

Health Care as a Human Right

A Rawlsian Approach

by

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AUTHOR'S DECLARATION

I hereby declare that I am the sole author of this thesis. This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

Abstract

This thesis looks at fundamental disagreements about the role of society in the delivery of health care services. In particular, it develops an argument for viewing health care as a human right, and in doing so, argues that society is at least partially responsible for the health of its members. In the first section of the thesis, I argue that health is a human need, and that the institutional goal of health care is to restore to an individual their health. As an institution, health care is a primary social good and, as such, it ought to be afforded the same institutional protections as other primary social goods, and encoded as a “human right.”

In the second section, I tackle the “Difficult Costs” objection, noting that while there is high financial cost associated with the provision of health care services, the moral and social cost of not providing health care and viewing it as a human right far outweighs the financial costs. With another appeal to Rawlsian principles, by way of reflective equilibrium, I argue that the design of an institution is paramount to the cost-effective distribution of health care resources in accordance with the view that health care is a human right.

In the final section, I acknowledge that the objections to health care as a human right should be taken seriously, and that they form the basis of the limits to this right. I argue that any right to health care cannot be extended beyond the restoration of basic, species-typical normal human function. I acknowledge that the Rawlsian ideal has difficulty rendering decisions where priority is a central concern. Finally, I suggest that these limitations can be overcome when the right to health care is viewed as progressively realizable, in conjunction with other basic human rights.

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Finally, I must give all praise and glory to God for it is He who sustains me.

Ephesians 3:20-21

Dedication

To my youngest sister Abigail. I love you!

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Chapter 1

Introduction

There has been much debate in recent times, especially in political circles, about the nature of health care, the costs associated with it, and the obligations that the state and private industry have towards other persons with respect to their health. There is ongoing political wrangling surrounding a recent move by U.S. President George W. Bush, vetoing the extension of a bill put forward by the United States Congress intended to provide an expansion of health insurance for disadvantaged children living in poverty across the United States. Bush's primary justification, according to the New York Times, was that it was simply too costly and would add to the government rolls children who were living in situations that did not qualify as 'poor'.¹ The president vetoed a revised bill on December 12, 2007, with Bush claiming the same general concerns, along with the claim that a bill of this type moves the health care system in the wrong direction.² This debate is especially emotional for those Americans who will be intimately affected by the results of this legislation, especially those who fall in the affected zone of population, and those who will lose funding altogether when the current bill expires.

In Canada, health care is always in the news. Anytime there is an election, whether federal or provincial, health care is an issue of primary concern. The Canadian Medical Association recently published a well-publicized policy paper calling for reforms to Canada's health care system, arguing that, in its current state, it simply cannot meet the health needs of

¹ "Bush Vetoes Child Health Bill Privately," New York Times, http://nytimes.com/2007/10/04/washington/04bush.html?_r=1&ref=washington&oref=slogan (accessed January 6, 2008).

² "President Vetoes Child Health Bill again," CNN, <http://www.cnn.com/2007/POLITICS/12/12/bush.schip> (accessed January 6, 2008).

ordinary Canadians in a timely and efficient manner.³ Calling for greater involvement of the private sector in the delivery of health care to Canadians, the CMA's plan underscores the obligation society has to provide health care to all members of society, regardless of their socio-economic status. While the CMA's plan has many detractors, those who agree with the plan and those who disagree with it can and do agree that the health of Canadians is of utmost importance and must be taken seriously. Moreover, they also agree that the provision of basic health care to all Canadians is obligatory upon society. That is, every Canadian has a right to basic health care, and can expect to claim that right of society whenever she needs, without fear of being turned away for lack of financial resources.

Thus, we see two different ways of looking at health care. On one hand – the American one – health care is seen as too costly, and thus not worthy of extended funding or expansion to cover children whose parents do not fall below a certain 'poverty' threshold. Health care is seen as the responsibility of the individual and too many undeserving people on the government coffers signifies undue and illegitimate spending of taxpayer dollars. On the other hand – the Canadian one – while there are major disagreements about the delivery mechanism of basic health care, and the efficiency and timeliness of that delivery, there is agreement that health care *is* a societal responsibility, something that is a basic and vital need for all humans regardless of their socio-economic status. According to the first view, society is not obligated to provide basic health care services to everyone; on the second, health care is a right and all health care solutions must first begin with the basic fulfillment of that right.

³ *It's Still about Access: Medicare Plus* (Ottawa, ON: Canadian Medical Association,[2007]), http://www.cma.ca/multimedia/CMA/Content/Images/Inside_cma/Advocacy/MedicarePlus/still_about_access.pdf (accessed January 6, 2008).

This thesis will look at the nature of this disagreement. It will explore some of the primary arguments against the view that health care is a human right, and will show how each of these arguments are unsuccessful in dismantling claims that health care is a human right. Once these arguments have been dismantled, and the framework for viewing health care as a human right is in place, I will argue that the concerns of the detractors of “health care as a human right” should still in a salient sense be taken seriously and that they, in fact, form the basis of the limits to this right.

1.1 Outline

This thesis has three major sections. The first section deals with “first-principles” approaches to health care as a human right and concerns itself with libertarian, egalitarian, and self-interest based approaches to health care. The second concerns the difficult costs of providing health care, the most commonly heard objection to health care as a human right. The final section explores some of the limits which befall any justified human right to health care.

The first section, found in Chapter 2, will explore various theoretical approaches to health care and human rights. I intend to show that a variety of theoretical approaches to the complex relationship between right-holders and duty-bearers can be fused together to form a justified approach to health care as a human right. To start, I will tackle a challenge made by libertarians concerning the nature of human rights. On the libertarian view, only those rights which prohibit action against another are legitimate human rights. They argue that any rights claim which requires something beyond inaction from a duty-bearer is not a true right. Rights that prohibit action against another (e.g. the right to life, the right to property, the right

to freedom) are known as ‘negative rights’ and find their roots in classical liberalism. Rights which require action from a duty-bearer (e.g. the right to subsistence, the right to an education, etc.) are known as ‘positive rights’ and find their roots in early 20th century political action, and find codification in the world’s most recognizable human rights document, the *United Nations Declaration of Human Rights*. According to the libertarian, the negative/positive rights distinction is vitally important and serves as the dividing line between legitimate and illegitimate rights claims. I argue that this distinction is not as sharp or as decisive as libertarians make it out to be, and thus cannot serve as a good argument for the exclusion of health care as a human right.

Having dismissed the minimalist approach of the libertarian, I will discuss approaches by some recent rights theorists to ground a right to health care in prudential self-interest, with an appeal to vital human needs. I evaluate Norman Daniels’ appeal to species-typical functioning and fuse it to Brian Orend’s discussion of vital human needs to establish that our health is not just something that we *would like* to have, but it is, rather, something we *need* to have. I differentiate between health needs and health *care* needs, arguing that health care needs are a smaller class of health needs that concern themselves with the institutionalization of species-typical functioning. This institutionalization qualifies health care needs as primary social goods rather than natural primary goods, laying the appropriate groundwork for a liberal egalitarian justification for health care as a human right.

After establishing health as a human need, pursued by way of prudential self-interest - I make use of John Rawls’ principles of justice. I focus in particular on the difference principle, tying it back to a practical mode of distribution, found somewhere between moral principles and practical realities, arguing that the conceptual framework of equality-with-

priority-given-to-liberty is the best framework within which to pursue health care as a human right.

The second section, found in Chapter 3, deals with the difficult costs nevertheless associated with the just distribution of health care resources. I will outline the argument that the cost of providing health care to everyone who needs it is just too high; the provision of health care to all is simply unattainable, and thus the establishment of health care as a human right is unjustified. I will argue that the total costs of providing health care are simply unknown, and liable to be somewhere between what proponents of universal, free-for-all health care claim and what the detractors of health care as a human right claim. Moreover, there is evidence to suggest that many countries, such as Canada, Sweden, and the UK, which have taken the claim that health care is a human right seriously have not bankrupted themselves or their society. While it is not within the scope of this thesis to conduct an in-depth analysis of the successes and failings of each of these systems, or to suggest ways that they can be made better, I will suggest that the broad institutional framework recognizing health care as a human right has been successful and that this framework is worth taking seriously.

I will then argue that the moral, social and security costs of *not* viewing health care as a human right are too high. I will explore recent studies that suggest a strong correlation socio-economic inequality and poverty with ill health and will argue that the failure to provide adequate basic health care services to those with unmet vital needs is to renege on a very important social obligation, often with dire consequences.

Finally, I will suggest that the real culprit with the problem of difficult costs is institutional design. With another appeal to Rawlsian principles of justice as fairness, by way of reflective equilibrium, I will argue that the design of an institution is paramount to the cost-effective distribution of health care resources in accordance with the view that health care is a human right.

The final section of the thesis, found in Chapter 4, will acknowledge some of the limits to the right to health care. It will take into account the criticisms mentioned in the prior sections of the thesis, but will pay special attention to the problem of difficult costs. It will suggest that a right to health care does not guarantee to everyone that each and every ailment, scratch or scrape will be cured, or even that they will be evaluated with the same level of attention. What it does guarantee is that each and every person has a right to the level of health care required to meet their vital needs and restore, where possible, their bodies to species-typical normal functioning. This is predicated upon the argument laid out in the previous chapters, i.e. that just and fair institutional design will enable society to afford the costs associated with the return of our bodies to species-typical normal functioning.

One further limit to this right to health care, following from the discussion about just and fair institutional design, is that the right encompasses and includes access to basic health care services, *but it does not include anything beyond that*. That is, a person cannot claim, as a human right, health care that goes above and beyond the care required to restore them to the state in which their vital needs are met. Claims of that sort require justification over and above what a human right to health care can grant and, as such, those claims will not be the focus of this thesis.

Chapter 2

Framing a Rights Based Approach to Health Care

There are various theoretical approaches to rights talk, some of which are minimalist in nature, and others of which are broader and incorporate many different, sometimes competing, rights. However large the difference in scope between theorists, there is consensus around what the basic components of a right are. W.N. Hohfeld's analysis of claim rights, liberty rights, power rights and immunity rights provided much of the groundwork for contemporary notions of human rights.⁴ The common thread found throughout all four types of rights is that in, each case, there is always a claim being made from one person or group against another. Thus, at the core of a right is found *a claim to something*, something *that is owed* to the claimant. When A asserts their right to *x* from B, they are claiming that B is morally obligated to provide them with *x*. Jack Donnelly argues that rights are about the special relationships that are found between A and B, as a result of the claims on *x*. He explains, “‘A has a right to *x* (with respect to B)’ specifies a right holder (A), an object (*x*) and a duty-bearer (B) and indicates the relationships in which they stand as a result of the right... B stands under correlative obligations to A (with respect to *x*) and, should it be necessary, A may make special claims upon B to discharge these obligations.”⁵ It is the nature of these complex relationships which requires that rights be justified. If any claim is to be morally binding, it must be sufficiently backed up with sufficiently good

⁴ Brian Orend, *Human Rights : Concept and Context* (Peterborough, Ont.: Broadview Press, 2002), 272 p.

⁵ Jack Donnelly, *Concept of Human Rights* (London: Croom Helm, 1985), 25.

reasons. If there is insufficient reason for a claim to be made by A for x , from B, then B is under no obligation to provide x to A.

All rights theorists agree that claims, obligations, duties and objects are vital components of a right but, not surprisingly, not all rights theorists agree on the nature of these components. This chapter will seek to clarify the nature of these relationships, especially with respect to the claim that health care is a human right. I will begin by arguing that the minimalist libertarian approach to human rights is mistaken and cannot take into consideration the complexities of the relationships found between the right-holder and the duty-bearer. With a purely minimalist approach out of the picture, I will turn to a discussion of prudential self-interest and basic human needs, arguing that humans have basic vital needs that they cannot always provide for themselves, but it is within their self-interest to obtain. I will conclude the chapter by arguing that a liberal egalitarianism, patterned after John Rawls' theory of justice as fairness, provides the best conceptual framework in which to find the fulfillment of these basic vital needs and encode them as human rights.

2.1 The Libertarian Objection

The libertarian approach to human rights is characterized by its minimalist approach to rights language. In particular, the libertarian holds that the only legitimate rights are the so-called negative rights, with the primary right being the right to liberty. Using the language of claims and duties, Jan Narveson distinguishes between a negative right and a positive right. In the first instance, "A has a right against B to do x " means that "B has a duty to refrain from preventing A from doing x " and, in the second instance, "A has the right

against B to do x ” means that “B has the duty to assist A to do x .”⁶ Negative rights then, are simply about refraining from action. Narveson places the burden of proof on those who would argue in favour of positive rights, saying that they would have to specify exactly what a duty-holder would be responsible for providing and just how much of it ought to be provided. This gives rise to the possibility of exorbitant costs, making the enforcement of a positive right toothless, thereby compromising the worthiness of that positive right as an actual right. Negative rights, on the other hand, are said to be not subject to this problem, as they merely require the duty-bearer to do nothing at all. On this reading of rights and duties, the project of guaranteeing a right is concerned with ensuring that A is able to do x when she so desires without interference from B; thus the only right of consequence is the right to liberty.

This minimalist picture would have us hold that rights are only worth being called ‘rights’ when they do not impose on any individual the burden of excessive costs. Once the dichotomy between positive and negative rights has been shown to be a false dichotomy, the problem of excessive costs in the enforcement of a positive right will remain. I will therefore table the problem of excessive costs until the third chapter, where I will offer a solution to the problem of excessive costs in relation to a positive right to health care.

The minimalist picture of rights language would also have us hold that there is an actual dichotomy between positive and negative rights. Narveson claims that the distinction between the two is “a distinction in substance, not in form, and a distinction not in what we have the right to do by virtue of having one or another such right, but, rather, a distinction

⁶ Jan Narveson, *Libertarian Idea* (Philadelphia: Temple University Press, 1988), 58.

concerning which duties fall upon those against whom they are rights.”⁷ The conjunction of the potential unenforceability of positive rights and the fact that most (if not all) positive rights involve some kind of violation of liberty (that is, in order for B to fulfill his duty to A to assist her with *x*, B is required to take *y* from C, such that B will have the resources necessary to assist A with *x*) allows the libertarian to deny that positive rights are rights at all. The claim that the distinction is *substantive, and not merely incidental*, allows the libertarian to reason from the premise that negative rights are prior to positive rights to the conclusion that negative rights trump and overrule positive rights. On the libertarian view, no action done to fulfill a claim to a positive right is a duty; B is therefore not duty-bound to A when the rights claim requires B to do something. B is only duty-bound to A when the rights claim requires B to refrain from preventing A from gaining *x*, such that A’s liberty is respected to the greatest degree.

2.1.1 Responding to the Libertarian Objection

The distinction in substance is then predicated upon the fact that the fulfillment of a negative right requires inaction. Guaranteeing that it costs nothing is easy, as nothing is required. Liberty will always be respected, as no action is carried out and, as such, the other is not impeded from pursuing her goals. However, this is simply not correct. As I will show, the fulfillment of a negative right requires from the duty-bearer at least *some kind of action*. Moreover the enforcement of these negative rights must occur at a societal level, which carries with it societal costs of enforcement. Henry Shue argues that the characterization of the positive/negative rights distinction is *not* a distinction in substance, but rather a false

⁷ Ibid., 57.

distinction, as the enforcement of negative rights *requires* positive action. On Shue's view, the libertarian picture of inaction as a key feature of legitimate rights is simplistic, as it does not take into consideration the moral obligations which even negative rights carry.

The distinction between positive and negative rights depends upon action and inaction. Since rights of action are positive rights (Shue speaks of them as 'subsistence rights') and require action over and above those rights typically considered to be negative rights (Shue speaks of these as 'security rights'), those negative rights claim priority in terms of being fully guaranteed.⁸ The underlying argument is one of cost – guaranteeing and policing rights which require no action is cheaper and comes easier than guaranteeing a right which requires something of us. Yet the enforcement and guaranteeing of a negative right can itself involve positive actions. For example, take the well-known right to bodily security and life. This is a negative right, a right that prohibits others from killing us. But how can that right be secured without an appeal to a police force, a criminal justice system, lawyers, guards and the appropriate funding from taxes to support such a system? If the only legitimate right is the right to liberty (in this case the freedom to do what I wish with my own body, without fear of my body being compromised), that right will require *an infrastructure of enforcement*. While the libertarian may try to escape this, by showing that certain constraints on liberty may be in the best interest of liberty, she will still be forced to admit that *some* guarantees on liberty must be present, or the right to liberty falls prey to the same argument from unenforceability that she thinks is true of positive rights. Any infrastructure for guarantees (whether governmental or otherwise) is going to require action. Shue writes:

“The protection of negative rights requires positive measures, and therefore their actual

⁸ Henry Shue, *Basic Rights* (Princeton, N.J.: Princeton University Press, 1980), xiii, 231 p..

enjoyment requires positive measures. In any imperfect society, enjoyment of a right will depend to some extent upon protection against those who do not choose not to violate it.”⁹

It is important to note that just because there are positive components to all negative rights, it should not be assumed that positive rights are always and only about action and do not have any negative components to them. Shue argues that complex socio-economic decisions which have consequences for which no one in particular can take the ‘blame’ act as examples of how negative components factor into positive rights. He gives a thought experiment by way of a story in which economic decisions are made that have the unintended consequences of depriving some in society of sufficient subsistence. These decisions, made through the mechanism of private enterprise, where some individuals decided to act in a way that benefited themselves, so affected the economic landscape of the community (through non-interference with others) that they altered the ability of the rest of the community to pursue its goals. He argues that the consequences of the situation make the inaction no different from the impingement of the right to security of the person, a right that is normally considered to be a negative right. To reiterate, “the design, building, and maintenance of institutions and practices that protect people’s subsistence against the callous – and even the merely over-energetic – is no more and no less positive than the conception and execution of programmes to control violent crimes against the person.”¹⁰

It is, however, important not to conceive of all rights as being positive. Alan Gewirth presents a contrasting case between the protections that the American Bill of Rights gives to the freedoms of speech and religion, and the absence of any such negative legal rights

⁹ Ibid., 39.

¹⁰ Ibid., 45.

granted by the Chinese. This directs the way in which the American government acts with regards to speech and religion (it does not) while there is no directive for the Chinese government (and it does act with regards to those two items, often with devastating results).

Gewirth puts it all together in this telling paragraph:

“We may therefore distinguish three levels in the structure of the legal right to freedom of speech. First, there is the value of or interest in the free expression of ideas. Second, there is the negative right of freedom, that this value not be interfered with by government or others. Third, there is the positive right that governments enforce this prohibition of interference. It is the second level that provides the valuable rights content that the third level enforces. And it is this second level that differentiates the American from the Chinese situation. Without the second level we would simply have governmental acts of enforcement that, as such, do not distinguish the two situations.”¹¹

So it looks like the contention made by Narveson and others who want to keep positive and negative rights entirely separate is bogus. Quite simply, rights cannot be boiled down to one or two distinct things in one or two distinct categories to be dealt with in one or two distinct ways. Securing such a fundamental right as that of liberty involves much more than merely expecting others to follow the dictum of “Live and Let Live.” It means establishing a societal infrastructure that provides the enforcement of that dictum, even when it means that there are constraints on liberty that affect others. Orend writes, “if one defines the duties correlative to human rights in terms of a binary distinction between action and inaction, such a binary cannot be sustained.”¹² Contrary to Narveson’s claim, and the minimalist view of rights language, there is no substantive distinction between positive and

¹¹ Alan Gewirth, "Are all Rights Positive?" *Philosophy and Public Affairs* 30, no. 3 (Summer, 2001), 328.

¹² Orend, *Human Rights : Concept and Context*, 141.

negative rights, and any argument against a human right to health care predicated on that distinction will therefore fail.

2.2 Prudential Self-Interest and Vital Human Needs

With the libertarian challenge behind me, and the possibility of a positive right to health care in front of me, I am able to lay the groundwork for why we might think there is a human right to health care. One approach to the justification of health care as a human right is the appeal to prudential self-interest and vital human needs.

2.2.1 Prudential Self-Interest

One approach used to justify human rights is the argument that it is in our own best interest to respect and observe the claims which human rights make on us, not only as a society, but also as individuals. This approach takes the same general form as the golden rule, “Treat others as you would want to be treated,” though it adds the additional claim that doing so will be to your best advantage. James Nickel argues that it is prudent, in the view of most, to consent to follow and respect human rights because that will go a long way to assuring you that the things which you want in life (many of which are codified in human rights language) are respected. On his view, the best way to protect your own interests to life and health includes getting others to accept and comply with a system of moral norms that protects these kinds of interests for everyone.¹³ By encoding my interests, along with the similar interests of others, as moral norms and agreeing with others to treat them as such, complete with all the repercussions that come from the violation of these moral norms, I have reasonable assurance that these interests will be safe. Nickel argues that institutionalized

¹³ James W. Nickel, *Making Sense of Human Rights : Philosophical Reflections on the Universal Declaration of Human Rights* (Berkeley: University of California Press, 1987), 85.

moral education will see to it that the problem of free-riders on this system (that is, the violators of the encoded interests) will be reduced to a manageable minimum, ensuring that on the whole, my interests will be respected.

The form of this argument carries enormous weight when dealing with what James Nickel terms ‘fundamental interests’. Fundamental interests are those interests without which the ability to exist as a person, or the ability to express the central features of human personality, would be severely hampered.¹⁴ It should be noted that Nickel does not think that prudential self-interest gets us everything we need to make a rights claim,¹⁵ since anything at all could be construed to be something needed in one’s own prudential self-interest. Orend uses the example of a car in North America to illustrate this point. Knowing that owning a car can greatly increase my own self-interested aims and goals in daily living does not mean that I ought to extend the right to a car to just everyone at anytime.¹⁶ Rather, the argument from prudential self-interest carries most weight and allows for the extension into a human right when *fundamental* interests are involved, not just *whatever* interests I may have. I argue then, along with Nickel, that health care is a fundamental interest, for which the extension of a human right to health care would be in my own best prudential self-interest.

2.2.2 Vital Human Needs

It is not enough to claim that health care is a fundamental interest and work from there to develop a human right out of that fundamental interest. It still stands to be shown that health is so fundamental to all of us that it is something we just cannot live without. It

¹⁴ Ibid., 84.

¹⁵ Ibid., page 90.

¹⁶ Orend, *Human Rights : Concept and Context*, 80.

must be, in Orend's terms, a 'vital human need'. In his book, *Human Rights*, Orend provides some foundational arguments for holding that there are certain things which humans need. He holds that it is these needs which are the objects of our human rights, and that however these needs work themselves out in the way humans live their lives, they ought to be morally accounted for such that no one human being is deprived of these vital needs.

To begin, it is important to consider just what it means for something to be in our interest. Orend notes that it is more than just *taking an interest* in something. I take an interest in the game of hockey, and my favourite team is the Vancouver Canucks. However, when they lost to the New York Rangers in the Stanley Cup Finals in 1994, I was not so devastated that I could no longer function. Sure, I became emotional, and may even have shed some tears, but the loss was not something that cost me much more than my time, energy and attention. By contrast, when something is in my interest, it is very deeply personal and very emotional. When something is *in* my interest, it matters not just to my "pleasure meters", but it impacts the way I live my life and my overall well-being. That is, when something is in my interest, I am compelled to pursue that thing to the fullest extent that I can. If I fail to obtain that which is in my interest, *I will be harmed in some important way*.

Now, obviously, there are degrees when it comes to things that are in my interest. For example, it may be in my best interest to do well in school, and graduate at the top of my class, as that will provide me with the best opportunity to pursue my career goals. If I do not do well in school, my career options will be less than what they could have been, doing me some harm. However, the pursuit of good grades, in the interest of a good career, is not as

important to me as other needs, like food, water, basic clothing, shelter and things of that nature. These kinds of interests are known as vital needs. Orend explains: “To vitally need something is for it to be required to sustain one’s functioning as the very kind of creature that one is.”¹⁷ To be deprived of one’s vital needs is a grievous harm, as it impairs one’s ability to lead a minimally good life. It is in my interest to pursue and obtain, to whatever end possible, these vital needs.

2.2.3 Health as a Vital Human Need

David Wiggins argues that there are three things that someone would need to hold in order for that object to be a vital need. The first concerns the harm that the deprivation of that object would bring to the person’s very functioning as a human being. The second is that there be no acceptable substitutes for that object available, and the third is that the object is integral to that persons living a life of minimal value.¹⁸ Orend argues that there are five abstractly-defined objects that meet these requirements, forming the basis of the vitally basic needs all humans have.¹⁹ Each of the categories (personal security, material subsistence, elemental equality, personal freedom and social recognition) is broadly defined and can themselves contain many different objects, one object of which, I argue, is our health. Here I focus specifically sketching an argument that health is a vital human need.

Turning now to the literature on health care as a human right, I agree with Norman Daniels’ claim that a biological view of health care (as the restoration of normal, species-typical functioning) is a good foundation upon which to rest the right to health care. This

¹⁷ Ibid., 63.

¹⁸ David Wiggins, *Needs, Values, Truth : Essays in the Philosophy of Value*, 2nd ed. (Oxford, England: Blackwell, 1991).

¹⁹ Orend, *Human Rights : Concept and Context*.

view will show that health care becomes the object of our vital need to health, and that it is in our fundamental interest to institutionalize and morally codify as a human right.

Daniels' account views humans as a biological system with a level of species-typical functioning processes from which any deviance is cause for concern.²⁰ It is entirely scientific in nature, viewing the human being as an organism just like any other animal. In the same way as an elephant has some set of conditions that result in typical functioning processes, so do humans. Knowing what these conditions are and what a deviation from these conditions looks like, medical professionals are able to properly and adequately diagnose patients. Should some human being not meet the biological requirements of a species-typical functioning system, they can said to need care such that they are returned to a state of normal function.

There are two criticisms of this view that are worth mentioning, though they alone are not capable of dismantling this view as a basis for viewing health care as a response to inadequate normal functioning processes. The first is that this view has a difficult time accounting for the fact that humans are essentially social creatures, with a natural ability to acquire knowledge, communicate linguistically and co-operate with other members of the species. The second is that the biological view has a difficult time incorporating mental health issues. Many mental health problems are as much psychological as they are biological and thus it may seem that the biological model may not be able adequately to take mental health issues into consideration.²¹ The point, however, is not to construct a model of needs

²⁰ Norman Daniels, *Just Health Care* (Cambridge [Cambridgeshire]: Cambridge University Press, 1985).

²¹ Since Daniels' book was published in 1985, much work has been done in the field of philosophy of psychiatry. Paul Thagard argues, in a very recent working paper called "Mental Illness from the Perspective of Theoretical Neuroscience", that much of the mystery involved in mental illness can be

that will give us everything we want, but rather to show that there is some basic set of health needs common to all. These criticisms ought to be taken seriously, though they ultimately do no damage to the bottom line of the argument, as the argument concerns the baseline normal biological function of human beings. Daniels writes:

“It will not matter if what counts as a disease category is relative to some features of societal roles in a given society, and thus to some normative judgments, provided the core of the notion of species-normal functioning is left intact... My intention is to show which principles of justice are relevant to distributing health care services where we can take as fixed, primarily by nature, a generally uncontroversial baseline of species-normal functional organization.²²

All members of the human species have species-typical functioning processes. The design of the human species, based upon all the available biological data, determines what normal species-typical functioning is; it does not matter where in the world you live, or what your socio-economic status is, if you are a member of the human species, there exists an uncontroversial baseline of species-normal functional organization that you must meet in order to be a minimally functioning member of the human species. This is biologically basic to what it means to be human; the impairment of these processes has the effect of depriving a human subject of a good, meaningful existence at the most basic of levels.

explored using the methods of computational theoretic neuroscience. By exploring mechanistic approaches to brain activity, many of the psychochemical causes of mental illness can be isolated. Citing several experiments with regards to Schizophrenia (Cohen & Braver, 2002), Autism (Grosberg & Seidman, 2006) and ADHD (Frank et al., 2007), Thagard argues for the objectivity of mental illness as an example of biological malfunctioning. While mental health is made significantly more complex by the causal interactions of neural pathways, cognitive states, molecular biology and social realities, mental health problems are a genuine biological problem, and thus can be fully accounted for by a biological model of health.

²² Ibid.

How does this biological account of health as a baseline level of species-typical functioning match Wiggins' criteria? With regards to the first criteria, the deprivation of one's baseline health will quite clearly deprive a human subject of her ability to function as a human being. It is important to remember that the discussion does not concern just any cut or scratch, but instead views disease as impairment to the normal range of baseline human function. The impairment of normal, baseline biological function results in a human subject being unable to function in a normal manner, and thus meets the first criteria. The second criteria concerns acceptable substitutes for the object that is claimed as a vital need. It goes without saying that, due to the nature of our health, given that it is what makes humans work as biological animals, there is no acceptable substitute to a minimally functional, healthy body. The third criteria concerns the ability of the human subject to have a life of minimal value. Once again, the impairment of biological process is about the deprivation of a baseline human existence. It is impossible to live a life of minimal value if one's basic biological structure is not in proper working order. The search for food becomes almost irrelevant if one cannot get out of bed for health reasons. Acquiring proper shelter is a necessity of life that can be severely hampered if the state of one's health is such that mobility, communication, ability to obtain employment, and other prior necessities remain unfulfilled. As Orend says, health is "what you want, no matter what you want."²³

I have sketched an argument here for viewing health as a vital need. When viewed from a basic biological perspective, health meets all three of Wiggins' criteria as an object of vital need. Moreover, as I argued in 2.2.2, if health is a vital human need, it is also

²³ Orend, *Human Rights: Concept and Context*, 80.

something that is of fundamental interest. When viewed as both a vital human need and a fundamental human interest, there are sufficient reasons for thinking that it is within my prudential self-interest to claim the object of this need, even going so far as to encode it morally in such a way that others are bound to provide it to me, and I am bound to provide it to others. By encoding this fundamental human interest (note that it is not merely *my* fundamental interest) in prudential morality, by way of appeal to vital human needs, I have laid the necessary groundwork to develop more fully what it means to have a right to health care.

2.2.4 Health Needs and Health Care Needs

Having shown that health is a vital human need, it is important to consider whether there is any significant difference between health needs and health care needs. Madison Powers and Ruth Faden argue that a newer generation of bio-ethicists has largely abandoned the quest to establish health care as a human right, instead focusing on health and all that it entails. They write, “Insofar as the argument for a right to health care is based on equality of opportunity, health care no longer seems especially targeted as a candidate for being a right.”²⁴ The argument for health care as a human right based on the equality of opportunity is the account of health care that Daniels holds follows from his discussion of species-typical functioning biological function. While the argument I make in this thesis is not identical to Daniels’ specific argument, it resembles his argument closely enough that it is important to dispel the notion that a broader claim to health is the object of the human right, rather than the claim to health care. It is also worth noting that many of the criticisms of this newer

²⁴ Madison Powers and Ruth Faden, “Inequalities in Health, Inequalities in Health Care: Four Generations of Discussion about Justice and Cost-Effectiveness Analysis”, *Kennedy Institute of Ethics Journal*, 10, no. 2, (2000), 123.

generation of bio-ethicists are worth taking seriously, as they provide good reasons to think that the right to health care is a limited right, or at the very least, cannot be considered a thoroughly independent right, given current research on the social determinants of health. I will concentrate the present discussion on the establishing that health care is a human need and will consider these criticisms in more detail in Chapter 4.

In 2.2.2, I highlighted the difference between taking an interest in something and something being in our interest. I noted that if something that is in my fundamental self-interest fails to obtain, I would be harmed in an important manner. Daniels argues that the same sort difference holds between the kinds of objective criteria used to determine the needs that we have. The objective criteria used to determine needs is based not on preferences that people have, but rather upon the criteria established by the requirements of normal species functioning. As an example, Daniels claims that he would be more likely to help a friend in need of medical therapy (given his friend's lack of funds) than he would help his friend to purchase an expensive woodcut.²⁵ Few would disagree with this judgment, knowing that there is a greater moral weight placed upon the need for physical or psychological help than there is upon the aesthetic need for a new piece of art to hang in the living room. That greater moral weight exists because the basic vital health needs that are within our prudential self-interest are requirements for a life of minimum value. That is, these needs are objectively necessary because without them it would be impossible to carry out any desired life plans. There is, Daniels claims, wide agreement on the importance of meeting needs required for normal species functioning because people have a fundamental interest in

²⁵ Norman Daniels, *Just Health: Meeting Needs Fairly* (Cambridge, UK: Cambridge University Press, 2007), 33. (Page numbers refer to the circulated draft)

maintaining a normal range of opportunities within which to pursue their lives.²⁶ This is consistent with Wiggins' criteria for something to be considered a vital need, in that a life of minimal value is a life that has a minimum level of normal opportunities available for pursuit.

Armed with the claim that health needs have more objective moral weight than do other needs, Daniels reiterates the claim that health is a need, and more specifically, that health care is a need. In developing his argument, he notes that health care is a narrower class of needs than are health needs, a class of needs that is intrinsically tied to the species-typical functioning needs that humans, as biological animals, have. Indeed, when developing a list of basic health care needs that include, among other basic medical needs, appropriate distributions of the social determinants of health, Daniels argues that the list of needs is not constructed to conform to what we already *think* of health care needs, but rather to broaden the approach to health care. It is important to recognize that health care does not merely involve all the medical services that are normally included in the usual definition of health care, but it also includes “the quite diverse goods, services, and institutions that bear on health and its distribution.”²⁷ In effect, while health needs and health care needs, at times, may be different in scope, they cannot be divorced from each other. Health care, in particular, is concerned with the application, institutionalization and allocation of specific health needs, without neglecting to consider all the various factors involved in how species-typical biological function came to be impaired.

²⁶ Ibid., 35.

²⁷ Ibid., 42

Given that health needs and health care needs cannot be divorced from each other, the claim that health care is the object of our human right is contentious. In particular, how does one justify the moral encoding of health care needs, while leaving health needs open to be dealt with in other ways? In the section that follows (2.3), I will make use of John Rawls' principles of justice to establish health care as a human right, with special appeal to the social primary goods. It is important to note that Rawls' list of social primary goods consists not of natural goods but rather of institutions and opportunities. He writes, "This list includes mainly features of institutions, that is, basic rights and liberties, institutional opportunities, and prerogatives of office and position, along with income and wealth. The social bases of self-respect are explained by the structure and content of just institutions together with features of the public political culture..."²⁸ Indeed, when it comes to health, Rawls appeals to the institutional properties of health care with reference to his list of social primary goods, where the "aim is to restore people by health care so that they are once again fully cooperating members of society."²⁹ Thus, an appeal to health needs, taken as a whole, would include appeals to natural primary goods that are dependent, in part, on a natural lottery. The institution of health care, on the other hand, I argue, is an instance of a social primary good, and is thus governed by Rawls' principles of justice.

2.3 An Egalitarian Framework

After having established that health is a vital need, and a fundamental human interest which is prudently worth encoding in morality, and that health care is a subset of that vital need, there is only a short leap to be made in order to claim health care as a human right.

²⁸ John Rawls, *Political Liberalism* (New York, NY: Columbia University Press, 1996), 181.

²⁹ *Ibid.*, 184.

However, this short leap is not justified without sufficient argument. Here I propose a liberal egalitarian framework in which it is possible to accept health care not just as a vital need worth encoding in morality, but also as an actual human right. In this section, I will focus primarily upon a theory of justice proposed by John Rawls, in which fairness and equality are the central moral notions. I will briefly outline his theory and show that it is the best framework in which to see health care as a human right. I will defer an argument concerning the application of Rawlsian theory, and his notion of reflective equilibrium, to the next chapter.

2.3.1 Justice as Fairness

Rawls' contractarian approach to the principles of justice proceeds from a pre-societal state of nature. His thought experiment requires imagining an original position where the point is to make important decisions for the future of society. This original position places us behind a veil of ignorance. Those behind the veil do not know their social status, nor do they know anything about them that would make them unique. They do not know their economic status, whether they are male or female, their race, their place of residence, or any other data that might otherwise cloud their judgments of what a just society might look like. Rawls suggests that society would come out of this original position with two principles of justice. The first, the Principle of Liberty, is familiar. It states: "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."³⁰ The second principle is the most discussed, and contains two parts, which are sometimes separated in the literature into two distinct principles. The first part

³⁰ John Rawls, *Theory of Justice*, Rev. ed. (Cambridge, Mass.: Belknap Press of Harvard University Press, 1999), 53.

guarantees that “social and economic inequalities are to be arranged so that they are to the greatest benefit of the least advantaged, consistent with the just savings principle,” and the second part guarantees that “social and economic inequalities are to be arranged so that they are attached to the offices and positions open to all under conditions of fair equality of opportunity.”³¹ It is worth noting that those behind the veil of ignorance are importantly assumed to be rational persons capable of differentiating between their own ends and the ends of others. In 2.2.1, I argued that persons are capable of determining what is in their best prudential self-interest; rational persons would understand that the best way to ensure that their fundamental interests were respected is to encode them in a morality of sufficient strength to ensure that each individual’s common fundamental interests were protected. In Rawls’ Principles of Justice, we find that rational persons would come to a similar conclusion as Nickel, Orend, Daniels, Gewirth, etc: that they would choose a society in which they could pursue their own ends, but a minimum level of basic existence requires at least a minimum level of health care. Just as persons have prudential self-interest in the things they value most, they are aware that they would best be served if a minimum level of health care were guaranteed to all.

These principles of justice govern the distribution of primary social goods, which are the necessary objects that anyone would need before they could pursue any of their own personal ends. These are very similar to the vital needs discussed in 2.2.2, as they concern the basic things that human beings must have access to, in order to be able to lead a meaningful existence. Without liberty, opportunity, a basic subsistence income, and a stable, secure society (the list of primary social goods given by Rawls), it is hard to see how anyone

³¹ Ibid., 53.

could pursue any of their own ends or personal goals at all. Thus, argues Rawls, the principles of justice allow *these social goods to be built into the fabric of society* in such a way that each agent can pursue his own ends and do so with the confidence that he will not be unreasonably deprived of the ability to do so. These social goods are in the interest of all members of society; no rational agent under a veil of ignorance would choose to deny these social goods to any member of society, lest they wind up as that deprived member, once the veil is lifted and they discover their own social situation.³² The primary social goods, as I noted in 2.2.4 not natural goods. They do not depend on luck or on a natural lottery, but are goods that society maintains through the regulation of institutions. If health is a fundamental interest and vital human need, and there are prudential reasons to encode it morally in such a way that others are bound by obligation to provide each other with a basic minimum level of health, then any social institutions that govern or distribute these basic species-functional health needs, take on the nature of primary social goods, and are, therefore, governed by Rawls' principle of justice.

How then does Rawls' approach allow for the codification of health care as a human right? Thus far we have seen that there are prudential reasons to value health. It is a fundamental self-interest, and a vital need, without which meaningful existence becomes impossible. In addition, health is something that is in the interest of all human beings. That is, it is not only within *my* prudential self-interest to have a basic level of health, allowing for a minimum level of normal human function, but it is in the interest of *every* human being to have that same basic level of health.. It is in the self-interest of all, no matter their socioeconomic status or any other social influences, to have their health. Rawls' difference

³² Ibid., 84.

principle is a principle that reasonable people would agree to, (provided the Principle of Liberty was also in place) and would ensure that that the institutions responsible for providing basic levels of health structured to the benefit of the least advantaged. Orend captures the force of Rawls' approach thus: "There is no way, Rawls insists, that any reasonable agent would run the risk of not having primary goods, not having the all-purpose means needed to pursue other things in life. A life without primary goods is no life at all... Rawls concludes that the agents [in the original position, under the veil of ignorance] would agree to structure a society so that everyone, including the worst off, gets primary goods."³³

If these primary goods are so important to a basic level of meaningful existence, then it is fair to think that these primary goods are the objects of our human rights. Health is not, in and of itself, distributable in the same manner as income, opportunity, liberty or security. It is not an external object or otherwise externally distributed and secured, but rather it concerns the nature of biological humanity. In this way, health is conceived differently than the social primary goods; my basic level of biological health does not completely depend upon the actions or inactions of others. If health itself were the object of our human rights, we would have the right to be free of disease at all times. Yet this is unreasonable, as disease and poor health are inescapable features of being human. Moreover, the discussion has centered on a basic minimum of biological species-typical functioning, the prudential fundamental self-interest in having a basic functioning body, and the vital need for all human beings to have a body capable of a life of minimal value. While an individual's health cannot be completely guaranteed due to its uniquely individual biological nature, health care needs as externally distributed objects and institutions, are social primary goods, governed by the

³³ Orend, *Human Rights : Concept and Context*, 84

principles of justice, and can be guaranteed, at least in so far as they serve to aid human beings to obtain the basic minimum of health required to lead a minimally decent life.

2.4 Chapter Summary

This chapter has considered various theoretical approaches to human rights, and in particular, has argued for an egalitarian framework in which to ground health care as a human right. I have argued that the libertarian objection to positive rights of any kind fails, as there is no substantive distinction between positive and negative rights. Instead, rights with a generally positive character rely on negative components in order to be reasonably effective, and vice-versa. There is no difference in kind between the two, rather, both are required elements needed to realize any one given rights claim.

With a minimalist argument against health care as a human right out of the way, I turn to discussions of prudential self-interest. I argue that health is a fundamental self-interest that we would all seek to preserve for ourselves, even going so far as encoding it into morality in order to assure ourselves that we can have access to it. Moreover, health is a vital human need. Fusing Norman Daniels' approach to health as a species-typical biological functioning with Orend's account of vital human needs, I conclude that health meets David Wiggins' criteria for something to be considered a vital need. Finally, I argue that Rawls' theory of justice as fairness provides the tools within which one can understand the social significance of the concept of prudential self-interest and vital human needs. Not only does the theory recognize the priority of liberty and the primacy of choosing one's own ends, it also recognizes that a fair and equal society is a society that ensures that all the necessary primary social goods, of which health care is one, are distributed in an equitable manner.

Claims to the provision of health care services, taken by themselves, cannot sufficiently meet the criteria for valid rights claims. However, when various frameworks are fused together, it becomes clear that at least a basic minimum of health care is a legitimate rights claim. Not only is it within our prudential self-interest to provide these services to others when requested, but health is a vital human need without which a meaningful, decent existence would be impossible. A conceptual framework that recognizes the primacy of liberty and the utmost importance of equality in the distribution of primary social goods completes the picture and allows for the justified claim to health care as a human right.

Chapter 3

The ‘Difficult Costs’ Objection

Having established a justified rights claim to health care based on vital human needs, prudential self-interest and justice as fairness, it is important to consider an important objection to the legitimacy of such a rights claim. This objection, known as the ‘difficult costs objection’, holds that, while there may exist some justified claims to health care, these claims are not legitimate due to the high costs that the implementation of such a right would bring.

This chapter will seek to take this objection seriously, offering a brief explanation of the argument behind it. I will then argue that, while there *are* significant costs associated with the delivery of health care, the total costs are simply unknown; to deny the provision of basic health care services based on the costs objection, without making use of the resources that *are* available, is to deny individuals the opportunity to pursue their interests and live a life with a minimal amount of decency and value. Moreover, the costs associated with the failure of society to provide basic health care services are even higher. Pointing to recent studies that show a connection between socio-economic inequality, poverty and poor health, I will argue that the failure to provide basic health care services is a moral failure with significant social costs, costs that a society structured around the principles of justice as fairness would find unreasonable.

I will also argue that overcoming the costs objection has more to do with institutional design than it has to do with the rights claim itself. I will provide an example of a nation, Canada, that has structured their society in such a way as to meet and surpass the basic needs

model of health care delivery. While I do not intend to examine Canada's health care system in-depth, or to analyze its deficiencies, I will argue that its existence and successes show that the difficult costs objection is not a valid reason to deny the legitimacy of rights claims to basic universal health care services.

Finally, this chapter will consider a theoretical approach to institution design aimed at synthesizing the practical problems of health care resources distribution and the first principles approach to 'health care as a human right'. Appealing once again to John Rawls, I will argue that his concept of reflective equilibrium will allow health care policy makers, and the designers of social institutions, to design the institution of health care in a manner which admits and respects the human right to basic health care services, all the while being sensitive to the practical problems confronting the distribution of those resources.

3.1 The Objection

Opponents of 'health care as a human right' will often point to the high costs of the distribution of health care resources as a major flaw in the argument. Robert Rhodes writes: "One ought not take long to dispense with the notion that health care is a human right... Health care organizations would be depleted of their resources very quickly if we took seriously a right to health care."³⁴ Quite simply, the costs associated with the distribution of health care resources, and the costs of those resources themselves, far outweigh the ability of institutions to provide universal health care services to the citizens of a particular society. Some argue that most of the costs of health care must be taken from other, non-health care

³⁴ Robert P. Rhodes, *Health Care Politics, Policy, and Distributive Justice : The Ironic Triumph* (Albany: State University of New York Press, 1992), 19.

sources, resulting in an unjust appropriation of funds from other worthy social services, some of which may be even more fundamental to the human condition than the provision of health care.³⁵ Examples of such social services include appeals to education, basic nutrition, basic sanitary services, shelter and the like. When the costs for the provision of health care are separated out from costs associated with these services, it is thought that these costs are disproportionate to the costs of other basic services, placing an undue burden upon society. Health care, while an important part of human existence, is not important enough, or fundamental enough, to justify such expenditure of resources.

Those who oppose the human right to health care based upon the difficult costs objection do not typically claim that health care is unimportant, or that it is not worthy of discussion with regards to the cost-effectiveness of health care solutions. Rather, they argue that it is important to find ways to ensure that health care is distributed in the best and most cost-effective way possible, often referring to the concept of Quality-Adjusted Life Years (QALY's) to do so. On this approach, health care is distributed according to the measurement of additional life years, adjusted for quality. Value is attached to a life according to the number of years gained after a procedure, with one extra year of healthy life expectancy having a value of 1, and an unhealthy year of life expectancy to have a value less than one.³⁶ In this way, physicians and health care distributors are able to analyze cost-effective procedures for a patient, choosing the procedure or treatment which results in the best number of QALY's. Keeping costs down is a priority, with some patients being rejected for necessary treatments because the QALY's are not sufficiently high to justify the cost of

³⁵ Paul T. Menzel, *Strong Medicine: The Ethical Rationing of Health Care* (New York: Oxford University Press, 1990), 123.

³⁶ Walter Glannon, *Biomedical Ethics* (New York; Oxford: Oxford University Press, 2005), 151.

the procedure. This approach does not deny the importance of health care services, but it cannot admit that health care is a human right, as the human right approach could prove to be too costly, requiring providers to administer treatments that fall well below cost-effective levels when compared to the QALY's gained by a patient.

3.2 Responding to the Objection

The objection to health care as a human right by way of difficult costs is worth taking seriously, as it admits that even things society deems to be important cannot be fully secured if the costs are too high. At the beginning of Chapter 2, I argued that the division of rights into positive and negative, in order to avoid the costs issue, was a fallacious division and could not serve as ammunition for the opponent of health care as a human right. However, the objection still carries force, arguing that very costly things for which there are a limited amount of resources cannot be properly called a right, as that morally *commits* society to the provision of those things, despite the potentially devastating costs. I argue here that not only are the total costs unknown, but the moral and social cost of *not* providing health care and viewing it as a human right far outweighs the financial costs incurred by providing it.

3.2.1 Unknown Costs

It is important to remember that the object of the human right to health care is not the provision of care for every single ailment, itch, scratch or scrape. Rather, the object is the return of normal, species-typical biological function to a human being, such that she is capable of pursuing her own ends and living a life of minimal decency. In light of this fact, it seems unwise to make a broad, sweeping claim, as did Rhodes, that viewing health care as a human right will automatically bankrupt the providers of health care services. Rather the

claim that health care is a human right is worth evaluating in light of the possibility of high costs, and decisions about resource allocation ought to be made in light of those evaluations. In like fashion, claims about the cost-effectiveness of treatments with reference to QALY's seem to miss the point that viewing health care as a human right does not mean that any and all medical issues are to be human rights issues. As we will see later in this chapter, cost-benefit analysis often has unintended consequences that go against our intuitions about human life, and the deeply held commitment to basic living standards. Thus an argument against 'health care as a human right' based on costs will not hold unless the critic is able to clearly and completely delineate exactly how expensive providing basic health care to all is and, more importantly, the argument will not be complete without an explanation why the threshold for costliness in the implementation of human rights falls below that line. I suggest then, that the argument against health care as a human right based on costs be evaluated not on an absolute total cost of providing health care, but rather based on what the cost of *not* providing such services will be. In addition, claims about cost require empirical discussion of current systems and their overall costs. If 'health care as a human right' is too costly to implement, it seems reasonable to assume that there are no such systems currently in place. I will show in 3.3 that this is not the case, and will conclude then there is no merit to the claim that basic health care is too costly to enshrine as a human right. Some countries have actually done this and the cost has not bankrupted them.

3.2.2 The Social and Moral Costs of Not Viewing Health Care as a Human Right

Taking this objection seriously requires that the costs associated with *not* viewing health care as a human right be considered as well. These costs, I will argue, are higher and

more difficult; they result in moral and social problems that reach far beyond what is quantifiable in terms of economic resources.

One recent study has drawn a definitive link between poor health and socio-economic status. Richard Wilkinson's 1992 study shows that there is a direct correlation between the amount of income inequality in the shares of income and the average life expectancy of that society. While absolute size of the economic pie mattered very little, the degree of income inequality mattered very much. Further studies have also shown a correlation of income inequality with infant mortality rates in developing countries. This was achieved by comparing infant mortality rates in more equalized developing countries with infant mortality rates in less equalized countries.³⁷ It has also been shown that income inequality plays a forwardly causal role in ill health. That is to say that, when an individual or group of individuals is in a position of lower socio-economic status, they are more susceptible to a wider variety of illnesses and health abnormalities. Lower levels of education, result in an inability to care properly for the body and keep it at a species-typical, biologically functioning state. This forwardly causal role of socio-economic inequality also negatively impacts the accessibility of the institutions concerned with meeting health needs for those of a lower socio-economic status. This diminished ability to access health care results in complications to untreated ailments, leading to greater and longer-lasting serious health effects, among many other consequences. The study concluded that income inequality is a *direct cause* of lower life expectancy and acts as a good predictor for the levels of health over a population in that society.

³⁷ Richard G. Wilkinson, *Unhealthy Societies: The Afflictions of Inequality* (London ; New York: Routledge, 1996), 59.

Wilkinson also argues that the data points squarely towards the fact that those who are born into a lower socio-economic class and work their way up into a higher class are less healthy than those who start out in a higher socio-economic class and work their way up a comparatively similar amount. Even those who start out in a higher class and move downwards in socio-economic status are healthier, all things considered, than those who start out in a lower class.³⁸ What the data clearly shows is that socio-economic inequalities play an important negative role in the overall health of a society. Moreover, socio-economically equal societies do significantly better, health wise, across the total population.

Socio-economic inequality has a significant negative role on the overall health of a population. When a society is structured and designed with equality in mind, as is a society structured in accordance with Rawls' principles of fairness, that society is healthier with higher life expectancies and lower infant mortality rates. When the basic vital needs of human beings are met, they are able to pursue their own interests, without being unduly inhibited by a lack of access to necessary resources to do so. The financial burden of a society with significant socio-economic inequality may not be very high, but the moral and social costs are much higher.

In a society that values equality, people have a greater ability to pursue their own interests and contribute positively to society, whether through economic means or social ability. When an individual spends their life worrying about how they will afford to pay for basic levels of health care, the basic levels required to keep a species-typical, biologically functioning body, they are unable to care for and educate themselves or their children in a

³⁸ Ibid.

manner allowing for positive contribution to society. They are instead forced to worry about their own life expectancies, the possibility of losing their families to preventable and treatable illnesses, worrying about how they can maintain the level of income and education required to prevent such illnesses from occurring. Socio-economic inequality, with its negative effect on health, results in the inability of an individual to properly pursue his or her interests. Not only does it deprive the individual of that which is in her fundamental self-interest, but also that deprivation is causally related to the inability of that individual to live a minimally decent life.

The moral and social costs of not providing a minimally basic level of health care are thus very high. Not only are life expectancies reduced and infant mortality rates increased when there is socio-economic inequality in the distribution of resources, but the effects of that inequality cause a decrease in the individual's ability to contribute to the betterment of society. When something as fundamental to human life as health is not equally provided in a manner that allows for the exercise of personal liberty, a society that places a premium upon liberty will be unable to fully function at an optimal level. Not only does socio-economic inequality inhibit fully functional healthy human development, but it also indirectly inhibits liberty and the individual's ability to pursue her own ends.

3.3 Canada as an Example of a Successful Health Care System

With the recognition that the liberty of the individual is primary, and the understanding that socio-economic inequality negatively impacts fully functional and healthy human development, there is good reason to think that the costs associated with the implementation of a health care system which views health care as a human right are

acceptable costs. Those who continue to maintain that the costs are still too excessive need only look at several successful health care systems that have been implemented around the world. They provide examples of systems that essentially view the continued health of a fully functional human being as a human right, without excessive costs. Indeed, many publicly-funded systems around the world provide a far more comprehensive health care package which is required by the appeal to health care as a human right, and they do so without incurring the wrath of their citizens, and without excessive, inefficient or generally wasteful spending. In the interest of space and brevity, I will consider only the Canadian health care system as an example of a health care system which views health care as a human right.³⁹ The following should not be taken as a blanket endorsement of everything within the Canadian system, but rather as an example of an existing health care system that is not overly costly, and adheres, generally speaking, to the view that health care is a human right.

The Canadian commitment to universal health care is enshrined in the *Canada Health Act* and has, as its primary objective, a commitment to Canadians that the government of Canada will “protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers.”⁴⁰ The *Canada Health Act*, enshrined in law in 1965, directs the allocation of government resources to health care insurance providers (the provincial governments), based on five guiding principles which together entail a commitment to the view that health care is

³⁹ It is important to note that Canada is not the only country in the world that has a health care system committed to ‘health care as a human right.’ Other examples worth noting are the United Kingdom, Sweden, Japan, and France, among others, all of which feature, to varying degrees, publicly funded, universally accessible health care systems focused on the return of species-typical human function.

⁴⁰ *Canada Health Act*, (1985): C6-3, <http://laws.justice.gc.ca/en/ShowFullDoc/cs/C-6///en> (accessed January 6, 2008).

a human right. The first principle is that the provincial health insurance plan qualifies for federal transfer of monies if the health insurance plan is *publicly administered*. The second is that the provincial health insurance plan is *comprehensive*, ensuring that many medical services are covered under the health insurance plan of that province. The third is the principle of *universality*. This principle ensures that 100% of the persons insured by the provincial plan have complete access to the system and all of its services, as outlined by the principle of comprehensiveness. The fourth is *portability*, which ensures that the waiting period for acceptance to the provincial plan is, at maximum, three months. It also ensures that any resident of that province has coverage to equal services when visiting other provinces. Thus, any Canadian who has relocated from one province to another is still covered by the province they left for the duration of the waiting period. This principle also ensures that new Canadians, provided they have been in residence for three months or more, get access to the provincial health insurance plan. The final principle is that of *accessibility*, which ensures reasonable access to all necessary medical services for all those covered by provincial health insurance plans.

Canada's health care system is designed in such a way as to ensure that *everyone, regardless of residency, income level, or other socio-economic disability is assured of reasonable access to health care and reasonable care by medical professionals*. The system is publicly administered by each of the provinces, with funding from the federal government in order to maintain a level of accountability in fulfilling this goal among health care service providers, without discrimination based on age, sex, socio-economic status, or ability to pay.

There has been serious criticism, for instance, by the CMA, leveled at the Canadian government for disallowing explicitly for-profit health care providers. Though the private-public debate is of particular interest to Canadians, I will not spend much time on it here; I wish only to draw attention to fact that the CMA, while frustrated with the perceived rigidity of the Canadian system, still recognizes that publicly funded baseline health care is necessary for Canadians: “The CMA supports the concept of a strong publicly funded health care system where access to medical care is based on need and not on the ability to pay.”⁴¹ Thus, even medical professionals who are detractors of the Canadian system are committed to providing universal coverage for all Canadians through the public coffers, recognizing that medical care is something that is a necessity for the upkeep of species-typical human function.

But what of cost? It is clear that the structure of the Canadian system allows it to go above and beyond the basic view of health care as a human right. It is structured such that everyone in Canada has reasonable access to basic health care services and more, without worry of financial strain at the point of delivery and without leaving it to the individual to purchase their own personal health insurance at costs they may be unable to afford. One survey of the Canadian health care system, when compared to the American health care system, shows that the gap in total health care expenditures, per country, is increasing. However, the cost of health care in the United States is rising faster than the cost of health care in Canada. In 1971, when the health care systems were similar, health care costs (as a share of national income) were virtually identical, at 7.4% in Canada, and 7.6% in the U.S.A. As the Canadian system evolved, cost of health care rose in the United States, while

⁴¹ *It's Still about Access: Medicare Plus*, 3.

remaining stable in Canada. By 1981 their spending shares were 7.7% (Canada) and 9.2% (U.S.A.) and by 1989 Canada was at 8.6% while the United States was at 11% of the national income.⁴² The trend of difference in spending shares continues, with Canadians spending 9.3% and the United States spending 13.6%, as recently as 1999. In that same year, Americans spent \$4,090 per capita on health care, while Canadians spent \$2,340 per capita on health care.⁴³ According the World Health Organization, Canada's share in 2004 was 9.8%, while the United States spent 15.4%.⁴⁴ It is interesting to note that it is not that Canadians spend so little on health care, as they consistently rate among the highest spenders per capita in the world, but rather it is that the United States spends so much.

The authors of the 1989 study claim that one of the major ways that the Canadian system is able to better control costs is due to the administration and prepayment expenses that factor in to health care in the United States. In 1985, the overhead component of health insurance (that not given to physicians, hospitals and other direct medical providers), cost Americans \$95 out of their overall \$1,710 per person, while Canadians spent \$21, in Canadian dollars. In 1985, Canadians spent less to administer their universal comprehensive health care system than Americans did to administer Medicare and Medicaid alone.⁴⁵

The Canadian tax-financed system is not only less costly to administer, but the cost is felt by consumers differently than in the United States. In the United States, insurance rates

⁴² Robert Evans and others, "Controlling Health Expenditures - the Canadian Reality" In *How to Choose? A Comparison of the U.S. and Canadian Health Care Systems*, eds. Robert Chernomas and Ardeshir Sepeshri (Amityville, New York: Baywood Publishing Company, 1999), 12.

⁴³ Robert Evans and Noralou P. Roos, "What is Right about the Canadian Health Care System?" *The Milbank Quarterly* 77, no. 3 (1999), 395.

⁴⁴ "Core Health Indicators," World Health Organization, http://www.who.int/whosis/database/core/core_select_process.cfm?countries=all&indicators=nha (accessed January 6, 2008).

⁴⁵ Evans and others, *Controlling Health Expenditures - The Canadian Reality*.

are essentially regressive – the cost of insurance premiums is similar for everyone, regardless of income, resulting in the highest burden of cost falling on those with the lowest incomes, while those with the highest incomes have a relatively low burden of cost. In Canada, where the health care system is funded by progressive tax, tax-payers pay varying levels of tax according to their income, resulting in a more equitable distribution of costs.⁴⁶ This results in greater socio-economic equality, which is, as was argued in 2.2, a contributing factor to the overall health of a country.

One critic of the view that Canada's health spending is significantly less than that of the United States due to their universal health care coverage, argues that the real GNP growth differences in the two countries brings Canada's rising health care costs in line with the United States. Adjusting for inflation, Neuscheler charges, that beginning in 1968, Canada's economy grew faster than the United States, for a sustained period of 9 years. Over a 20 year period, (1967-1987), Canada's real GNP grew 74%, while the United States only grew 38%.⁴⁷ This accounts for the differences in spending, allowing Canadians artificially to keep costs down when compared to their southern neighbours. Even if this criticism holds, I still have license to make the claim that universal health care coverage is not too costly, at least when compared to the health care expenditures of the United States . If Neuscheler is correct, and spending increases at the same level in the United States and Canada, along with the increased efficiency in administration costs, Canada's public system demonstrates that

⁴⁶ Milton Terris, "Lessons from Canada's Health Program," *Journal of Public Health Policy* 11, no. 2 (Summer, 1990), 152.

⁴⁷ Edward Neuschler, "Debate on U.S./Canadian Health Expenditures: A - How Well is Canada Doing?" In *How to Choose? A Comparison of the U.S. and Canadian Health Care Systems*, eds. Robert Chernomas and Ardeshir Sepehri (Amityville, NY: Baywood Publishing Company, Inc, 1999), 60.

there is no reason to suppose that viewing health care as a human right would be too costly. If all the people in Canada have access to more than the baseline level of health care services at the same relative cost as the United States insures less than 90% of their population, it would seem that the cost of universal, comprehensive, baseline health care coverage is not too costly.

3.4 Reflective Equilibrium

With real world examples to show that the costs of providing basic health care are not excessively prohibitive, it is worth exploring one possible reason behind their success. I suggest that the reason countries such as Canada have been successful at providing universal health care services is because their health care institutions have been designed in such a way as to ensure that inequality exists only to the advantage of the least well off, provides the best opportunity for the exercise of liberty and, in doing so, have found a way to ensure that the species-typical biological function remains at optimal levels. That is, the institutional design of their respective health care systems, despite their differences, draws on the practical realities of cost-effectiveness in health care delivery, as well as a commitment to the first principle appeal to moral theory and human rights. To draw on the discussion of Rawls' theory of justice in 2.3, I suggest that Rawls' justification of his principles of justice, by way of reflective equilibrium, will act as a reasonable guide to institutional design in health care delivery. Rawls' reflective equilibrium will help the designers of health care systems balance the importance of viewing health care as a human right with the reality that health care costs are high and must be kept at a reasonable level.

In the context of the principles of justice, Rawls was concerned with showing that the principles arrived at were reasonable, coherent and cohesive principles. They would not be principles that were acceptable merely to some, but rather principles that would have a wide appeal to all kinds of people regardless of their various religious, cultural and socio-economic backgrounds. This is the reason for his appeal to the veil of ignorance, in the original position. Yet an appeal to ignorance was not nearly strong enough to ensure that those in the original position would come up with well-reasoned principles that had universal appeal. In order to strengthen his theory, he built into his system the idea of reflective equilibrium. So writes Rawls: “In searching for the most favoured description of this situation we work from both ends. We begin by describing it so that it so that it represents generally shared and preferably weak conditions. We then see if these conditions are strong enough to yield a significant set of principles. If not, we look for further premises equally reasonable.”⁴⁸ He continues, arguing that when differences are found between the further premises and the beginning-point of weak and shared conditions, we can either modify our original conditions, to fit the stronger and equally reasonable judgments, or we can modify these principles to better cohere with the original conditions, subject to their collective importance. What is important to note, is that for Rawls, all conditions are subject to revision upon further reflection. Ultimately, argues Rawls, “we shall find a description of the initial situation that both expresses reasonable conditions and yields principles which match our judgments, duly pruned and adjusted.”⁴⁹

⁴⁸ Rawls, *Theory of Justice*, 18

⁴⁹ Ibid.

This reflective equilibrium acts as a check on Rawls' principles of justice. It ensures that they do not develop out of self-evident premises that one person may use to convince another, nor are they conditions on some *a priori* principles. Rather the principles of justice develop out of rational deliberation through the mutual consideration of many views, into one coherent view about the world. That is, no one has cornered the market on justice, but it is determined by reasonable people entering into rational deliberation of a variety of views.

The Rawlsian rubric of reflective equilibrium provides a guide to the institutional design of health care systems. In a later piece, Rawls clarifies the differences between wide reflective equilibrium and narrow reflective equilibrium. While narrow equilibrium describes the manner in which individuals develop their own personal moral convictions by applying the process of reflective equilibrium to specific life situations, wide reflective equilibrium describes the manner by which society develops broader and more generalized moral institutions. Wide reflective equilibrium is, therefore, of interest to the designers of health care systems, and offers a reasonable explanation for how many societies have come to the understanding that the realization of a human right to health care is possible. Wide equilibrium "satisfies certain conditions of rationality... we investigate what principles people would acknowledge and accept the consequences of when they have had an opportunity to consider other plausible conceptions and to assess their supporting grounds."⁵⁰ This process is taken to the limit, and what develops is a conception that would survive the rational consideration of all feasible arguments for them.

⁵⁰ John Rawls, "The Independence of Moral Theory," *Proceedings and Addresses of the American Philosophical Association* 48 (1974), 8.

Norman Daniels concludes, along with Joshua Cohen, that Rawls' reflective equilibrium serves as an educational process in the design of institutions by groups. As people discover political realities for themselves through experimentation and rational reflection, they come to hold particular viewpoints. They see these viewpoints as 'the right thing' and take pains to convince others that their way is mistaken. Rather than think of this as indoctrination, Daniels argues, this should be thought of as part of the process of education. Experience and rational reflection on one topic meet with opposing views on that same topic and, after an appropriate level of consideration, a more coherent institution evolves. Daniels offers the example of the belief in political equality, especially as it pertains to civil and legal rights. By engaging those who oppose political equality in rational reflection, the concerns of the detractors are incorporated into a larger consensus about the place of political equality in society.⁵¹ So it works in the setting of the allocation of health care resources and the institutional design of the appropriate health care system.

One example of reflective equilibrium in action, as it relates to the design of health care systems occurred, in Oregon in 1990. In an effort to establish funding priorities for Medicaid, the Oregon Health Services Commission released a ranking of medical condition/treatment pairs, along with their cost/benefit calculations. One interesting result was that the capping of a tooth was ranked higher (and thus was deemed more important) than that of an appendectomy. This was because the appendectomy cost \$4000 more than a capped tooth, and the aggregate net benefit of many capped teeth was higher than that produced by one appendectomy. In the face of public uproar, Oregon revised its

⁵¹ Norman Daniels, *Justice and Justification: Reflective Equilibrium in Theory and Practice* (Cambridge, [England]; New York: Cambridge University Press, 1996), 165.

methodologies, placing certain medical treatments in an ‘untouchable’ category for the benefit of those who were seriously ill.⁵² As Daniels explains, the problem with aggregation of cost/benefit is that, while we are good at making one-to-one comparisons (the appendectomy is worth more because it saves a life), we are not always good at making one-to-many comparisons, resulting in strange conclusions and even stranger solutions that seem to go against the moral commitments we hold.⁵³ While the cost of certain procedures may be prohibitive, moral commitments to the preservation of human life (that is, to the prudential preservation of our fundamental interests) often overrule considerations of cost and compel the design of institutions to work around the costs.

The Oregon case also illustrates why the QALY approach noted in 3.1 does not work.⁵⁴ The unit of benefit as a QALY is measured identically from person to person, regardless of who gets it, or what their circumstances are. Yet it is morally important to us that the more seriously ill patient receive extra benefits, perhaps even at the expense of someone with a lesser illness. We may also morally object to the aggregation of minor benefits across large populations when these aggregations outweigh the aggregate benefits of major benefits to fewer people, for the purpose of saving lives. The Oregon case, where something resembling the process of reflective equilibrium was used to cordon off certain life-saving procedures, is an example of how our moral sensitivities to fundamental prudential human interests result in achieving a delicate balance between the need to

⁵² Ibid., 322 ; Norman Daniels, *Just Health: Meeting Needs Fairly* (Cambridge, UK: Cambridge University Press, 2007), 116. (Page numbers refer to the circulated draft)

⁵³ Daniels, *Justice and Justification : Reflective Equilibrium in Theory and Practice*, 322.

⁵⁴ Ibid., 124.

efficiently and effectively control costs and the moral requirement to treat our fundamental interests with care.

It is worth noting that the Canadian health care system contains components of this Rawlsian reflective equilibrium. While it has committed itself to the five principles that govern the *Canada Health Act*, it is wide open to criticism with regard to the length of time spent waiting for medical care. In the Canadian system, long waiting lists are a by-product of the commitment to accessibility and universality. Thus, the rationing of health care resources happens in the Canadian system - just as it does in other systems - resulting in a tension between the desire to respect the right of all Canadians to health care and the practical realities of limited resources and high costs. The CMA policy document criticizes the Canadian government for its failure to deliver timely access to the Canadian public, especially in priority areas, such as cardiac care, cancer care, diagnostic imaging, joint replacement and sight restoration.⁵⁵ On the CMA's view, Canadians may be able to access their health care system with near universality, but they do not have individual recourse should the waiting be excessively long. This pressure from the Canadian medical community is a useful questioning of the health care system's commitment to first principles, without, on their view, adequately considering the costs associated with those first principles. In the vein of Daniels' argument, this creates an atmosphere of dialogue and education, which will result, through the process of reflective equilibrium, and a commitment to progressive change, in an improved health care system committed both to the first principle argument of fundamental self-interest and vital human needs, and the necessary 'reality check' of limited

⁵⁵ *It's Still about Access: Medicare Plus.*

resources and rising costs. It is worth reiterating that the Canadian system is an example of a system that meets and then exceeds the basic levels of health care called for by the appeal to health care as a human right, and it has done so by responding to the arguments made from both sides.

3.5 Chapter Summary

This chapter has focused on responding to a popular objection to the claim that health care is a human right. Many have argued that the high cost of health care is so prohibitive that health care providers would soon go bankrupt if forced to treat health care as a human right. Others have argued that considering health care to be a human right would require unwarranted appropriation of funding from other social services more fundamental, or just as fundamental, to the human condition. Those who object to the view that health care is a human right, based on the objection of difficult costs, will often resort to the use of Quality-Adjusted Life Years to evaluate the cost-effectiveness of particular medical treatments. This approach admits that health care is important to the quality of life of a human being, but it cannot admit that health care is a human right, as that may result in mandatory treatments that are far too costly for the perceived gain in overall quality.

In order to tackle this objection, I argue that it is not worth considering exactly how much the provision of health care will cost as these costs are so many and so disparate as to be virtually unknown; the focus ought to be on the social and moral costs associated with *not* providing a basic level of health care necessary to ensure a life of minimally decent value for everyone. I point to recent studies that show a direct correlation between socio-economic inequalities and health inequalities, noting that those in lower socio-economic classes are

more susceptible to a wider variety of illnesses and health abnormalities. An inability to access the health care system and a lack of education contribute to health complications, resulting in greater and longer-lasting serious health deficiencies. Moreover, income inequality is a direct cause of lower life expectancy and acts as a good predictor for the levels of health over a population. Thus, I argue, a society designed with equality in mind will have a more positive effect on the health of that society. People will have a greater ability to pursue their own ends and contribute to society, rather than worrying about how they will be able to afford to feed, clothe and educate themselves and their dependents in a manner consistent with the good life. The moral and social costs of *not* providing reasonable health care services in a manner consistent with an egalitarian society are very high, and bear consideration in determining just how costly the implementation of ‘health care as a human right’ is.

I offer a real world example of the Canadian health care system, which successfully delivers a basic level of health care services to all and compare its costs with the costs of the American system, which offers no such guarantee. Not only do Canadians consistently spend less on health care (as a share of the national income) than do Americans, but the Canadian system has built into its guiding principles a commitment to equality, accessibility, universality, public administration of health care services, and portability. These principles ensure that the Canadian system treats health care as a human right, in accordance with the discussion in Chapter 2. Moreover, even if Canadians were to be spending the same on health care as do Americans, as some critics have argued, their health care system covers

more people, and is funded by progressive taxes, resulting in greater socio-economic equality.

Turning again to theoretical discussions of ‘health care as a human right’, I offer the Rawlsian tool of reflective equilibrium as a guide in the design of health care institutions. The goal is to balance the importance of viewing health care as a human right with the reality that health care costs are high and must be kept at a reasonable level. I suggest that reflective equilibrium acts as an educational tool, stimulating debate and causing change, resulting in better institutional design. I show how this rubric was used to rescue some life-saving procedures from the unintended consequences of QALY-related cost-effective analysis. I also suggest that the Canadian health care system employs this method as it seeks to improve the cost-effectiveness of its system, while maintaining basic public health care services that are accessible to all, regardless of a person’s socio-economic status.

Chapter 4

Setting Limits: Rights Claims in Focus

The difficult costs objection is the most forceful objection to the view that health care is a human right. While an appeal to the cost of *not* viewing health care as a human right may persuade some, it is unlikely to persuade all. Moreover, those who would criticize the Canadian health care system for its excessively long waiting lists and the high taxes required to run the system are unlikely to be entirely convinced that the costs are not prohibitive, especially with respect to the prioritization of some procedures over others, and some patients over others. While they may agree that the process of reflective equilibrium aids in the development of cost-effective health care together with a commitment to first principles, they may remain skeptical of the claim that health care is a human right, as they fear that the appeal to first principles will overrule these real-world dilemmas in the allocation of health care resources. It is with this in mind that I admit that the right to health care I have defended has limits.

This chapter argues that while the ‘difficult costs’ objection, as argued in the previous chapter, cannot be taken as a knockdown argument against the claim that health care is a human right, it does impose limits on the extent of the claim. However, this particular objection is not solely responsible for the limits imposed on the rights claim. I will argue that the definition of health undertaken in 2.2.3 necessarily *limits the objects of the proper rights claim* to the restoration of normal, species-typical human functioning. Moreover, an appeal to reflective equilibrium in the development of fair and just health care institutions will necessarily limit the extent to which health care is delivered, as it seeks to tread carefully

around the tensions between difficult costs in health care and the first principles that establish health care as a human right.

I will briefly consider some criticisms of the Rawlsian ideal method with respect to the pursuit of health care as a human right. I will argue that, while the Rawlsian method acts as a reasonable guide to the development of a just view of health care, it cannot completely account for all of the complex issues that arise when bio-ethicists, medical professionals and administrators are charged with equitably prioritizing limited resources. This weakness on the part of Rawlsian theory limits the object of the right, such that the only legitimate claim is to equitable access to *basic care required to restore an individual to the state in which their vital needs are met*. Anything over and above this base level of health care provision will require further justification, and in particular, will need to engage questions of equitable resource prioritization that reach beyond Rawlsian ideal theory. Moreover, the claim that health care is a human right only makes sense in light of the reality that the satisfaction of that claim depends, in large part, on the satisfaction of other rights claims.

4.1 The Limits of the Right to Health Care

The limits to be imposed on the right to health care have thus far only been alluded to. In 2.2.3, I argue that health is a vital human need that is within our fundamental interest to protect. To the extent that health is a vital human need, it is an object of our human rights, and, to the extent that this object is institutionalized as a primary social good in the form of universally accessible health care, health care is a human right. That is, universally accessible health care that aims to meet, to the fullest extent possible, the basic requirements

of species-typical normal human functioning is a human right. Nothing beyond that goal can be considered a human right, at least not without further argument.

Some have objected that making the claim that health care is a human right misses the point. Rather, bio-ethicists and the designers of social institutions ought to be concerned with the right to health. Dan Brock writes:

“More important, *inequalities* in health among individuals and groups that are within human and social control are not primarily the result of access to or use of health care... Differences in access to and use of health care have only a negligible effect on health inequalities among social groups, in particular, individuals of different socio-economic classes... if inequalities in access to health care are of moral concern because they result in inequalities in health, then focusing on health care will miss most of the action of the real matter of concern – health and health inequalities.”⁵⁶

In responding to this charge, Daniels argues that the claim to a right to health care is just one component of a larger right to health. Society is obliged to develop institutions and distribute important goods in certain ways,⁵⁷ and one institution that society is obliged to develop is a system that will adequately deal with the set of vital human needs, including the need for the restoration of species-typical biological function. This approach does not neglect the social determinants of health, but rather, as I argue in 2.2.4 and 3.2.2, the social determinants of health play an important role in the development of equitable institutions that will deliver on our vital needs. In 2.2.4, it was argued that health care institutions are required to take into account appropriate distributions of the social determinants of health, while in 3.2.2 I argued that socio-economic inequality has a serious negative effect on those

⁵⁶ Dan Brock, "Broadening the Bioethics Agenda," *Kennedy Institute of Ethics Journal* 10, no. 1 (2000), 31.

⁵⁷ Daniels, *Just Health: Meeting Needs Fairly*, 162.

social determinants of health. In fact, socio-economic inequality was determined to have a forwardly causal role on ill health, and as such, needs to be incorporated into the way the institution of health care is conceived. Thus, health inequalities broaden the thinking of where health care institutions should to focus their efforts, providing valuable information that can be used in the prioritization, allocation and distribution of scarce resources. What they do not do, however, is take away the core function of the institution of health care as a primary social good, that is, the return of basic, species-typical human function needed to pursue a minimally decent life. The Rawlsian argument presented in this thesis concerns the institution itself, and not the wider reaches of ill health. While the social determinants of health play a major role in determining what the social institution of health care will look like and how it will be conceived in the language of rights, they cannot be seen to surpass the importance of basic health needs. To do so would quite simply put the cart before the horse.

Moreover, the need to limit this particular right to the normal baseline of human functioning does not prevent further argument for a broader right to health, including preventative measures, or other socially controllable factors, where they impact the social determinants of overall population health. Nor does it stipulate that discussions of health care are limited only to species-typical function, rather it admits that society can only be morally responsible for what it can reasonably meet, given the resources it has. The Rawlsian argument from social primary goods and reflective equilibrium can only yield this much – anything further would go beyond the discussion of social goods, requiring consideration of natural goods, which goes beyond the scope of this particular Rawlsian argument.

As Daniels argues, not all health needs can be met under reasonable resource constraints. Deciding which health needs to meet requires considerable moral judgment, and a wealth of empirical knowledge about the effects of alternative allocations. For example, while there may be obvious health care cases that warrant exclusion from extensive allocation due to their failure to satisfy the aforementioned baseline criteria, such as prescribing the drug Viagra, there are other cases that may be far more controversial. Consider instead the choice to provide, via public health services, immunizations for teenage girls against the cancer-causing HPV virus, where society recognizes the importance of a commitment to the health needs of safe sexual practices and preventative measures. When faced with the possibility of preventing a large number of cervical cancer cases, in addition to curtailing the spread of a sexually transmitted disease, the distribution of such immunizations seems reasonable. However, when immunizations against the HPV virus are placed alongside arguably more basic lifesaving medical procedures, such as emergency surgeries performed after car accidents, or an urgent coronary artery bypass surgery, it becomes difficult to tell exactly how resources ought to be allocated, and at what level baseline species-typical human function crosses the upper bounds of what is considered 'baseline'. Thus, it is important to note that even within the argument from vital needs and baseline species-typical functioning, decisions of prioritization and resource allocation remain difficult, though not insurmountable, given a commitment to the Rawlsian rubric of reflective equilibrium, as argued in 3.4. While it has been argued in Chapter 3 that the 'difficult costs objection' cannot be taken as a complete denial of the right to health care, it must be noted that costs will still bear on the level of health care covered by its associated human right,

necessitating a restriction of the right to health care to the return of basic species-typical human function.

I argue then that the provision of health care is a right only in so far as it meets vital human needs, and only in so far as it is prudent to encode it as one of the most fundamental human interests. Health becomes a vital human need when viewed through a narrow biological lens, when a lack of baseline species-normal functional organization impedes the individual's ability to function and pursue her own ends. The moral and social costs associated with the failure to pursue one's own ends are high, resulting in undue socio-economic inequality, a failure to contribute positively to society and possibly over time, crime and conflict. When viewed in conjunction with Rawls' principles of justice, basic health care, as an externally distributed, social primary good is necessary for a minimally decent life.

4.2 The Limits of Ideal Theory

Brock also brings to light the problems faced by the promoter of a right to health care with regards to the prioritization of resources. He argues that a failure to address how health care resources and programs should be justly prioritized have resulted in narrow-minded approaches to health care delivery that seek to maximize aggregated health, such as the cost-effective programs exemplified by the Oregon experiment of 1990, or seeks to maximize health solely for the worst off, without paying proper attention to the health needs of the better off.⁵⁸

⁵⁸ Brock, *Broadening the Bioethics Agenda*, 25, 37.

Colin Farrelly suggests that some of the difficulties with prioritization are a result of the cost-blind approach to human rights, found within the moderate ideal theory attributed to Rawls. He argues that this approach has impoverished the ability of those interested in distributive justice to be fact-sensitive, instead choosing to alter Rawlsian theory to fit the circumstances of the particular human right in which they are interested. Farrelly writes: “A crucial assumption that Rawls slips in his discussion of maximin is that the contracting parties would be in a society that exists in the circumstances of justice under *reasonably favourable conditions*.”⁵⁹ In a society with reasonably favourable conditions, the principle of liberty becomes easy to deliver, as people will automatically recognize the liberty of others and will leave them well enough alone. However, just as the libertarian position on rights is open to the criticism that negative rights have positive components, so Rawls’ liberty principle is open to the criticism that the existing world is not a place of reasonably favourable conditions. Rather, securing and enforcing the liberty principle requires significant and costly contributions by society. The costs associated with enforcing the liberty principle cut into the costs that Rawls admits are a part of the enforcement of the difference principle, precisely what Rawls wanted to avoid when he insisted on the serial ordering of the two principles. Thus, appeals to the serially ordered Rawlsian principles are not sufficiently capable of taking into account the complexities of the real world and the cost of rights.

Farrelly takes specific aim at the idea that Rawlsian principles can be used to justify a return to normal range of human function in health care. In particular, under the ideal

⁵⁹ Colin Farrelly, "Justice in Ideal Theory: A Refutation," *Political Studies* (Forthcoming), 11, <http://politicalscience.uwaterloo.ca/Farrelly/JusticeinIdealTheory.pdf> (accessed January 6, 2008).

conditions in which all inequalities are maximized as to be of benefit to the least advantaged, there would be no reason to invest in a system intended to maintain that level of normal human function. Instead, Rawls passes the buck, insisting that the costs associated with maintaining that normal range of human function would be determined at the legislative stage, out of the hands of the difference principle itself.⁶⁰ This is, in effect, an attempt to pass the question of prioritization away from the principles of justice and onto the legislative process, taking with it all of the problems associated with the cost of maintaining a health care system with the view of maintaining the normal range of human function. When the costs associated with the prioritization of resource allocation are taken out of the hands of ideal theory, Farrelly argues that the theory becomes useless as guide to determining how a just society ought to distribute its scarce resources.

These criticisms of Rawls are worth taking seriously, as they highlight the tension between taking the costs of health care seriously and commitments to first principles. They also highlight the need to set limits on what can be expected of a right to health care; these tensions show that the limit of this prudential Rawlsian approach to health care is limited to explaining *why* there is a right to health care, while leaving the *how* questions unanswered.

In an effort to counter the objection that a theory of health care based on Rawlsian principles of justice is not sufficiently based in the ‘real world,’ of difficult costs, Daniels suggests that the realization of this right should be seen as progressive in nature. Admitting that this right is progressively realizable does not impugn on the *moral* qualities of the individual right to health care. Prudential reasons of fundamental self-interest in obtaining

⁶⁰ Ibid.

basic vital human needs such that the pursuit of liberty is possible necessitate the individual moral right to normal, species-typical biological function. Instead, the progressive realization of the right to health care is aimed at limiting claims to the right, such that no one could claim all interventions resulting in improved health are justified, regardless of cost or other factual considerations. Rather, it recognizes that

“realizing a right to health is closely related to and depends on the robust political and legal satisfaction of other rights, including rights to food, housing, work, education, non-discrimination, privacy, access to information, and freedoms of association, assembly and movement, as well as adequate resources, as well as a properly functioning public health care sector.”⁶¹

When it comes to priority setting, and the delivery of health care services, there must be a recognition that the right to health care is one right among many, and its satisfaction depends, in large part, on the political climate of a particular society and the available resources in play. It is not enough merely to establish that there exists a right to health care and demand that this right be fulfilled. Instead the right to health care can be realized only in conjunction with other rights. Claims made on society for health care can only be made relative to the resources available, including political resources. Thus, while there exists a moral right to health care, it may not always be the case that this right can be fulfilled and, in particular, it is unlikely that it can be filled on demand. It is one thing to claim the object of the right, but the satisfaction of that right requires political and financial commitment to all other rights. It has been suggested that the admission of the progressive realizability of the right to health care would invalidate the claim that difficult costs are not a reasonable barrier to the establishment of an institution that has as its goal the return of normal baseline human

⁶¹ Daniels, *Just Health: Meeting Needs Fairly*, 358.

function. However, admitting that the right to health care is progressively realizable is very different from admitting that a right to health care *cannot* be realized due to excessive costs. Daniels acknowledges that the satisfaction of any right to health care, whether in the minimalist form advocated in this thesis or in some wider form, will be dependent upon the satisfaction of other rights as well. If a particular society has the resources to develop a health care system that meets basic vital human health needs, but does not yet have a basic infrastructure upon which to build a health care system, that society is responsible for ensuring that the necessary infrastructure is built, that the residents of that society have adequate access to water and food, among other things. The right to health care is not an independent or ‘special’ right; its satisfaction cannot be guaranteed without a prior commitment to “robust political and legal satisfaction of other rights.” The argument from difficult costs dismissed the right to health care as an *independent* right on account of the excessive costs it may incur, and in particular, because it may take away from resources devoted to other ‘more worthy’ rights.⁶² However, as Daniels argues (and I have argued throughout this thesis), health care is itself worthy as a human right, and must be respected with the same level of commitment as the right to education, adequate housing, food, water, etc. Just as the satisfaction of other primary social goods require political, legal and financial commitments from society, so does the primary social good of health care. In short, the specific content of the rights claim to health care cannot be specified independently of the social and political realities within a particular society, nor can it be satisfied without a commitment to the satisfaction of all associated interdependent rights claims.

⁶² See Chapter 3, pp. 32-33.

Daniels offers a generic example as illustration of how the human rights approach would work to avail itself of the resources available. In this example, he considers a relatively poor country with a relatively large population seeking to improve maternal and child health among its population. Offering 5 distinct programs that would be live possibilities in a rights-based approach, he considers each one in turn. Evaluating each program, he concludes that each of the possible programs have positive and negative components and, in some cases, one program satisfies one rights claim while leaving another open to abuse. When it comes to prioritizing each of the programs, and offering a preferred program that would best satisfy a broader right to health or a narrower right to health care, he argues that the rights-based approach comes up empty. All it can do, Daniels argues, is identify the different claimants competing for resources that would lead to better satisfaction of different rights: “It does not determine which program should take priority since there is no basis for saying that claimants to one right have priority over claimants of another.”⁶³

The criticism that Rawlsian ideal theory is too ideal, remaining cost-blind has some merit to it. There exists a priority-setting problem within the claim that health care is a human right. However, the problem of priority-setting is not enough to defeat the claim that there is a *moral* human right to health care. Rather, it serves as a cautionary note for those who wish to claim more than the right allows for. It forces the defender of health care as a human right to recognize that there are indeed significant costs associated with the delivery of the object of the rights claim and, in particular, offers a sobering reality check to those who might think that making a claim to health care as a human right entitles them to immediate care for every and any ailment they may have. Moreover, it causes the defender

⁶³ Ibid., 363.

to admit that the satisfaction of this right depends, in large part, upon the satisfaction of others, and thus cannot be filled on-demand. While there is sufficient reason to believe that there exists a human right to the baseline health required to live a minimally decent life, there is not sufficient reason to think that claiming health care as a human right can, on its own, immediately satisfy the difficult real-world problems associated with the prioritization of services, nor can it give a detailed list of exactly what the satisfaction of that right will look like.

4.3 Chapter Summary

This chapter admits that there are limits on the claim that health care is a human right. It has spelled out exactly what is entailed by the present account of ‘health care as a human right’, based upon prudential self-interest and vital human needs. It has also recognized that the satisfaction of a claim of this magnitude is far more complex than Rawlsian ideal theory can elucidate, admitting in particular that the problem of prioritization cannot be fully answered with a human rights approach.

I argue that, due to the nature of prudential self-interest and vital human needs, the encoding of health care as a human right only goes as far as the fulfillment of the basic requirements for species-normal human functioning. All claims to health care, above and beyond this basic level required for a life of minimal decency, will require further argumentation if they are to be counted as a human right, and such is not the purpose of this essay. In addition, the institution of health care is a part of a larger component of human health concerns, and this argument does not preclude further arguments for a broader right to health. Instead, it lays out the basic requirements for just institutional design, recognizing

that society can only be responsible for the needs it can reasonably meet, given the resources it has.

I considered the claim that approaches to health care as a human right are ill-equipped to handle questions of prioritization in the delivery of health care services. Responding to criticisms of Rawlsian ideal theory, I agree with the critics, arguing that the nature of the argument renders it incapable of delivering absolute verdicts on the prioritization of resources. However, the right to health care must be viewed in conjunction with other rights, and its satisfaction depends, in large part, upon the satisfaction of other rights within a society. This approach admits that there are significant costs in the satisfaction of the human right to health care, but sees the right as one among many, holding that as each right is satisfied and promoted, the right to health care will be satisfied in turn. While there exists a moral right to health care, the satisfaction of that right will depend on available resources, including political resources and a commitment to human rights, more generally.

Chapter 5

Conclusion

The stated purpose of this thesis was to make an argument for viewing health care as a human right. I have achieved this goal, moving from foundational considerations about the nature of rights to discussions of prudential fundamental self-interest and vital human needs. By showing that health is a vital human need that is within our self-interest to protect, I have argued that baseline species-typical human functioning is worthy of encoding in morality. Appealing to the principles of justice established by John Rawls, I argue that it is not only in my individual self-interest to have a minimum level of normal function, but it is in the interest of everyone, such that they may pursue their own ends and contribute positively to society. Health care is a primary social good, something without which no person could pursue other things in life. This primary good is the object of a human right; health care is a distributable primary good, and therefore it is an object of our human rights. Moreover, it ought to be available to all, in accordance with the liberty principle and the difference principle.

In an effort to consider the most salient objection to the view that health care is a human right, I argued that the difficult costs objection is not fatal. Rather, the objector must face the costs of *not* admitting a right to health care, including an increase in infant morality rates, a decrease in life expectancy, lower levels of education, and inability to contribute to the betterment of society, among many other negatives. The negative effect of socio-economic inequality on health gives good reason to think that an equitable health care system

would go a long way towards enabling members of society to pursue their own goals, in accordance with Rawls' principle of liberty.

I argued that the detractors of a human right to health care based on costs ought to look to Canada as one example of a nation that provides universal, equitable and accessible health care to its citizens, at reasonable cost. The Canadian example illustrates a system with a demonstrated commitment to the view that health care is a human right, and, when compared with health care costs in the U.S.A., exhibits lower overall expenditures on health care, as a share of the national income. I argued that, based on the Canadian model, costs for the provision of baseline health care were not so prohibitive as to deny associated rights claims. Turning to questions of institutional design, I argued that a commitment to reflective equilibrium will allow the designers of a health care system to account for the high costs of health care delivery, while being sensitive to human rights claims to a baseline level of care.

I have also outlined some limits to the claim that health care is a human right. Responding to the objection that concentrating on health care unnecessarily excludes discussions of health, I argued that the argument based on vital human needs does not preclude further arguments to a more general right to health. When viewed from the constraints of prudential self-interest and vital human needs, however, the human right to health care can only admit whatever procedures are required to restore the human body to species-typical functioning, functioning consistent with the pursuit of liberty and the ability to contribute positively to society.

Finally, given the strength of the difficult costs objection, especially as it relates to the problem of prioritization of health care resources, I argued that this account makes no

statements about exactly *how* health care resources are to be distributed. It is limited to explaining *why* we have a human right to health care, and to showing the methods by which institutions can be designed in order to minimize questions of cost. This limit underscores the importance of a society's commitment to human rights more generally, as it is only in conjunction with the fulfillment of inter-related rights that the right to health care can come to its fullest satisfaction.

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