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IS THERE A NATURAL RIGHT TO HEALTHCARE?

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Abstract: In recent years, policy debates in the United States have focused heavily on rising healthcare costs and what measures can be taken to ensure greater provision of healthcare to individuals of limited means. Much of the rhetoric on this subject has taken on an explicitly moral character, and one common sentiment is that healthcare is or should be viewed as a basic human right. However, the notion of a right to healthcare has not been well articulated, and critics have failed to distinguish between legal and moral rights. Additionally, there are numerous problems inherent to viewing healthcare as a basic human right—many of which are in direct conflict with distinctly American conceptualizations of rights. The present paper reviews the debate over "rights"—both legal and natural—to healthcare, and argues that problems associated with natural rights arguments render them severely compromised. Instead, market systems commonly accepted in American society may be better suited to reducing healthcare costs and increasing access to services in the United States.

Key words: healthcare reform; health insurance; healthcare costs; human rights; natural rights

Is there a natural right to healthcare?

In the United States, arguments for greater provision of healthcare products and services using taxpayer funds during recent years can be classified as being one of two types: (1) practical arguments that medical care can be provided by the government (through socialized medicine or a single-payer option) more efficiently and to a greater number of people than through markets alone, or (2) arguments that healthcare is a right, and allowing market forces to operate in the arena of health care is fundamentally immoral. This distinction has been characterized as one of the defining differences between American political parties, liberals and conservatives, the left wing and the right (Mechanic 2006)[1]. The view that healthcare as

[1] This left/right, liberal/conservative distinction may be unique to the United States, where the term "liberal" has come to be associated with left-wing or progressive movements that favor government

a fundamental right can be seen in some of the earliest works of the progressive movement, as it falls into the more general category of "freedom from want" (Roosevelt 1941), or the demands of social/distributive justice (see Jackson 2005 for an overview of recent social justice claims).

At the most fundamental level, arguing that healthcare is a right may originate in an emotive or sentimentalist rejection of death and disease when a treatment or cure is available given existing levels of technology. Certainly, only the truly sadistic prefer to see such suffering go unaddressed, and very few fail to see a lack of healthcare provisions to the poor as a problem. The question is what ought to be done to ameliorate healthcare disparities, and what grounds can be established for such action. The argument that healthcare is a right comes out of an entirely different discussion—one in which the concept and definition of rights itself is at issue. One need not hold a Darwinian view of society or believe that those of limited means are morally destined to suffer in order to argue that healthcare is not a right—it is a view which follows a longstanding tradition of Anglo-American thinking that prizes human flourishing. However, the fundamental assumptions this position makes are vastly different than those driving arguments for a right to healthcare.

The goal of the present paper is to define precisely what is meant by a "right to healthcare" in a philosophical (as opposed to legal) sense, then address whether or not there exist sufficient grounds for arguments in favor of healthcare rights to be accepted as true or plausible. In particular, I will consider whether or not healthcare can be viewed as distinct—that is, categorically different—from other types of goods and services, and therefore deserving of special consideration by philosophers and social critics. I will approach the argument for a natural right to healthcare in the context of American history and the philosophical tradition to which it is most closely tied. In doing so, I hope to shed some light on why America remains one of only three industrialized nations whose government does not provide some form of universal access to healthcare (Carey, Herring, Lenain 2009), and why the question of healthcare access remains so controversial today.

It is important to note that the failure to find a right to healthcare does not necessarily mean that single-payer and socialized medical systems are unwarranted, as such arrangements can be justified on practical grounds—i.e., that medical care is cheaper and more efficiently provided to more people under these systems than under purely market-based systems (although I believe this is not the case, it is certainly possible). Practical tradeoffs between markets and the universal provision of services have been made in numerous areas of American society in particular. For example, the first fire departments in the United States were established not because there was profit to be made from their services or because protection from fires was assumed to be an unassailable right, but rather because there was a general recognition that fires often spread from one property to another, and a universal protective service was the most practical way of dealing with this threat (see Brands 2000, for an example). Likewise, private security firms can (and often do) provide protection much like accredited law enforcement outfits, but most of this workload has been shifted to the public sector for practical reasons—i.e., it is easier for a representative of the state, county, or

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intervention, and the term "conservative" is associated with advocacy of markets and limited government.

municipal government to make arrests and aid in prosecutions. In the same way, healthcare and the profession of medicine could theoretically be moved into the public sector solely on practical grounds. Thus, proposing that there is a right to healthcare and proposing that healthcare should be paid for by the government can be two very different arguments. As I will argue, however, there are certain realities that favor market-based reforms over statist reforms, and these realities are tied to a perception that healthcare is a right.

Defining "rights"—natural and legal

When one speaks of a natural right to healthcare, two interpretations are possible: (1) that an argument in favor of freedom to engage in commercial transactions with healthcare providers is being advanced, or that (2) an argument that the sick can make a moral claim to the labor or healthcare providers (or, more precisely, the resources of society as a whole in the form of payment through taxation), regardless of their ability to pay for such services, is being advanced. These two claims are entirely different—the former is very much a classical liberal or libertarian argument, while the latter is quite clearly a progressive or new left argument that relies on distributive justice claims. For the purposes of the present paper, I shall assume that arguments in favor of a right to healthcare fall into the latter category. This is the most logical assumption, as all but the most extreme anti-capitalist ideologies believe that the sick have a right to purchase healthcare, and healthcare providers have a right to be compensated for their services.

We may break the notion of "rights" into two separate groups: descriptive statements about what a specific legal system has deemed intrinsic to its proper function or the function of the society it serves, and normative statements about what nature imparts to every human being. In the United States in particular, the former category is well exemplified by the American Bill of Rights, which enumerates specific types of laws which may not be enacted, lest the legal rights of American citizens be abridged in specific, essential areas. Thus, we commonly refer to the rights of freedom of speech, assembly, religion, etc. Additionally, individuals are afforded certain legal rights in specific contexts. For example, Americans have a right to remain silent after being placed under arrest (so-called "Miranda Rights"), a trial by jury, and an attorney at their own or state expense. Legal rights are, by definition, rights which exist beyond question (at least as long as they remain in the context of the law). While courts and legal scholars may argue about the implications, depth and breadth of enumerated legal rights (for example, whether or not freedom of speech is equally applicable to political campaign ads funded by both corporate entities and individuals), there is very little debate over the existence of legal rights themselves.

Natural rights, however, are another matter, particularly in the minds of Americans. As Corwin (1928; 1929) has noted, the bases of American constitutional provisions have traditionally been viewed in much loftier terms, appealing to centuries of western philosophy for their justification. The distinctly American conception of natural rights can be traced largely to the Enlightenment and the English philosopher John Locke in particular. The now-famous phrase Thomas Jefferson employed in the Declaration of Independence, that "all men are created equal; that they are endowed by their creator with inalienable rights to life, liberty, and the pursuit of happiness" can be traced to Locke's belief in rights of life,

liberty, and property. These beliefs do not refer to laws enacted by a legislature or through jurisprudence, although their authors saw the protection of such rights as one of the potential responsibilities of government. Rather, they are viewed as existing prior to any government at all (Konvitz 2001). Thus, natural rights can be viewed as external to any legal structure.

There is much confusion regarding the distinction between natural and legal rights, and it may be argued that other categories of rights exist. For example, a social-contractual theory might hold that healthcare rights exist as a consequence of an implied contract between an individual and the society in which he or she resides. Edicts such as the United Nations Universal Declaration of Human Rights and the Charter of Fundamental Rights of the European Union seem to attempt to bridge the gap between natural and legal rights, making broad, philosophical statements that carry with them the force of law. A complete discussion of whether or not additional types of rights exist is beyond the scope of this paper; however, for the purposes of the topic at hand distinguishing between the two categories of rights—natural and legal—should be sufficient.

Given these definitions, a logical question is whether or not rights claims regarding healthcare in the United States typically refer to natural or legal rights. Since legal rights have historically been—among other things—quite utilitarian, a legal right to healthcare is a much different proposition than a natural right to healthcare. To say that every person has a natural right to healthcare is making a strong statement about the nature of man and his relationship to society. However, it is the very fact that a right to healthcare is being claimed which reveals the nature of the argument being made. When a person affirms that all Americans have a right to healthcare, they are making what is essentially an empirical statement. Since no such right has been enshrined into U.S. law, it can only be assumed that such statements are being made in reference to natural rights. It is only in making a normative proposition (e.g., "all Americans *should* have a right to healthcare") that one can assume the author of such a statement is referring to legal rights. Thus, I contend that in the context of the debate over healthcare reform in the United States—particularly that which has occurred over the past two years[2]—it is safe to assume that all empirical statements regarding a right to healthcare are being made in reference to natural rights rather than legal ones. As such, in all future instances wherein I refer to "healthcare rights," I will be referring specifically to natural rights.

Positive and negative rights in the United States

The idea that human beings have a natural right to healthcare—while having enjoyed popularity in much of the industrialized world—has remained controversial in the United States. Because it involves the provision of services from others, a right to healthcare is an inherently social proposition. Traditional references to natural rights in Great Britain and the

[2] It is worth noting that during the debate over healthcare reform in the United States, when speaking of healthcare rights, President Obama appeared to be careful and quite specific in stating that healthcare *should* be a right, rather than making a statement of fact. In one example (Obama 2008), he phrased his views in this manner even when a question was posed to him about whether or not healthcare *is* (rather than should be) a right. This may be incidental and unintentional, but it also seems possible that it was a deliberate effort to avoid taking a much more complex position.

United States have centered on those aspirations which could be realized in relative isolation, and Enlightenment philosophers—particularly British thinkers such as John Locke—tended toward conceptions of rights which lead naturally to restrictions on state power. The political climate of the time led the prominent writers of the era to recognize an oppressive state as the greatest threat to human happiness. Thus, the conceptions of rights emanating from this period focused on what are today commonly called *negative* rights—i.e., rights to remain unmolested and pursue one's own goals without interference from the state or other individuals.

A right to healthcare, however, is qualitatively different—falling into a separate category of rights, loosely referred to as "positive" or "social" rights. While negative rights carry with them a concurrent obligation on the part of others *not* to act (e.g., not assaulting someone; not stealing from others), positive rights carry with them a concurrent obligation on the part of others *to* act (e.g., providing healthcare, social services, etc.). A comprehensive discussion of positive and negative rights is beyond the scope of the present paper; however, it should be noted that the idea that positive rights exist remains controversial in American political discourse (see Cross, 2001 for an extended analysis of positive rights as they are viewed in the United States). Thus, if a right to healthcare exists, it must be because there is something unique about healthcare; something that makes healthcare deserving of special consideration as a valid positive right.

Is healthcare unique?

The idea that humans have a right to healthcare has enjoyed tremendous popularity among American progressives, and has become a staple in left-wing rhetoric. However, relatively little work has been done to specify exactly why a right to healthcare exists, and more specifically, why healthcare should be differentiated from other types of goods and services. Arguments for healthcare rights usually begin with the assumption that such rights must exist, and then proceed to describe the practical benefits associated therewith. Or, to whatever extent scholars have attempted to establish a basis for healthcare rights, their work has been unconvincing due to its complexity. The enormous amount of logical machinery necessary to assert that a right to healthcare exists must give us pause in considering whether or not such assertions have any logical basis. For example, Daniels (1979)—a prominent advocate of healthcare rights—has admitted that his efforts were based primarily on an intuition that "we ought to have access to adequate health care, regardless of our income" (p. 190) rather than a rationale constructed from the ground up. Such admissions—while admirable in their forthright nature—are apt to leave more logically rigorous readers wondering how the a priori assumption that healthcare rights exist was arrived at. The absence of an explanatory narrative in this vein is a weak point in the foundation of healthcare rights arguments that must be addressed.

A number of observations regarding the potentially unique nature of healthcare may be made without engendering much controversy:

1. The provision of healthcare is often a matter of life or death.
2. As an empirical matter, there are great disparities in the availability of healthcare, particularly in the United States (as well as between the developed and developing worlds).

3. The rapidly advancing nature of healthcare technology means new tests and treatments are devised much more rapidly than market mechanisms can make them broadly available, thereby limiting access of (potentially lifesaving—see point 1) services to individuals of limited means.
4. Good health—the ultimate goal of healthcare—is a condition almost universally sought, yet one which will inevitably become unattainable for any mortal animal.

The question before us is therefore whether or not any of these properties makes healthcare inherently different from other goods and services traditionally provided through market mechanisms (as is presently the assumption with healthcare in the U.S.).

A number of theories regarding healthcare's unique nature have been advanced, but as we shall see, they share in common a reverence for health as a prerequisite for human flourishing, with illness being an exceptional condition. For example, Sigerist has argued that "[t]o be ill means to suffer—to suffer in a twofold sense. To suffer means to be passive. The sick man is cut off from the active life to the extent that he is even unable to procure his own food. He is literally helpless and is assigned to the care of other persons" (1929, 11). Perhaps best known among social theorists is Parsons' (1951) definition of the "sick role" as affording an ill individual with specific rights and obligations (e.g., being exempt from usual social expectations; required to take every reasonable measure in an effort to get well). Based on these observations from Sigerist and Parsons, the sick occupy a special position in society, and their needs and rights can therefore be seen as unique.

Others (e.g., Jost 2003) make more general arguments for the unique nature of sickness and healthcare, referencing its large economic impact and relationship with a society's productive output. More recently, this debate over the unique nature of healthcare has been a prominent feature in the U.S. Supreme Court (the top appellate court in the United States): the government, arguing in favor of new healthcare reform legislation, posited that because everyone will undoubtedly need healthcare at some point in their lives, medical services are a unique sector of the economy (Verrilli 2012). This argument was eventually rejected in a narrow vote, although the substance of the new law was retained as a tax.

When considered in tandem, these two arguments—while making empirically accurate observations—actually provide an excellent example of why it is so difficult to argue that healthcare is a right. Most problematic is the self-contradictory nature of the arguments cited above: a sick person cannot occupy a unique position in society while healthcare remains a necessity that almost everyone will use. After all, being sick is a universal part of the human experience. Since even the healthiest person will endure illness in some form during their lifetime (if nothing else, they will eventually die due to some ailment), it is therefore questionable whether or not sickness constitutes a "special position," or is a regularly visited condition that occasionally results in dire outcomes. Likewise, if the healthcare market will inevitably be used by nearly everyone, it is difficult to see how it can be viewed as categorically distinct from other goods and services due to the impact illness has on the lives of specific individuals.

Arguments that healthcare is unique may also rely on less specific appeals to principles of justice and fairness, since illness is often a matter of luck and factors beyond one's control. For example, Daniels (2008) has outlined a somewhat complex extension of Rawls' (1999) theory of justice, arguing that—in simplified terms—healthcare is unique because it

can be classified as a need rather than a preference. That is, good health is a prerequisite to normal human functioning, and therefore, some obligation must exist on the part of society to provide healthcare when it is needed in an effort to satisfy the demands of justice.

Despite its prominence, there are a number of problems with Rawlsian theory, broadly speaking (a famous example being Nozick's [1974] reply). Within the context of health and healthcare in particular, this distinction between needs and preferences becomes problematic due to the extraordinary diversity of our species on an individual level. While almost everyone may value good health on some level, many humans engage in activities that endanger their health. A smoker or drinker chooses (at least in absence of chemical addiction) to indulge his or her vices, presumably with full knowledge of the health consequences associated therewith. The distinction between needs and preferences is, in this sense, quite murky. Moreover, such a distinction places the obligations associated with healthcare rights on a slippery slope—one with potentially serious implications. For example, should behaviors with obviously negative health consequences be prohibited legally for fear that they could compromise the integrity of a healthcare system? Arguing in the affirmative seems to place more emphasis on the importance of health as a value than is warranted.

It may also be argued that a right to healthcare carries with it an obligation on the part of the general public to do everything in their power to avoid getting sick. Put another way, if the sick can make a claim on the talents and abilities of healthcare providers and resources of the general public in an effort to ameliorate their suffering, then healthcare providers and the general public can make a claim on the behavior of the potentially sick (assumed to be every member of society), and demand that they avoid unhealthy behaviors and engage in health-promoting activities, in an effort to control their costs. One can imagine a wide variety of behaviors which could be banned under such circumstances (e.g., smoking, alcohol use, as discussed previously), and an equally wide variety of behaviors which could be required (e.g., joining a gym, maintaining a healthy diet). Although cost/benefit calculations can be made in this respect, given trends toward viewing health behaviors as moral issues (Conrad 1992), it seems that those in favor of regulating such activities would have the upper hand at present. Thus, a right to healthcare carries with it a concurrent obligation on the part of the sick and potentially sick. Such obligations would go beyond the traditional responsibility of the sick to attempt to get better (as most explicitly outlined by Parsons, 1951), since their failure to do so would entail more than simple indictment for their condition—it would involve a much greater cost to society and the healthcare system as a whole.

Even the life-sustaining nature of healthcare, combined with its unusually high cost appears insufficient to categorize healthcare as a unique commodity. Again, a limiting principle is both necessary and difficult to locate, and one can easily call to mind a large list of goods and services which could be both lifesaving and are unusually expensive: for example, automobiles are a staple of American life, and some models are a great deal safer than others. It would almost certainly save lives if every American were to be provided with a maximally safe automobile, although such a plan would incur great expense. The fact that automobile accidents have not risen to the level of consciousness in the American mind presently occupied by healthcare seems to be the only reason why no proposal has been made to furnish every U.S. citizen in need of transportation with particularly safe automobiles. Even more directly relevant to the maintenance of life is basic sustenance—food and water.

Despite the essential nature of food, discussions of a "right to food" have yet to emerge in any significant way, at least with respect to domestic matters in American political discourse (international issues being another question entirely). It has even been argued that the expense associated with purchasing higher quality, more nutritious foods prohibits individuals of limited means from maintaining healthy diets (e.g., Drewnowski 2010), thereby reducing their overall health and putting them at risk for an earlier death. Should we therefore assume that access to sustenance of the highest quality (given available technology) is a basic human right?

This brings us to a final argument for the uniqueness of healthcare—one which falls outside the domains discussed previously, because it rests on empirical observation rather than a rational system of moral judgment: markets have failed in the arena of healthcare. That is, while food prices have been substantially reduced through competition and remain quite low (Ridley 2011), the price of medical goods and services has not. Two points are relevant here: first, the real-world price of healthcare is an issue far removed from the more philosophical question of whether or not healthcare rights exist. Second, market failures have been identified in a multitude of areas, such as the provision of utilities, but no one argues that human beings have a right to electrical power, Internet access, and cable television. Thus, a market failure cannot constitute a justification for healthcare rights. Moreover, the so-called market failure associated with healthcare may actually be seen as a *consequence* of the view that humans have a right to healthcare. As a final point, I will direct my attention to this possibility.

Implications and consequences of a right to healthcare

I have argued that, for relatively simple reasons, healthcare should not be considered a natural right. However, there is a corollary to this argument: specifically, it may be that that the widespread presumption by philosophers and policymakers that healthcare is a right is precisely what is responsible for making healthcare inaccessible for those of limited means. Within the United States specifically, since the Second World War, Americans have increasingly come to expect health insurance from their employers—historically, a consequence of wage restrictions during WWII (Schumann 2003; Starr 1982). As a result, health insurance has become commonplace. Policymakers have accepted this trend, and crafted laws which are designed to make health insurance as widely available as possible. The majority of U.S. citizens with employer-provided health insurance have essentially universal access to mainstream goods and services in the medical field, giving credence to the notion that universal access is the norm. However, in practical terms, this reliance on insurance—specifically, that which is provided by employers and the state—has resulted in a distortion of basic market principles which would otherwise drive down the price of accessing even the latest medical technology. That is, by assuming that healthcare is a basic right, Americans presume that some third party must be responsible for providing it, and therefore fail to seek out cheaper healthcare goods and services of better quality (as they would with other goods and services).

To illustrate this point, consider the following: within the United States, the cost of medical procedures which are routinely covered by health insurance has been rising

precipitously for the past 50 years (Organisation for Economic Co-operation and Development 2011). In contrast, the market price of many procedures which are typically *not* covered by insurance (either private or state-provided, such as Medicare and Medicaid) has been dropping. For example, despite the rapid advancements in laser eye surgery (Laser-Assisted in Situ Keratomileusis or LASIK), such procedures have enjoyed significant overall declines in price since their inception. The same can be said for many types of cosmetic surgery which are rarely covered by any type of insurance (Herrick 2008). Numerous commentators (e.g., Cannon 2009; Gratzer 2006) have observed that this is almost certainly due to the selective operation of market mechanisms; specifically, individuals take the time to shop around when they are paying for a particular medical procedure. In contrast, medical procedures which are covered by insurance operate under a unique set of circumstances, wherein the customer is not the consumer—that is, the entity receiving the service is not responsible for paying it. When a third party insurer (again, either private or public) is responsible for footing the bill, there is no incentive for an individual patient to take price into consideration when making decisions about his or her healthcare.

Such observations regarding the efficiency of markets are unremarkable when viewed in isolation, but they cut to the heart of claims that the high cost of rapidly advancing healthcare technology makes healthcare a unique candidate for rights-based arguments. Ironically, if Americans rejected the notion that a right to healthcare exists and accepted that market forces will inevitably affect the availability of healthcare, the cost of healthcare might be substantially reduced, and greater access to healthcare across classes might increase. If this—greater access to better quality healthcare for more people—is truly our goal, it is worth considering the possibility that rights-based arguments actually do a great deal more harm than good. [3]

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