



A universal right to healthcare. Michael Boylan.
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Health Care is something most of us have to face at one time or the other in our lives. In one sense it is an "invisible" commodity because it is not really apparent to us until we need it. With the advances in medical science in the last seventy-five years there is increasingly more that can be done for us by modern medicine. All of this has a price tag. And the price tag is staggering. But not all Americans have actual access to health care. ("actual access" means the ability to utilize appropriate health care providers for the remedy of health conditions.) (1) This lack of actual access is generally due to lack of insurance. Health insurance is not cheap. Therein lies the genesis of the problem. If comprehensive health care is a right, then it is not presently actually accessible to all.

Because health care is over 15% of our economy (thus constituting a cluster of businesses in themselves) and because virtually every business is confronted with the health insurance issue, some careful thinking on these issues is very important. The purpose of this essay is: 1. To outline the strengths and weaknesses of the current health care system; 2. To sketch the ethical arguments on human rights and health care; and 3. To argue that everyone has a right to health care consistent with the "ought implies can" doctrine. (An appendix to this essay outlines the structures of the present health care delivery systems.)

STRENGTHS AND WEAKNESSES OF THE PRESENT SYSTEM

When my grandfather was in medical school, around the turn of the twentieth century, there were still classes that used Galen as their basis. I am a great admirer of Galen, but the medical world that Galen knew depicted the physician as one who set broken bones, helped delivering babies, prescribed diet/ exercise, and suggested herbs to balance the four humors of the body.

With the advent of the twentieth century, Galenic medicine became a thing of the past. Medicine advanced rapidly on two fronts: (a) pharmacology, and (b) surgery. The former was stirred by advances in specialized medical research and the latter by advances in technique (including ways to keep the patient alive both during and after an operation) and biomedical technology (including prosthetics, improved surgical equipment and monitoring apparatus). The "new medicine" enabled miracles to be performed that were thought to be impossible in my grandfather's medical school days.

With the new medicine came a greater price tag. Most of this price tag was associated with hospitalization. To enable people to be able to afford expensive hospitalization, medical insurance was promoted. Originally health insurance was designed for catastrophes. (Insurance often works best when it protects its policyholders against an unlikely catastrophe--as in homeowners' insurance.)

In the post World War II period health insurance gradually began adding other features to its coverages: pregnancy and childbirth, office visits, and prescription drugs. At the same time medical advances were increasing rapidly. Hospitals bought new and expensive machines which had to be paid for by each and every patient who entered the door--whether he/she needed those services or not. Medical accountability also rose as the litigious climate heated up. Each and every time that things "went badly," it had to be "somebody's fault." (Somebody's fault means a malpractice suit.) This created a climate in which both physicians and hospitals had to establish careful guidelines about what the "prudent practitioner" would do in such and such situation (i.e., standards of professional practice). If anyone varied from this, then he/she was liable for malpractice.

Hospitals had to add layers of administrative staff to comply with the demands of high accountability. This meant an increasingly larger price tag.

Insurance companies, who had routinely paid every bill presented to them in the fifties and sixties, were now auditing bills more carefully for mistakes and fraud. This also increased the costs.

The good news is that health care in the United States has enabled people to live longer lives. The bad news is that this aging population has greatly increased health care needs. Medicare was established to help meet these needs, but Medicare pays only a fraction of what procedures actually cost on the open market. (2) This meant that younger patients (and their insurance companies) were forced to subsidize the difference. It is an invisible tax.

The late 1980s saw an explosion of health insurance costs that were caused by a similar rise in health care costs. More people were getting knee and back operations instead of hobbling around as their parents had. Americans were using their health insurance as they never had before because it really improved the quality of their lives.

By the 1990s health insurance was too expensive for many Americans. Family coverage was often as costly as the rent or mortgage. Americans were not used to paying such a high percentage of their income on health insurance. For many there was no choice. They could not afford the high premiums and went without coverage. This gamble works so long as you don't need to go to the hospital. But if you do, then you can find yourself forced to go to public hospitals that are overcrowded and often without the latest medical equipment. (3)

For the very poor, Medicaid is available though "welfare reform" has limited these numbers. Eligibility varies according to each state, but like Medicare, it does not reimburse at the market rate. The difference is made up by "paying customers" (meaning people with insurance).

ETHICAL ARGUMENTS ON HUMAN RIGHTS AND HEALTH CARE

Obviously one important part of the health care debate is whether or not a citizen of a country has a right to health care. If he or she does, then it is the government's correlative duty to provide this good to the individual. (4) Thus, if all citizens have a right to health care, then the government has the correlative duty to provide it.

Therefore, it is an important question whether or not individuals have a right to health care. This brief exposition does not attempt to fully explore this issue, but merely raises

some important issues and point to the way that the question might be answered. To this end let us examine two theories for the basis of human rights: (a) Deontologically based rights theory; (b) Community based rights theory. In each case, I will contend that one can derive a strong right to health care. Then in the final section of this essay I will discuss a limitation upon this right (the "ought implies can" caveat).

Deontologically Based Rights Theory

There are a number of versions of deontologically based rights theory. Many follow from a natural rights tradition. (5) What concerns us here is a form of the theory that states that there is some characteristic that all people possess that justifies their claim to that good as a right. This good is thus claimed solely on the basis of the claimant's status as a human being (or in some cases an "adult" human being).

There are several persuasive writers in the natural rights tradition that, at least, began with John Locke (if not earlier). The principle problem with this tradition is being able to ground a theory of rights upon some intersubjective principles. Following Kant, Alan Gewirth, Alan Donagan and others have tried to ground a deontological theory based upon the grounds of human action as per the following argument. (6)

The Argument for the Moral Status of Basic Goods

1. Before anything else, all people desire to act--Fact
2. Whatever all people desire before anything else is natural to that species--Fact
3. Desiring to act is natural to homo sapiens--1,2
4. People value what is natural to them--Assertion
5. What people value they wish to protect--Assertion
6. All people wish to protect their ability to act beyond all else--1,3,4,5
7. The strongest interpersonal "oughts" are expressed via our highest value systems: religion, morality, and aesthetics--Assertion
8. All people must agree, upon pain of logical contradiction, that what is natural and desirable to them individually is natural and desirable to everyone collectively and individually--Assertion
9. Everyone must seek personal protection for her own ability to act via religion, morality, and/or aesthetics--6,7
10. Everyone upon pain of logical contradiction must admit that all other humans will seek personal protection of their ability to act via religion, morality, and/or aesthetics--8,9
11. All people must agree, upon pain of logical contradiction, that since the attribution of the Basic Goods of agency are predicated generally, that it is inconsistent to assert idiosyncratic preferences--Fact

12. Goods that are claimed through generic predication apply equally to each agent and everyone has a stake in their Protection--10,11 1

13. Rights and Goods are correlative--Assertion

14. Everyone has at least a moral right to the Basic Goods of Agency and others in the society have a duty to provide those goods to all--12, 13

From the moral status of Basic Goods a more robust picture of human rights can be constructed--all based upon their proximity to the foundations of human action. My depiction of these relations is as follows.

Moral Goods and their Accompanying Levels of Embeddedness

Basic Goods

Level One: Most Deeply Embedded (7) (that which is absolutely necessary for human action): Food, clothing, shelter, protection from unwarranted bodily harm

Level Two: Deeply Embedded (that which is necessary for effective basic action within any given society):

- * Literacy in the language of the country
- * Basic mathematical skills
- * Other fundamental skills necessary to be an effective agent in that country, e.g., in the United States some computer literacy is necessary
- * Some familiarity with the culture and history of the country in which one lives
- * The assurance that those you interact with are not lying to promote their own interests
- * The assurance that those you interact with will recognize your human dignity (as per above) and not exploit you as a means only.
- * Basic human rights such as those listed in the U.S. Bill of Rights and the United Nations Universal Declaration of Human Rights

Secondary Goods

Life Enhancing: Medium to High-Medium Embeddedness

- * Basic societal respect
- * Equal opportunity to compete for the prudential goods of society
- * Ability to pursue a life plan according to the Personal Worldview Imperative
- * Ability to participate equally as an agent in the Shared Community Worldview Imperative

Useful: Medium to Low-Medium Embeddedness

- * Ability to utilize one's real and portable property in the manner she chooses
- * Ability to gain from and exploit the consequences of one's labor regardless of starting point
- * Ability to pursue goods that are generally owned by most citizens, e.g., in the United States today a telephone, television, and automobile would fit into this class

Luxurious: Low Embeddedness

- * Ability to pursue goods that are pleasant even though they are far removed from action and from the expectations of most citizens within a given country, e.g., in the United States today a European vacation would fit into this class
- * Ability to exert one's will so that one might extract a disproportionate share of society's resources for one's own use

What is the justification for this classification? Let us start at the beginning. I have parsed the Basic Goods into two levels. The first level is the most deeply embedded. On this level there is an appeal to the biological conditions of agency. What does every human need in order to act from a biological point of view? Every person needs so many calories (based on a number of different variables such as body mass and metabolic rate, etc.) on a regular basis. Without this requisite number of calories the individual will not be able to act, but instead will become sick and eventually die. The same is true with the second two categories of clothing and shelter. These are for the sake of maintaining a core body temperature and protecting the individual from the ravages of nature. In more temperate climates, there is less of a need for clothing, but generally some need, nonetheless, for shelter (to protect the individual from storms and high winds). Finally is the related item of protection from unwarranted bodily harm. If a person lived in the forest without any shelter, there are many predators (large and small) that may attack him. One cannot act--from a biological point of view--and live this way for long. When we sleep we are vulnerable to attacks of all sorts. If we are totally unprotected, it is probable we will suffer.

These above considerations are important. But there are many other necessary biological requirements. These may have to do with health and the proper operation of our bodies, through the protection from unwarranted bodily harm. I have not set these out because my purpose here has been to highlight those goods that might be able to be provided by society.

The second level of basic goods (deeply embedded) concentrates upon providing the agent with the goods necessary to be an effective actor within a particular society. These goods are what any agent could claim in order to act at a basic level of proficiency within that society. These goods are of two types. The first sort of second level basic good refers to education and skills that are necessary within some society. Because these requirements are society/historically-specific, there is some relativism regarding the actual goods involved. However, necessity exists regarding the more theoretical requirement, viz., that there are goods affecting education and skills that all members of that society need in order to be effective agents at a basic level.

The second sort of level two basic goods are those having to do with human liberties

such as those set out in the U.S. Bill of Rights and the United Nations Universal Declaration of Human Rights. These goods are also necessary in order for agents to be effective actors in any given society.

The secondary goods have three groups. In the first group are the life enhancing goods (medium to high medium embeddedness). These goods seek to enable the agent to be able to compete at an equal starting line. These goods are not as important as basic goods because basic goods enable (a) the biological conditions of action and (b) the basic societal skills as well as the basic human rights that allow any effective action. However, that is not to say that life enhancing secondary goods are in any way trivial. They are not. They promote equality of action and equal opportunity.

The next level of secondary goods are those that are useful to us (medium to low-medium embeddedness). These goods are the prudential goods that most of us strive for as a primary precondition to living the sort of life that will make us happy. Again, there is some relativity here because what might make one person pleased in one country/historical era might not satisfy another.

The lowest level of secondary goods are the luxury goods (low embeddedness). These goods are aimed at providing pleasurable accessories to action. Luxury goods come in all sorts of packages. Some are small (such as gourmet coffee beans) while others are very large (such as a membership in an exclusive country club). The point here is that this class is the farthest removed from the fundamental conditions for action.

Clearly, when our bodies are assailed by microbes (disease) or accident, we are subject to unwarranted bodily harm. Since the protection from such is a basic good of agency, there is a strong rights claim for the same against all members of the society subject to the "ought implies can" caveat.

Now some might object on the grounds that certain types of life-styles might make "unwarranted" bodily harm actually "warranted" bodily harm. This is a controversial argument that some pose. (8) There is one sense that it is correct. If x does P and P happens to be detrimental to x, then x is responsible for her ailment. In this case, it would seem as if "unwarranted" should be revised to "warranted" (and thus outside the sphere of moral obligation).

However, I would demur. In most cases, behavioral life-styles are either entered into consciously or via an opaque context. In the case of conscious choices, it would be my contention that most who choose a deleterious behavior do so out of ignorance. For example, many in the United States engage in exercise. It is presented as a healthy lifestyle. But this author is a living example of how exercise (long distance running) can lead to multiple knee and back operations. A friend of mine who heads one of the largest orthopedic surgery practices in the Washington, D.C. area told me that sports and exercise have combined to lead to a substantial increase in his practice over the years. Most of these patients thought they were engaging in something healthy, but it turned out to be otherwise. By intention these individuals believed that they were engaging in healthy behavior. There was good scientific evidence to support this belief. However, in fact, they were planting the seeds of their own injury. They were ignorant of the actual state of affairs. This is a classic case of ignorance mitigating culpability. (9)

The second category concerns opaque contexts. (10) In this case, the agent does not understand that what she is doing is actually hurting her. This is because she does not

properly make inter-substitutable connections. For example if Jane drinks whiskey, she knows (a) that whiskey gives her pleasure and (b) that whiskey will kill her liver. However, when Jane considers drinking she does not say to herself, "I will now drink whiskey in order to kill my liver." This is because the context is opaque. Jane does not make the requisite substitution, and thus only sees the proposition, "I will now drink whiskey in order to receive pleasure." Since an opaque context is another instance of ignorance, it is my contention that it, also, is not fully culpable. Because of this, medical personnel should feel secure in fulfilling their professional obligation of beneficence without regard to the behavior of their patient. (11)

Thus, from the point of view of the above deontological theory, all people have a claims-right to level-one basic goods of agency. This is not an endorsement of medical procedures that concern secondary goods (such as cosmetic surgery). First, we have to address the claims of level-one basic goods.

Community Rights Theory

Community rights theories may have their origin in Hegel and have been recently advanced by Michael Sandel. (12)

Another contemporary version of the argument has been presented by Beth Singer. (13) I will focus my comments upon Singer's version of communitarianism. Under Singer's theory, we can characterize rights as operative or not operative. This means that a human community recognizes the rights or does not recognize them. On this view, the "rights relation" is a social institution governed by the attitudes of a normative community. It is, in one sense, an empty question to ask what rights one has that are not exhibited. This is because "having" and "taking" are different modes. Rights that are not already possessed (by being recognized in the human community) must be "taken" in order to be operative. This is a political, sociological, and historical truism. The discussion of rights--not operative--must turn on how and by what means they will, in the future, be "taken."

Once taken, these claims are in the repertoire of rights recognized by the community. It is clear that citizens in the United States do not now have universal, comprehensive health care. Thus, they have no right to universal, comprehensive health care until such time as the reciprocal attitudes of the individual and the community change on this subject.

The process of making health care an operative right in this society can become a question of justice as well as of rights. (14) There are several approaches one could make when one wishes to justify his/her solution in terms of distributive justice. Not all of these choose a "rights" viewpoint to frame the solution. Since "rights" has an individual perspective associated with it, some might rather make the argument in terms of group oriented criteria such as "maximizing freedom" or "maximizing the general utility." Since this essay intends to prove its argument in terms of rights, the justice argument justified in other terms will not be developed. (15)

Justice for the Singer-style communitarian must show that it is in the community's interest that a universal right to health care be established. This could be done in a homogeneous community via ethical intuitionism. Everyone simply immediately grasps the justification for a right to health care. More popular for communitarians is an appeal to virtue ethics. In this argument one might appeal to the virtue of benevolence (for example) and the shared commitment to the consequences that benevolence would entail for community health care.

Utilitarianism could also be enlisted to support a communitarian argument if it could be demonstrated that the public utility would be demonstrably improved by initiating a program of universal health coverage in the United States. Surely the United States would be a stronger country if everyone knew that s/he had basic health coverage--no matter what her/his employer offered or didn't offer. (A similar approach was tried by the Clintons in the early 1990s without much legislative success.)

I believe the most effective argument from the communitarian standpoint would be the virtue ethics approach as one tries to knit together various constituencies and their understandings of what benevolence as a virtue would mean to them and the larger whole (the United States as a country). (16) People would admit that communities should support at some basic level those who are not covered by the present system. Regardless of the moral theory employed, I believe that a case can be made to create an operative communitarian right to health care (though the communitarian argument must, of necessity, be subject to the descriptive forces that govern the enactment of any law or entitlement). The advantage of making the argument in this sphere is that the scope of communitarian ethics is social/political in nature. Often when one addresses an issue solely from an ethical point of view the social dynamics are not accounted for. Thus, what communitarianism brings to the table is a social/political dimension to the problem. Both perspectives are important in a comprehensive discussion of the issue. (17)

The Right to Health Care

Depending upon the theory you have chosen to depict human rights, you have two different answers to whether there is a "right" to health care. The reason I have presented both a deontological and a communitarian (virtue ethics) approach is because in the social arena deontology alone is often insufficient to provide the political motivation for action. This is because deontology focuses upon the individual and his rights and duties. However, it is certainly possible that disputes about this can mitigate social action. Whereas deontology focuses upon the individual, communitarianism focuses upon the general will. As I have argued for recently, there is an important sense in which the general good should be accommodated even when it is individually inconvenient. (18) These situations occur when the individual's claim for himself involves a secondary good (most often a third-level luxury good) against another person or group's claim for a basic good. In these cases the communitarian doctrine of the dominance of the general will takes precedence--but only because it is substantiated by the table of embeddedness provided above.

There is still one question that must be addressed This is the Kantian doctrine that "ought implies can." (19) Under this doctrine no one can be said to have a binding moral duty to perform something that it is practically impossible for him to do. This maxim is important to Kant for without it, his theory is doomed to inconsistency. (20) Thus, the question may be whether the United States can institute comprehensive universal health care. If they can, then they should.

But what lies behind this "can"? Does the can mean (1) "logically possible" or (2) "practically possible" or (3) "comfortable to implement" or (4) "may be implemented without raising taxes or cutting other programs" or (5) "politically easy to bring about." Obviously the answers to these interpretations of "can" are different. Therein lies a large part of the practical implementation of any health care reform.

ASSESSING THE "OUGHT IMPLIES CAN" RESTRICTION ON COMPREHENSIVE

UNIVERSAL HEALTH COVERAGE

The number of practical impediments to establishing a comprehensive universal health care system in the United States is very large. It is not difficult to sketch some of them. First, there are the vested interests that will be disturbed. These include hospitals, doctors, pharmaceutical companies, insurance companies, and the myriad of medical support facilities. It is a political fact that entrenched interests are difficult to overcome in a democracy. This is one aspect of the "can" described in the last section.

A second element of the "can" equates to "economically afford." This, in turn, requires a specification of "afford." Clearly this word implies a value system that ranks alternatives. If one puts comprehensive universal health care at the top of the list, then the United States can certainly afford it. But few people seem inclined to do so. Much of the current dissatisfaction with health care revolves around the cost of health care. Americans seem reluctant to put it very high on the list of priorities. Many people want the "best available care," but at the same time do not want to pay for it. Unless there is a will to rank health care high, comprehensive universal coverage will never occur. This is because it is very costly. How costly is difficult to determine, but in a peacetime economy it is likely to be the largest single item in the federal budget (after payment on the national debt).

Few really believe that comprehensive coverage can be obtained without either raising taxes significantly or cutting existing programs. This latter alternative always sounds great because each of us has a different idea of which programs are ripe for cutting. (Those programs that don't benefit us, personally, are usually those that we think are ripe for cutting.)

The establishment of "political will" is a job for politicians (and is reminiscent of the focus of the communitarian argument). Unless the American people accept that comprehensive universal health coverage is important, it will never pass--no matter how "right" it is.

The third sense of "can" involves what sort of health care we want. Do we desire everyone to have access to the "best available care" or will we settle for a rationing formula? If so, then what sort of formula? If the rationing formula is too restrictive, then it may not be an improvement over what we presently have. Again, the "can" is involved with people making a conscious decision about whether they believe "best available care" is an integral part of their well being (or at least a more integral part of their well being than a second car, boat, or summer home).

The last sense of "can" involves who will pay for it. At the writing of this essay, the most popular candidate is business. When health care was inexpensive, it became a standard fringe benefit of most employers. As health insurance became more and more costly, employees have taken on an increasingly greater share of the premium payments.

There is often a false sense among individuals that if payment for some good does not come directly out of their pockets, then they are not paying for it. Thus, government and big business are thought to be able to provide fringe benefits "free of cost" to the average person. This, of course, is untrue. The government depends upon taxes for its revenue and business passes on its expenses to consumers. We all pay.

Some have suggested that we take the mechanism of health insurance out of the workplace and make it like car insurance, which is privately purchased though, at the same time, mandatory in most states.

Small businesses are most vocal for this option citing the thin margins on which they work and the limited reserve capital they have at any given time. Indeed, it has been small businesses that have been the greatest critics of comprehensive universal coverage because they feel it will put them out of business.

It is hard to assess this claim. But if it is true, then some sort of accommodation must be made for small business. What about sole proprietors? These individuals have no employees but themselves. These people make up the largest percentage of the present uninsured population. How can these people be monitored so that they are compelled to purchase health insurance. These hardworking individuals--be they painters, carpenters or whatever--have often made the choice in the present situation not to purchase health insurance. What makes us think that they will purchase health insurance under a different scenario? They will say they have no money left after rent, food, and clothing to purchase insurance. Tax "write-offs" are not significant to people with little money coming in and no appreciable savings. This sort of argument is a further dimension of the "ought implies can" dilemma.

There are a considerable number of difficulties associated with establishing comprehensive universal health care coverage in the United States. The task will not be an easy one. But then large changes are never easy. It seems to me that the moral "ought" supports the change. There are many candidates for this "ought" being overridden by practical problems (the "can"). I do not believe these practical difficulties are definitive. Rather, I believe them to be largely excuses rendered by those who are financially well off who do not relish the increased tax or premium burden of paying for expanded health insurance protection for others.

Therefore, I think that the moral ought which is derived from the table of embeddedness and brought into fruition through a communitarian-style support of the general will supports a universal right to health care. This, in turn creates a duty that needs to be acted upon. Either through business, or government, or a combination of these, I believe we in the United States ought to go forward with comprehensive universal coverage in some form.

NOTES

(1.) In this context, "actual access" means access to health care that involves the basic goods of agency (as set out later in this essay). There is no argument for access to health services that are designed to enhance secondary goods. I have made this argument more completely in my book (along with Kevin Brown), *Genetic Engineering: Science and Ethics on the New Frontier* (Upper Saddle River, NJ: Prentice Hall, 2002), part three.

(2.) This is evidenced by the recent wave of insurance companies who have left the Medicare HMO marketplace. Companies cannot make money on Medicare patients unless they engage in the practice of "skimming" (meaning that they take only the healthiest patients) or they have a very large client base that includes enough health patients to compensate for those who need care the most. It has been said that in the last months of life a typical patient may require a cost outlay equal to his or her entire life combined. Thus it is that private insurance companies shy away from Medicare unless forced to do so by legislation.

(3.) Some county hospitals that are accustomed to provide healthcare to all needy

individuals are in desperate shape. One prominent example is D.C. General Hospital in Washington, D.C. that has recently been closed as a full service hospital. Many other such hospitals are in deep financial trouble since the public has little inclination at present to support costly hospitals that serve the disenfranchised of society.

(4.) This idea of correlative rights is derived from Wesley N. Hohfeld, *Fundamental Legal Conceptions* (New Haven Conn.: Yale University Press, 1919). In that work Hohfeld describes a "claims right." A claim is a right with a specific correlative duty of the form "x has a right to y against z in virtue of p." In this case x and z are individuals. Z has a duty to give x some good, y, because of p (some institution which validates the transaction). Thus, if x lends \$10 to z, then because of the institution of paying debts, x has a right to that \$10 at some specified time from z. In this way, rights and duties are correlative. A right of one agent is identified as the duty of some other agent. A right is a duty seen from another standpoint.

(5.) Some articles to note on this controversy are: H.L.A. Hart, "Are There Any Natural Rights?" *Philosophical Review* 64 (1955): 176-177; W.W. Buckland, *A Text-Book of Roman Law from Augustus to Justinian* (rpt. Cambridge: Cambridge University Press, 1963), pp. 58; *Elementary Principles of the Roman Private Law* (Cambridge: Cambridge University Press, 1912), pp. 9, 6 1-62; *A Manual of Roman Private Law* (Cambridge: Cambridge University Press, 1925), p. 155; Michel Villey, *Lecons d'histoire de la philosophie du droit* (Paris: Vrin, 1957), chapters 11 and 14; S. 1. Bean and R. S. Peters, *Social Principles and the Democratic State* (London: George Allen and Unwin, 1959); Michael Boylan, "Seneca and Moral Rights" *The New Scholasticism* 53, 3 (1979): 362-374; A. I. Melden, *Rights and Persons* (Berkeley, CA.: University of California Press, 1977); Jacques Maritain, *Les droits de l'homme et la loi naturelle* (rpt. N.Y.: Editions de la Maison Francais, 1942); Roscoe Pound, *Jurisprudence* (St. Paul, MN.: West Publishing Co., 1 959); Beth Singer, "Community, Mutuality, and Rights" in *Gewirth: Critical Essays on Action, Rationality, and Community*, ed. by Michael Boylan (NY: Rowman and Littlefield, 1999). See also Jeffrey Reiman's commentary on Singer's article.

(6.) For an overview of these positions see: Immanuel Kant, *Groundwork of the Metaphysics of Morals*, trans. by H. J. Paton (London: Hutchinson, 1948), Alan Gewirth, *Reason and Morality* (Chicago: University of Chicago Press, 1978), Alan Donagan, *The Theory of Morality* (Chicago: University of Chicago Press, 1977). From Kant, I borrow an inclination toward logical features of axiomatic theory to support a moral claim. From Gewirth and Donagan, I borrow an analysis of human action theory and how certain generic features dialectically compel agents to accept certain moral imperatives. For a further exposition of my argument see Boylan and Brown, op. cit., Chapter Two, and Michael Boylan and James A. Donahue, *Ethics Across the Curriculum* (Lanham, MD and New York: Lexington Books, 2002), Chapter Three.

(7.) "Embedded" in this context means the relative fundamental nature of the good for action. A more deeply embedded good is one that is more primary to action.

(8.) For a discussion of some of these issues see: Rosamond Rhodes, "A Review of Ethical Issues in Transplanting," *The Mt. Sinai Journal of Medicine* 61, 1 (1994): 77-82 and Brian Smart, "Fault and the Allocation of Spare Organs" *Journal of Medical Ethics* 20 (1994): 26-31.

(9.) Ignorance is generally held to be a mitigating factor in calculations of culpability. For a discussion of the philosophical foundations of this position see Michael Boylan, *Basic*

Ethics (Upper Saddle River, NJ: Prentice Hall, 2000), Introduction.

(10.) Most philosophers consider the work of Willard Van Orman Quine to be pioneering with respect to opaque contexts. Basically, an opaque context is created when a construction resists the substitutivity of identity. Quine uses the example, (1) "'Tully was a Roman' is trochaic." (1) is a true proposition. Now Tully is identical to Cicero, so it would seem as if you could create the proposition (2) "'Cicero was a Roman' is trochaic." But (2) is false since "Cicero" is a dactyl. For a more complete discussion see Willard Quine, *Word and Object* (Cambridge, MA: M.I.T. Press, 1960), pp. 141 ff.

(11.) The foundation of medicine is compassion for those in need. The Hippocratic duty to do no harm and to act for the well being of the sick should thus be an act, simpliciter, without regard for blame which (at the very least) is a tortured judgment.

(12.) See Hegel's *The Philosophy of Right*, trans. by T. M. Knox (Oxford: Clarendon Press, 1942); see also Michael Oakeshott, *Rationalism in Politics* (London: Methuen and Co., 1962). The sociological angle is developed by George Herbert Mead in *Mind, Self and Society* (Chicago: University of Chicago Press, 1934). The contemporary communitarian slant has been championed by Michael J. Sandel in *Democracy's Discontent: America in Search of a Public Policy* (Cambridge, MA: Belknap Press, 1996) and *Liberalism and the Limits of Justice*, 2nd Edition (Cambridge: Cambridge University Press, 1998).

(13.) Beth Singer, *Operative Rights* (Albany, N.Y.: SUNY Press, 1993).

(14.) See James Drane's discussion of health care in terms of justice in, "Justice Issues in Health Care Delivery" *Bulletin of the Pan American Health Organization* 24, 4 (1990): 566-578. Others who have made a similar approach include James Sterba, "Justice" in *Encyclopedia of Bioethics* ed. Warren T. Reich (NY: Simon and Schuster Macmillan, 1995), pp. 1308-1315; Norman Daniels, *Just Health Care* (Cambridge: Cambridge University Press, 1985); and Alan Gibbard, "The Prospective Pareto Principle and Equity of Access to Health Care" *Milbank Memorial Fund Quarterly/Health Care Society* 59,4 (1982): 399-428.

(15.) I should note that not everyone who views the problem in terms of rights agrees with a firm right to health care. For example, Tom L. Beauchamp and Ruth Faden in, "The Right to Health and the Right to Health Care," *Journal of Medicine and Philosophy* 4,2 (1979): 118-131, conclude that "the major issues about right to health and health care turn on the justifiability of social expenditures rather than on some notion of natural, inalienable, or preexisting rights." Others such as Charles Dougherty, "The Right to Health Care: First Aid in the Emergency Room" *Public Law Forum* 4, 1 (1984): 101-128 and Rashi Fein, "Entitlement to Health Services Reappraised" *Bulletin of the New York Academy of Medicine* 66, 4 (July-August, 1990): 319-328 argue for interpretations which are consistent with the one I am advocating.

(16.) It is certainly possible that other virtues might also be chosen to support this standpoint. The above is merely representative and not exhaustive.

(17.) I have made such an argument in, "Justice, Community, and the Limits of Autonomy" in James P. Sterba (ed.), *Social and Political Philosophy: Contemporary Perspectives* (London and New York: Routledge, 2001), pp. 187-202.

(18.) Ibid.

(19.) This doctrine has its own controversies. For a discussion see Christine Korsgaard, "Kant's Formula of the Universal Law," *Pacific Philosophical Quarterly* 66(1985): 24-47.

(20.) The inconsistency is this: on the one hand one may have a duty to do x, yet on the other hand it is impossible to do x. Thus the individual is put in the position of a moral dilemma. No matter what one does, s/he is immoral. If s/he tries to do his/her duty and fails (which must happen if doing his duty is impossible), then s/he is immoral. If s/he ignores his/her duty, then s/he is immoral. For a discussion of the consequences of moral inconsistency for Kant (or similar systems) see Donagan, *The Theory of Morality*, op. cit., Chapter 5.

Related article: APPENDIX: MAJOR SORTS OF HEALTH PLANS AVAILABLE IN THE UNITED STATES AND IN OTHER WESTERN DEMOCRACIES

Types of Health Insurance in the United States

1. Traditional Indemnity Insurance. Under this type of coverage the policyholder pays an annual deductible and then is reimbursed under a co-insurance arrangement with the insurance company (usually 80%-20%). When the policyholder's expenses reach a "stop-loss" limit, the company pays 100% up to the limits of the policy (usually 1 million to 5 million). Coverage is available only for accident or sickness (pregnancy is generally treated as any other illness). In most cases there is no preventative care coverage. This sort of health insurance is quickly becoming obsolete. It is being replaced by the plans described below.

2. HMO. Health maintenance organizations (begun in the early 1970s) are either setup as full service centers (like Kaiser Permanente) or networks of physicians (like individual practice associations, IPAs). In either case the patient generally has no deductible except a small office payment (usually \$5 to \$20). Routine coverages are broader in an HMO. Every routine coverage that an indemnity plan covers is covered in an HMO with the addition of preventative care coverage.

In return for expanded routine coverages, the patient gives up some control of his or her health care choices. The primary care physician decides whether you need to see a specialist. If that primary care physician says "no," then you don't go. It is this "managed care" feature that makes HMOs more economical than indemnity plans. The economical advantages and broader coverages are balanced against less control over one's own health care decisions.

There are also some restrictions on who one sees for treatment. One must see a participating member of that particular HMO. If the doctor you want is taking no more new patients, or if you do not like any of the physicians in the HMO, then you are out of luck. This is another distinction from the traditional indemnity plans that allow you to choose any doctor who has a license to practice medicine.

Finally, managed care is generally more restrictive on the types of "big ticket items" it will pay for. Many exclude transplants all together. Most have annual caps on the amount of prescription drugs they will pay for. In a survey I did among twenty HMO's in the Washington, D.C. area the average prescription drug cap was \$3,000 per year. There are a substantial number of physical afflictions that require more than \$250 per month

(\$3,000 per year). The patient must make up the difference.

To offer a real incentive for cost containment, many HMO primary care physicians are given a "budget" that varies according to how many patients they oversee. If they are under their "budget," then they receive all or some of the difference. Thus, the physician has a financial interest in holding down the number of tests and expensive procedures s/he allows you to have.

3. PPO. The PPO is a variant of the traditional indemnity plan. In the PPO there is a list of participating physicians (much like the IPA-HMO outlined above). These physicians agree to charge predetermined prices to PPO patients. In return, they are listed in the directory and presumably get more business. The insurance company knows in advance what its costs will be. Whenever an insurance company can fill in an unknown figure with a known figure, its costs decrease. Thus a PPO is more economical than the traditional indemnity plan, but it is not as economical as the HMO.

Like the indemnity plan, the PPO does not cover preventative care. Like the indemnity plan there are more permissible "high ticket treatments" that are covered. And like indemnity plans there is the pre-existing condition clause.

Unlike the indemnity plan there is less choice. One must choose a physician in the network. However, there is no primary care physician. Virtually all choice for medical treatment lies in the patient's hands. Like the HMO there is generally no deductible--save for a modest co-payment for an office visit.

4. Point-of-Service Plans. Because patient empowerment/autonomy is so popular to consumers, many HMO and PPO plans now have an "opt out" feature. This means that if you don't want to use the HMO or the PPO, you can opt out of the plan and your health insurance becomes a traditional indemnity plan.

To encourage policyholders to use the HMO or PPO, insurance companies often add some restrictions to the opt out option. This is important to the insurance companies so that they can avoid "adverse selection." (Adverse selection occurs when two or more plans exist and there are incentives for the sicker members of the population to utilize one plan to the exclusion of the others.)

Health Insurance in Other Countries

The following two plans are the most popular alternatives to health care as practiced in the United States.

5. Government Run Health Plans. Many countries in the world have government run health plans. In these plans physicians are really employees of the government. They have a quota of patients for a practice and see people on their list whenever those people are in need of health care.

There are a number of attractive features in government run health plans: (a) there is universal, comprehensive coverage; (b) since physicians are employees of the government, the litigious malpractice climate is largely eliminated; (c) because physicians work on salary, they do not have to have their minds distracted with running a business and can concentrate on practicing medicine.

There are some disadvantages to government run health plans: (a) because physicians are employees of the government, their salaries are far less than those of private practice physicians. (Most countries with a government health service also allow physicians to see fee-paying clients.) Some say that this is a disincentive for the "best and brightest" to enter medicine and practice in the government health service. (That is, if we assume that high compensation is a critical incentive for people entering medicine as a career.) If the compensation incentive is correct, then a country with a government run health plan will have less able physicians than countries which rely upon private practice physicians. (That is, if we assume that the "best and brightest" make the best physicians.); (b) to lower costs, many physicians have large practices and this can lead to long waiting times to see doctors. This "clinic" atmosphere may discourage some from going to the doctor--even when they need to. They might not have an hour or two to sit waiting; (c) most countries that have government run health plans also have private practice physicians who are hired only by the rich. This creates a "two tier" health system. The average person may rightly perceive that s/he is getting a different level of care than the rich. In the United States, those with health insurance may be on a more "even playing field." (However, this disregards those who have no health insurance and are not covered by Medicare or Medicaid.)

6. Single Payer Plans. In a single payer model private practice physicians are maintained. They are paid by insurance. The difference is that there is only one insurance company: the government. With one payer there is only one set of regulations and guidelines. Sub-units of the country (provinces or states) are given health care "budgets" (much like the budgets mentioned above in the HMOs). Once one's budget has been exhausted there is severe pressure to limit further services (though further services are never completely "cut off.") If one's budget has money at the end of the year, the health care community may share in this surplus.

Like a planned economy in economics, the single payer system has the advantages of central control. Health policy can be uniform. Most theories of distributive justice promote treating "like cases" in the same way.

Like a planned economy in economics, the single payer system has the disadvantages of central control. Centrally controlled economies are less efficient. The converse suggests that "small," diverse, and competitive models are more efficient because they can adapt to market conditions more readily.

Many view the single payer system as having the advantages of government run health care (such as comprehensive universal coverage) without the drawbacks.

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