest a defensible analysis yielding equitable distribution of resources for different clinical problems.

Nevertheless, the idea of constructing a formula for making such comparisons is attractive. One feels reassured (however falsely or justifiably that may be) by assigning quantitative values to the various health care interventions. Certainly, ranking interventions allows for prioritisation, the orderly introduction of new interventions as funding becomes available, and coherent longitudinal planning.14 If we properly

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weight the important elements of a health care intervention, then perhaps we could give each intervention a score for each element and rank the interventions by overall score. Usually such a formula yields a cost per unit benefit ratio. Thus, rationing decisions are made easy: the lowest ranking items (i.e., the items with the highest cost per benefit) can be eliminated. We arrive at a generic formula something like the following:

\[
\frac{\text{Net Costs}}{\text{Net Benefits}} = \text{price per unit benefit.}
\]

Net costs include the total cost of the intervention less the costs of treatment that is forgone, and net benefits assigns a value to the benefit gained with a factor for the chances of success less a value for potential harms with a factor for the chance of harm. In short, a good cost benefit analysis will attempt to take into account all of the possible short-comings. It will use a well-reasoned account of costs and a rich conception of benefits that values both survival and quality of life. The detail of how to derive and weight each element is not important to us here. Our interest is whether such a model is consistent with our ethical standards.

A major attempt at defining benefit has been Quality Adjusted Life Years (QALYs) which attempt to combine length of survival and quality of life. The best description of a QALY is provided in the following passage by its inventor, Alan Williams.

The essence of a QALY is that it takes a year of healthy life expectancy to be worth 1, but regards a year of unhealthy life expectancy to be worth less than 1. Its precise value is lower the worse the quality of life of the unhealthy person (which is what the 'quality adjusted' bit is all about). If being dead is worth zero, it is in principle, possible for a QALY to be negative i.e. for the quality of someone's life to be judged worse than being dead.

The general idea is that a beneficial health care activity is one that generates a positive amount of QALYs, and that an efficient health care activity is one where the cost per QALY is as low as can be. A high priority health care activity is one where the
cost per QALY is low, and a low priority activity is one where the cost per QALY is high.\textsuperscript{15} QALYs represent an attempt to compare different treatments for different diseases, but the concept contains serious ethical deficiencies.

Consider the following chart which shows the results of an actual attempt at prioritisation in Oregon prior to Oregon adopting the method previously outlined.\textsuperscript{16} The chart illustrates an inherent weakness in cost-benefit analysis.

\begin{table}[h]
\centering
\begin{tabular}{|l|c|c|c|c|c|}
\hline
TREATMENT & NET BENEFIT & DURATION (YEARS) & COST (US$) & PRIORITY RATING$^+$ & PRIORITY RANKING \\
\hline
tooth capping & .08 & 4 & 38.10 & 117.6 & 371 \\
surgery for ectopic pregnancy & .71$^+$ & 48 & 4015.00 & 117.8 & 372 \\
splints for temporomandibular joint disorder & .16 & 5 & 98.51 & 122.2 & 376 \\
appendectomy & .97 & 48 & 5744.00 & 122.5 & 377 \\
\hline
\end{tabular}
\caption{An Example of Cost-Benefit Analysis}
\label{tab:cost-benefit}
\end{table}

The estimates in the chart appear reasonable. The denominator of the Priority Rating (i.e., Net Expected Benefit X Duration of Benefit) is obviously a QALY-type measurement of benefit. Dental caps were estimated to produce an average quality-of-life improvement of about 8\%, whereas an appendectomy was expected to produce a 97\% improvement (virtually the difference between being alive and being dead). The reasonable estimates, however, did not translate into reasonable relative priority rankings.\textsuperscript{17} Albeit both surgical procedures for appendectomy and ectopic pregnancy were correctly estimated to entail a far higher level and duration of benefit than either of the two minor treatments, the relatively


\textsuperscript{17}These results were from the initial ranking in Oregon. For a number of reasons, one of which was nonsense results like these, the priority list was significantly reworked. In the final ranking surgery for appendicitis and ectopic pregnancy were both ranked in the top ten services, while splints for temporomandibular joint disorder were dropped near the bottom of the list and dental caps were eliminated.
high costs of surgery effectively neutralised these outcome considerations, producing nearly identical priority rankings for all four treatments. The question that needs to be answered is "How much benefit is enough, even when the intervention is cheap?" Cost benefit analysis cannot help answer the question. Surgery for appendicitis and ectopic pregnancy deserve a priority ranking well above dental caps and splints for temporomandibular joint disorder, but cost benefit analysis does not discriminate between them.

Norman Daniels has called this the aggregate problem.\textsuperscript{18} When should we allow an aggregation of modest benefits to larger numbers of people to outweigh more significant benefits to fewer people? As David Eddy points out, our moral intuitions are largely based on comparing conditions on a one-to-one basis.\textsuperscript{19} Thus a single appendectomy is more important than a single tooth capping because it saves a life rather than merely reducing pain. Our intuitions are much less well developed when it comes to making one-to-many comparisons. Moral views on this topic are complex and difficult to express as clear principles, but it is clear the formulas have steered us in the wrong direction in this case. We recognise that aggregate maximising is appropriate in some circumstances, but maximising can lead to unacceptable policies. Jonsen has rightly observed that people cannot stand idly by when an identified person's life is visibly threatened and effective rescue measures are available, and has dubbed this powerful human proclivity to rescue endangered life "The Rule of Rescue."\textsuperscript{20} The rule of rescue helps to explain our intuitions in comparing small benefits to many with large benefits to few, but our inclinations contain more than highly valuing survival. Some benefits are too minor (perhaps tooth capping, for example) to deserve a high priority no matter how low their cost per QALY.


Another thorny issue for QALYs is that, all other things being equal, QALYs explicitly prefer a longer period of survival to a shorter period, no matter the length of either period. For this reason, many accuse QALY-type calculations of being ageist. Consider the following example. Rachel, 31, is suffering from cervical spondylosis, causing her severe pain in the neck, head and arms. Her doctors have decided that she requires a cervical disk operation. Wendy, 63, is suffering from the same condition and her doctors have decided that she too needs a cervical disk operation. Let us consider the QALY value of the operation for both Rachael and Wendy. Rachael has a longer life expectancy than Wendy solely because she is younger. This means she has a much greater number of years for which we must calculate the quality adjusted value. The QALY value of the operation will be much higher for Rachael than it is for Wendy, solely on the basis of the differences in their ages. Now imagine QALYs being applied to all candidates for cervical disk operations and we can see that they would tend to value this operation higher for younger people. QALYs do, in practice, discriminate on the basis of age. Daniels calls this the fair chances/best outcomes problem. Most of us see the logic in preferring someone who will survive 25 years over someone who will only benefit for 3 months, or perhaps even 5 years versus 6 months. What about 18 years versus 13 years? At some point we decide that both of the candidates are going to live long enough to warrant the intervention, despite the fact one candidate is likely to live longer. At this point, many argue that each candidate deserves a fair chance at the intervention even if only one of the two can receive it.

To summarise, cost-benefit analysis contains too many ethical difficulties to guide us very far with rationing decisions. The problem of incommensurable health benefits for different conditions is probably insurmountable. Furthermore, since the range of benefits is relatively small (0 to 1) and the range of costs is great, cost assumes disproportionate importance. The utilitarian underpinnings of CBA makes the greatest good for the greatest number into no expensive goods for anyone.


Ignoring important, but expensive, benefits for the individual returns us to the problems of rationing by cost and violates the goals of the health service.

Are waiting lists an ethically acceptable way to ration?

Due to limited resources, waiting for non-urgent surgical and medical procedures is a characteristic of all publicly funded health care systems. Presumably all patients who are on the waiting list meet the indications for the procedure. Queuing is the way non-urgent procedures are rationed. Properly managed, waiting lists do not violate the dignity standard, but, improperly managed they raise ethical problems.

Waiting lists affect a large number of people. There are about 60,000 people recorded on waiting lists in New Zealand (at a given point in time). Elective procedures represent about 35% of a hospital's workload (although this proportion varies considerably between specialties). Hence policies for running waiting lists are important for the health system.

Waiting serves important purposes. It allows the patient to adjust to the idea of surgery, gives him/her a chance to organise his/her life around it, and it gives an opportunity for him/her to change his/her mind. Waiting also allows for the health system to have reasonable control of patient load. Moreover, it allows for the kind of prioritization which Robert Veatch would advocate: directing our attention to the most needy. Waiting lists function on patients' ability to wait. The top priority patients are those who have the greatest need (and ability to benefit from the procedure). Waiting lists consisting of well chosen patients with reasonable waiting times where the neediest are given priority are ethically sound.

Unfortunately, they do not always work that well. In New Zealand there is a heterogeneous mix of cases and policies for waiting lists. This leads to unnecessary uncertainties for all who are concerned, and fails to meet the standard of a health system required for a life of dignity.

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24Ibid., p. 18.
Consider this example. Dennis is a 63 year old dairy owner who has suffered from osteoarthritis for years. His pain is worst in his right knee, and he and his GP decide he should see an orthopaedic surgeon for possible joint replacement. He attends the orthopaedic outpatient clinic (after a wait of several months), and is advised he will be placed on the waiting list. A letter to his GP follows a few days later. Then the awful wait begins—nothing is heard for weeks, months. Dennis wonders quite frequently where he is on the list. Has his file been misplaced? He considers ringing the surgeon, but decides not to bother her. He does ask his GP whether she has heard anything. She has not. She may, if she considers it her responsibility, enquire on behalf of her patient. In the meantime, Dennis's life is on hold: he does not go on even a short holiday for fear he will miss the important call. Optimistic and full of hope, Dennis waits. Fraser, Alley and Morris have called the waiting list an outdated, insensitive process, and when it operates like this example it certainly is. Dennis should not be in such a vague position. There is nothing objectionable to waiting for an explicit (even lengthy) period until surgery in a non-urgent case, but waiting for an indeterminate period is unacceptable. Fraser, Alley and Morris have advocated explicit criteria for priority assessment for elective procedures and "booking" a time for the procedure. Thus, patients are only on the list if indicated, patients are treated in order of need, and they are not left waiting indefinitely. This seems a vast improvement.

Is rationing technology ethically acceptable?

Daniel Callahan has argued that rationing medical progress is an essential ingredient to making health care affordable in the long-run. His argument is compelling:

As fast as we try to remove high costs, we are adding a steady stream of new, usually expensive forms of technology. If one takes 1970 as the baseline year, the number of new forms of technology introduced since then is astonishing; there are so many that I, at least, have not even been able to list them fully. Our commitment to unlimited medical innovation has not been seriously hampered by cost-containment efforts. How, then, are we
supposed to hold down costs while constantly adding new forms of technology?\textsuperscript{25}

Callahan's question is all the more legitimate when we add to the picture that medicine has been reluctant to eliminate old technology. It is not as though new, better, more expensive technology replaces older, inferior, less expensive technology; it is simply added to the armament at the doctors' disposal.

There is more than one way of addressing this issue. The weakest claim is to say that we must demand better assessment of new technology. This will provide a remedy insofar as it allows us to discover and eliminate useless and marginally useful forms of technology. To be sure, some types of medical technology are subjected to more stringent assessment than others. Pharmaceuticals have to undergo a long and arduous process to gain approval while many diagnostic tests undergo only minimal evaluation before their introduction into clinical medicine. There should be no ethical objection to more rigorous assessment of technology. While this is clearly a cost-saving exercise, it could, in fact, also be viewed as protecting patient safety. Requiring thorough testing of new medications before they are introduced to the market is obviously in the interest of safety. Assessing new diagnostic tests for sensitivity and specificity as compared with old technology before introducing them to the market would also be in patients' best interest. By knowing the limitations of a test, misdiagnoses and inappropriate treatment would be avoided. And requiring new treatment modalities to be examined and have demonstrated efficacy before being covered in the public health system would also spare patients unnecessary procedures (as well as save the health system money). There is a small issue regarding the patients for whom treatment is unavailable while the technology is being assessed. This was highlighted by the outcry of HIV patients at the lengthy FDA process of evaluating new HIV drugs. In some situations (like HIV) the process must be truncated, but, on the whole, technology assessment is potentially cost-saving exercise that increases patient safety. This approach

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is excellent for eliminating useless technology, but it does little to guide us with new technology that is truly effective but expensive.

A stronger claim is to say that we need better assessment of technology, and it must be demonstrated to be both effective and cost effective. Many authors want to eliminate/never introduce useless and marginally useful technology as well as technology with costs that outweigh benefits. Andreas Laupacis et al argue for such an evaluative system.\textsuperscript{26} They propose five grades of recommendation depending on the cost and effectiveness of the new technology compared with existing technology. The highest recommendation is for more effective, less expensive technology, and rejection is recommended for less effective, more expensive technology. The other three grades are combinations of less expensive, less effective and more expensive, more effective as outlined in table five.

<table>
<thead>
<tr>
<th>TABLE 5: Grades of recommendation for the adoption and appropriate utilisation of new technologies\textsuperscript{27}</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Compelling evidence for adoption and appropriate utilisation</strong></td>
</tr>
<tr>
<td>The new technology is as effective as or more effective than the existing one and is less costly.</td>
</tr>
<tr>
<td><strong>B. Strong evidence for adoption and appropriate utilisation</strong></td>
</tr>
<tr>
<td>a) The new technology is more effective than the existing one and costs less than $20,000 per quality-adjusted life-year (QALY) gained.</td>
</tr>
<tr>
<td>b) The new technology is less effective than the existing one, but its introduction would save more than $100,000/QALY gained.</td>
</tr>
<tr>
<td><strong>C. Moderate evidence for adoption and appropriate utilisation</strong></td>
</tr>
<tr>
<td>a) The new technology is more effective than the existing one and costs $20,000 to $100,000/QALY gained.</td>
</tr>
<tr>
<td>b) The new technology is less effective than the existing one, but its introduction would save $20,000 to $100,000/QALY gained.</td>
</tr>
<tr>
<td><strong>D. Weak evidence for adoption and appropriate utilisation</strong></td>
</tr>
<tr>
<td>a) The new technology is more effective than the existing one and costs more than $100,000/QALY gained.</td>
</tr>
<tr>
<td>b) The new technology is less effective than the existing one, but its introduction would save less than $20,000/QALY gained.</td>
</tr>
<tr>
<td><strong>E. Compelling evidence for rejection</strong></td>
</tr>
<tr>
<td>The new technology is less effective than or as effective as the existing one and is more costly.</td>
</tr>
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</table>

This is a helpful framework; it helps us to maintain patient safety as in the weaker claim, and it points out advancements that may be too expensive.


\textsuperscript{27} Ibid., p. 475.
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Thus costs are further contained. This approach is possibly consistent with the goals of the health service, but like the cost benefit analysis approach (in which it is based) it should not be applied blindly. One example of technology in the article that would receive the weakest recommendation for adoption is universal precautions to prevent HIV transmission to health care workers. It has been estimated that universal precautions costs about Can$565,000 per life-year saved. Eliminating universal precautions, I would suggest, would not be consistent with a communal definition of dignity. Employed discriminately, however, technology assessment is consistent with maintaining a health care system that aims to enhance the dignity of people's lives.

The strongest claim—the one Callahan seems to make at times—is that we need to ration all advances in technology that will increase the total spent on health care. Callahan is not against advances that lower costs, but he says "we cannot possibly afford every medical advance that might be of benefit." This could be read as a claim similar to Laupacis et al, but Callahan seems to be saying more. He seems to think we already spend too much, or at least enough, on health care, and further expansion is unacceptable: "We risk becoming a hypochondriacal society, one that has sacrificed much that is good and necessary for a rounded life out of an obsession with health." Perhaps Callahan is only asserting that we should spend no more on health care overall which is less objectionable. But to put a wholesale ban on technological advances which increase costs is going too far. Some advances, like many new pharmaceuticals, will have such an impact on living a life of dignity that they merit high priority. Consider this example. Jennifer is a 25 year-old with seizure disorder. She had her first seizure at age 14 and has been on a range of anti-convulsant medications over the past 11 years. She is a compliant patient, but her seizure control comes and goes. She has enjoyed as much as two years without a seizure. During these seizure-free periods she leads a relatively normal life except the burden of following her medication

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30Ibid., p. 1813.
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regimen. When she is having seizures and during the months that follow, however, her life is far from normal. She cannot drive, she visits her neurologist more frequently, and she must explain her illness to many people she encounters, a disorder that still has a stigma attached to it. Being quite certain all of the standard treatments have been tried, the neurologist wants to try treating Jennifer with a new anti-convulsant medication which will cost several times more than the standard alternatives, several thousand dollars per year. The health system has refused to fund all new medications which cost more than the older alternatives. It seems Jennifer merits a trial on the new medication. Eliminating seizures from her life would have a tremendous impact on her quality of life, and despite the cost a trial is warranted. If seizure control is not obtained, there is a good case for returning her to the less expensive alternatives. Of course, we are discussing setting priorities within a fixed budget, and if this drug is paid for, something else will not be. But it seems better to remove an intervention of lower priority than to ban technological advances, and this approach is more consistent with a life of dignity. If the new technology receives a low priority, it may never be funded, but that is a result of its low priority not its status as new technology.

The case against a strong ban on technological progress is strengthened by the fact that new, expensive, high tech care is only partial explanation of the increasing cost of health care. Expanding indications for older technology are a large contributor: for example, the number of patients undergoing coronary artery bypass graft surgery in America has increased dramatically. As surgeons become better at the technique and the risks are decreased, they can offer net benefit to a wider range of patients. Furthermore, it is not just expensive interventions that are driving costs up. Moloney and Rogers have argued that regulating technology will do less to control costs than the advocates suggest. They "present evidence that technologies such as the CT scanner account for far less of the growth in medical expenditures than do the collective expenses of thousands of small tests and procedures." They advocate the more discerning use of all technology. This may be more difficult to achieve, but it is more acceptable than narrowly rationing new technology only.

CONCLUSION

Certainly there are other ways to ration that have escaped my attention or are yet to be devised. The same sort of analysis should precede the application of each approach. Of each new rationing device we must ask "Does this method, as being applied, assist or detract from the health service reaching its goal of enhancing the dignity of individuals' lives?"

In this chapter it was argued that a priority list of interventions (with sufficient detail and latitude for clinical decision making) and cost-effectiveness analysis are very important rationing tools. Waiting lists and technology assessment are also useful tools which have important applications, but each can be applied inappropriately. Finally, rationing by cost and cost-benefit analysis contain too many ethical difficulties to guide us very far with rationing decisions; neither method assists the health service in reaching its goals.
In summary, the moral importance of health care lies in its ability to maintain and enhance the dignity of individual lives. That was true fifty years ago when medical science could treat effectively or cure far less, and it remains true today. The constructivist stand is that we have human rights to those things needed for human dignity and that conceptions of dignity vary importantly from community to community. Thus, we have a human right to health care because of the significant impact many forms of health care have on living a dignified life. Hence, health care interventions should be prioritized by their relative ability to enhance the dignity of people's lives.

The right to health care being discussed is a moral, positive *in rem* right, i.e., a morally-justified, resource-intensive entitlement to health care which can be claimed against society at large. There are also interesting and persuasive moral arguments for health care as a broadly conceived negative *in rem* right and as a weak obligation of beneficence. While the idea that health care is a natural extension of our right to collective protection and the argument that we all have obligations to help those in need are both solid arguments which hold water, neither argument holds as much water as most proponents of a right to health care would like. To dispense with the metaphor, while both arguments morally justify certain health care interventions, neither can be logically extended to include all of the personal entitlements to private health services which most proponents feel a right to health care should include. This is not meant to undermine either argument but rather to make a stronger claim. Hence, discussing the right to health care as a moral, positive *in rem* right approaches the subject head-on and is sure to include treatment for the full range of diseases.

There are some theoretical difficulties with positive rights. Rights have been given considerable moral status, and they are entrenched in our system of moral justification such that considerations of rights "trump" all non-rights considerations. However, positive rights are dependent on resources to be fulfilled, and these resources are scarce. As a result, the
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The content of a positive right is dependent on the amount of resources available to a given community. Negative rights (i.e., liberties), by contrast, are not subject to the shifting sands of resource availability. While the claim that positive rights are dependent on available resources seems intuitive, extreme situations are problematic. During a famine, for example, we might conclude that there is no right to food. Some rights proponents would argue that rights are inalienable, and, hence that this is an unacceptable theory. Perhaps the resolution of this conflict may lie in broadening the boundaries of our *in rem* community during extreme circumstances, although this requires further exploration. At any rate, making the content of positive rights subject to the resources of the community makes sense under less extreme circumstances. Thus we arrive at the reasonable conclusion that positive rights entail different things in a developed nation than in a developing one.

Prioritization is necessary because no society has sufficient resources to provide all potentially dignity-enhancing health care. This is probably true in the sense that we simply cannot afford all beneficial health care (if we insist on even small benefits), but it is certainly true if we consider that we have human rights to *all* of the various things needed for a life of dignity. Health care is one of many things (along with food, shelter, education, etc.) which is required for dignity, and, with limited resources, health care should not be funded to the detriment of these other human rights.

The necessity of prioritization is made clearer when one examines the trends of the last thirty-five years. Health care expenditures are rising far faster than overall economic growth in all of the Organization for Economic Cooperation and Development (OECD) countries. In New Zealand, health care expenditure rose from 4.4 percent of Gross Domestic Product (GDP) in 1960 to 7.3 percent of GDP in 1990; in the USA health expenditure went from 5.2 to 12.4 percent of GDP over the same period! Health care is consuming a progressively larger portion of the economy. There have been so many advances in health care that we have reached a point where we cannot afford all beneficial health care. Implicit rationing has been with us for some time, and, as resource constraints remain with us while new health care technologies become available, the need for more explicit rationing becomes more pressing. There is no reason to think this trend will cease.
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Furthermore, the morally relevant criterion for rationing, *dignity*, does not lend itself to implicit rationing. Dignity requires a community definition, and extensive input from the public will be required to prioritise health care interventions by this criterion. Rationing is a difficult and painful, though necessary, process, and it will require considerable effort from the community to be carried out well. This time and effort, however, will be well spent as the prioritization and the methodology used to determine it will allow the systematic rationing of health care and the proper prioritization of future technology. This is sure to be superior to random and implicit rationing.

No less important than the prioritization of services are the rationing tools which should be applied to all services, regardless of priority. Simply because society places a high priority on certain services, it does not follow that those services are exempt from any rationing. It should be kept in mind that low priority services make some contribution to dignity also, and we should labour to fund as much of the list as possible. Controlling costs high on the priority list is a vital way to fund more of the list. Thus, coronary artery bypass grafting may be given a high priority, but it may still be subject to a waiting list or waiting time of reasonable length. Rationing tools identified in chapter five as ethically acceptable in some of their applications include cost-effectiveness analysis (CEA), waiting lists and technology assessment. The envisioned system is to prioritise all health care interventions 1 through, say, 1000, and then to apply various constraints (e.g., CEA to the treatment of various disorders, capped numbers of specific elective surgeries, etc.) to the entire list. Then it could be actuarially determined how far the list would be funded. If society could afford funding through, say, 846, then items 847 through 1000 would not be funded. Such a project would be open to wide public negotiation and scrutiny.

The system which ultimately is being advanced as best to fulfil the moral right to health care in a liberal society is a publicly funded system which people can either join or not join regardless of the individual's financial situation. More specifically, the public system should not be a health care system only for the poor and "uninsurable." Presumably, this system would be funded by general tax revenues, and even those who opt
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out of the public health care system would share (to some extent)\(^1\) in the communal obligation to fund that system. Such a system would retain freedom of choice and freedom to spend one's private resources as desired--a value identified as important when discussing egalitarianism and the idea of levelling all health care up or down to match society's resource constraints. A system which demands participation and prohibits purchasing health care outside the public system seems to violate these basic premises.

Standard applications of several theories of justice to health care were examined in chapter three, and strengths and weaknesses of the standard theories were illustrated. Resource allocation decisions were presented as falling along a continuum from macro allocation to micro allocation, and the claim was made that a well founded right to health care would take into account the full spectrum of allocation decisions. While the bulk of what has been presented about the constructivist theory and health care has concerned macro allocation decisions, the constructivist theory accommodates the full spectrum of allocation decisions well.

To conclude, the constructivist theory can be seen to be applicable across the spectrum of resource allocation. At the extreme macro end of the spectrum, the constructivist theory of human rights asks the question "What are the entitlements necessary to live a life of human dignity?" This is a strong starting point as it captures the big picture: it is not just freedoms, shelter, food, education, or health care that enables each of us to have a truly human life. We should apportion our resources to positive in\(^{\text{ rem}}\) rights so as to reflect the vital importance of each of these areas. Focusing on health care, the constructivist theory asserts that we should prioritise health services with specific reference to the ability of health care

\(^1\)Deciding how to spread the burden of financing this public health system is a difficult matter beyond the scope of this thesis. If one opts out of the public system, it seems reasonable to say one has a smaller responsibility to fund the public system; however, differing tax rates for those who opt in and those who opt out amounts to an incentive for the rich to leave the public system. This oversimplified example should illustrate. Assume this health system will be funded by a 5% income tax on those who participate and 3% on those who do not. Someone who earns $20,000 would pay $1000 as a participant or $600 as a non-participant, and someone who earns $100,000 would pay $5000 as a participant or $3000 as a non-participant. As it is difficult to purchase health insurance for $400 but relatively easy to buy it for $2000, it is not unlikely that the more wealthy person would opt out while the less wealthy would opt in. This seems an undesirable outcome, but it is also worth noting that the wealthy person who opted out of the system would still contribute three times the amount the less wealthy person would. This is a complex issue which I will not explore further.
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to maintain dignity. Finally, at the extreme micro end of the spectrum, the constructivist theory asserts that the doctor-patient relationship should have the dignity of the patient as its focus.
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